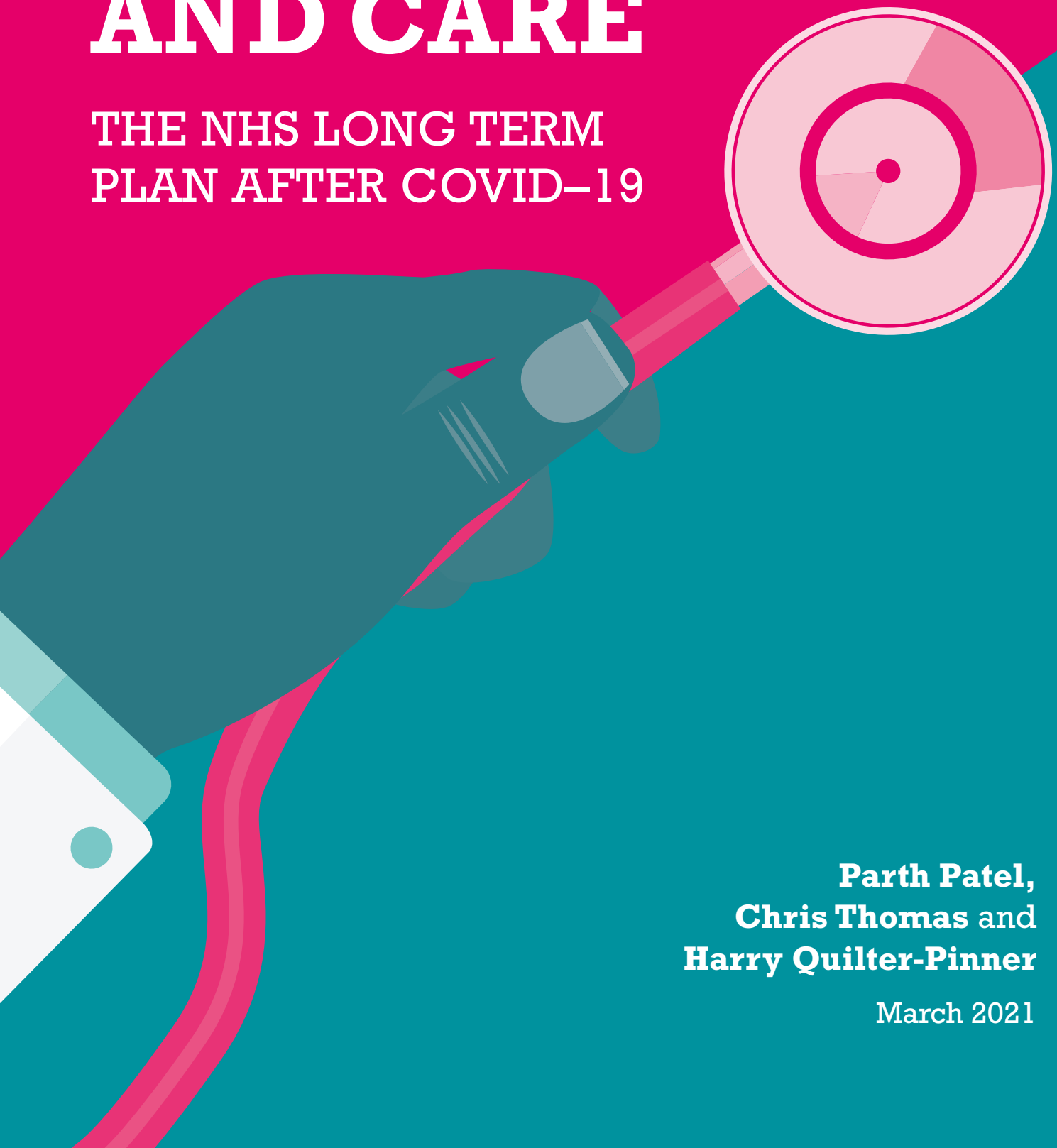
Institute for Public Policy Research

STATE OF HEALTH AND CARE

THE NHS LONG TERM PLAN AFTER COVID–19



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ABOUT THIS REPORT

This report contributes to IPPR's charitable purpose of reducing the impact of illness and disease.

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SUMMARY

After a decade of austerity, *The NHS Long Term Plan* was meant to be a turning point for healthcare. The 10-year plan, published in early 2019, looked to break with a decade of declining performance and growing financial pressure. It came with a funding settlement amounting to an additional £20.5 billion for day-to-day NHS spending by 2023/24. And it outlined 'ambitious but realistic' reform plans – based on improving prevention, driving integration and universalising best practise – to 'give everyone the best start in life; deliver world-class care for major health problems, such as cancer and heart disease, and help people age well'.

However, those plans have been severely disrupted by the coronavirus pandemic. Covid-19 was declared a public health emergency by the World Health Organisation just days before the first anniversary of *The NHS Long Term Plan*. As a result, before implementation could really begin in earnest, the NHS was thrust into a significant crisis. It has spent the past year contending with overwhelmed acute sites, severe strain on its workforce, and the highest excess mortality since the second world war. In order to manage these new pressures, the NHS has rationed access to non-urgent care and patients themselves have often refrained from seeking urgent support.

Our new analysis shows the scale of the damage done by the pandemic across several major health conditions. The impact of Covid-19 is a significant backward step for people with cancer, mental illness, cardiovascular disease and multiple long term conditions.

TABLE S1

The impact of the pandemic on *The NHS Long Term Plan*'s key targets in cancer, mental health, cardiovascular disease and multimorbidity care

Major health condition	*The NHS Long Term Plan* target	Pandemic disruption
Cancer	75% of cancers diagnosed while still highly curable (by 2028)	Fall from 44 to 41% of cancers diagnosed while still highly curable, leading to 4,500 avoidable cancer deaths attributable to the pandemic
Mental illness	2m more people accessing mental health services (by 2024)	Access reduced and over 1.8m new referrals expected by 2024, cancelling out planned gains on 'parity of esteem'
Cardiovascular disease	Prevent 150,000 heart attacks, strokes and vascular dementia cases (by 2029)	Highest cardiovascular mortality in a decade, with a further 12,000 avoidable heart attacks and strokes expected by 2025 if missed treatment initiations are not made up for
Multimorbidity	Integrate and personalise care by expanding primary care (by 2024)	Over 31m fewer GP appointments than expected since the pandemic began

Source: IPPR analysis

This large-scale disruption is far from the start *The NHS Long Term Plan* intended.

There is an urgent need to recapture the trajectory of *The NHS Long Term Plan*. As we emerge from the worst of the Covid-19 pandemic, the NHS undoubtedly needs to address the growing backlog of care. But Covid-19 should not become an excuse for low ambition. Despite the rhetoric around the NHS, it is outperformed in terms of healthcare outcomes by most comparable countries. World-class healthcare must remain the overall goal. The government must turn 'build back better' from rhetoric to reality.

This will require bolder health policy and an eye for innovation. 'Building back better' requires important shifts in the government's approach to health policy. First, we need bold action that restarts progress in health. It is time to fast-track ambitions to deliver a sustainable workforce, a functioning social care system and a stronger approach to health inequalities. Second, we need to harness the opportunities created by the pandemic. Our analysis shows how diffusion of digital care, more intelligent regulation and new ways of working together have led to improvements.

We recommend a package of six ambitious changes to 'build back better'. These policies are designed to do three things. First, they intend to ensure the pandemic does not cause lasting damage to healthcare services for future generations. Second, they look to bring in areas – like social care and public health – that are not covered in *The NHS Long Term Plan*, but which Covid-19 has harshly reminded us are integral to healthcare. Third, they look to capture the innovations that occurred during the pandemic. Together, our recommendations form a £12 billion blueprint to 'build back better' health and care.

