Institute for Public Policy Research

FROM THE FRONTLINE

EMPOWERING STAFF TO DRIVE THE NHS REFORM AGENDA

Annie Williamson
and **Parth Patel**

November 2024

ABOUT IPPR

IPPR, the Institute for Public Policy Research, is an independent charity working towards a fairer, greener, and more prosperous society. We are researchers, communicators, and policy experts creating tangible progressive change, and turning bold ideas into common sense realities. Working across the UK, IPPR, IPPR North, and IPPR Scotland are deeply connected to the people of our nations and regions, and the issues our communities face.

We have helped shape national conversations and progressive policy change for more than 30 years. From making the early case for the minimum wage and tackling regional inequality, to proposing a windfall tax on energy companies, IPPR's research and policy work has put forward practical solutions for the crises facing society.

IPPR
4th floor,
8 Storey's Gate
London
SW1P 3AY

E: info@ippr.org
www.ippr.org
Registered charity no: 800065 (England and Wales),
SC046557 (Scotland)
This paper was first published in November 2024.

The progressive policy think tank

CONTENTS

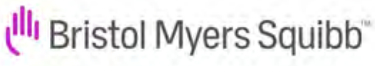
ABOUT THE AUTHORS

Dr Annie Williamson is a research fellow in health and care at IPPR.

Dr Parth Patel is associate director of democracy and politics at IPPR.

ACKNOWLEDGEMENTS

The authors would like to thank Chris Thomas, Joseph Evans, Henry Parkes, Jamie O'Halloran, Abi Hynes, Richard Maclean, Jim Caunter, David Wastell, Liam Evans, Georgia Horsfall, Siva Anandaciva, Diane Coyle, Stephen Duckett, Penny Pereira, Will Warburton, Sebastian Rees, David Vines, Helena Roy, Isabel Lawicka, Marie Gabriel, and Naomi Fulop.



Download
This document is available to download as a free PDF and in other formats at:
http://www.ippr.org/articles/from-the-frontline

Citation
If you are using this document in your own writing, our preferred citation is:
Williamson A and Patel P (2024) *From the frontline: Empowering staff to drive the NHS reform agenda*, IPPR. http://www.ippr.org/articles/from-the-frontline

SUMMARY

England's over-centralised health service is misfiring. That much is clear. Less clear is how to fix it. The return on public investment has weakened since the pandemic; more money is not leading to many more patients being treated overall. At the same time, people in the service are calling it quits, loudly and quietly. The challenge is huge, but decisive solutions are yet to been found.

The Labour government has declared finding these solutions a key priority. In truth, it has little choice in the matter. Voters, especially those who voted for Labour, say fixing the NHS is the most important issue facing the country. In success or in failure, the government will be judged on this task.

That is why the word 'reform' is central to every discussion of the health service. Broad and susceptible to re-interpretation, it has taken on different meanings for different people over recent decades. The introduction of markets and competition; the introduction of centrally set targets; the removal of regional health authorities; the reintroduction of regional health authorities.

In the absence of new ideas, policymakers reach back to old ones. The cyclical history of NHS reform is a near-perfect illustration of this.

This report attempts to break free from that. It puts forward a new approach to 'reform' for the NHS. One that is based on ideas of democracy and decentralisation as the way to achieve better decision-making throughout the NHS.

It argues the twin crises in the NHS – low productivity and poor staff retention – are interlinked and reinforce one another. Staff churn and discontent leads to high costs and holds back care, while widespread workplace inefficiencies drive staff dissatisfaction.

Low autonomy for people working in the health service is the common factor underlying the twin crises. Decision-making in the NHS, from top to bottom, is hamstrung by a lack of key information and insights from clinical staff. It is why decision-makers spend money on locum doctors when what is needed are computers; purchase new software before a discharge co-ordinator; and top up winter crisis funding but not community services to keep people well.

Unlocking the ideas and motivation of NHS staff could energise the reform that the NHS needs in this parliament. That is because while a lack of staff voice may be a common factor to low productivity and low retention – it also points the way to new solutions. We propose ideas to embed more staff voice into decision-making in the NHS, from the level of clinical service design through to national policymaking. We call for three sets of reforms.

1. **Empowering frontline staff** to transform clinical services and drive innovation.
    - Every NHS trust should develop staff insight pathways for service improvement by establishing a permanent trust-level team of improvement specialists. All staff should have time protected to participate in these schemes.
    - Trusts should ensure productivity benefits are shared with staff, such as through time off in lieu or 'earned autonomy' for high-performing clinical service teams.

2. **Organisations that listen and respond to staff** on key decisions, and share what works.
    - Each trust should establish a staff board, parallel to the board of directors, to represent ideas from the wider workforce and consult on all matters affecting staff wellbeing.
    - Every ICS should have an Improvement Team whose responsibilities include improving resource allocation and shared learning across services (such as acute and community care).
    - NHS IMPACT should support frontline teams to share best practice more effectively, by using data to link teams facing similar challenges into 'learning networks'.

3. **Staff voice in setting national workforce policy.**
    - The government should increase staff voice in setting national NHS workforce policy, which could include reforming pay review bodies into tripartite pay review negotiations, or a formal duty to consult staff as in the Scottish Partnership model.

The NHS needs considerable investment, especially to upgrade its capital, infrastructure and technologies. The 2024 autumn budget is a promising step to this end. But not all investment is the same. Without setting the right priorities and purpose, the full benefit of spending is far from guaranteed. Quite the opposite: billions of pounds worth of care rely on rewiring the NHS for success.

That is why staff voice matters. It opens the way to better decision-making across the health service. It is often the people on the shop floor that know best what the shop needs. The same is true for the NHS. Insights from the frontline might just unlock the best of the world's largest health service and restore it to a place where people love to work once more.

1. INTRODUCTION: THE TWIN CRISES IN THE NHS

NHS performance on virtually every measure is at record lows. From being the top-ranked health service in the world under a decade ago, the NHS has fallen behind (Schneider et al 2017). Patients are, on average, waiting longer on elective lists and in A&E corridors than even watered-down interim targets allow (King's Fund 2024a). The UK now ranks worse than comparable countries in terms of access, diagnosis and survival rates for most major conditions. In the decade from 2010, there would have been 240,000 fewer avoidable deaths had the UK matched comparable European countries (Carnall Farrar analysis for IPPR, see Patel et al 2023).

Low productivity is even more evident in its effects on patient experience and public opinion. In 2009, public satisfaction with the NHS in England was at record highs (Darzi 2024). Now, under half of all patients find it easy to contact their GP, and three-quarters of patients with mental illness must turn to emergency services or crisis lines for support while they wait (RCPsych 2022). In 2024, the public largely think of using the NHS as an experience of long delays, confusing processes, and telling the same story to different clinicians again and again (CQC 2024; Healthwatch 2023).

Moreover, this is harming the economy. Almost three million people are out of work due to long-term sickness, particularly concentrated in areas of higher deprivation (Atwell et al 2023). Even as NHS funding per procedure fell across the 2010s, a sicker population and more treatments offered mean that health makes up almost a third of all UK public service spending – up from 21 per cent in 1997 (Gainsbury 2023; Stoye et al 2024).

Meanwhile, the NHS workforce is also suffering. On one hand, there is dissatisfaction with working conditions, from pay to exhausting shift work and a lack of spaces to rest (Unison 2022). On the other, NHS staff are frustrated by providing suboptimal care and shouldering the blame for barriers beyond their control; from printers that don't turn on, to surgeries cancelled because the ceiling has fallen in (Campbell 2024). One in nine people working in the English NHS left on average each year from 2010 to 2023, compared to one in 11 in 2009/10 (NHS Digital 2024a).

For social, economic and political reasons, "building an NHS fit for the future" is a key priority for the Labour government. This report examines how the two main challenges in the English NHS – poor productivity and low retention – might be related as twin crises, and it proposes a new approach to 'reforming' the NHS in the 21st century.

1.1. PERSISTENTLY LOW PRODUCTIVITY

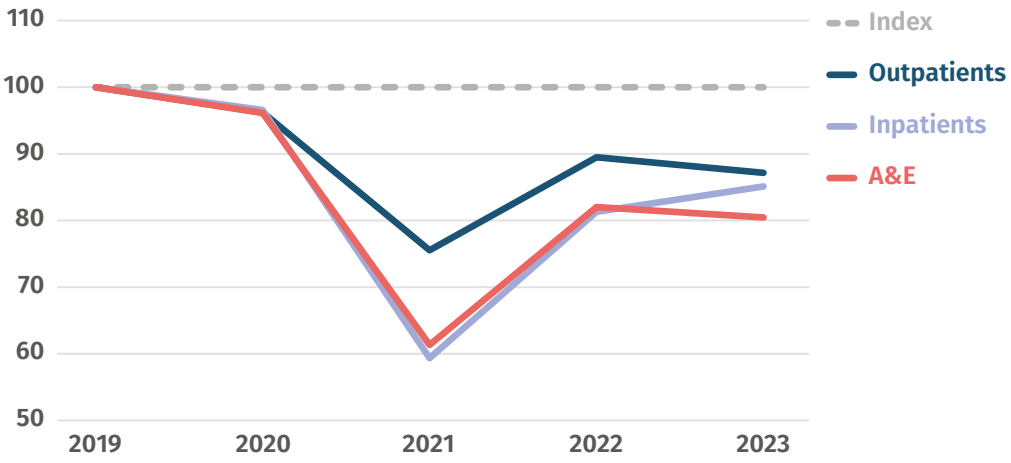
NHS productivity has fallen precipitously since the Covid-19 pandemic. Despite political attention and a recent increase in staff and funding for the health service (although much of this was Covid-related spending), the NHS is barely treating the same number of patients as in 2019 (Warner and Zaranko 2023; Barron and Tether 2024). Productivity is down across inpatient, outpatient and A&E services – with almost 20 per cent fewer patients seen per A&E consultant in 2023, the latest data, than in 2019 (figure 1.1). Even accounting for the rising complexity of health needs, it is clear to patients and staff that there is untapped potential to deliver care

more efficiently. As Azeem Majeed, professor of primary care and public health at Imperial College London, explains, "there is a real problem with productivity in the NHS" (Mahase 2023).

FIGURE 1.1

Productivity has fallen across inpatients, outpatients and A&E

Outpatients seen and completed inpatient stays per consultant (all specialities), and emergency attendances per A&E consultant, each indexed to 2018/19



Source: Author's analysis, NHS Digital 2024a, 2024b

When quantifying healthcare productivity, quality and health outcomes matters just as much as the number of people treated. This is more difficult to capture, but measures exist that incorporate indicators of quality - such as time waited for care, or avoidable emergency readmissions. NHS England estimates find that when compared to 2019/20, quality-adjusted productivity was 11 per cent lower in 2023/24 (Kelly 2024).

The total NHS budget for 2023/24 was £171 billion (OBR 2024). Because the NHS was delivering 11 per cent less than pre-pandemic, this means £19 billion worth of additional care could've been delivered in that year alone if productivity had matched 2019/20. Improved efficiency then opens a wide range of options – the NHS could treat more people with the same budget or invest in other services, and these productivity opportunities accrue every year going forward. **In 2023/24 alone, these savings would've been enough to build 900 new health centres** (authors' analysis, applying HMT 2024a estimates). Given there are 1,250 primary care networks in England, some with health centres already, these unlocked funds would've been almost enough to deliver the Neighbourhood NHS in one year alone.

What's more, our 'baseline' scenario of 2019/20 was not an NHS firing on all cylinders, but one already under serious pressure (NHS Confederation 2023a). There could be further untapped value if the NHS becomes even more productive than previously achieved.

The new Labour government have now announced a major uplift to NHS spending in the 2024 autumn budget, taking the planned daily expenditure budget to £192 billion (OBR 2024). As health secretary Wes Streeting said, "I owe it to taxpayers that their money is well spent." Yet this is far from guaranteed. Turning up the dial on productivity will be crucial to ensuring maximum benefit for patients. The NHS have been tasked with delivering 2 per cent productivity growth per year. Meeting this target would be worth an additional £3.8 billion worth of care in 2025/26 alone.

This sum could more than triple the number of CT and MRI scanners in the NHS (authors' analysis, applying HMT 2024b estimates).

Resource use provides different indicators of poor productivity, for instance surgical theatre time spent operating on patients. One NHS trust found that surgeons only spent 51 per cent of the working day actually operating on patients at a major trauma centre, and just 46 per cent at an elective centre (Kirk et al 2024). Getting It Right First Time (GIRFT), the national elective recovery programme, supports providers to improve in-theatre efficiency, but they highlight barriers throughout the elective journey that hold up high-quality care (GIRFT 2024).

Many patients have their own experience of delays – from being sent to the wrong location for a scan to waiting in a corridor for an operation that gets cancelled, or discharges being held up by missing paperwork. Persistently low productivity is not just a statistic; it takes a human toll.

Every pound spent should help patients – yet a third of all healthcare is estimated to be of low value, duplicated or wasteful, and the NHS is no exception (OECD 2017). Government healthcare spending in England was 9 per cent of GDP last year, and the UK overall spend on health (across government and the population) is almost exactly equal to the EU and G7 average (King's Fund 2024a). However, analysis by Lane, Clarke and Peacock projects this will exceed 11 per cent by 2033 if the nation's health and NHS productivity continue to stagnate (see Patel et al 2023). The difference between this path and an alternative trajectory which delivers 0.5 per cent higher productivity growth is estimated to equal £17 billion per year by 2033/34.

1.2. DEMOTIVATED AND DEPARTING STAFF

Alongside poor productivity, the NHS is plagued by a second crisis: staff frustration and departure. From 2010 to 2023, the average NHS leaver rate was 11.2 per cent – one in nine staff per year (NHS Digital 2024a). This is higher than the NHS in Scotland (9.4 per cent in 2023), or other sectors in England such as teaching (9.6 per cent in 2023) (NHS Education for Scotland 2023; DfE 2023). It also stands in stark contrast to the same data for 2009/10 when the NHS leaver rate was 9.5 per cent – a low never since reached (NHS Digital 2024a).