Ensure a sustainable workforce: The pandemic has demonstrated that we can do little in health without our workforce. But even before Covid-19, workforce shortages were considered the key threat to delivery of *The NHS Long Term Plan*. We recommend a new deal to catalyse recruitment and retention – including a pay rise, a new wellbeing offer, and improved training and progression.

Fund the NHS to deliver and sustain transformation: The funding settlement for *The NHS Long Term Plan* did not account for a pandemic. Enabling the transformation to a world-class service means avoiding a trade-off with the pandemic care backlog. Our estimates suggest the NHS needs an additional £2.2 billion per year until 2025/26 to meet the elective care backlog and rise in mental illness. No longer can the NHS be expected to fund increasing services out of efficiency savings that come at the expense of resilience, sustainability and transformation.

Empower integration from the bottom up: Integrated care has been an ambition in health policy for decades. But it has been stunted by a centralised command-and-control approach that has not aimed to foster a collaborative culture and permit local determination. We recommend a shift to bottom-up integration – through system-focussed regulation, reformed financial incentives and permissive legislation.

Upgrade the digital NHS: Digital care has been a revelation of the pandemic. To harness its benefits, problems around inequalities in access and quality of care will need to be addressed. That means providing internet access as a basic public service, understanding patient preferences and investing in the NHS's digital infrastructure.

Fund and reform social care: The NHS is at its best when social care is at its best. That requires bold reform – including free personal care for everyone aged 65 and over, improving the quality of social care, better pay for care workers, and immigration rules that do not lead to catastrophic shortages.

Level up the nation's health: Finally, we need to reduce healthcare need wherever possible, through better public health and reduced health inequalities. Health must form a key part of the government's post-pandemic 'levelling up' agenda. To achieve this, we recommend a public health cabinet committee to co-ordinate policy functions across Whitehall, and greater devolution of funding and powers to local government to tackle on the primary determinants of health.

TABLE S2

Summary of the investment required to 'build back better' health and care

Policy	Additional expenditure (£bn)
5% NHS staff pay rise (excluding consultants and senior managers)	1.4
NHS pandemic funding settlement	2.2 (until 2026)
Capital investment	1.4
Internet access reimbursement	0.3
Living wage guarantee for care workers	1
Free personal care for ≥65 years	5
Restore public health grant	1
Total	12.3

Source: IPPR analysis

1.
THE NHS LONG TERM PLAN, COVID-19 AND THE FUTURE

> *The NHS is the closest thing the English people have to a religion*
>
> Nigel Lawson, former chancellor

Public pride in the NHS binds the health service to politics. It means bold manifesto pledges for tomorrow's NHS are a feature of every election in recent history. Rarely are they met.

This was especially true of the last decade. David Cameron's government committed to deliver GP access 12 hours a day, seven days a week, and routine diagnostic imaging and hospital outpatient clinics at the weekend (Cameron 2015). This has not transpired, and his promise to 'cut the deficit, not the NHS' was fallacious.

The NHS Long Term Plan is only the second time a vision for the NHS has been set out by the NHS – not politicians.[1] It is a 10-year plan to improve quality of care and health outcomes in the context of an ageing population and widening health inequalities. It involves a set of targets, structural reforms and a funding deal worth £20.5 billion by 2023/24.

1 The first was *The Five Year Forward View* (2014)

THE NHS LONG TERM PLAN

The NHS Long Term Plan, published in 2019, sets out a widely supported route-map to meet modern health challenges (relating to demographic and epidemiological changes), improve outcomes and achieve financial sustainability. It includes an extensive list of targets across several clinical areas. Key targets are:

Major health condition	Target	Significance	Timeline
Cancer	75% of cancers diagnosed while still highly curable	Improve cancer survival	2028
Mental illness	2m more people accessing mental health services	Improve access to mental health care	2024
Cardiovascular disease	Prevent 150,000 heart attacks, strokes and vascular dementia cases	Improve cardiovascular mortality	2029
Multimorbidity	Integrate and personalise care by expanding primary care	Improve patient experience and outcomes	2024

It set out to deliver these targets by driving integration between services, shifting care into the community and adopting a range of new models of care. Key to this are integrated care systems (ICS), which are geographically defined partnerships that bring together providers and commissioners of health and care services (including NHS bodies, local government, voluntary and independent sector organisations).

Accompanying *The NHS Long Term Plan* is a funding settlement amounting to an additional £20.5 billion for day-to-day NHS spending by 2023/24. This funding settlement is in line with IPPR's funding ask in the Lord Darzi Review (Darzi 2018). It is the largest increase in NHS funding since the period between 2004/5 and 2009/10, after which funding stagnated due to austerity. The funding settlement does not cover workforce training or capital spend.

Historically however, the challenge has not been setting out the plan for reform but delivering it. Previous reform agendas have also aimed to integrate care and improve outcomes, often relying on investment and structural reforms to achieve this (table 1.1). Some of these have delivered improvements but many have fallen short – and the UK still lags behind comparable countries in terms of the quality of care (Papanicolas et al 2019). Examples such as devo-health in Greater Manchester demonstrate that it is possible to drive improvement in England. Universalising this best practice is the challenge. This is what *The NHS Long Term Plan* aims to do.

TABLE 1.1

Timeline of major NHS reforms and plans

Reform	Developed by	Year
NHS and Community Care Act	Thatcher government	1990
The NHS Plan	Blair government	2000
Health and Social Care Act 2012	Cameron government	2012
Five Year Forward View	NHS England	2014
The NHS Long Term Plan	NHS England	2019

Source: IPPR analysis

The Covid-19 pandemic has made an already difficult proposition harder. Waiting lists have ballooned, diagnoses missed, and treatments have been cancelled – and the full impacts of the second wave are yet to play out. This is partly due to the severity and extent of the UK's Covid-19 epidemic. But it is also a result of austerity and efficiency drives that undermined the healthcare system's resilience (Thomas 2020). The lack of spare capacity meant coping with Covid-19 has been at the expense of other health priorities.

Recovering, and addressing the care backlog are urgent, but it would be a mistake to let the short term distract us once again. Recovery alone is not enough. The NHS has among the lowest number of doctors and nurses per capita, and lower rates of survival from cancer, heart attacks and strokes than most comparable countries (Papanicolas et al 2019). When it emerges from the Covid-19 crisis, we should make this a moment of progress for the NHS, not a regression to the mean. To not just recover, but to 'build back better'.

In this context, this report sets out to answer two questions:

1. What has been the effect of the Covid-19 pandemic on key targets in *The NHS Long Term Plan*?
2. What is required to 'build back better' health and care?

We analyse the disruption – and innovation – that has arisen from the pandemic across the four leading causes of death and disability in the UK: cancer, mental health, cardiovascular disease, and multimorbidity. Each of these are central tenets of *The NHS Long Term Plan*, clinical priorities after the pandemic, and key to Conservative party manifesto pledges. Where possible, we model the impacts the pandemic has had on delivering *The NHS Long Term Plan*'s key targets for each health condition, and indicate where efforts should be focussed moving forwards.

Although clinical priorities can change, the structures and policies that determine our ability to deliver them do not. To answer the second question, we examine the key policy areas that will determine the NHS's ability to both recover from Covid-19 and deliver the targets set out in *The NHS Long Term Plan*. For each policy area, we have interrogated options and made recommendations we believe will create the conditions to 'build back better' health and care. In our conclusions, we discuss which of the policy priorities are most urgent.

RESEARCH METHODS

This report has been informed by:

1. descriptive and predictive statistical analyses using data from multiple sources including NHS Digital, Hospital Episode Statistics, Office for National Statistics and Public Health England
2. polling 172 senior NHS and local government officials (director and executive level)
3. over 50 semi-structured interviews and a policy roundtable with leading stakeholders across the NHS, government and the voluntary and independent sector
4. literature reviews of major research published on the impact of Covid-19 on health and care services.

2.
THE PANDEMIC HAS DERAILED PROGRESS

2.1 CANCER

Recent decades have seen significant efforts to improve cancer outcomes in England. This has included the creation of a national cancer action team and specialist cancer centres and alliances. These initiatives, alongside better population health and new diagnostics and treatment, have contributed to improvements in 1- and 5-year survival rates (Arnold et al 2019).

However, the UK still lags behind its international competitors. For example, the International Cancer Benchmarking Partnership finds that the UK has the lowest 1-year survival rates for stomach, colon, rectal and lung cancer of the seven comparable countries in the partnership (ibid). Worse population health and late diagnosis are consistently identified as key factors for underperformance in England.

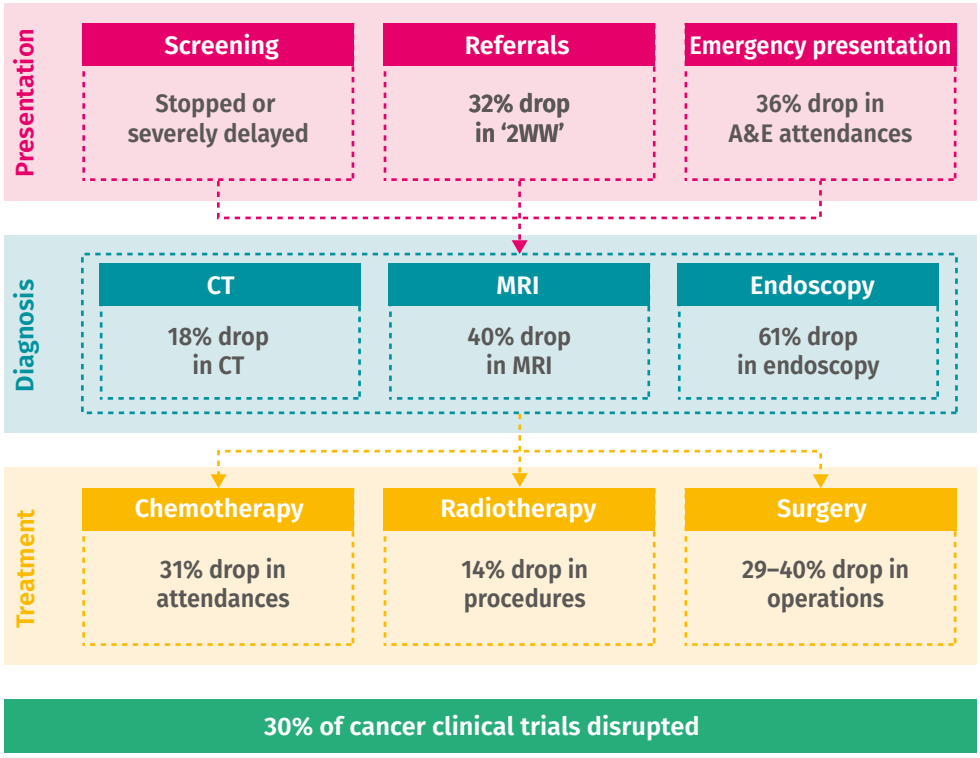
The NHS Long Term Plan sets out ambitious aims to address these weaknesses through better prevention and earlier diagnosis (NHS 2019). It builds on previous reform plans, including *The NHS Cancer Plan* in 2000 and the *Five Year Forward View* in 2014, to improve cancer outcomes in England. In particular, *The NHS Long Term Plan* commits to widening screening programmes, earlier cancer diagnoses and accelerating access to treatment. Specifically, it aims to increase the proportion of cancers diagnosed while still highly curable (at stage 1 or 2) from around 44 per cent to 75 per cent by 2028. The overarching objective of this activity is to continue – if not increase – the rate at which 1- and 5-year survival rates for all major cancers are improving.

Cancelled cancer care

These targets have been severely disrupted by Covid-19 across the clinical pathway – from prevention to treatment (figure 2.1).

FIGURE 2.1

Disruptions to cancer services in 2020 due to the Covid-19 pandemic



Source: CF analysis

During the first wave of the Covid-19 pandemic, breast, bowel and cervical cancer screening programmes were all paused. This could have resulted in over 3 million people missing their screening appointments (Cancer Research UK 2020). While screening has restarted and stayed open during the second wave, it is not yet back to full capacity and is facing a large backlog.

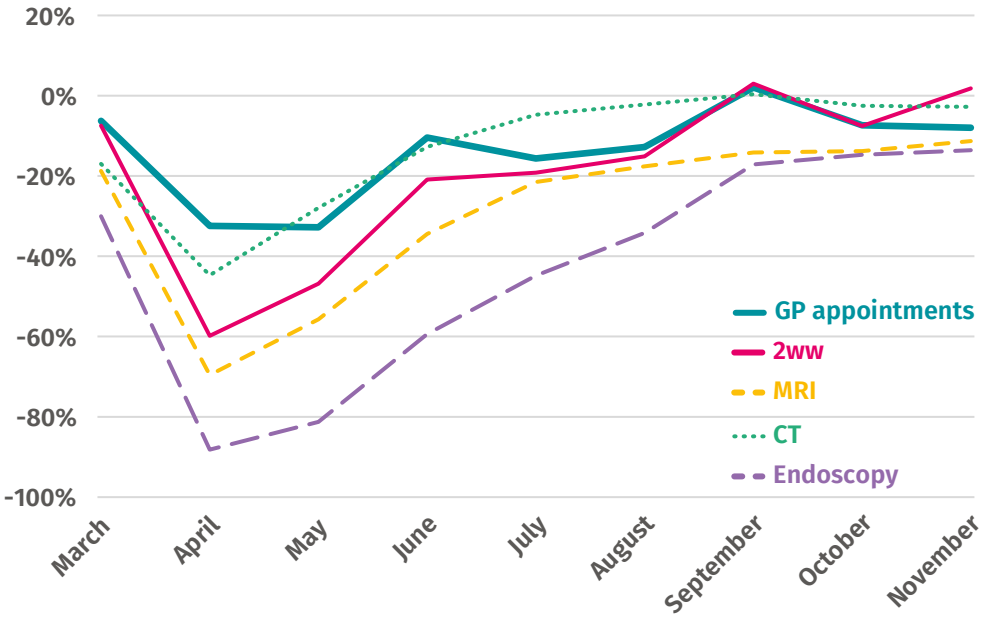
Likewise, volumes of suspected cancer referrals through the urgent two-week wait pathway, which accounts for nearly half of all cancer diagnoses, dropped significantly during the first Covid-19 peak and recovered slowly. There were 280,000 fewer two-week wait referrals than expected in 2020, which could mean 14,000 missed cancer diagnoses last year.[2] The good news is, as of December 2020 (latest data at time of writing), two-week wait referrals had recovered to normal levels for most cancers (figure 2.2). Suspected lung cancer referrals, however, remain 29 per cent below expected levels, perhaps reflecting the overlap in symptom profile with Covid-19. The full impact of the second wave of coronavirus on cancer referrals is not yet clear, although it is likely they will be far less affected than during the first wave.

The recovery in diagnostics – particularly MRI and endoscopy – has been slower. Both are near 20 per cent below their 2019 levels, likely in part reflecting productivity losses due to new infection control procedures (figure 2.2).

2 Based on 5.3 per cent of referrals leading to a cancer diagnosed (Sud et al 2020)

FIGURE 2.2

Change in service levels in 2020 by month, compared to 2019 levels



Source: CF analysis of NHS Digital 2021a

Meanwhile, treatments (such as chemotherapy and surgery) were cancelled for thousands of patients during the first wave of Covid-19. This started to recover in the second half of 2020, until the severity of the second wave caused cancellations in 2021 once again. The full extent of these cancellations is yet to be revealed.