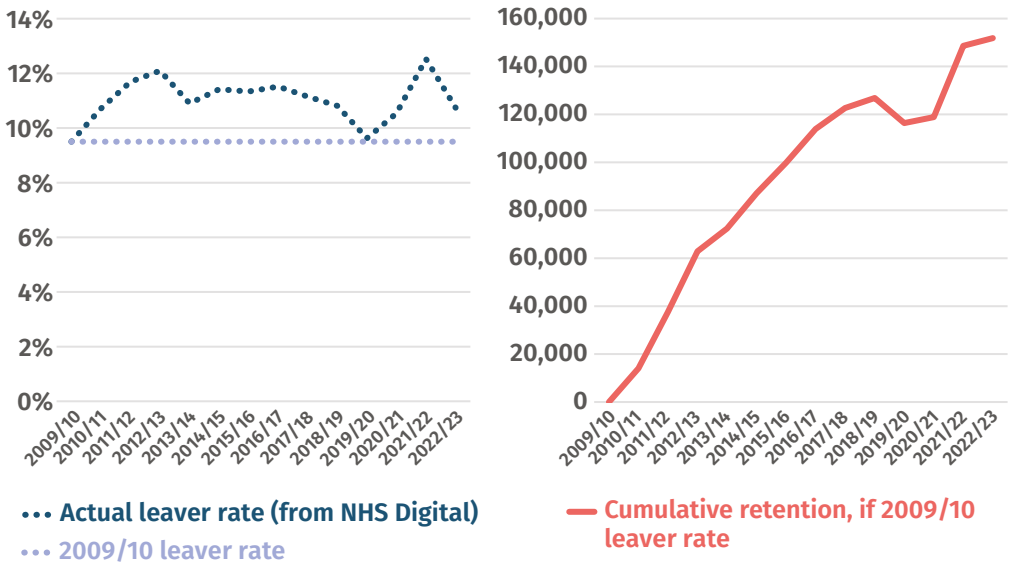
Using this historical precedent, we estimate the potential impact if this level had been maintained. Maintaining a leaver rate of 9.5 per cent between 2010 to 2023 could have meant an average of 12,000 staff retained each year (figure 1.2). If the leaver rate had held steady at 9.5 per cent while maintaining entrants at the same level, this would equate to around 150,000 additional staff retained cumulatively. This would meet half the staffing shortfall expected by 2036/37, simply by retaining existing staff (Holden 2023).[1]

1 It is possible that change over recent decades may mean that the historical low leaver rate could not be maintained even with better policies. The Covid-19 crisis, and overall population ageing, are two factors to consider. First, Covid-19 and its aftermath did correlate with an increase in leaver rates. However, the leaver rate had already often been above 11 per cent prior to 2019, suggesting that the pandemic was not the only key driver. Moreover, burnout rates during Covid-19 vary widely across countries, suggesting that even if some spike in departures is unavoidable in a pandemic, the scale and duration of this increase depends heavily on retention policies (Wright et al 2022).Second, in terms of workforce ageing, UK comparisons suggest retirement is unlikely to be the main driver. Additional departures have not primarily occurred among older staff – among nurses in 2022, younger age brackets saw the largest increase in leavers, and two-thirds of leavers were younger than 45 (Holmes 2022). The Scottish NHS consistently saw leaver rates of 5.2 per cent to 6.6 per cent from 2013 to 2021 (increasing to 9.4 per cent in 2023, still below 2009/10 in the English NHS), despite Scotland ageing faster than England (NHS Education for Scotland 2023; Scottish Government 2010).

FIGURE 1.2

Leaver rates persistently exceed historic lows, with 150,000 excess departures

NHS leaver rates and cumulative retention, actual compared to 2009/10 counterfactual



Authors' analysis of leaver rates Sept–Sept, NHS Digital 2024a

The retention problem also affects the quality and experience of staff working in the NHS. The share of NHS staff in their current post for less than a year has doubled since 2015 (Rolewicz 2024). High turnover among senior clinicians, such as senior nurses and midwives, mean a higher proportion of the workforce are new to their career or new to their workplace.

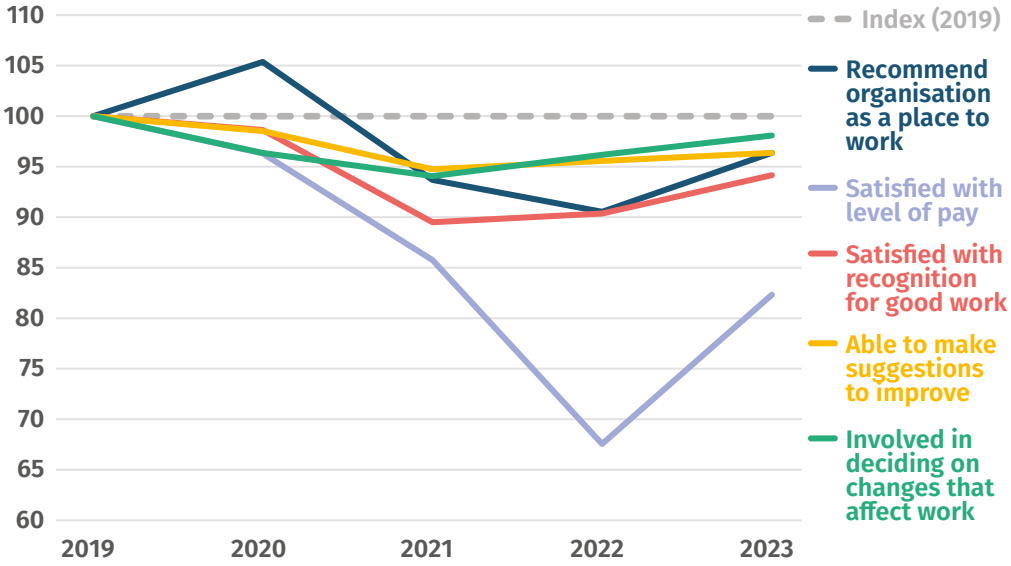
Just as poor productivity harms everyone who relies on the NHS, staff turnover brings risks for all involved. A recent study found one fewer nurse on shift increased the chance of patient death by almost 10 per cent, with absence of senior nurses affecting patient safety even more (Zaranko et al 2023).

Crucially, the staff retention crisis is symptomatic of diminished staff wellbeing itself. Off the back of the exhaustion of the pandemic, many staff continue to feel overworked and undervalued. The latest NHS Staff Survey reveals that despite extensive efforts, staff still feel worse than before the pandemic on key issues including autonomy, pay and recognition (figure 1.3). Even after nursing strikes were resolved with a pay deal in 2023 (while doctors' strikes continued), the proportion of overall staff satisfied with their pay was almost 20 per cent lower than in 2019 – and comparisons between staff groups may have caused tensions to develop.

FIGURE 1.3

NHS staff satisfaction remains worse than pre-pandemic on key measures

% of staff responding 'agree' or 'strongly agree' for key indicators of satisfaction and autonomy from 2019 to 2023, each indexed to score for that indicator in 2019



Authors' analysis of NHS Staff Survey, NHS 2024

There are broadly speaking two options for workers faced with worsening circumstances: voice – either through negotiation or protest – or exit (Hirschman 1970; Dowding and John 2012). The NHS shows evidence of both. Recent industrial action among nurses, doctors and allied health professionals reached unprecedented levels, including the first ever strikes led by the Royal College of Nursing, the first among physiotherapists, and the longest ever doctors' strikes across consultants and resident doctors. At the same time, staff departures have remained high, with significant numbers leaving the health service for other sectors or other countries.

1.3. THE LINK BETWEEN POOR PRODUCTIVITY AND RETENTION

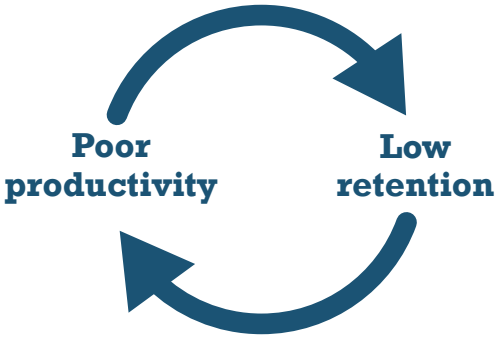
The NHS now seems stuck in these twin crises of underperforming services and demotivated staff. Every year brings new productivity drives and targets, and efforts to value and engage with frontline staff are widespread and well intentioned, yet both crises persist overall.[2]

This report argues that these two crises are related, with one exacerbating the other (figure 1.4).

2 Most significantly, the NHS People Plan was developed in late 2020, and endorses practical actions to "look after our people", including psychological support and rest spaces at work (NHS People Plan 2020). There are also a range of effective programmes at local level, such as East London NHS Foundation Trust's data-led approach to staff benefits and a proactive improvement culture (NHS Employers 2019; IHI 2024).

FIGURE 1.4

The link between productivity and retention



Source: Authors' analysis

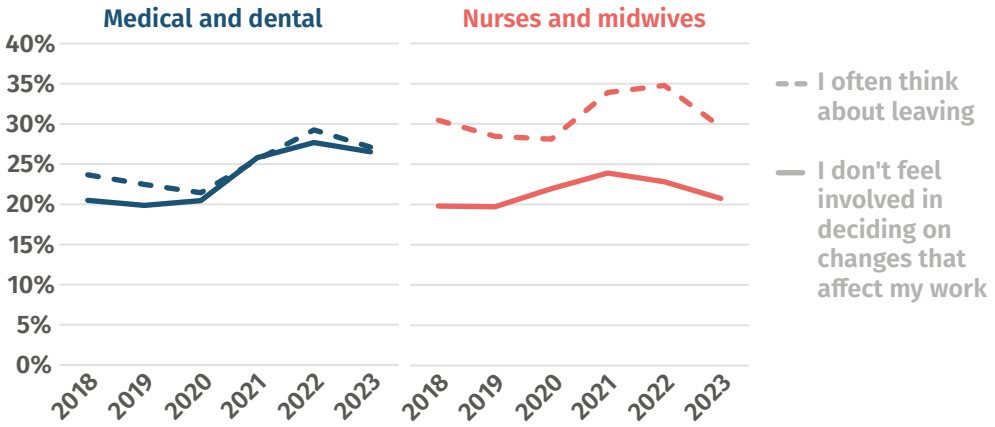
On one hand, staff departures undermine productivity and quality of care. It costs up to £12,000 to replace a fully trained nurse, while fully training a new consultant doctor may exceed £300,000 (NHS SBS 2023; BMA 2024). The loss of experience and institutional wisdom adds further to the cost of 'staff churn', as new staff take time to hire and train, and are less productive initially (Freedman and Wolf 2023).

On the other hand, frustration and burnout are worsened when staff feel unable to deliver effective and efficient care for patients. We find that the proportion of doctors and dentists reporting "low involvement in deciding on changes at work" has risen by over a quarter in the past five years, tracking closely with the rise in those thinking of leaving the NHS (figure 1.5). Similar patterns are observed across the workforce, with the strongest correlations seen in major patient-facing staff groups: medical and dental, nurses and midwives.[3] It is important never to confuse correlation for causation, but qualitative evidence also points to the moral distress of not being able to provide sufficient quality of care as a key factor in career planning (BMA 2021).

FIGURE 1.5

Feeling low autonomy and having thoughts of leaving are closely intertwined

% responding 'agree' or 'strongly agree' to questions on low autonomy and thinking of leaving, by NHS staff group



Authors' analysis of NHS Staff Survey, NHS 2024

3 We find a strong correlation across the NHS between self-reported lack of autonomy and thinking of leaving (R2= 0.36), with a particularly notable relationship for medical and dental staff (R2= 0.88) and nurses and midwives (R2= 0.51).

Over the past 14 years, the twin crises have persisted and even entrenched despite extensive recent efforts. The impacts are brought into sharp relief by the recent Darzi review, and firsthand accounts across the NHS (Darzi 2024). It is time that policymakers working to 'reform' the NHS consider a different approach.

BOX 1.1 METHODOLOGY

We began with the impetus of the IPPR Commission on Health and Prosperity, which sets out the clear health and economic case for a proactive NHS as part of an effective health creation service (Thomas et al 2024).

For this report, we then undertook extensive research across NHS hospitals, general practices, trusts and integrated care systems (ICSs), as well as detailed interviews and roundtables with more than 25 frontline clinicians, NHS leaders, academics and policy experts from the UK, Australia and Canada. These interviews informed the hypothesis that staff voice is a key, undervalued component in policies to support productivity and retention. We then tested and refined a set of policy proposals with these same experts, developing six feasible and high-impact recommendations based on the strongest evidence and frontline experience.

2. MISSING A PIECE OF THE PUZZLE

Many people have puzzled over the productivity crisis facing the NHS. There are three current leading explanations described by NHS leaders and supported by detailed analysis from a range of research organisations. Each has value in understanding the problems holding back better performance and quality of care.

- **Workforce and management numbers:** the NHS relies on millions of skilled staff who embody the care it offers, so staff and skills shortages have left services 'stretched to the limit', especially in key areas from community health to radiology (NHS Providers 2023a).
  Although the NHS workforce has increased, important roles have been missed. One key group is managers, following a 17.5 per cent cut in management over the early 2010s (King's Fund 2015). England lags comparable nations in number of healthcare managers, meaning reduced capacity to support frontline staff and drive improvement (Nosheen 2024; Thomas 2024).
- **Underinvestment and capital starvation:** during a decade of austerity, NHS spending "virtually flatlined" relative to population – and was diverted away from repairs, buildings and technology that equip health services for the future (NHS Providers 2023b; Darzi 2024). NHS productivity initially appeared more positive at this time, with growth exceeding other public services and the wider economy (Kelly 2024). Yet this concealed the harms of underinvestment (Coyle 2023). Austerity-era 'improvements' came from tight budgets and delayed capital investment. From 2010 to 2019, the UK spent 55 per cent less on healthcare capital as a share of GDP than the EU14 average, equating to a £33 billion shortfall (Rebolledo and Charlesworth 2022). In the short term, the NHS struggled to 'do more with less', but this drove exhaustion and a backlog of inefficiency. Almost half of all English NHS hospitals have closed wards or services due to maintenance issues since 2020, directly hampering productivity (Hewitt 2023).
- **Technology:** innovation and digital technology promise faster, better and more integrated care, from mobile stroke units treating blood clots on the road to AI-supported triage in GPs (Hume 2020; Health Innovation Yorkshire & Humber 2023; Refsum et al 2024). Yet as clinicians and experts make clear, most of the NHS is far from this frontier (Darzi 2024). The NHS in England has fewer CTs and MRIs than almost any comparable country, while many hospitals still use pagers, and "the NHS is still in the foothills of digital transformation" (Kelly and Tallack 2024).

Other people have been scratching their heads on retention, focusing on two key drivers. Staff groups like the BMA and the Royal College of Nursing highlight pay as an immediate source of discontent and departure, following over a decade of real-terms pay cuts prior to 2023 and widening pay differentials between the English NHS and similar jobs abroad (BMA 2024; Church 2024). Employers and researchers, meanwhile, emphasise the importance of organisational values and culture as a key determinant of staff morale. This view is based on evidence of the importance of compassionate leadership and mutual respect for wellbeing and retention (West 2021; Wang 2024). This thinking has informed the development of the NHS People

Plan and a range of local initiatives to create a "compassionate and inclusive culture" (NHS Employers 2022).

2.1. NECESSARY BUT NOT SUFFICIENT?

Each of these explanations offers an important diagnosis of one or more problems holding back the health service. The NHS doubtless requires a stronger and more flexible workforce with the right skillset to deliver; rapid repair of the capital backlog alongside investment in future innovation; and a sustainable commitment to ensure staff are paid and valued highly.

Yet if we followed these prescriptions, would that be sufficient to restore the NHS to its best? Our view is that it would not.

Staffing

First, it is notable that low productivity has persisted, even since the NHS has hired more staff (Freedman and Wolf 2023). Even focusing on specific staff groups, NHS-wide evidence reveals that simply hiring more managers has no consistent positive effect on hospital performance; the added benefit comes from manager quality rather than numbers alone (Asaria et al 2021).

This prompts a further question: how do we motivate high-quality staff to stay in post and retain their expertise? Just as pouring in water won't fix a leaky bucket, staffing levels and experience looks to be a key part of the problem – but more staff has not sufficed to solve the crisis.

Capital

Second, evidence shows that although restoring investment is key, this alone cannot ensure that productivity will naturally improve. While some NHS spending delivers huge benefit, other outlays have led to extra spending without the health return intended. One study found that in the early years of foundation trusts (FTs), they spent significantly more on capital inputs than non-FTs but achieved no consistent increase in productivity (Castelli et al 2015). Similar findings are evident for non-capital investment: an NHS-wide study of investment in chronic disease and emergency care found *no* evidence of an overall reduction in emergency admissions linked to additional local spending (O'Cathain et al 2015). Put simply, investment is only helpful if we know how to spend it wisely, and if we've empowered the right people to be making those spending decisions.

Technology

Third, as with physical capital, investment in technology is a necessary bedrock on which to build a better NHS. Yet it is also not a complete solution, without a mechanism to prioritise between promising options. While many innovations improve care, some have been wasteful, such as the National Programme for IT abandoned at a cost of over £10 billion (Syal 2013). Political and market incentives skew towards 'breakthroughs' and high markups, which risks widening inequalities and leaving behind those who need simple improvements most (Acemoglu 2023). Cancer specialists, for instance, bemoan excess focus on technologies 'hyped as magic bullets', like AI for administration and treatment, while many centres lack scanners to diagnose in the first place (Aggarwal et al 2024).

Moreover, technology can generate its own demand. Digitisation and pharmaceuticals bring the hope of better outcomes but may also permanently raise expectations of service delivery. From remote consultations to new injectable obesity drugs, many innovations have led to a rise in overall health demand and staff expectations (Castle-Clarke 2018; Ochi and Roughley 2024). In some cases, these innovations are worth the cost – in others, novel treatments may not bring real value. This highlights the importance of frontline staff insights, for example

when expert clinicians rightly contribute to assessments of new dementia drugs that currently lack "high-quality evidence of clinically meaningful impacts at an affordable cost" (Scott 2024).

Pay and conditions

Lastly, although recent strikes have focused on pay, staff say their frustration is equally driven by working hours, conditions and lack of support (IPPR/YouGov, Patel and Thomas 2021). The NHS workforce has risen to meet many challenges but has become demotivated in a way that pay alone can't fix. Equally, organisational culture is clearly correlated with staff wellbeing and retention – but it is far easier to describe the culture of a major organisation than to change it through strategy announcements or staff networks. Without true empowerment and input to decisions that affect the day-to-day wellbeing of the frontline, "this can be felt as 'lip service' without any clear value to staff" (University Hospitals Birmingham NHS 2023).

Even taken together, the current leading explanations may not be sufficient to unlock actual *improvements* in health services – those that lead to a more productive, more motivated NHS.

BOX 2.1 POLITICAL TARGETS AND TRANSFORMATION: WHY WHAT WORKED BEFORE ISN'T ENOUGH

Many point to the health successes of New Labour, who combined record investment with top-down targets and internal competition to deliver world-leading care and productivity growth over 2 per cent (Schneider et al 2017). This showed high productivity is possible in a public health service. However, this previous approach relied on major spending and ongoing political capital, neither of which could be sustained when the 2008 financial crisis hit. Even before then, productivity had plateaued by 2007, suggesting 'extrinsic' motivation may have run out of road – replaced by "a slightly tired, perhaps even complacent sense of having 'been there, done that'" (Blythe and Ross 2022). The top-down approach was also criticised for demotivating staff, failing to account for local knowledge, and prioritising targets above overall care (Quilter-Pinner and Khan 2023).

Even if huge additional spending and targets worked once, this route to health service productivity is no longer a likely option politically. The NHS now faces a triple challenge that demands a new approach. Compared to 1997, far more precarious public finances constrain spending increases (Emmerson et al 2024). Demographics mean health demand is higher than ever before – and with ever-growing health complexity, targets may be less suitable (King's Fund 2024b). Finally, staff and services have been stretched to the limit to keep patients safe through austerity and an unprecedented pandemic (BMA 2021). The NHS needs new ideas for how to operate better in the context of 21st-century constraints and opportunities, working more creatively and effectively for patients and staff alike.

2.2. INFORMATION AND DECISIONS: THE MISSING PIECE OF THE PUZZLE?

To identify the missing piece of the puzzle for productivity and retention, we start with what is preventing better decisions in the NHS. Three constraints hamper planning and delivery, when compared to leading health systems abroad. These counteract the equally distinctive promise of the NHS – a vision of high-quality healthcare free at the point of use for all.

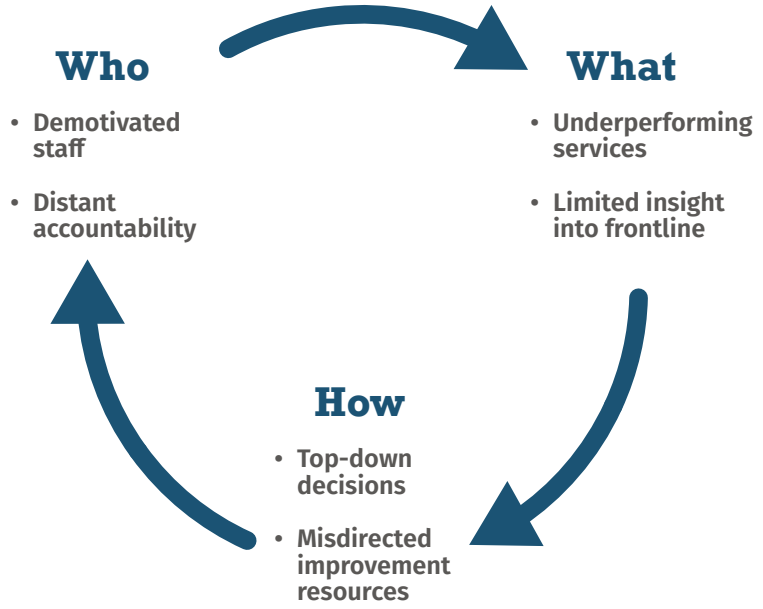
- **Poorly informed:** the NHS is the largest single health system in the world, made up of thousands of different units (NHS 2020). However, limitations in management, data and technology lead to 'information asymmetries' and a lack of local understanding (Coyle and Manley 2023; Stein 2024). Decision-makers lack access to the real-time information held on the frontline about what is going wrong and what is needed to improve (Keith et al 2022).
- **Over-centralised:** the NHS is highly centralised, and despite the rollout of ICSs, funding priorities and accountability still sit with the centre. This is especially true when things go wrong – the media and national regulators expect leaders to wrest back control. As Clive Smee, former chief economic advisor to the Department of Health, explained, it is "difficult to reconcile devolved accountability with the demand for detailed monitoring … the centre is drawn into a whole range of issues" (Smee 2005). Yet this can impair prioritisation and delivery, especially for urgent issues. The national Test and Trace programme faltered due to a lack of relationships with local authorities, while thousands of staff stood underutilised in a remote call centre (Ham 2020). Conversely, the Covid vaccine rollout succeeded through delegation to local clinicians and managers (Charles and Ewbank 2021).
- **Lacking ownership:** staff buy-in is low due to top-down decisions and distant, limited management. Staff are often blocked from directly addressing inefficiencies due to lack of time, limited incentives and unstable organisational structures (de Silva 2015). From infinite paperwork to establish a pre-operative reminder text service, to a change-averse attitude to improving rota design, those with good intentions are rarely supported in making effective change tailored to their local setting. "Ask a clinician about waste in their service … you will see them light up with ideas on ways to improve how services are run" (Anandaciva 2024). Yet only 56 per cent of staff report feeling able to make improvements happen at work (NHS 2024).

Together, these factors create a vicious cycle of poor decision-making (figure 2.1), with negative impacts on the following.

- **Who** is empowered and motivated to lead change.
- **What** local, regional and national leaders understand, and what services look like.
- **How** change is pursued and priorities chosen.

FIGURE 2.1

A vicious cycle of poor NHS decision-making



Source: Authors' analysis

2.3. STAFF VOICE: UNTAPPED SOLUTIONS FOR THE TWIN CRISES

The NHS needs new solutions to tackle the two related long-standing problems of low productivity and retention. The government has tried haphazard cycles of austerity and spending, which fail to deliver better services or health outcomes in the long run. Frustrated staff are no longer willing to wait for long-promised improvements, especially when these efforts feel distant from the challenges they face every day on the frontline.

Prior to austerity, the political target-setting of New Labour had run out of road, especially once funding increases plateaued. Political vision is, without question, essential to improve the NHS. Yet the answers to frontline inefficiencies and demotivated staff lie within the system, not above it – especially in a service already under pressure. Attempts to apply performance targets since 2010 have underdelivered and 'run the system hot' to the point of exhaustion (NHS Confederation 2023a).

Instead, a different approach is needed – one that combines technical solutions with human insight. Such an approach recognises that staff behaviours and institutional practices matter just as much as equipment and tools (Marjanovic et al 2020).

This report makes the case that poor productivity and low retention are underpinned by a shared failing: lack of staff voice when making decisions.

'Staff voice' here refers to both the power to speak (frontline autonomy to shape better services) and organisations that listen (higher-level decision-makers who consult the workforce on issues that matter most).

Information is held on the frontline about how to improve services, but this rarely reaches those with power and accountability to drive change. To take just one example, Bolton Hospital found that a blood test involved 309 steps, including blockages and unnecessary processes, yet no single individual held oversight or accountability (Jones and Mitchell 2006). Careful redesign allowed this process

to be reduced by 80 per cent. Yet similar inefficiencies are too often unseen by leaders with power, and remain unresolvable for those frustrated every day.

Meanwhile, frontline priorities for staff too often go unheard by leaders with responsibility for their wellbeing. Most staff have very little say over their working conditions, or how their workplace is set up to deliver the best care for patients.

This is a fundamental problem. Without the insights and understanding held on the frontline, NHS leaders cannot know where to prioritise spending limited resources. And without a meaningful voice on top priority issues, staff are not only demotivated but disempowered – with many leaving the NHS or the country entirely.

If staff voice is a common factor worsening both poor productivity and low retention, this also points the way to new solutions to both crises. Each of the leading explanations – staffing, capital and technology – are crucial to understanding the challenges holding back the NHS. Yet even if delivered together, they would not be enough to solve these crises. Frontline insights offer an under-considered source of new solutions, more closely informed by patient priorities, and can support better prioritisation of spending on staff, investment and technology alike.

To drive productivity, improve wellbeing and unlock the best of the NHS, we call for a new focus on this missing piece of the puzzle: frontline insights for better decisions (figure 2.2).

FIGURE 2.2

A positive alternative for NHS decisions

Source: Authors' analysis

This requires steps to:

- improve information flows from the frontline to decision-makers with power
- align decision-makers' incentives to use this information for better services
- recognise and remotivate staff by listening to their priorities in decisions at every level.

True improvement demands a major shift in approach: **from inefficiency to insight**.

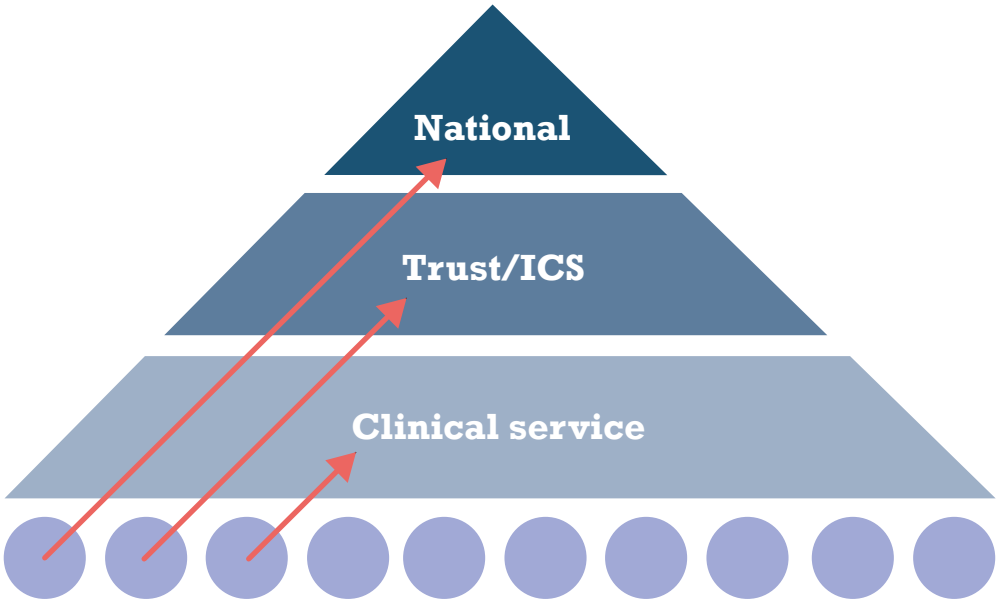
3. UNLOCKING THE BEST OF THE NHS: FROM INEFFICIENCY TO INSIGHT

Making good decisions about the running of an organisation can be challenging, even in the simplest of circumstances. In its current state, the NHS will struggle to transform organically, given its current rigidity and low levels of autonomy. To deliver on the promise of staff voice, concerted effort is needed to build channels for insight throughout the NHS.

This final chapter asks what policies could help to unlock this missing piece of the productivity and retention puzzles. We set out policy proposals for three levels of the NHS: clinical services, trusts and integrated care systems (ICSs), and national-level decisions.

FIGURE 3.1

A three-level reform agenda to bring staff voice to the heart of NHS decisions



Source: Authors' analysis

We call for reforms at each level to deliver the shift from inefficiency to insight:

1. **Empowering frontline staff** to transform clinical services and drive innovation.
2. **Organisations that respond** to staff views on key decisions, then truly share what works.
3. **Staff voice in setting national workforce policy** through reform to pay review process.

Together, these changes form a ladder of insight – staff voice at every level to unlock the best of the NHS. With the right structures, the NHS can break out of its twin crises by learning what information the frontline holds, empowering those who are best placed for good decisions, and sharing the benefits in a way that supports continuous improvement.

We note that centring patient voice is a similar principle to unlocking staff insights, with many potential benefits. This lies outside the scope of this report but is an equally important consideration. Better patient and public engagement are key recommendations of IPPR's Commission on Health and Prosperity, and a range of wider work on NHS accountability, shared decision-making and improving care (Patel et al 2023; Healthwatch 2019; NHS Confederation 2023b).

3.1. EMPOWERING FRONTLINE STAFF

Every frontline NHS professional can describe a long list of frustrations that waste their time, hold up patient care, and stand in the way of well-functioning clinical services. Here, 'clinical services' refer to local pathways that diagnose and treat a condition, such as the gallstones pathway run by a surgical department, or the knee injury pathway run by a community rehabilitation team.

Examples of wasted time in frontline clinical services are endless: copying out paper notes; walking across the hospital for equipment; waiting for discharge papers to print; phoning around wards to find out how many beds were free (NHS 2017). A national survey estimated that over a third of nurses spend at least an hour per shift finding equipment like pumps or drip stands – as one nurse said, "some days it feels like I spend all day looking for things" (Nursing Times 2009). Little has changed since this study over a decade ago; overall NHS productivity is no higher in the latest data than in 2009 (King's Fund 2024b).

This waste of time and resources affects everyone involved. Patient priorities and perspectives are not reflected in services, and care can be delayed or even harmed as a result. Any patient who has had a procedure cancelled due to missing laboratory tests, or who has spent hours in a waiting room observing the chaos, can speak to this reality. Forty-five per cent of nursing managers polled felt that time wasted on bureaucracy was impacting service users' health, and 6 per cent said it had cost lives (Nursing Notes 2023). Yet inefficiencies persist, and it has proven difficult to implement effective improvements at scale.