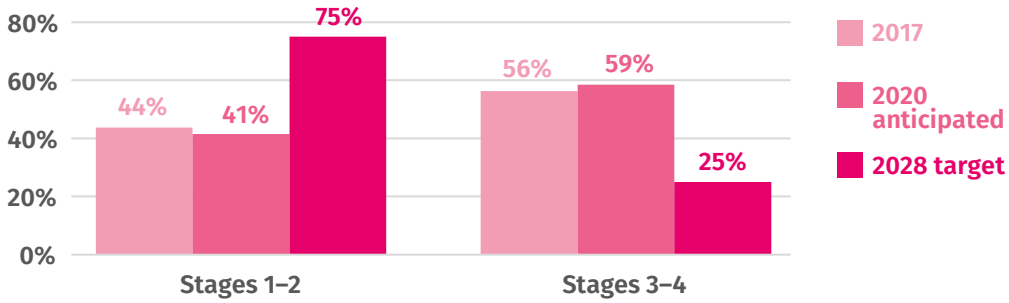
Falling further down international rankings

Delays in referral lead to delays in diagnosis. Delays in diagnosis lead to delays in treatment, and delays in treatment lead to premature deaths. Put simply: early diagnosis and treatment can make the difference between life and death (Cancer Research UK 2017). We have analysed the potential impact of late diagnosis on cancer outcomes for patients impacted by the disruption in services during the pandemic. We have focussed on three leading causes of cancer death: lung, colorectal and breast cancers. Across each we have assumed that the pandemic's disruption between April and August 2020 led to diagnosis occurring one stage later than would otherwise have been the case. Our modelling finds that the number of cancers diagnosed in 2020 while they are still highly curable (stage 1 and 2) has fallen from 44 per cent to 41 per cent as a result of the pandemic's disruptions to cancer services. It means we are travelling in the opposite direction to the early diagnosis target set out in *The NHS Long Term Plan* (figure 2.3).

FIGURE 2.3

Number of cancers diagnosed while still curable is dropping

Anticipated distribution of cancer diagnoses in 2020, via stages, compared to 2017 and the 2028 target in The NHS Long Term Plan



Source: CF analysis, NCRAS 2017

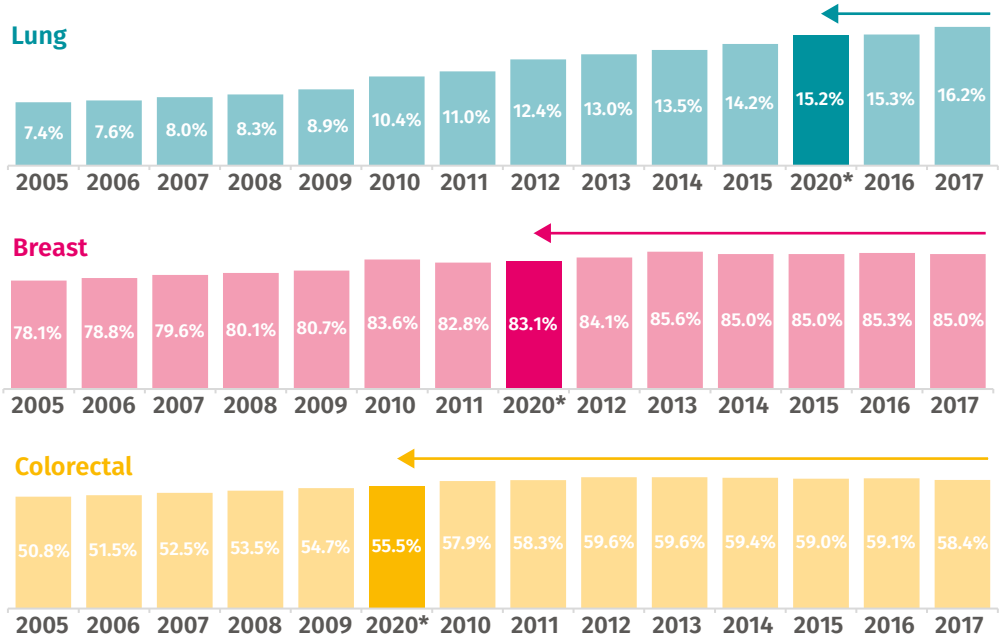
This will mean worse outcomes for people living with cancer in the coming years. Our modelling finds this stage shift in diagnosis will lead to an extra 4,500 cancer deaths this year. These are the result of disruptions in the first wave of the Covid-19 pandemic. At the time of writing, relevant data on the second wave was not available, but many regions are reporting cancelled cancer care.

The impact on five-year survival rates is also significant. It is equivalent to a loss in progress of two, six and eight years respectively in lung, breast and colorectal cancer (figure 2.4). To put that in context, these cancer survival outcomes are comparable to those seen in South Africa, Turkey and Lithuania (before the pandemic). They are a substantial set-back to *The NHS Long Term Plan*'s objectives.

FIGURE 2.4

The pandemic has reversed improvements in cancer survival

Five-year survival over time and anticipated for 2020, by cancer type, in England



Source: CF analysis, ONS 2019a

However, worse outcomes are not inevitable. There has been innovation during the pandemic that could be a basis for building back better cancer care. In particular, Covid-19 has accelerated the shift to providing more care in the community and at home. Community diagnostic and treatment hubs have been set up to provide cancer care away from hospitals dealing with Covid-19. Many patients have been trained to self-administer treatment such as chemotherapy at home, and remote monitoring and digital consultations ensure clinicians can continue to provide coronavirus-safe care to cancer patients.

Recovery and beyond

The difference between a decade of lost progress, and catching up with international standards, is decisive policy.

As previously recommended by IPPR (Quilter-Pinner 2020b), the greater provision of out-of-hospital cancer care should be maintained, and community diagnostic capacity expanded significantly further as recommended in Sir Mike Richards' review of diagnostic capacity in the NHS (Richards 2020). It will both help tackle the backlog and deliver *The NHS Long Term Plan*'s earlier cancer diagnoses target.

Cancelled cancer surgeries are one of the most urgent parts of the backlog to recover, given the clinical consequences of further delays. The most deprived regions of England experienced the greatest cancellations (Propper, Stockton and Stoye 2020); they must now experience the greatest recovery. Otherwise, regional health inequalities will entrench further.

This builds the case for additional backlog funding, capital investment (such as more MRI, CT, endoscopy and radiotherapy equipment) and workforce expansion. Policy relating to funding and workforce is discussed further in chapter 3.

2.2 MENTAL HEALTH

Mental health disorders are the leading cause of disability in working age adults (Vos et al 2020).[3] This has profound impacts on the economy – mental illness accounts for at least £70 billion in lost output (Layard 2015). More importantly however, mental health is the single biggest factor influencing whether people are satisfied with their life (Layard et al 2014).

Yet only around one in three people with mental health problems receive treatment (APMS 2016). Although this figure is trending upwards, it is some distance from 'parity of esteem' – a principle enshrined in law which states that mental health should be considered just as important as physical health, with equal care access and quality standards. Successive governments have made achieving 'parity of esteem' a key objective; most recently it was reiterated in the latest Conservative party manifesto.

Rightly, *The NHS Long Term Plan* prioritised mental health. Building on the *Five Year Forward View* (NHS 2014), it looks to make progress on achieving 'parity of esteem'. Accompanied by ringfenced mental health funding worth an additional £2.3 billion a year by 2023/24, *The NHS Long Term Plan* commits to providing mental health services to an additional 2 million people (including 345,000 more children and young people). In particular, it aims to expand drug and alcohol services, increase access to psychological therapies, and improve quality of care for those with severe mental illnesses (including joining up mental and physical health care).

3 including substance abuse disorders as mental health problems

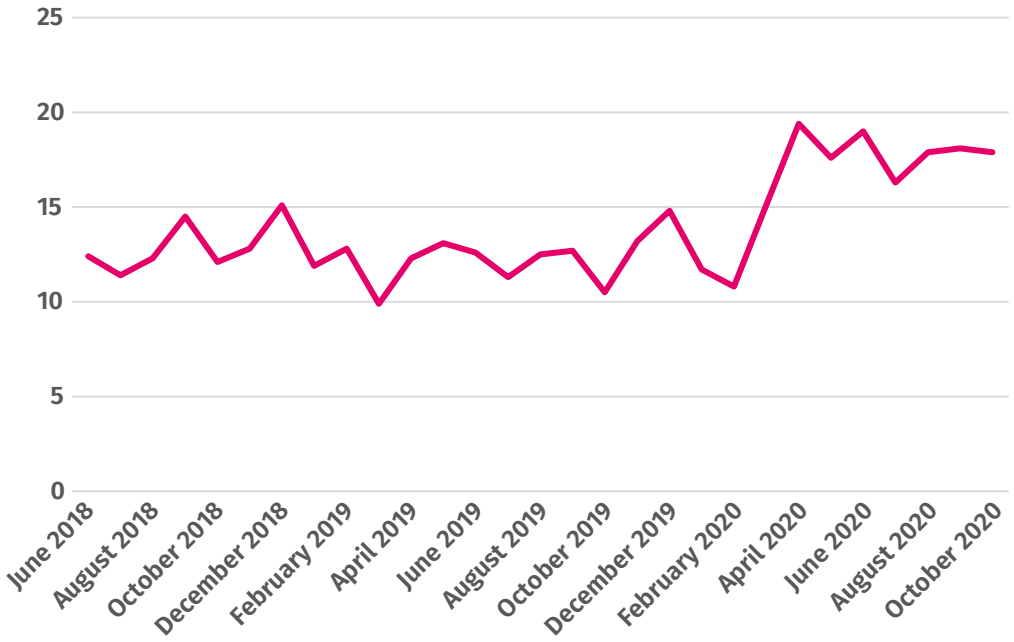
A pandemic of mental health disease

Social isolation, bereavement and job insecurity are fertile soil for mental illness. The pandemic has led to increases in both the risk factors that predispose people to mental illness, and to observable mental illness rates more directly. The starkest effects are in the mental health of children, likely related to school closures.

The NHS Long Term Plan hopes to prevent 50,000 alcohol-related admissions to hospital in the next five years. This will be more difficult given the sustained increase in the number of people drinking alcohol at risky levels since the start of the pandemic (figure 2.5). This comes at a time when alcohol-related hospital admissions and drug-related deaths are already at record levels (NHS Digital 2020c; ONS 2020d). Loneliness, unsurprisingly, has been persistently high during the pandemic (ONS 2020a). Stress levels are also high across the population, but highest among families with children, people from minority ethnic backgrounds, and those with low incomes (Covid-19 Social Study 2021). As job support schemes come to an end and unemployment rises (particularly youth unemployment), we can expect further rises mental illness (Thern et al 2017).

FIGURE 2.5

The number of people drinking at risky levels has increased during the pandemic
Percentage of people drinking alcohol at risky levels: June 2018 to October 2020



Source: IPPR analysis of Alcohol Toolkit Study 2020

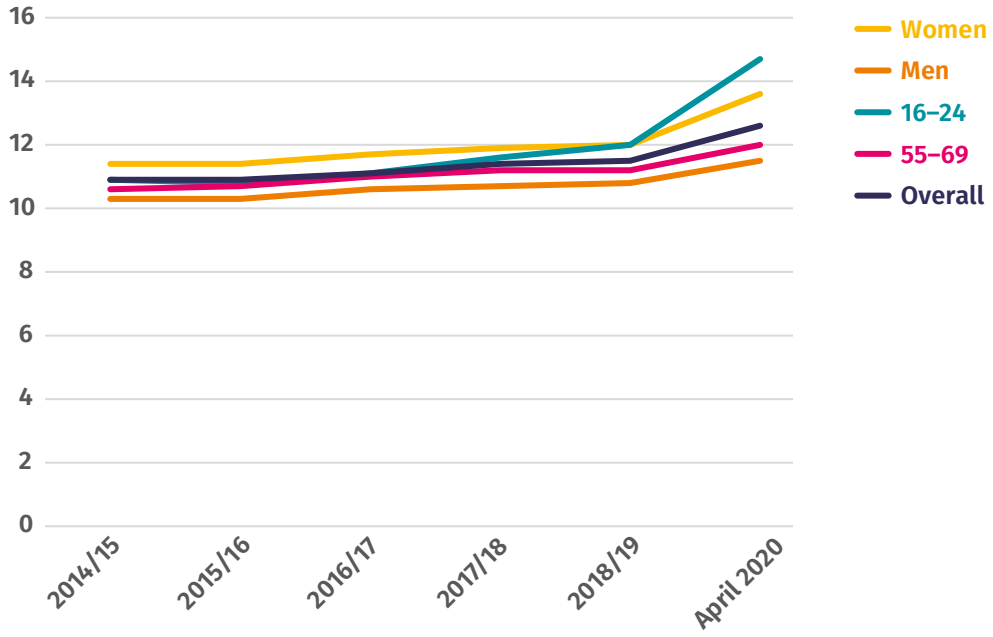
More directly, the mental health of adults in the UK has, on average, worsened by almost 10 per cent – and by 22.5 per cent for young adults and 13.3 per cent for women (figure 2.6).[4]

4 Based on the GHQ-12 survey, a validated, widely used screening instrument to detect common psychological disorders such as anxiety and depression

FIGURE 2.6

Adult mental illness rates have increased during the pandemic, particularly in women and young adults

Population GHQ-12 (screening tool to identify common mental disorders) mean scores over time



Source: Pierce et al 2020

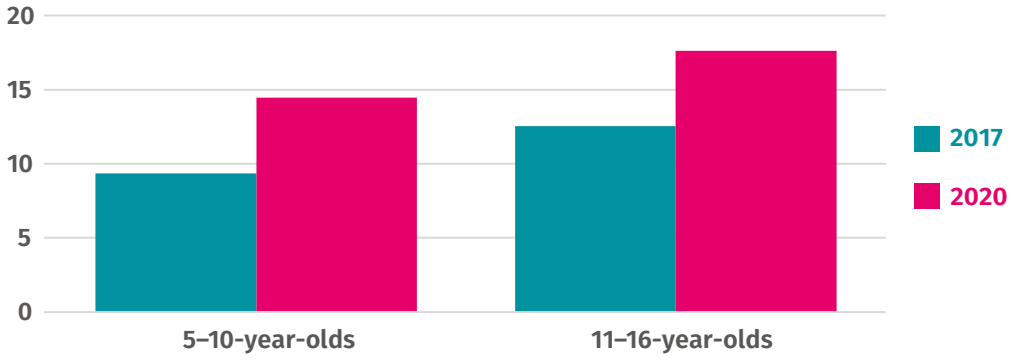
Children's mental health has declined most sharply during the pandemic, with large rises in both common and severe mental illness rates (figures 2.7 and 2.8). This is likely attributable to school closures. Children with mental health problems are more likely to live in households that have fallen behind on their bills, are less likely to have a desk or reliable internet to study at home, and are more likely to have a parent or guardian who cannot work from home (NHS Digital 2020b). The doubling in the number of referrals for eating disorders, which have the highest mortality rate of any psychiatric disorder, is particularly worrying (figure 2.8). It has pushed waiting list lengths to a five-year high.

Overall, it has been forecast that over 1.8 million new referrals to mental health services will occur in the next three years as a result of the first wave of the coronavirus pandemic (The Strategy Unit 2020). Although sufficient data is not available at the time of writing to understand the effects of the second wave on population mental health, it is very likely to sustain and amplify the trends described.