Frontline staff equally bear the brunt of wasted time and effort. An international review of health workers in the UK, US and France highlights the impact of short staffing and inappropriate service models on staff wellbeing: "clinicians are increasingly exposed to avoidable moral conflicts engendered by organisational decisions … that compromise care in various ways" (Dean et al 2024). And the Carter Review of hospital productivity found "unwarranted variation" explains 9 per cent of total annual spend – money that could be saved by sharing best practice, not to mention new improvements (Carter 2015).

Voiceless staff means ideas go unheard

Staff who face frustrations every day often have ready answers for how to improve services. A hospital porter walking endless flights of stairs and seeing surgeries delayed due to "a lift with bespoke parts that keep breaking" (Anandaciva 2024) can offer a personally informed view on priorities for capital repair. Yet the fact that only 56 per cent of staff report feeling able to make improvements happen means almost half the NHS frontline holds untapped ideas (NHS 2024).

Crucial knowledge is spread across thousands of clinical services, and these ideas too often go unheard. As one service lead explains: "staff feel far less ownership

and ability to improve services in their patch than a decade ago." The causes of this lost insight are twofold.

1. **Voicelessness:** often staff don't know who to speak to when problems arise, and express doubts that they would be heard. Just 50 per cent of staff felt confident that their organisation would address a concern if they spoke up about something (NHS 2024). Local leaders being empowered to act on ideas was a key determinant of the success of ward-level improvement initiatives across 13 NHS hospitals (Morrow et al 2014)
2. **Staying silent:** even when staff are formally empowered to make changes, many do not speak up or act on this agency. Staff describe insufficient time and resources to think about or implement ideas, especially after the pandemic and in overstretched services like community health that may need improvements most (de Silva 2015). Three further barriers afflict the NHS more so than other countries: limited improvement experience among staff; fewer incentives to improve; and unstable organisational structures (ibid).

BOX 3.1 WHY NOT DEVOLVE ALL DECISION-MAKING TO FRONTLINE CLINICAL STAFF?

It may seem that a logical implication of centring staff voice would be to shift all decisions to the lowest possible level, decentralising power to the frontline. Yet this risks new challenges.

1. Staff empowerment must be aligned with accountability. At the end of the day, someone with overall vision must be responsible for decisions made – especially if it involves money, facilities and patient outcomes. The NHS needs more, not less, clarity around who is responsible for making decisions and delivering improvements. However, this requires a high level of transparency when deciding priorities and trade-offs, so staff can understand leaders' reasoning and feel that processes are fair even when they don't agree (Magnavita et al 2022).
2. Devolving every decision would also place excess burden on the frontline. Surgeons and theatre nurses may know firsthand what is going wrong in their hernia pathway, but this is not the same as running the service – from ordering scalpels to theatre deep-cleans. Leaders and managers who listen to the frontline may be better placed to help perform at their best, without shifting full responsibility for management.

The potential to transform services

Existing approaches have proven insufficient, and we do not want to shift the entire burden of decision-making to the frontline. Instead, policymakers should seek to pioneer and embed new structures to bring insights from the frontline up to local leaders and managers with the skills, resources and incentives to listen and act on these ideas.

This case for listening to frontline insights isn't unique to the NHS. In fact, what sets our health service apart is how far we are from insight-based structures for decision-making. In other sectors, from car manufacturing to air travel, organisations have transformed underperformance into productive excellence.

Looking to these other sectors has led to a range of promising approaches. 'Lean management' is one influential model in which organisation-wide structures learn from the shop floor (Teich and Faddoul 2013). First pioneered by the Toyota Motor Corporation, this system focuses on *Kaizen* ('continuous improvement') and careful

end-to-end planning to reduce waste (Weber 2006). Staff are incentivised to halt production if they see an issue or inefficiency to resolve, with ideas applied within days. Toyota also invested extensively in skills training so frontline staff felt valued and bought in to the improvement process. This insight-led approach took the company from struggling for survival in 1945 to become the world's largest car company in 2008.[4]

Unsurprisingly, NHS trusts that follow these principles and genuinely engage staff do achieve better results. There is a strong positive correlation between staff engagement, particularly whether staff would recommend the NHS trust they work for, and the CQC rating for that trust (Ham 2014; Behan 2015).

Lean and similar models have been applied in many health settings (see case study 3.1). Cross-sectional evidence across hospitals finds that, on average, lean implementation contributes to superior performance (Narayanan et al 2022). Other promising models include the Leeds Improvement Method (Meacock et al 2021), the IHI Triple Aim which also includes population health improvement (IHI 2024), and Virginia Mason's 'continuous improvement' (VMI) model which saw the Seattle-based health service rise to the top 1 per cent of hospitals on quality and cost, and increased nursing time with patients from 33 per cent to 90 per cent (Kenney 2010).

CASE STUDY 3.1 INTERMOUNTAIN HEALTHCARE ADVANCED TRAINING PROGRAM, UNITED STATES

Intermountain Healthcare is a non-profit network of 385 clinics, 33 hospitals, and more than 60,000 staff covering four western US states. Since 1992, the Advanced Training Program in Clinical Quality Improvement has a two-pronged focus on continuous improvement and staff involvement in technological innovation.

This provides dedicated training to all staff, alongside a well-established system to curate, escalate and test staff ideas based on lean and other methodologies. Frontline leaders then are supported by a small permanent team of improvement experts to innovate, evaluate success and iterate improvements.

Outcomes

- improved care, including a 60 per cent reduction in patient time on ventilators
- financial savings: $5.5 million saved per year by identifying and reducing resource overuse, and $50 million saved by averting unnecessary labour induction and C-sections
- successful technology integration: staff engagement led to early adoption of telehealth remote monitoring in Covid-19, and reduced time spent on electronic health records by 45 per cent over five weeks.

Source: Economist Impact 2022

Nonetheless, despite these compelling case studies, real-world implementation has seen mixed successes and limited durability (Schonberger 2007). The NHS is no stranger to improvement initiatives, and many show promise but a lack of sustained success (see box 3.2).

4 See: https://www.toyota-global.com/company/history_of_toyota/75years/data/automotive_business/production/production/overview/index.html

BOX 3.2 LEARNING FROM THE PAST: PREVIOUS EFFORTS TO DRIVE NHS IMPROVEMENT

The NHS has seen a wide range of policy interventions to drive innovation and improve care. While some of these delivered benefits, independent reviews also criticised the lack of a coherent and sustained approach (Ham et al 2016). A selection of policies include:

- **NHS Modernisation Agency (2001–2005):** a national agency to support NHS organisations and improvement networks, growing rapidly to reach 800 staff in two years. This growth led to national centralisation, in place of local leadership. The agency then developed into a smaller national body, the NHS Institute for Innovation and Improvement, driving initiatives like 'productive wards'. However, they struggled to establish credibility as a source of expertise (Ham et al 2016; DHSC 2021).
- **Financial incentives:** New Labour sought to bring internal competition into the NHS including payment-based incentives such as Commissioning for Quality and Innovation (CQUIN). Evidence suggests this led to modest short-term improvements in productivity, although it also created some risk of 'gaming' depending on design (Meacock et al 2014; King's Fund 2024a). When seeking to drive innovative improvement rather than just delivery against targets, NHS reviews and academics concur that "reliance on inspection is too costly, too weak and inimical to dynamic change", and intrinsic motivation is also key (Ham et al 2016; Orsini 2013). Mandatory CQUIN was paused in 2023 (NHS 2023).
- **GIRFT (2015–):** a clinician-led programme using national data and trust 'deep dives' to identify and reduce unwanted variation across 40 specialties. One evaluation found benefits include improved orthopaedic practices and shorter patient length of stay, though cost savings were offset by the cost of visits (Barratt et al 2022). Others found that the clinical and technical focus can struggle to ensure system-wide buy-in and managers' engagement (Timmins 2017)
- **Innovation ideas from outside the NHS:** NHS organisations have piloted ideas including lean management for several years (NHS Improvement 2017). Some achieve success, such as the Leeds Improvement Method reducing neurosurgical cancellations up to 90 per cent (Meacock et al 2021). However, an assessment of less successful trusts found that improvement ideas risk being "initially championed, later diluted, and ultimately eroded" if lacking ongoing support, evidence of impacts and shared benefits (McCann et al 2015).
- **NHS IMPACT (2023–):** NHS England now leads a new national improvement approach, focused on a culture of 'continuous improvement' and inspiring organisations based on the success of others. Yet experienced leaders highlight that NHS IMPACT relies on trusts working with existing funding constraints, and may struggle to deliver without initial resources to give staff the time and space to focus on improvement (Hartley 2023).

Meaningful channels for staff ideas

Effective channels for staff voice in clinical services should be designed to bring frontline ideas to local service leaders with the training and incentives to listen to staff – and the resources and power to act on insights delivered. We identify three key priorities for clinical service improvement pathways:

1. **Generating ownership:** ensure staff feel valued and engaged, and retain ownership of ideas alongside clear accountability. Policy needs to focus not just on identifying ideas, but also on agility to implement effectively (Horton et al 2021). Open, transparent and fair decision-making also supports ongoing staff engagement and wellbeing (Magnavita et al 2022).
2. **Listening to insights:** whole-system thinking to involve staff across a care pathway in identifying inefficiencies and potential improvements, rather than looking to 'quick fixes'. This requires local system leadership, to overcome siloed thinking and opposition to change – as seen in London's successful reform of stroke services (Turner et al 2016).
3. **Supporting sustainable change:** once a change is implemented, ongoing evaluation and sharing benefits with staff is key for sustained impact (Schonberger 2007).

We recommend each NHS Trust develop staff insight pathways for efficient and effective clinical services, reporting to frontline clinical leads.

The design and implementation of these pathways should be supported by a small team of trust-level improvement specialists, which could develop in-house expertise, look to peer organisations like Leeds NHS Foundation Trust (Meacock 2021), and draw on best-practice models from non-profit organisations like Q Initiative (Health Foundation 2024) or commercial equivalents. Organisational research shows that a range of insight pathway designs can work well; what matters most is ensuring staff and board buy-in and consistent application (Bohmer 2016; Jones et al 2019).

Trust-level improvement teams should be able to provide small amounts of funding to give frontline staff the time and resources to consider system processes, test improvements and sustain positive change. They should also provide clinical and financial information to identify waste, as seen in Bolton and Leeds Hospitals where financial data is made available to clinicians to help improve high-value services for patients (HFMA 2014).

Supporting staff to speak

Staff-led continuous improvement requires training and support at every level. We call for NHS investment to create an enabling environment for improvement, through:

- a strong grounding in system improvement methodologies taught in all healthcare degrees, from medicine and nursing to management
- training for all NHS roles to include the value and use of staff and patient insight pathways
- paid self-development time (currently offered to resident doctors) extended to the wider multidisciplinary team, so teams have protected time to collectively engage in improvement.

Further, the NHS must incentivise staff to unlock their untapped insights for productivity. Staff may know best where potential improvements lie, but change may involve upfront time and effort, the friction of trying new approaches, and – too often – resistance from colleagues or even managers who've 'seen it all before' (de Silva 2015).

Social network analysis reveals that strong, collaborative relationships between staff is key to successful improvement (see box 3.3).

BOX 3.3 NHS PARTNERSHIP PILOTS WITH THE VIRGINIA MASON INSTITUTE

Recently, five NHS trusts partnered with the Virginia Mason Institute through a five-year pilot to build a culture of lean improvement. Each achieved significantly reduced 'lead times' (time from referral to appointment), with knowledge-sharing across trusts (Jones 2022). However, the two trusts with lower CQC ratings struggled to scale changes to offset wider performance issues. Those already performing well were better able to succeed, due to higher staff connectedness and organisation-wide commitment to improvement (Burgess et al 2021).

To reduce these barriers, clinical service-level pathways must reward staff for contributing insights, including sharing productivity gains with staff. This requires a balance to be struck so productivity is improved for patients and the NHS overall, but careful design could unlock win–win incentives. For instance, Chiswick Health Practice (see case study 3.2) applied staff ideas to improve the flow of GP appointments, then shared benefits with staff by ensuring clinicians finished shifts on time.

CASE STUDY 3.2 PRODUCTIVE GENERAL PRACTICE QUICK START

Chiswick Health Practice in Hounslow struggled with patient access to appointments, and clinicians often finishing late. Staff noted a key problem; patients were unable to cover everything in a 10-minute appointment, so ran over or booked additional slots to do this.

Supported by the NHS Productive General Practice programme, the team undertook a root cause analysis process which led to positive change cycles including extending appointments from 10 to 15 minutes, all recalls scheduled by GPs themselves, and better signposting to allied health professionals.

Outcomes

- released more than 600 GP hours and 1,200 administrative hours per year, allowing two admin staff to undertake healthcare assistant training and spread workload more equally
- patient continuity of care has increased, as GPs manage their own caseload
- GPs "feel they have adequate time with the patient and are now able to complete any onward administration without it building up", and are far more likely to finish shifts on time.

Source: Chiswick Health Practice 2019

We recommend that service leads should be encouraged to consider how to share productivity gains with staff from the outset. This could be through collective rewards such as team lunches, time off in lieu, or greater access to flexible working (Thomas et al 2024). Benefits can be shared so that a significant productivity surplus goes to treating future patients, but a share is used to reward staff and incentivise similar effort in the future.

Trusts should also consider options to better align staff incentives with productivity, including 'earned autonomy' for high-performing clinical service teams (following Hewitt 2023). This would see high-performing teams given responsibility for a pre-set list of surgical cases, or people requiring care in the community, each month. If the team finish cases early or help people learn to self-administer medications safely at home, they would be rewarded by time off rather than further added work – encouraging collaboration in pursuit of a goal that could be more ambitious than current service levels. This strategy has improved productivity and shared rewards in both surgical and community care settings (GSTT 2022; Monsen and deBlok 2013).

Investing in better leaders

Improvement efforts for a clinical service are best led by local service leads who proactively involve patients and frontline staff – while also having time and incentives to initiate steps towards better care (Bohmer 2016). This proximity reduces barriers to expressing staff views, improves leadership quality, and supports ongoing improvement and buy-in (Morrow et al 2014; Bailey and West 2022).

To deliver on this promise, however, local leaders must earn the trust and cooperation of their team (Sfantou et al 2017). Frontline service leaders should be valued, trained and supported to develop the right mindset for system improvement (Messenger 2022). Currently, this is lacking – service leads who are clinicians themselves are often thrown into a leadership post with no preparation or induction at all, simply because a post needs filling. Meanwhile, non-clinical leaders often lack incentives or clarity over priorities for long-term improvement (Black 2024). As one surgical lead explained:

> ***"Leaders with short-term posts look for short-term fixes, rather than iterative improvement. Conversely, clinical staff feel they've 'seen it all before', and are less likely to buy in if a similar idea has been tried and faltered."***

Every clinical service lead should be funded to undertake training in system improvement and leadership skills, in the same way as many consultants have reserved time for research. This could be delivered through the new government's manifesto pledge for a Royal College of Clinical Leadership, with support from programmes such as the Faculty of Medical Leadership and Management, NHS IMPACT or the Health Foundation's Q Initiative (FMLM 2024; NHS Impact 2024; Thorlby and Pereira 2020).

To avoid frontline improvement programmes fading away as has occurred previously (McCann et al 2015), staff voice must be an ongoing priority for all local leaders. Systematic evidence shows durable leadership commitment is key to sustained improvement and this requires ongoing coaching of frontline leaders (Laureani and Antony 2017). We call for continuous peer-to-peer mentoring between leaders at the local level, focus on ongoing skills development and holding one another accountable for listening to frontline staff voice.

RECOMMENDATIONS

- Every NHS Trust should develop staff insight pathways for service improvement by establishing a permanent trust-level team of improvement specialists. All staff should have time protected to participate in these schemes.
- Trusts should ensure productivity benefits are shared with staff, such as through time off in lieu or 'earned autonomy' for high-performing clinical service teams.

3.2. ORGANISATIONS THAT LISTEN AND RESPOND

Staff suffering in silence

NHS staff report high levels of dissatisfaction, low motivation and the lowest perceived autonomy level of any major profession (NHS 2024; Worth 2020). Large swathes have gone on strike over the past two years, and staff departures remain a persistent challenge. The proportion of doctors and dentists reporting low autonomy has risen by over a quarter in the past five years, tracking to a 20 per cent rise in those thinking of leaving (NHS 2023).

Although strikes have focused on pay, staff across the board say their frustration runs much deeper (IPPR/YouGov polling, Patel and Thomas 2021). Many cite factors relating to a lack of control over their immediate working conditions, from patient safety concerns to inflexible working hours.

Symbolic efforts to value and engage with staff at the local trust level are already widespread in the NHS, from staff 'listening forums' to 'speaking up' champions. While these initiatives have value, the spike in leaver rates since 2020 suggest listening alone is not enough. That is because forums for expression are not the same as having voice in the workplace. NHS staff at large have very little say over their working conditions when it comes to the things that matter most – like rotas and rest spaces.

Qualitative evidence deepens the link between disempowerment and departure. Lunch breaks are just one powerful example. According to a 2022 survey, "more than one in five (23 per cent) say they sit in offices for lunch breaks, 17 per cent use their cars, 7 per cent in corridors and 6 per cent visit store cupboards" (Unison 2022). To eat lunch in a store cupboard creates a feeling that your workplace doesn't care about you – and the fact that this hasn't been fixed speaks to staff powerlessness. Inadequate facilities should be top of the agenda – yet the NHS lacks avenues to listen to and heed this call.

At the moment, NHS workers have only two real avenues to express their voice:

- Industrial action: the past year has seen unprecedented strikes in the NHS, including the longest ever resident doctor strikes, coordinated action between consultants and juniors, and same-day strikes by nurses and ambulance staff (Campbell 2023; BMA 2024)
- Leaving the NHS: NHS England leaver rates averaged 11.2 per cent from 2010 to 2023, compared to far lower rates in comparable countries like Scotland (9.4 per cent in 2023) (NHS Education for Scotland 2023). Between 15,000 to 23,000 doctors left the NHS prematurely in the year to September 2023, with almost a third moving abroad (BMA 2024; NHS Employers 2024a).

These are both extreme expressions of worker voice. That they are being utilised so extensively should give reason to pause and consider creating new mechanisms for staff voice.

Local workplaces, local voice

Listening to the frontline is not only important to improve care for patients, but equally to improve care for staff.

The NHS must dramatically transform at the organisational level to genuinely listen to staff views on all decisions that affect wellbeing. This requires reforming how NHS trust decisions are made. Although the NHS is a national organisation, local trusts are direct employers that determine key decisions affecting staff wellbeing (NHS Providers 2015).

For mechanisms to deliver this transformation at the trust level, they must be credible rather than tokenistic, including feedback mechanisms that communicate

changes back to staff. For example, Northumbria NHS Foundation Trust collates weekly survey data on staff experience, health and wellbeing, leading to initiatives such as discounted travel cards and easy-access loans, and proactive engagement to demonstrate to staff they have acted on results (Northumbria NHS 2023). The trust achieved the highest response rate, and the highest scores on three of seven key indicators nationally, out of all Acute and Community Trusts in the NHS Staff Survey (NHS 2024).

Extensive fieldwork found that NHS boards with 'mature' quality improvement governance shared key features: explicit board focus on improvement; engaging staff and patients; and ensuring two-way communication enabled by board-level clinical leaders (Jones et al 2017).

We recommend establishing staff boards or similar representative forums parallel to the board of directors in each NHS trust, including acute, community and mental health trusts. This board should match overall workforce composition and represent the wider workforce through locally designed mechanisms to collate ideas. It should be formally consulted by the board of directors on all issues that affect staff wellbeing, including working hours and rotas, working conditions, and physical environment. Staff boards could also advise on areas where they will hold valuable insights – for instance which new diagnostic technologies to purchase.

Parallel staff boards offer three potential benefits to the NHS:

1. **Staff engagement and motivation:** staff involvement in organisational governance increases worker satisfaction and improves performance, as shown by data on 16,000 staff from 17 countries (How Institute and LRN 2016).
2. **Better ideas for productivity:** democratic representation improves decision-making and collective insight, especially for complex problems (Estlund and Landemore 2018). Evidence across UK public organisations suggests "involving workers in decision making … might be beneficial for both employees (through higher job satisfaction) and businesses (through higher productivity and innovation)" (Altunbuken et al 2020).
3. **Specialist expertise without groupthink:** NHS boards balance responsibilities, and "the paradox of ensuring patient safety at the same time as pursuing performance improvement and innovation (clinical effectiveness and efficiency) is ever-present" (Chambers et al 2017). Many trusts have 'Joint Consultative Committees' or staff on executive boards, but evidence shows that NHS boards don't always centre critical and diverse perspectives at present. One study of eight English NHS trusts finds most board meetings are chair-led, with a tendency towards agreement (Endacott et al 2013). Parallel boards could offer space for more deliberation, varied perspectives and constructive critical engagement.

Several NHS trusts have created staff boards or 'shadow executives' along these lines. This brings staff insights from the frontline directly to the trust board, offering an insight pathway focused on wellbeing and retention (see case study 3.3).

CASE STUDY 3.3 BARKING, HAVERING AND REDBRIDGE (BHR) SHADOW EXEC

BHR first established a Shadow Exec in 2022, composed of 24 staff members drawn from groups underrepresented at the top of the trust. It has now been through three competitive cohorts, who meet with senior decision-makers over the course of a year. They do not have formal decision-making power, but contribute views and shape the board agenda.

Outcomes

- Since 2022, staff vacancy rates have fallen by a quarter from a high of 17 per cent.
- Staff reflections are highly positive:

  "Matthew [Trainer, trust chief executive] really takes on board a lot of what we say and shows us how our comments feed into conversations between the execs. I felt very heard." (Caesar Sanchez, endoscopy charge nurse)

  "The Shadow Exec helped lessen that divide between those of us who work on the shop floor treating patients and the Trust Exec team." (Manpreet Sahemey, ED consultant)

Source: BHRUT 2023

Mechanisms for staff voice without formal power could risk being seen as symbolic if there is not a clearly defined influence over the trust's decision-making and two-way communication to explain when priorities cannot be actioned immediately.

One route to influence would be to offer staff boards a veto power over issues directly affecting staff wellbeing. Parallel boards have recently been established to this end in a number of Premier League football clubs. For instance, Liverpool Football Club Supporters' Board meets with senior officials four times a year, and holds a legally binding role in decision-making, including veto power over existential issues – such as whether to join any future breakaway Super League (Pearce 2022).

However, granting staff boards a veto power carries potential risks. First, fair selection of board membership is crucial, balancing proportionate weighting of different staff groups against the need to amplify the voices of those with less power. This is even more important for a parallel worker board vested with significant responsibility. A careful selection process is key to ensuring that more powerful staff groups – or niche interests – do not dominate to the detriment of others (Safe Work Australia 2018). However, fair representation must be balanced against the risk of unwieldy boards if people are recruited for whom they represent rather than for board-level skills (Greer et al 2003).

Second, staff boards holding a veto power could slow down important and time-sensitive decisions such as financial plans or winter crisis response. Evidence shows that more diverse boards may encounter deadlock more often, especially without careful processes to facilitate deliberative decisions (Donaldson 2020).

To balance this risk, we recommend an alternative accountability measure instead of a formal veto. Following the model of the Bank of England, the board of directors could be required to publish an open letter in response to any issues raised formally by the staff board. This supports open debate and transparency, without risking deadlock. If concerns are not felt to be adequately addressed, independent support from NHS Resolution or union processes are available to mediate and support with resolving concerns (NHS Resolution 2024).

RECOMMENDATIONS

- Establish a staff board or similar forum in each acute and community trust, parallel to the board of directors, to represent ideas from the wider workforce and consult on all matters affecting staff wellbeing.
- Board of directors to be required to publish an open letter in response to any issues raised formally by the staff board, with NHS Resolution support in resolving concerns.

Sharing best practice across ICS organisations

Frontline staff, NHS leaders and politicians have now united around one area of consensus: the health service does not need another large-scale reorganisation (Alderwick et al 2021). Health Secretary Wes Streeting has been clear that the priority is reform rather than top-down reorganisation (Gault 2024). Yet this relies on reform that works – truly supporting the current organisational structure to deliver on its promise and work at its best (Hewitt 2023).

Since 2022, the NHS has been governed by 42 regional ICSs across England, responsible for delivering integrated health services and reducing inequalities. This carries a promise of devolved governance and local providers empowered to drive improvements and learning together. Yet ICSs often display 'allocative' inefficiency – poor resource use due to service duplication or prioritising the wrong level of care. For instance, spending on avoidable hospital admissions may be less efficient than shifting funds to primary or social care (Health Foundation 2022).

We recommend implementing the ICS duty to 'enhance productivity and value for money' through a responsibility for regional improvement. This should be actioned by an Improvement Team led by a Director of Improvement or similar in every ICS, responsible for the following.

- Improved resource allocation through service mapping to identify duplication and engage cross-organisational teams in redesign where needed, through approaches like the 'shared stewardship' model used by Mid and South Essex ICS (Atkinson and Scolding 2024).
- Real-time data sharing, integrating data into ICS-wide dashboards to identify bottlenecks and priority areas for population health, evaluate the effectiveness of reforms, and share what works. Rather than waiting for 'perfect' data infrastructure, ICSs should start by pooling available information and recognise that data will improve over time (Bohmer 2016).

As one ICS service lead explained: "ICSs offer an optimal level to share best practice, as providers often face common challenges and can pool expertise." For example, Greater Manchester ICS pools demographics, primary care, adult social care and specialist service records (Vaughan 2024). This informs community health profiles to support idea-sharing across 10 local councils.

When it comes to sharing best practice more widely, the NHS has historically been excellent at pilots, but less effective at sustainable, large-scale knowledge-sharing. This is limited by the following.

- Slow or ill-suited evidence, such as analysis that summarises benefits in a specific setting without considering transferability of results to other contexts (Hussey et al 2013). As one clinician we spoke to explained: "pilots that succeeded in one trust founder when transported to another."
- Insufficient tools for spreading what works, with too much information simply published but too little direct information flow across frontline settings.

- Low staff buy-in due to top-down imposition of ideas to impose ideas externally from a tertiary centre to a district general hospital, or from a clinic with electronic records to one with paper notes, risks resistance rather than buy-in (de Silva 2015).

The key to better distribution of ideas lies in empowering the frontline to share bottom-up rather than scale top-down (Hussey et al 2013). Active 'knowledge management' is a well-evidenced way to share programmes between frontline leaders who may stand to benefit, while empowering the recipients of ideas to tailor to their local context (Kosklin et al 2022).

This means connecting frontline teams, within an ICS or across the country, into 'learning networks' based on data showing they serve common patient populations, with similar opportunities – supporting to share insights and learn from one another. For example, the QUEST collaborative in the US linked up hospitals from a pool of 141 members, sharing evidence and peer-to-peer coaching to reduce mortality by 10 per cent more than control hospitals that were offered similar resources but no learning network (Kroch et al 2015).

Previous IPPR research has called for the formation of clinical networks following the London Challenge for school improvement, which improved pupil outcomes faster than was seen nationally (Kidson and Norris 2015). Pilots of NHS learning networks by NHS Confederation and the Health Foundation offer promise along these lines (Pereira 2023).

The newly formed NHS IMPACT could step in to deliver on this promise of learning networks. We suggest expanding the remit of NHS IMPACT beyond its current function supporting QI training and development, to include proactive data-led linking of frontline teams into 'knowledge-sharing networks'. This should be based on common patient needs and service opportunities, linking successful teams to other clinical leaders in a way that empowers both.

RECOMMENDATIONS

- Every ICS should have an Improvement Team whose responsibilities include improving resource allocation and shared learning across services (such as acute and community care).
- Support frontline teams to share best practice more effectively, through NHS IMPACT using data to link teams facing similar challenges into nationwide 'learning networks'.

3.3. STAFF VOICE IN NATIONAL PAY AND CONDITIONS

Mechanisms for staff voice in clinical services, trusts and ICSs are crucial steps. However, these alone won't solve all aspects of staff discontent and disempowerment. Certain shared grievances are shaped nationally, notably pay and worker rights – and therefore require representation at a national level.

Decisions imposed, not negotiated

NHS salaries are currently set by government, informed by Pay Review Bodies (PRBs), which are independent but only able to make recommendations within a pre-set cap on overall pay growth (Tetlow and Pope 2022).

The PRB panel does not include staff representation through unions, who are instead invited to 'submit evidence' for consideration. As a result, unions describe these decisions as imposed rather than negotiated, without a forum for staff voice in advance of decisions (Unite 2023). The process was boycotted by all 14 major

health unions in 2023/24, who instead called for direct pay talks with ministers and relevant NHS employers (Moretta 2024). Current arrangements also fail to consider non-unionised or contracted workers.

The NHS Staff Council is intended to serve as the forum for staff negotiation, bringing together unions and NHS Employers and holding 'overall responsibility' for pay and conditions through Agenda for Change – the pay scale used for most non-medical staff (NHS Employers 2024b). However, it includes no role for either government or Treasury and has no remit over pay settlements. This means any changes to pay banding must fit within existing NHS budgets.

Meanwhile, PRBs have no remit to consider working hours or conditions. For instance, standard nursing contracts of four back-to-back night shifts are often impossible for those with parental or caring responsibilities (Patel and Thomas 2021). Frustrations abound over access to parking or subsidised travel, and expensive food options at work. Yet conditions are discussed in the separate Social Partnership Forum, which facilitates discussions between government, staff and employers. Yet the SPF also lacks a mandate to negotiate investment, so can only call for changes without the funding to deliver.[5]

The consequence of the current PRB model is that strikes are the only meaningful avenue for NHS staff to express collective voice over major decisions around pay or working conditions. It is clearly suboptimal for strikes to be the only way to 'negotiate', rather than a last resort.

A better way?

This wasn't always the case. The NHS was once characterised by collective bargaining, with pay scales and conditions for each staff group set by negotiation until 2004 (Galetto et al 2011; NHS Staff Council 2015). This was changed largely due to differences between staff groups, with unequal outcomes between similar occupations. However, in the shift to a more 'equal' system, negotiation and staff representation have been lost.

PRBs are also far from the norm when compared to neighbouring countries. Scotland follows a model of Partnership Agreements, with unions involved in each stage of NHS management decisions. This resulted in a very different pay landscape in 2022/23. For instance, a 17.5 per cent pay rise for junior doctors over two years was negotiated proactively between staff and management without recourse to hostile strikes (BMA 2023).