FIGURE 2.7

Children's mental health has declined sharply during the pandemic

Percentage of children with a probable mental disorder in 2017 and July 2020, 5–10-year-olds and 11–16-year-olds

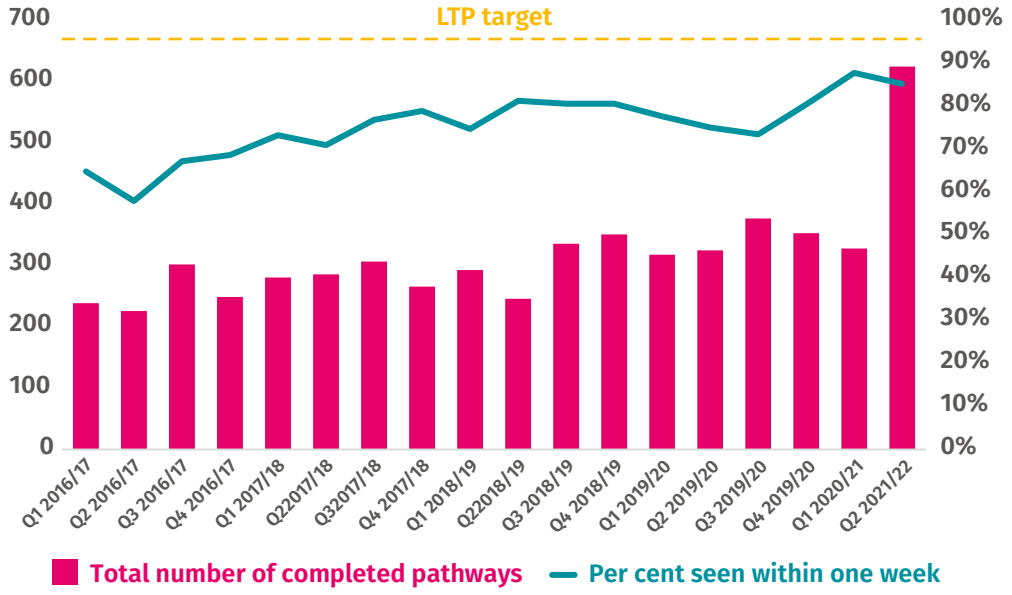


Source: IPPR analysis of NHS Digital 2020b

FIGURE 2.8

Referrals for childhood eating disorders have doubled

Number of completed urgent treatment pathways for childhood eating disorders over time



Source: IPPR analysis of NHS England 2020a

Rising demand, falling supply

Demand far outstripped supply in mental health care well before the pandemic. *The NHS Long Term Plan* sought to rebalance this. But the rise in incidence of mental illness outlined above has been matched by a fall in supply, stifling all progress towards 'parity of esteem'. This has set the NHS back several years in terms of progress.

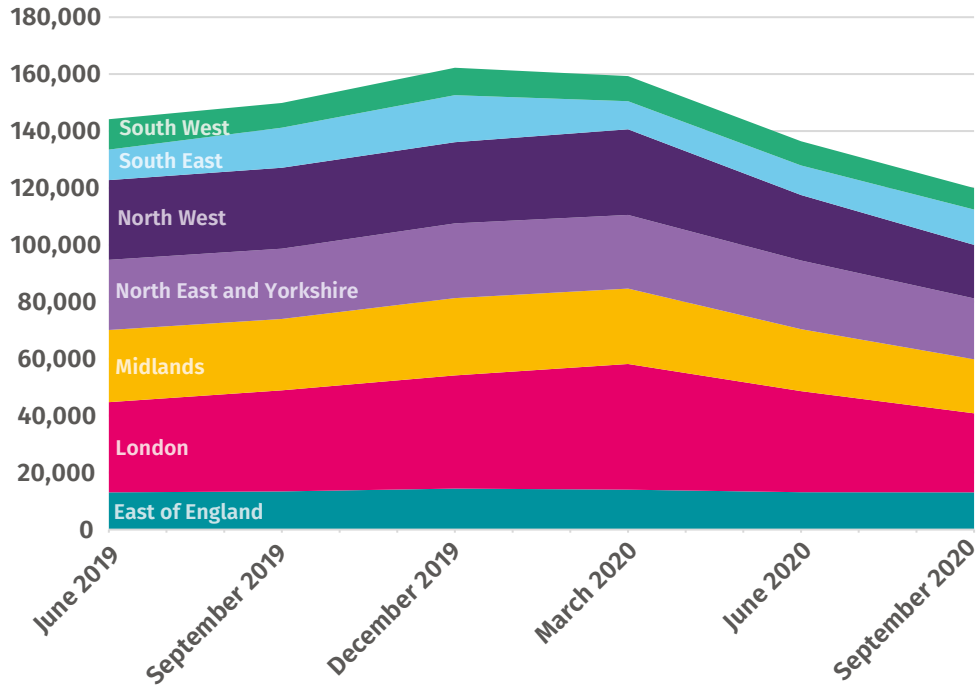
Between March and August 2020, 235,000 fewer people were referred for psychological therapies compared to the same period in 2019 (NHS Digital 2021c). Even before the pandemic, the NHS was already off its trajectory to ensure 1.9 million adults are accessing psychological treatment by 2023/24; this will dent progress further. The good news is that quality of psychological care appears to have been maintained, with over 50 per cent of people recovering after therapy (*The NHS Long Term Plan* target). The volume of referrals to psychological therapies has been recovering in the second half of 2020, although remains below normal levels. At the time of writing, it is not clear if the second wave of the pandemic has affected this rate of recovery.

Services for people with severe mental illnesses (SMI) such as schizophrenia and bipolar disorder have been disrupted particularly severely. Those with severe mental illness die 10 to 20 years earlier than the average person, and this gap is widening (Hayes et al 2017). Most of this premature mortality is driven by physical illness, particularly cardiovascular diseases. Recognising this, *The NHS Long Term Plan* aims to scale up physical health checks for patients with SMIs to 390,000 checks a year by 2023/24. By September 2020, the NHS fell to below a third of this target (figure 2.9).

FIGURE 2.9

Health checks for people with severe mental illnesses have fallen far below the NHS target

Number of people with SMI in England who received a physical health check in the past year, by region



Source: IPPR analysis of NHS England 2020b

However, there are pockets of progress to build on. In early March 2020, just under half of all mental health trusts had a 24/7 mental health crisis support telephone line (NHSEI 2020a). A month later, all did – achieving a goal of *The NHS Long Term Plan* a year early. Providing more care digitally is a broad ambition of *The NHS Long Term Plan* and Covid-19 has forced many trusts to accelerate their capacity to do this (NHSEI 2020b). Tribunal courts for Mental Health Act appeals have also continued virtually, ensuring the rights of those with severe illnesses are upheld as

best as possible. An important shift to harness in health and care is the increasing role and recognition of community assets – local support networks and mutual aid groups set up during the Covid-19 pandemic reveal the critical role community can play in care (Public Health England 2020c).

Expanding mental health care services

The health and care leaders we polled most often identified the rise in mental health problems as the most important challenge to tackle in the context of the Covid-19 pandemic (figure 3.2). If *The NHS Long Term Plan*'s targets for the number of people accessing mental health care is not revised upwards, hundreds of thousands of people will fall into despair and a generation of young people will be left scarred by the pandemic. The mental health of children and young people must become a central focus for the post-pandemic NHS and any update to *The NHS Long Term Plan* must reflect this.

Much more than the £500 million announced in the 2020 comprehensive spending review will be required to adequately expand mental health capacity; The Strategy Unit have estimated £3–4 billion is needed (The Strategy Unit 2020).

But extra funding is of limited value without the workforce to deliver care. A survey conducted by the British Medical Association (BMA) just before the pandemic began found 63 per cent of mental health staff worked in a setting with rota gaps, and 69 per cent of these said such gaps occurred either most or all of the time (BMA 2020). The pandemic will have worsened this. Solutions to the workforce crisis are urgent.

Policy relating to funding and workforce is discussed further in chapter 3.