Further afield, Fair Pay Agreements are a well-established legal framework to enable sector-level negotiations over pay and broader working conditions including hours and flexibility. They gained recent recognition with the New Zealand FPA Act 2022 covering public industries including care work and transport (Wesselbaum 2022). Similar models have existed across Europe for years, from negotiating childcare pay without adversarial strikes in Ireland (Labour Court 2022) to healthcare collective bargaining in Sweden (Kjellberg 2019).

5 See: https://www.socialpartnershipforum.org/about-us

CASE STUDY 3.4 SECTORAL COLLECTIVE BARGAINING FOR CHILDCARE PROFESSIONALS IN IRELAND

In 2020, the Irish government committed to establishing a Joint Labour Committee (JLC) for collective bargaining in the childcare sector to improve working conditions. The JLC included the Labour Court, six employee and six employer representatives, and an independent chair and deputy.

In September 2022 the JLC's negotiations concluded, introducing a minimum hourly wage of €13 for early years educators and additional wage rates for managers. This framework facilitated a pay agreement without adversarial industrial relations, and with no lost days of service provision due to strikes.

Source: Labour Court 2022

Bringing staff voice into national decisions

National NHS policy needs a better process for negotiations, so staff feel their voice is heard. We set out two options to this end, based on NHS policy analysis and global precedent.

Option 1: strengthen staff voice within existing PRB mechanism

PRBs could be reformed to embed direct staff engagement, including through appointment of PRB members in consultation with unions (Moretta 2024), and a duty to consult staff like that seen in Scotland (BMA 2023). Under the Scottish Partnership Agreement model, all matters of pay and working conditions are discussed early through the Partnership Forum, an institution similar to the NHS England Social Partnership Forum but with a formal duty to consult on all emerging changes.[6]

This would be compatible with continuing to have an independent PRB that makes final recommendations. If this consultative approach is chosen, then staff could also be given a voice in how the chair and members of the PRB are appointed (Palmer 2023). However, there is a risk that these limited reforms might only deliver surface-level consultation for staff, and so fail to meaningfully change from a process of imposition to true consultation.

Option 2: reform PRBs into Pay Review Negotiations (PRNs)

PRBs could transform further into a forum for formal collective bargaining over pay and working conditions (Moretta 2024). This could take the form of annual tripartite negotiations between unions, NHS Employers and the government via the Treasury and the DHSC. This PRN would carry out an annual review of pay, working conditions and wider staff priorities (directly considering staff priorities including from the NHS Staff Survey).

The PRN should have statutory authority to determine pay rates for the coming year, and to set priorities for working conditions with funding attached. From there, power can be handed over to ICSs to design local delivery mechanisms for these priorities.

If negotiations fail, parties enter mediation, with the Advisory, Conciliation and Arbitration Service as a final arbiter. This proposal would entail no change to the right to strike for staff.

Under either option 1 or 2, pay agreements should include a *force majeure* clause, so they are reviewed if economic or service conditions fall outside set parameters. Negotiations rely on forecasts, which can never be exact. However, in some cases –

6 See https://www.socialpartnershipforum.org/about-us

such as Covid-19 and the inflation that followed – conditions change so much that review is necessary (Palmer 2023).

Either option to increase national staff voice brings key advantages for the NHS.

1. **Improved staff retention:** the first, and most direct, promise is that staff are more likely to stay. Analysis of employment surveys in Britain (Workplace Employment Relations Study) and France (REPONSE survey) finds that a union representative in the workplace is associated with a lower quit rate in both countries (Amossé and Forth 2016).
2. **Shift from confrontation to collaboration:** listening to the frontline also offers the promise of anticipating discontent, rather than waiting for confrontation. Workplace disputes will arise in any industry, but negotiations can minimise hostility and resolve conflict in a timely way. US data shows that collective bargaining is associated with reduced dispute costs and shorter duration (Currie and McConnell 1994). Evidence suggests a PRN approach may be better able to deliver this benefit. For example, Denmark has some of the highest collective bargaining rates in the world, which results in almost all conflicts resolved through workplace conflict resolution instead of strikes or lock-outs (Limborg et al 2019).
3. **Win–win policies:** listening to frontline perspectives can also bring a "joint problem-solving focus" that is fairer for all parties when issues arise (Limborg et al 2019). Collective bargaining has been shown to reduce persistent unemployment and improve resilience in economic downturn (Blanchard and Wolfers 2000).

RECOMMENDATION

- The government should increase staff voice in setting national NHS workforce policy, which could include reforming PRBs into tripartite Pay Review Negotiations or a formal duty to consult staff as in the Scottish Partnership model.

3.4. CONCLUSION

Staff voice is pivotal to any effective service, and its relative absence in the NHS has been overlooked for too long. Focusing on frontline insights for better decision-making offers a new set of solutions to both poor productivity and low retention – and can also improve the effectiveness of existing proposals from technology to political reform.

The importance of seizing the potential of the frontline cannot be overstated. The NHS faces profound challenges, laid bare in the Darzi review and many reports preceding it (Darzi 2024). The coming years require visionary change in priorities for health and care delivery, from reactive hospitals to preventative, primary-care-led services, and from waiting for sickness to creating health (Thomas et al 2024). To deliver this bold health agenda for the 21st century, the NHS and the government must unlock the best of every person working in the NHS. Only with frontline insights and motivated staff can we rebuild our health service – and the health of the nation itself.

REFERENCES

Acemoglu D (2023) 'Distorted innovation: Does the market get the direction of technology right?', *AEA Papers and Proceedings*, 113. https://www.aeaweb.org/articles?id=10.1257/pandp.20231000.

Aggarwal A, Simcock R, Price P, Rachet B, Lyratzopoulos G and Walker K (2024) 'NHS cancer services and systems: Ten pressure points a UK cancer control plan needs to address', *The Lancet Oncology*, 25(8): e363–e373. https://doi.org/10.1016/S1470-2045(24)00345-0.

Alderwick H, Dunn P, Gardner T, Mays N and Dixon J (2021) 'Will a new NHS structure in England help recovery from the pandemic?', *BMJ*, 372. https://www.bmj.com/content/372/bmj.n248?ijkey=9a134ba84f04d0d39f0a6c62a3206ef3f90f9e4f&keytype2=tf_ipsecsha

Altunbuken U, Bukowski, P, Machin P and Slaughter H (2020) *Power plays: The shifting balance of employer and worker power in the UK labour market*. Resolution Foundation. https://economy2030.resolutionfoundation.org/reports/power-plays/

Amossé T and Forth J (2016) 'Employee expression and representation at work: Voice or exit?', in *Comparative workplace employment relations: an analysis of practice in Britain and France*. Palgrave Macmillan.

Anandaciva S. (2024) 'Thoughts on the NHS's productivity decline', *The King's Fund*. https://www.kingsfund.org.uk/insight-and-analysis/blogs/nhs-productivity-decline

Asaria M, McGuire A and Street A (2021) 'The impact of management on hospital performance', *Fiscal Studies*, 43(1). https://doi.org/10.1111/1475-5890.12293

Atkinson A and Scolding P (2024) 'How to use data to support stewardship-led transformation', *Healthcare Leader*, 13 March. https://healthcareleadernews.com/integrated-care-boards/how-to-use-data-to-support-stewardship-led-transformation/

Atwell S, Vriend M, Rocks C, Finch D and Farrington-Douglas, J (2023) *What we know about the UK's working-age health challenge*. Health Foundation. https://www.health.org.uk/publications/long-reads/what-we-know-about-the-uk-s-working-age-health-challenge

Bailey S and West M (2022) 'Tired of being exhausted: Seven key actions for leaders in the NHS workforce crisis', *The King's Fund*. https://www.kingsfund.org.uk/insight-and-analysis/blogs/tired-of-being-exhausted-seven-key-actions-leaders-nhs-workforce-crisis

Barratt H, Hutchings A, Pizzo E, Aspinal F, Jasim S, Gafoor R, Ledger J, Mehta R, Mason J, Martin P, Fulop N, Morris S and Raine R (2022) 'Mixed methods evaluation of the Getting it Right First Time programme in elective orthopaedic surgery in England: An analysis from the National Joint Registry and Hospital Episode Statistics'. *BMJ Open*, 12(6) :e058316. https://doi.org/10.1136/bmjopen-2021-058316

Barron J and Tether V (2024) *Are people getting less from the NHS?* NHS Confederation. https://www.nhsconfed.org/articles/are-people-getting-less-nhs

BHR University Hospitals NHS Trust [BHRUT] (2023) *Annual report and accounts 2022/23*. https://www.bhrhospitals.nhs.uk/download.cfm?doc=docm93jijm4n5853.pdf&ver=15241

Black S (2024) 'The mythbuster: An ill-disciplined NHS is to blame for the lack of capital spending', *Health Service Journal*. https://www.hsj.co.uk/daily-insight/the-mythbuster-an-ill-disciplined-nhs-is-to-blame-for-the-lack-of-capital-spending/7036499.article

Blanchard O and Wolfers J (2000) 'The role of shocks and institutions in the rise of European unemployment: The aggregate evidence', *The Economic Journal*, 110(462): C1–C33. https://doi.org/10.1111/1468-0297.00518

Blythe N and Ross S (2022) *Strategies to reduce waiting times for elective care*. The King's Fund. https://www.kingsfund.org.uk/publications/strategies-reduce-waiting-times-elective-care

Bohmer RMJ (2016) 'The hard work of health care transformation', *New England Journal of Medicine*, 375(8): 709–711. https://doi.org/10.1056/NEJMp1606458

British Medical Association [BMA] (2021) *Moral distress and moral injury: recognising and tackling it for UK doctors*. British Medical Association. https://www.bma.org.uk/media/4209/bma-moral-distress-injury-survey-report-june-2021.pdf

British Medical Association [BMA] (2023) *Junior doctors in Scotland accept pay offer*, *The British Medical Association is the trade union and professional body for doctors in the UK*. https://www.bma.org.uk/news-and-opinion/junior-doctors-in-scotland-accept-pay-offer

British Medical Association [BMA] (2024) *When a doctor leaves: Tackling the cost of attrition in the UK's health services*. British Medical Association. https://www.bma.org.uk/media/gsmfle1o/tackling-the-cost-of-attrition-uks-health-services.pdf

Burgess N, Currie G, Crump B and Dawson A (2022) *Leading change across a healthcare system: How to build improvement capability and foster a culture of continuous improvement*. Warwick Business School. https://warwick.ac.uk/fac/soc/wbs/research/vmi-nhs/reports/report_-_leading_change_across_a_healthcare_system_22.09.2022.pdf

Campbell D (2023) 'Junior and senior doctors in England to strike together for first time in NHS history', *Guardian*, 31 August. https://www.theguardian.com/society/2023/aug/31/junior-doctors-nhs-england-vote-to-continue-strikes-through-winter

Campbell D (2024) 'Patients evacuated and scans cancelled after Stockport hospital ceilings fall in', *Guardian*, 3 May. https://www.theguardian.com/society/article/2024/may/03/patients-evacuated-and-scans-cancelled-after-stockport-hospital-ceilings-fell-in

Care Quality Commission [CQC] (2015) *Most people are receiving good care: But strong leadership and collaboration are crucial to facing challenges ahead*. https://www.cqc.org.uk/news/releases/most-people-are-receiving-good-care-%E2%80%93-strong-leadership-collaboration-are-crucial

Care Quality Commission [CQC] (2023) *National survey highlights decline in people's experience of urgent and emergency care*. https://www.cqc.org.uk/press-release/national-survey-highlights-decline-peoples-experience-urgent-and-emergency-care

Care Quality Commission [CQC] (2024) *Adult inpatient survey 2023*. https://www.cqc.org.uk/publications/surveys/adult-inpatient-survey

Carter, Lord (2016) *Operational productivity and performance in English NHS acute hospitals: Unwarranted variations*. https://www.gov.uk/government/publications/productivity-in-nhs-hospitals

Castelli A, Street A, Verzulli R and Ward P (2015) 'Examining variations in hospital productivity in the English NHS', *The European Journal of Health Economics*, 16(3): 243–254. https://doi.org/10.1007/s10198-014-0569-5.

Castle-Clarke S (2018) *What will new technology mean for the NHS and its patients?* The Health Foundation, the Institute for Fiscal Studies, The King's Fund and the Nuffield Trust.

Chambers N, Harvey G and Mannion R (2017) 'Who should serve on health care boards? What should they do and how should they behave? A fresh look at the literature and the evidence', *Cogent Business & Management*, 4(1). https://www.tandfonline.com/doi/full/10.1080/23311975.2017.1357348

Charles A and Ewbank L (2021) *The road to renewal: Five priorities for health and care*. The King's Fund. https://www.kingsfund.org.uk/insight-and-analysis/long-reads/covid-19-road-renewal-health-and-care

Chiswick Health Practice (2019) *600 GP hours released a year after reducing inappropriate appointments*, NHS England. https://www.england.nhs.uk/gp/case-studies/600-gp-hours-released-a-year-after-reducing-inappropriate-appointments-chiswick-health-practice-london/

Church E (2024) 'More and more nurses applying to leave England for "better pay"', *Nursing Times*, 12 March. https://www.nursingtimes.net/news/workforce/more-and-more-nurses-applying-to-leave-england-for-better-pay-12-03-2024/

Coyle D (2023) 'What will the NHS look like at 100?' REAL Challenge annual lecture, The Health Foundation. https://www.health.org.uk/about-the-health-foundation/get-involved/events/what-will-the-nhs-look-like-at-100

Coyle D and Manley A (2023) 'What is the value of data? A review of empirical methods', *Journal of Economic Surveys*, p. joes.12585. https://doi.org/10.1111/joes.12585.

Currie J and McConnell S (1994) 'The impact of collective-bargaining legislation on disputes in the U.S. public sector: No legislation may be the worst legislation', *The Journal of Law & Economics*, 37(2): 519–547. https://chicagounbound.uchicago.edu/jle/vol37/iss2/9

Darzi A (2024) *Independent investigation of the NHS in England*. Department of Health and Social Care. https://www.gov.uk/government/publications/independent-investigation-of-the-nhs-in-england/summary-letter-from-lord-darzi-to-the-secretary-of-state-for-health-and-social-care

de Silva D (2015) *What's getting in the way? Barriers to improvement in the NHS*. The Health Foundation. https://www.health.org.uk/publications/what%E2%80%99s-getting-in-the-way-barriers-to-improvement-in-the-nhs

de Spiegelaere S, Jagodzinski R and Waddington J (2023) *European Works Councils: contested and still in the making*. The European Trade Union Institute. https://www.etui.org/publications/european-works-councils-contested-and-still-making

Dean W, Morris D, Llorca PM, Talbot SG, Fond G, Duclos A and Boyer L (2024) 'Moral Injury and the Global Health Workforce Crisis — Insights from an International Partnership', *New England Journal of Medicine*, 391(9): 782–785. https://doi.org/10.1056/NEJMp2402833.

Department for Education [DfE] (2024) *School workforce in England, Reporting year 2023*. https://explore-education-statistics.service.gov.uk/find-statistics/school-workforce-in-england#dataBlock-71f45e3d-4c19-430f-b5a5-66722b71cbae-tables

Department of Health and Social Care [DHSC] (2021) *Integration and innovation: Working together to improve health and social care for all*. https://www.gov.uk/government/publications/working-together-to-improve-health-and-social-care-for-all/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-html-version

Department of Health and Social Care [DHSC] (2023) *Annual report and accounts 2021–22*. https://assets.publishing.service.gov.uk/media/63e50dc0d3bf7f05c8e947a8/dhsc-annual-report-and-accounts-2021-2022_web-accessible.pdf

Donaldson J, Malenko N and Piacentino G (2020) *Deadlock on the Board*. Finance Working Paper No 645/2019. European Corporate Governance Institute. https://www.ecgi.global/sites/default/files/working_papers/documents/donaldsonmalenkopiacentinofinal.pdf

Dowding K and John P (2012) *Exits, Voices and Social Investment: Citizens' Reaction to Public Services*. Cambridge: Cambridge University Press (Theories of Institutional Design). https://doi.org/10.1017/CBO9781139136709.

Economist Impact (2022) 'Intermountain Healthcare: Towards an integrated, value-based model'. *The Economist*. https://impact.economist.com/projects/towards-higher-value-care/case-studies/#one

Emmerson C, Johnson P and Zaranko B (2024) *Public finances and the 2024 general election*, *Institute for Fiscal Studies*. https://ifs.org.uk/articles/public-finances-and-2024-general-election

Endacott R, Sheaff R, Jones R and Woodward V (2013) 'Clinical focus and public accountability in English NHS Trust Board meetings', *Journal of Health Services Research & Policy*, 18(1): 13–20. https://doi.org/10.1258/jhsrp.2012.011154.

Estlund D and Landemore H (2018) 'The epistemic value of democratic deliberation', in *The Oxford Handbook of Deliberative Democracy*. Oxford University Press.

Faculty of Medical Leadership and Management [FMLM] (2024) *Raising the standard of patient care by improving clinical leadership*. https://www.fmlm.ac.uk/?gad_source=1&gclid=Cj0KCQjwu-63BhC9ARIsAMMTLXQIYO8VuiUyE9KlIPji_MD-FL2KJyDqD_toDn451LYR8vUdlRjsryMaAsxNEALw_wcB

Freedman S and Wolf R (2023) *The NHS productivity puzzle*. Public First and Institute for Government. https://www.instituteforgovernment.org.uk/sites/default/files/2023-06/nhs-productivity-puzzle_0.pdf

Gainsbury S (2023) *NHS spending plans and reality over the past 10 years*. Nuffield Trust. https://www.nuffieldtrust.org.uk/resource/nhs-spending-plans-and-reality-over-the-past-10-years

Galetto M, Marginson P and Spieser C (2011) 'Collective bargaining and the changing governance of hospitals: a comparison between the UK, Italy and France', *Sciences Po HAL* [Preprint]. https://sciencespo.hal.science/hal-03461594/file/2011-spieser-collective-bargaining-and-the-changing-governance-of-hospitals.pdf

Gault B (2024) *No more top-down reorganisation, says health secretary*, Healthcare Leader. https://healthcareleadernews.com/news/no-more-top-down-reorganisation-says-health-secretary/

Getting It Right First Time [GIRFT] (2024) 'Theatre productivity'. https://gettingitrightfirsttime.co.uk/hvlc/theatre-productivity/

Greer A, Hoggett P and Maile S (2003) 'Are quasi-governmental organisations effective and accountable?', in *The governance of public and non-profit organizations*. Routledge.

Guy's and St Thomas' NHS Foundation Trust [GSTT] (2022) *NHS staff find innovative way to tackle surgery waiting lists.* https://www.guysandstthomas.nhs.uk/news/nhs-staff-find-innovative-way-tackle-surgery-waiting-lists

Ham C (2014) *Improving NHS care by engaging staff and devolving decision-making*. The King's Fund. https://www.kingsfund.org.uk/insight-and-analysis/reports/improving-nhs-care-engaging-staff-devolving-decision-making

Ham C (2020) 'A "world beating" test and trace service is far from the current reality', *BMJ Opinion*. https://blogs.bmj.com/bmj/2020/06/19/chris-ham-a-world-beating-test-and-trace-service-is-far-from-the-current-reality/

Ham C, Berwick D and Dixon J (2016) *Improving quality in the English NHS: A strategy for action*. The King's Fund. https://www.gloshospitals.nhs.uk/media/documents/The_Kings_Fund_-_Improving_quality_in_the_English_NHS.pdf

Hartley J (2023) 'NHS IMPACT: A positive step for trust-wide improvement', NHS Providers. https://nhsproviders.org/news-blogs/blogs/nhs-impact-a-positive-step-for-trust-wide-improvement

Health Foundation (2022) 'Improving efficiency in the NHS'. The Health Foundation. https://www.health.org.uk/news-and-comment/newsletter-features/improving-efficiency-in-the-nhs

Health Foundation (2024) *Understanding, measuring and improving the engagement of staff in major change*, Q Community. https://q.health.org.uk/insight/defining-and-measuring-good-staff-engagement-in-major-change/

Health Innovation Yorkshire & Humber (2023) *Klinik's AI patient triage system saves PCN £300,000*. https://www.healthinnovationyh.org.uk/?case_study=using-ai-to-triage-patients-provide-better-patient-experience-and-reduce-pressure-on-frontline-staff

Healthcare Financial Management Association (HFMA) (2014) *Future-focused finance*. https://www.hfma.org.uk/articles/future-focused-finance

Healthwatch (2019) *Putting patient voices at the heart of the NHS*. https://www.healthwatch.co.uk/sites/healthwatch.co.uk/files/20190315%20Healthwatch%20England%20submission%20to%20the%20NHS%20Mandate%20-%202019-2020%20FINAL.PDF

Healthwatch (2023) *A vision for health and care: What do patients want?*. https://www.healthwatch.co.uk/blog/2023-09-22/vision-health-and-care-what-do-patients-want

Hewitt P (2023) *The Hewitt Review: An independent review of integrated care systems*. https://www.gov.uk/government/publications/the-hewitt-review-an-independent-review-of-integrated-care-systems

Hirschman AO (1970) *Exit, voice, and loyalty*. Harvard University Press. https://www.hup.harvard.edu/books/9780674276604

HM Treasury (HMT) (2024a) *Opposition policy costing – New GP Hubs – Labour*. https://assets.publishing.service.gov.uk/media/664713daae748c43d3793d89/20240129_Opposition_costing_-_New_GP_Hubs.pdf

HM Treasury (HMT) (2024b) *Opposition policy costing –Double the number of NHS scanners – Labour*. https://assets.publishing.service.gov.uk/media/66471375993111924d9d36f8/20240129_Opposition_costing_-_Double_the_number_of_NHS_scanners.pdf

Holden J (2023) *The NHS Long Term Workforce Plan Explained*, The King's Fund. https://www.kingsfund.org.uk/insight-and-analysis/long-reads/nhs-long-term-workforce-plan-explained

Holmes J (2022) *The NHS nursing workforce: Have the floodgates opened?*, The King's Fund. https://www.kingsfund.org.uk/insight-and-analysis/blogs/nhs-nursing-workforce

Horton T, Mehay A and Warburton W (2021) *Agility: the missing ingredient for NHS productivity*. The Health Foundation. https://www.health.org.uk/publications/long-reads/agility-the-missing-ingredient-for-nhs-productivity

HOW Institute and LRN (2016) *The How Report*. The HOW Institute and LRN. https://pages.lrn.com/hubfs/2020%20Migration/the-how-report-2016.pdf

Hume, H. (2020) '"Ground-breaking" mobile stroke unit relaunched to save lives', *East Anglian Daily Times*. https://www.eadt.co.uk/news/21340677.ground-breaking-mobile-stroke-unit-relaunched-save-lives/

Hussey P Bankowitz R, Dinneen M, Kelleher D, Matsuoka K, McCannon J, Shrank W and Saunders R (2013) 'From Pilots to Practice: Speeding the Movement of Successful Pilots to Effective Practice', *NAM Perspectives* [Preprint]. https://doi.org/10.31478/201304e

Institute for Healthcare Improvement [IHI] (2024) *Fostering an improvement culture: Learning from East London NHS Foundation Trust's improvement journey over 10 years*. https://qi.elft.nhs.uk/wp-content/uploads/2024/07/IHI_Fostering-Improvement-Culture-ELFT-10-Years.pdf

Jones B (2022) *Building an organisational culture of continuous improvement*. The Health Foundation. https://www.health.org.uk/publications/long-reads/building-an-organisational-culture-of-continuous-improvement

Jones D and Mitchell A (2006) 'Lean thinking for the NHS'. NHS Confederation. https://www.leanuk.org/wp-content/uploads/2020/03/Lean-Thinking-in-the-NHS-Daniel-T-Jones-and-Alan-Mitchell.pdf

Jones L, Promeroy L, Robert G, Burnett S, Anderson JE and Fulop NJ (2017) 'How do hospital boards govern for quality improvement? A mixed methods study of 15 organisations in England', *BMJ Quality & Safety*, 26(12): 978–986. https://doi.org/10.1136/bmjqs-2016-006433.

Keith J, Grimm F and Steventon A (2022) *How better use of data can help address key challenges facing the NHS*. The Health Foundation. https://www.health.org.uk/publications/long-reads/how-better-use-of-data-can-help-address-key-challenges-facing-the-nhs

Kelly E and Tallack C (2024) *NHS productivity: from diagnosis to action*, *The Health Foundation*. https://www.health.org.uk/news-and-comment/blogs/nhs-productivity-from-diagnosis-to-action

Kelly J (2024) 'NHS productivity'. NHS England. https://www.england.nhs.uk/long-read/nhs-productivity/

Kenney C (2010) *Transforming Health Care: Virginia Mason Medical Center's Pursuit of the Perfect Patient Experience*. CRC Press.

Kidson M and Norris E (2015) *Implementing the London Challenge.* Joseph Rowntree Foundation and Institute for Government. https://www.instituteforgovernment.org.uk/sites/default/files/publications/Implementing%20the%20London%20Challenge%20-%20final_0.pdf

King's Fund (2015) *Quarterly monitoring report (QMR): How is the NHS performing?*. https://www.kingsfund.org.uk/insight-and-analysis/projects/quarterly-monitoring-report-qmr

King's Fund (2024) *What's going on with A&E waiting times?* https://www.kingsfund.org.uk/insight-and-analysis/long-reads/whats-going-on-with-ae-waiting-times#:~:text=Only%2072%25%20of%20people%20were,reported%20achieving%20the%20national%20standard

King's Fund (2024a) *NHS: Key facts and figures*. https://www.kingsfund.org.uk/insight-and-analysis/data-and-charts/key-facts-figures-nhs

King's Fund (2024b) *Productivity in the NHS and health care sector*. https://www.kingsfund.org.uk/insight-and-analysis/data-and-charts/productivity-nhs-health-care-sector

Kirk W, Barter R, Seyed-Safi P, Davies A and Sabharwal S (2024) 'The Importance of Surgical Cutting Time as a Key Performance Indicator Alongside Touchtime Utilisation in Operating Theatre Efficiency Optimisation', *Cureus* [Preprint]. https://doi.org/10.7759/cureus.69660

Kjellberg A (2019) 'Sweden: Collective bargaining under the industry norm', in T Müller, K Vandaele and J Waddington (eds) *Collective bargaining in Europe: Towards an endgame*. ETUI (European Trade Union Institute), pp 583–603. https://www.etui.org/publications/books/collective-bargaining-in-europe-towards-an-endgame-volume-i-ii-iii-and-iv

Kosklin R, Lammintakanen J and Kivinen T (2023) 'Knowledge management effects and performance in health care: A systematic literature review', *Knowledge Management Research & Practice*, 21(4): 738–748. https://doi.org/10.1080/14778238.2022.2032434.

Kroch E, Duan M, John M, Bankowitz R and Kugel M (2015) 'The effectiveness of a multicenter quality improvement collaborative in reducing inpatient mortality', *Journal of Patient Safety*, 11(2), p. 67. https://doi.org/10.1097/PTS.0000000000000155.

Labour Court (2022) *Second Early Years' Service: Employment Regulation Order 2022*. https://www.irishstatutebook.ie/eli/2022/si/458/made/en/pdf

Laureani A and Antony J (2019) 'Leadership and Lean Six Sigma: A systematic literature review', *Total Quality Management & Business Excellence*, 30(1–2): 53–81. https://doi.org/10.1080/14783363.2017.1288565.

Limborg HJ, Gensby U and Viemose S (2019) 'Mediation and Conciliation in Collective Labor Conflicts in Denmark', in Euwema, MC, Medina F, García A and Pender E (eds) *Mediation in collective labor conflicts*. Springer International Publishing (Industrial Relations & Conflict Management): 47–69. https://doi.org/10.1007/978-3-319-92531-8_4.

Magnavita N, Chiorri C, Acquadro Maran D, Garbarino S, Di Prinzio RR, Gasbarri M, Matera C, Cerrina A, Gabriele M, Labella M (2022) Organizational justice and health: A survey in hospital workers. *International Journal of Environvironmental Research and Public Health*, 19(15): 9739. https://doi.org/10.3390/ijerph19159739

Mahase E (2023) 'Measures of NHS productivity do not reflect reality, says NHS England chief', *BMJ*, 383, p. p2712. https://doi.org/10.1136/bmj.p2712

Marjanovic S Altenhofer M, Hocking L, Chataway J and Ling T (2020) 'Innovating for improved healthcare: Sociotechnical and innovation systems perspectives and lessons from the NHS', *Science and Public Policy*, 47(2): 283–297. https://doi.org/10.1093/scipol/scaa005.

McCann L, Hassard JS, Granter E and Hyde PJ (2015) 'Casting the lean spell: The promotion, dilution and erosion of lean management in the NHS', *Human Relations*, 68(10). https://journals.sagepub.com/doi/10.1177/0018726714561697

Meacock J, Mukherjee S and Sheikh A (2021) 'Increasing patient flow through neurosurgical critical care: The Leeds Improvement Method', *BMJ Open Quality*, 10(2), p e001143. https://doi.org/10.1136/bmjoq-2020-001143.

Meacock R, Kristensen S and Sutton M (2014) 'Paying for improvements in quality: Recent experience in the NHS in England', *Nordic Journal of Health Economics*, 2(1). https://doi.org/10.5617/njhe.794.

Messenger G (2022). *Health and social care review: Leadership for a collaborative and inclusive future*. Department of Health and Social Care. https://www.gov.uk/government/publications/health-and-social-care-review-leadership-for-a-collaborative-and-inclusive-future

Monsen K and deBlok J (2013) 'Buurtzorg Nederland', *AJN The American Journal of Nursing*, 113(8), p. 55. https://doi.org/10.1097/01.NAJ.0000432966.26257.97

Moretta A (2024) *Pay review bodies: their past and their future*. Institute of Employment Rights. https://www.ier.org.uk/pay-review-bodies-their-past-and-their-future/

Morrow E, Robert G and Maben J (2014) 'Exploring the nature and impact of leadership on the local implementation of The Productive Ward Releasing Time to CareTM', *Journal of Health Organization and Management*, 28(2): 154–176. https://doi.org/10.1108/JHOM-01-2013-0001.

Narayanan S, Vickery SK, Nicolae ML, Castel MJ and McLeod MK (2022) 'The effects of lean implementation on hospital financial performance', *Decision Sciences*, 53(3): 557–577. https://doi.org/10.1111/deci.12510.