2.3 CARDIOVASCULAR DISEASE

In recent decades, falling rates of smoking and significant advances in treatment have resulted in improving cardiovascular disease outcomes (Bhatnagar et al 2016).[5] However, despite being largely preventable, cardiovascular disease is still the leading cause of death in the UK (Vos et al 2020). This distribution of deaths is highly unequal: people living in Blackburn are twice as likely to die from cardiovascular disease than those who live in Chelsea (Bhatnagar et al 2015).

The risk of death after a heart attack is higher in the UK compared to the average for OECD countries. This mortality rate gap between the UK and the OECD average has been growing since 2011 (OECD 2020a). Worryingly, mortality figures from 2019 showed an increase in cardiovascular disease deaths among people under 75 – the first such rise in half a century (British Heart Foundation 2019). Given the scale of cardiovascular diseases, these reversed trends will accelerate life expectancy falls occurring in deprived parts of the UK (Hiam et al 2020) – including in so-called 'red-wall' seats. The Conservative party has pledged to increase healthy life expectancy by five years by 2035.[6]

The NHS Long Term Plan regards cardiovascular disease as 'the single biggest area where the NHS can save lives over the next 10 years,' and explicitly aims to 'prevent up to 150,000 heart attacks, strokes and dementia cases over the next 10 years'. It proposes to achieve this through three key improvements: by increasing access to prevention services to reduce rates of smoking, alcohol consumption and obesity; by detecting cardiovascular disease risk factors – such as high blood pressure, abnormal cholesterol and abnormal heart rhythms – earlier; and by spreading best practice treatment including specialist hyper-acute stroke care and rehabilitative intervention across the NHS.

5 Cardiovascular disease is a general term for conditions affecting the heart and blood vessels, such as heart attacks and strokes

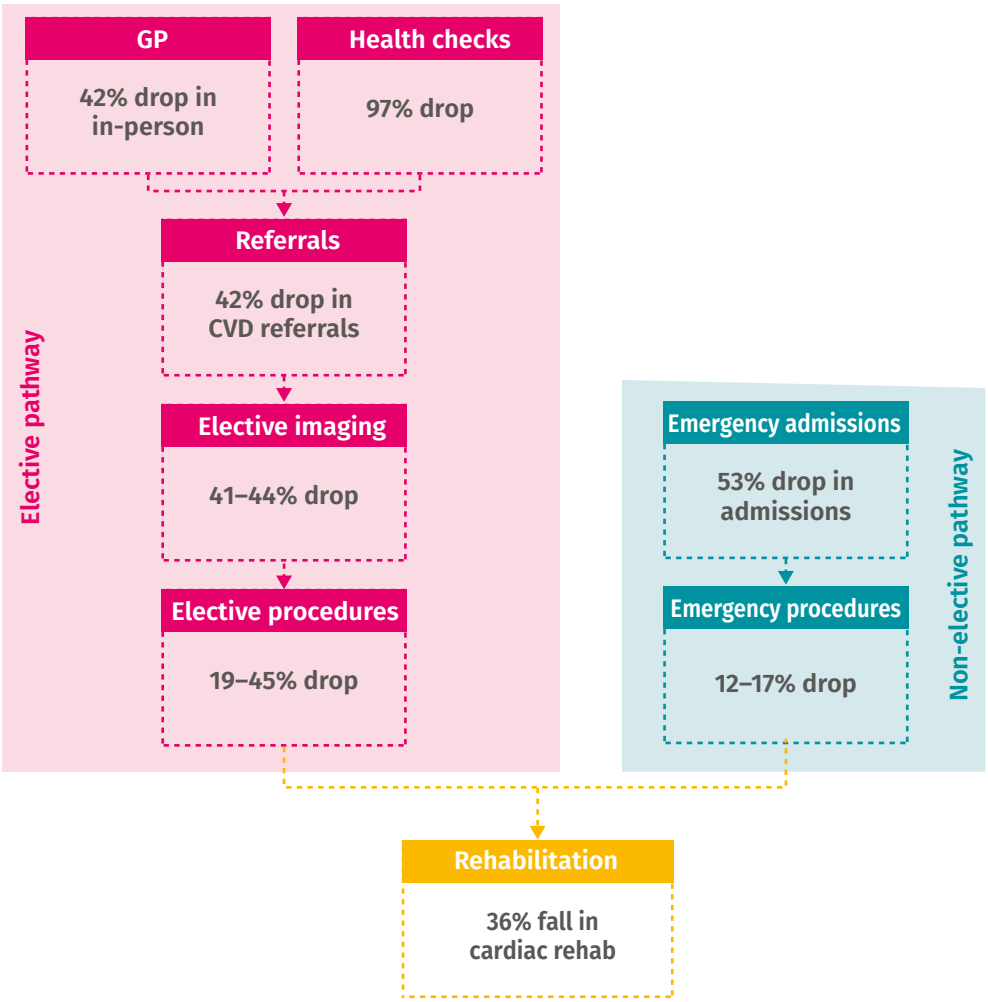
6 Healthy life expectancy is defined as the number of years a person can expect to live in good health or free from limiting illness or disability

The pandemic has side-lined prevention

The pandemic has had significant impacts on cardiovascular disease, with disruptions to prevention, diagnosis and treatment (figure 2.10).

FIGURE 2.10

Disruptions to cardiovascular care services in 2020 due to the Covid-19 pandemic



Source: CF analysis

The pandemic has had a mixed effect on behavioural risk factors for cardiovascular disease. As described in the mental health section of this report, high-risk alcohol consumption has increased. An estimated 15 per cent of people also report purchasing more processed food, a dietary risk factor for cardiovascular disease, than usual (Food Standards Agency 2020). However, over one in three adults report doing more physical exercise than usual (Savanta ComRes 2020), and there has been a rise in the number of people attempting to quit smoking (Smoking Toolkit Study 2020).

Primary care is at the heart of the NHS's plans for earlier detection of cardiovascular disease, but almost 80 million fewer in-person GP appointments took place between March and December 2020 compared to the previous year (NHS Digital 2020a). The incredible rise in telephone GP appointments mitigated the reduced access to care this would otherwise have caused, but rushing the shift to remote care comes with a warning about quality. For example, information usually gained through clinical

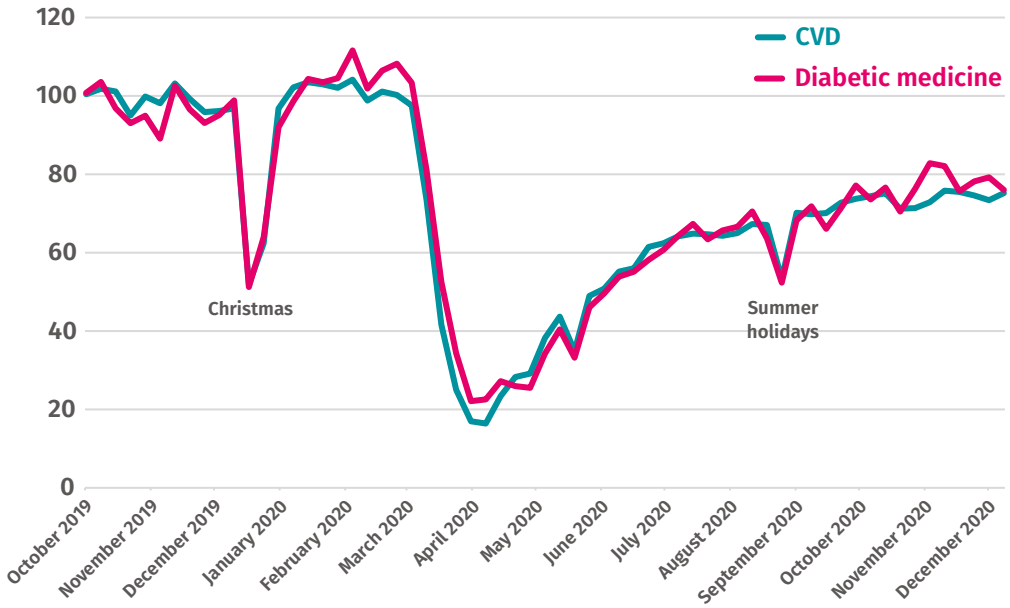
examination – which is especially important to identify cardiovascular disease risk factors such as high blood pressure and abnormal heart rhythms – is lost.