NHS (2020) *NHS becomes the world's first national health system to commit to become 'carbon net zero', backed by clear deliverables and milestones*. https://www.england.nhs.uk/2020/10/nhs-becomes-the-worlds-national-health-system-to-commit-to-become-carbon-net-zero-backed-by-clear-deliverables-and-milestones/

NHS (2022) *2021/22 National Cost Collection Data Publication*. https://www.england.nhs.uk/publication/2021-22-national-cost-collection-data-publication/

NHS (2023) *Consultation: Proposed amendments to the 2023/25 NHS Payment Scheme*. https://www.england.nhs.uk/long-read/consultation-proposed-amendments-to-the-2023-25-nhs-payment-scheme/

NHS (2024) *NHS Staff Survey*. https://www.nhsstaffsurveys.com/results/

NHS Confederation (2023a) *Understanding public perceptions and attitudes to the NHS*. https://www.nhsconfed.org/publications/understanding-public-perceptions-and-attitudes-nhs

NHS Confederation (2023b) *Transformative, not tokenistic: The patient voice in integrated care systems*. https://www.nhsconfed.org/long-reads/transformative-not-tokenistic-patient-voice-integrated-care-systems

NHS Confederation (2023a) *The state of integrated care systems 2022/23*. https://www.nhsconfed.org/publications/state-integrated-care-systems-202223

NHS Digital (2024a) *NHS workforce statistics: June 2024*. https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/june-2024

NHS Digital (2024b) *Provisional monthly hospital episode statistics for Admitted Patient Care, Outpatient and Accident and Emergency data*. https://digital.nhs.uk/data-and-information/publications/statistical/provisional-monthly-hospital-episode-statistics-for-admitted-patient-care-outpatient-and-accident-and-emergency-data

NHS Education for Scotland (2023) *NHS Scotland workforce*. https://turasdata.nes.nhs.scot/data-and-reports/official-workforce-statistics/all-official-statistics-publications/05-december-2023-workforce/dashboards/nhs-scotland-workforce/?pageid=10601

NHS Employers (2019) *Case study: Reviewing staff benefits and reward*. https://www.nhsemployers.org/case-studies/reviewing-staff-benefits-and-reward

NHS Employers (2022) *Improving staff retention*. https://www.nhsemployers.org/publications/improving-staff-retention

NHS Employers (2024a) *GMC report reveals why doctors may leave the UK*. https://www.nhsemployers.org/news/gmc-report-reveals-why-doctors-may-leave-uk

NHS Employers (2024b) *NHS Staff Council*. https://www.nhsemployers.org/NHSStaffCouncil

NHS Impact (2024) *NHS England*. https://www.england.nhs.uk/nhsimpact/

NHS Improvement (2017) *Going lean in the NHS*. https://www.england.nhs.uk/improvement-hub/wp-content/uploads/sites/44/2017/11/Going-Lean-in-the-NHS.pdf

NHS People Plan (2020) *We are the NHS: People Plan for 2020/2021*. https://www.england.nhs.uk/wp-content/uploads/2020/07/We-Are-The-NHS-Action-For-All-Of-Us-FINAL-March-21.pdf

NHS Providers (2015) *Building a healthy NHS around people's needs*. https://nhsproviders.org/media/1036/introduction_to_nhs_fts_and_trusts_-_nhs_providers_-_may_2015.pdf

NHS Providers (2023a) *Stretched to the limit: Tackling the NHS productivity challenge*. https://nhsproviders.org/media/696112/stretched-1gd.pdf

NHS Providers (2023b) *No more sticking plasters: Repairing and transforming the NHS estate*. https://nhsproviders.org/media/695193/no-more-sticking-plasters.pdf

NHS Resolution (2024) *NHS Resolution*. https://resolution.nhs.uk/

NHS SBS (Shared Business Services) (2024) *Improving staff retention with workforce analytics*. https://www.sbs.nhs.uk/case-study/workforce-analytics/

NHS Staff Council (2015) *NHS Job Evaluation Handbook*. https://www.msg.scot.nhs.uk/wp-content/uploads/NHS_Job_Evaluation_Handbook_-_fifth_edition.pdf

Northumbria Healthcare NHS Foundation Trust [Northumbria NHS] (2023) *Staff engagement/improving staff experience*. https://patientexperiencenetwork.org/wp-content/uploads/2023/10/Staff-Engagement-Improving-Staff-Experience-Northumbria-Healthcare-NHS-Foundation-Trust-Improving-staff-Health-and-Wellbeing.pdf

Nosheen S (2024) *Are there too many NHS managers?* NHS Confederation. https://www.nhsconfed.org/articles/are-there-too-many-nhs-managers

Nursing Notes (2023) *Survey finds nurse managers waste hours a day on admin and bureaucracy*, *Nursing Notes*. https://nursingnotes.co.uk/news/survey-finds-nurse-managers-waste-hours-a-day-on-admin-and-bureaucracy/

Nursing Times (2009) 'Nurses waste "an hour a shift" finding equipment', *Nursing Times*, 10 February. https://www.nursingtimes.net/archive/nurses-waste-an-hour-a-shift-finding-equipment-10-02-2009/

O'Cathain A, Sampson F, Strong M, Pickin M, Goyder E and Dixon S (2015) 'Do marginal investments made by NHS healthcare commissioners in the UK produce the outcomes they hope to achieve? Observational study', *BMJ Open*, 5(11), p. e009336. https://doi.org/10.1136/bmjopen-2015-009336.

Ochi T and Roughley H (2024) *An exploration of Ozempic*, *British Pharmacological Society*. https://www.bps.ac.uk/publishing/pharmacology-matters/april-2024/an-exploration-of-ozempic

Office for Budget Responsibility [OBR] (2024) *Economic and fiscal outlook – October 2024*. https://obr.uk/efo/economic-and-fiscal-outlook-october-2024/#chapter-3

Organisation for Economic Co-operation and Development [OECD] (2017) *Tackling wasteful spending on health*. https://www.oecd-ilibrary.org/social-issues-migration-health/tackling-wasteful-spending-on-health_9789264266414-en

Orsini J (2013) *The essential Deming: Leadership principles from the father of quality.* McGraw-Hill Professional.

Palmer B (2023) *Basis of negotiation: Recommendations to improve the NHS pay review process*, *Nuffield Trust*. https://www.nuffieldtrust.org.uk/news-item/basis-of-negotiation-recommendations-to-improve-the-nhs-pay-review-process

Patel P *et al.* (2023) *For public health and public finances: Reforming health and social care*. IPPR. https://www.ippr.org/research/publications/for-public-health-and-public-finances

Patel P and Thomas C (2021) *Recover, reward, renew: A post-pandemic plan for the healthcare workforce*. IPPR. https://www.ippr.org/articles/recover-reward-renew#:~:text=This%20paper%20aims%20to%20resolve,people%20to%20join%20the%20sector

Pearce J (2022) 'Explained: Liverpool, their new supporters' board and safeguards against a Super League', *The Athletic*. https://theathletic.com/3495557/2022/08/17/liverpool-super-league-supporters-board/

Pereira P (2023) 'Learning and improving across systems: A new peer learning programme', *The Health Foundation*. https://q.health.org.uk/blog-post/learning-and-improving-across-systems-a-new-peer-learning-programme/

Quilter-Pinner H and Khan H (2023) 'Great government: A new playbook for public service reform', *IPPR*. https://www.ippr.org/articles/great-government-a-new-playbook-for-public-service-reform

Royal College of Psychiatrists [RCPsych] (2022) *Hidden waits force more than three quarters of mental health patients to seek help from emergency services*. https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2022/10/10/hidden-waits-force-more-than-three-quarters-of-mental-health-patients-to-seek-help-from-emergency-services

Rebolledo I and Charlesworth A (2022) *How does UK health spending compare across Europe over the past decade?* The Health Foundation. https://www.health.org.uk/news-and-comment/charts-and-infographics/how-does-uk-health-spending-compare-across-europe-over-the-past-decade

Refsum C, Bradshaw A, Large O and Ward D (2024) *Preparing the NHS for the AI era: A digital health record for every citizen*. Tony Blair Institute for Global Change. https://institute.global/insights/public-services/preparing-the-nhs-for-the-ai-era-a-digital-health-record-for-every-citizen

Rolewicz L (2024) 'The changing experience levels of NHS staff'. https://www.nuffieldtrust.org.uk/resource/the-changing-experience-levels-of-nhs-staff

Safe Work Australia (2018) 'Worker Representation and Participation Guide'. https://www.safeworkaustralia.gov.au/doc/worker-representation-and-participation-guide

Schneider ECS, Sarnak DO, Squires D, Shah A and Doty MM (2017) *Mirror, Mirror 2017: International comparison reflects flaws and opportunities for better U.S. health care*. Commonwealth Fund. https://doi.org/10.15868/socialsector.27698.

Schonberger RJ (2007) 'Japanese production management: An evolution—With mixed success', *Journal of Operations Management*, 25(2): 403–419. https://doi.org/10.1016/j.jom.2006.04.003.

Scott IA (2024) 'Monoclonal antibodies for treating early Alzheimer disease: A commentary on recent "positive" trials', *Age and Ageing*, 53(2). https://doi.org/10.1093/ageing/afae023.

Scottish Government (2010) *Demographic Change in Scotland*. https://www.gov.scot/publications/demographic-change-scotland/

Sfantou DF, Laliotis A, Patelarou AE, Sifaki-Pistolla D, Matalliotakis M and Patelarou E (2017) 'Importance of leadership style towards quality of care measures in healthcare settings: A systematic review', *Healthcare*, 5(4), p 73. https://doi.org/10.3390/healthcare5040073

Smee (2005) *Speaking truth to power: Two decades of analysis in the department of health*. Routledge. https://www.routledge.com/Speaking-Truth-to-Power-Two-Decades-of-Analysis-in-the-Department-of-Health/Smee/p/book/9781857757811

Stein T (2024) *Why our conversations about productivity in the NHS are not very productive*, Nuffield Trust. https://www.nuffieldtrust.org.uk/news-item/why-our-conversations-about-productivity-in-the-nhs-are-not-very-productive

Stoye G, Warner M and Zaranko B (2024). *The past and future of UK health spending*. Institute for Fiscal Studies. https://ifs.org.uk/publications/past-and-future-uk-health-spending

Syal R (2013) 'Abandoned NHS IT system has cost £10bn so far', *Guardian*, 17 September. https://www.theguardian.com/society/2013/sep/18/nhs-records-system-10bn

Teich ST and Faddoul FF (2013) 'Lean management: The Journey from Toyota to healthcare', *Rambam Maimonides Medical Journal*, 4(2). https://doi.org/10.5041/RMMJ.10107

Tetlow G and Pope T (2022) *Pay review bodies*, Institute for Government. https://www.instituteforgovernment.org.uk/explainer/pay-review-bodies

Thomas C, O'Halloran J, Parkes H, Hawkey D, Williamson A, Patel P, Poku-Amanfo E and Quilter-Pinner H (2024) *Our greatest asset: The final report of the IPPR Commission on Health and Prosperity*. IPPR. https://www.ippr.org/articles/our-greatest-asset

Thomas C, McNeil C and Gandon A (2023) *Finding hope: The final report of the IPPR health and care workforce assembly*. IPPR. https://www.ippr.org/articles/finding-hope

Thorlby R and Pereira P (2020) *The Q community*, The Health Foundation. https://www.health.org.uk/what-we-do/supporting-health-care-improvement/partnerships-to-support-quality-improvement/the-q-community

Turner S, Ramsay A, Perry C, Boaden R, McKevitt C, Morris S, Pursani N, Rudd A, Tyrrell T, Wolfe C and Fulop N (2016) 'Lessons for major system change: centralization of stroke services in two metropolitan areas of England', *Journal of Health Services Research & Policy*, 21(3): 156–165. https://doi.org/10.1177/1355819615626189.

Unison (2022) '"No breaks, no food" culture leaving NHS staff hungry and affecting care, says UNISON', *UNISON National*, 31 May. https://www.unison.org.uk/news/press-release/2022/06/no-breaks-no-food-culture-leaving-nhs-staff-hungry-and-affecting-care-says-unison/

Unite (2023) *Unite blasts NHS Pay Review Body as "long past its sell-by date"*. https://www.unitetheunion.org/news-events/news/2023/january/unite-blasts-nhs-pay-review-body-as-long-past-its-sell-by-date

University Hospitals Birmingham NHS (2023) *Independent organisational culture review: Report for University Hospitals Birmingham NHS Foundation Trust*. https://www.pslhub.org/learn/investigations-risk-management-and-legal-issues/investigations-and-complaints/investigation-reports/trust-investigations/independent-organisational-culture-review-report-for-university-hospitals-birmingham-nhs-foundation-trust-27-september-2023-r10192/

Vaughan V (2024) 'How digital transformation is working in Greater Manchester', *Healthcare Leader*, 25 January. https://healthcareleadernews.com/insight-and-analysis/how-digital-transformation-is-working-in-greater-manchester/

Wang W, Creese J, Karanika-Murray M, Harris K, McCarthy M, Leng C and King C (2024) 'Can compassionate leadership of senior hospital leaders help retain trainee doctors?', *BMJ Leader*, p. leader. https://doi.org/10.1136/leader-2024-001010.

Warner M and Zaranko B (2023) *Is there really an NHS productivity crisis?*, Institute for Fiscal Studies. https://ifs.org.uk/articles/there-really-nhs-productivity-crisis

Weber DO (2006) 'Toyota-style management drives Virginia Mason', *Physician Executive*, 32(1): 12–17. https://www.researchgate.net/publication/7269195_Toyota-Style_Management_Drives_Virginia_Mason

Wesselbaum D (2022) 'Welfare and economic impacts of Fair Pay Agreements in Aotearoa', *Journal of the Royal Society of New Zealand*, 52(5): 580–586. https://doi.org/10.1080/03036758.2022.2030371.

West M (2021) *Teamworking, psychological safety and compassionate leadership*, NHS Employers. https://www.nhsemployers.org/articles/teamworking-psychological-safety-and-compassionate-leadership

Worth J (2020) *Seven new insights into teacher autonomy*, National Foundation for Educational Research. http://www.nfer.ac.uk/blogs/seven-new-insights-into-teacher-autonomy/

Wright T, Mughal F, Babatunde OO, Dikomitis L, Mallena CD and Helliwella T (2022) 'Burnout among primary health-care professionals in low- and middle-income countries: systematic review and meta-analysis', *Bulletin of the World Health Organization*, 100(6): 385-401A. https://doi.org/10.2471/BLT.22.288300.

Zaranko B, Sanford NJ, Kelly E, Rafferty AM, Bird J, Mercuri L, Sigsworth J, Wells M and Propper C (2023) 'Nurse staffing and inpatient mortality in the English National Health Service: a retrospective longitudinal study - PubMed', *BMJ Quality & Safety*, 32(5): 254–263. https://doi.org/10.1136/bmjqs-2022-015291

Institute for Public Policy Research

GET IN TOUCH

For more information about the Institute for Public Policy Research, please go to www.ippr.org

You can also e-mail info@ippr.org or find us on X @ippr

Institute for Public Policy Research
Registered Charity no. 800065 (England & Wales),
SC046557 (Scotland), Company no, 2292601 (England & Wales)

The progressive policy think tank