Meanwhile, the NHS Health Check, a check-up programme offered to people aged 40 to 74 years to spot cardiovascular disease and risk factors, have seen even greater declines: a 97 percent fall between April and June 2020 compared to the same period in the previous year (Public Health England 2020b).

Subsequent falls in referrals to specialist services and diagnostic imaging have been enormous and unequal. Referrals to cardiovascular disease and diabetes specialists fell dramatically in the first wave of coronavirus to 16 and 22 per cent of expected levels respectively – and though these referrals are recovering, they remain a quarter below expected volumes (figure 2.11). Compared to the year before, 280,000 fewer outpatient echocardiograms (key to diagnosing long-term heart conditions) were performed between March and November 2020. Many regions with high levels of coronary heart disease mortality have experienced some of the steepest falls in echocardiograms performed (figure 2.12). This means the backlog of cardiovascular disease referrals and diagnostics is very large and unequally distributed.

FIGURE 2.11

Referrals to cardiovascular and diabetes specialists have been slow to recover
Weekly percentage of cardiovascular disease and diabetic medicine referrals relative to pre-Covid levels

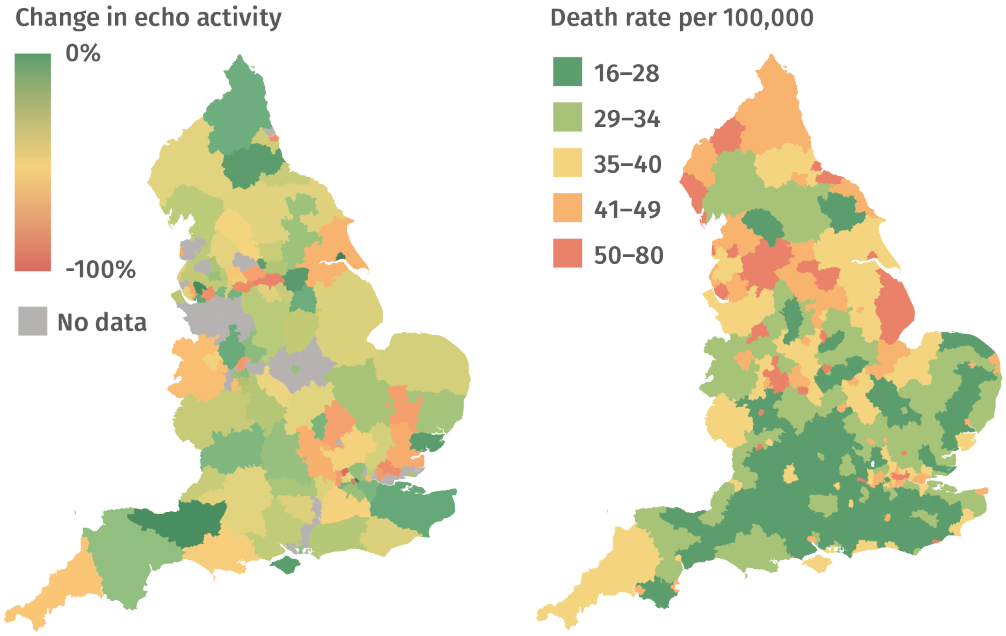


Source: CF analysis of NHS Digital 2021a

FIGURE 2.12

Reduction in echocardiograms has entrenched regional inequalities in heart disease

Change in echocardiogram activity and death rate by region



Source: CF analysis of HES 2020 and PHE 2021

Both emergency and elective cardiovascular disease procedures and operations have been disrupted by the pandemic. During the first wave, the fall in emergency procedures performed for heart attacks and strokes corresponds to the reduction in patient presentation to emergency services. Although the health service was pre-occupied with Covid-19 cases, quality standards of emergency stroke and heart attack care was largely maintained (SSNAP 2020; Wu et al 2020). Cancelled elective procedures during the first wave of the pandemic has led to a long list of patients at high risk of heart attack and stroke while they wait (table 2.1). Disruptions during the second wave of Covid-19 means that most of these patients are still waiting, and this list is likely to be growing.

TABLE 2.1

Falls in elective cardiovascular disease procedures and operations during the first wave of Covid-19 compared to the same period the year before

Procedure/operation	Significance	Impact of Covid-19
Elective percutaneous coronary interventions (PCI)	Heart attack prevention (cardiac reperfusion)	25% reduction
Coronary artery bypass grafts (CABG)	Heart attack prevention (cardiac reperfusion)	45% reduction
Carotid endarterectomy	Stroke prevention (cerebral reperfusion)	31% reduction
Cardiac pacemaker and/or defibrillator implant procedures	Cardiac arrest prevention	19% reduction

Source: CF analysis of NHS Digital 2020d

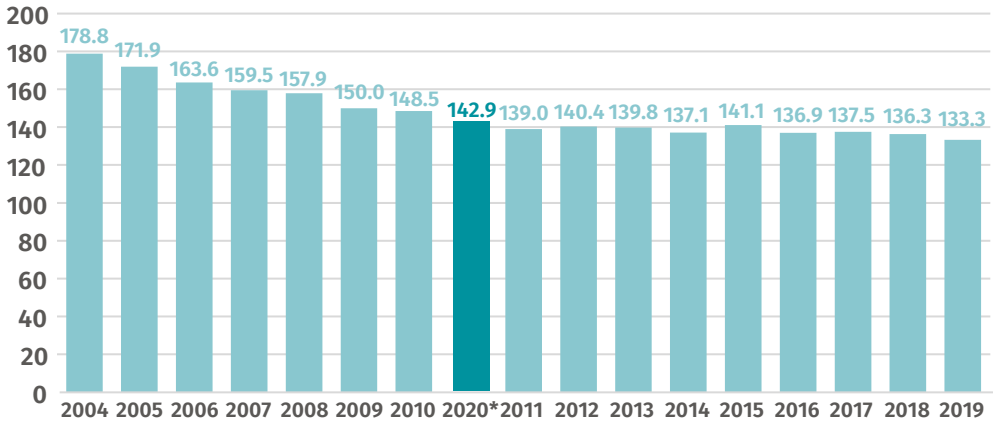
A fatal disruption

There were over 5,600 more deaths than expected from cardiovascular diseases last year (Public Health England 2020a), bringing cardiovascular mortality to the highest level seen in a decade (figure 2.13). The majority of these excess deaths are attributable to healthcare disruption caused by the pandemic.[7]

FIGURE 2.13

Cardiovascular mortality is at the highest level seen in a decade

Deaths from cardiovascular disease in England per year (thousands)



Source: CF analysis of PHE 2021, British Heart Foundation 2020
***2020 levels are calculated as a five-year rolling average that includes excess cardiovascular disease deaths observed during the pandemic**

This may only turn out to be the thin end of the wedge. Cardiovascular diseases are long-term conditions, and most of the disturbance during the pandemic has been to early detection and secondary prevention. That means the biggest impacts are yet to unfold.

Our analysis finds 470,000 fewer new prescriptions (people commenced on a medication for the first time) of preventative cardiovascular drugs such as antihypertensives, statins, anticoagulants and oral antidiabetics between March and October 2020 compared to the previous year (figure 2.14).[8] If these people are not found, diagnosed and commenced on treatment, we estimate an additional 12,000 heart attacks and strokes will occur in the next five years. The higher levels of electronic prescribing however, a positive shift, has ensured patients receiving repeat prescriptions have been able to access their regular medications without disruption.

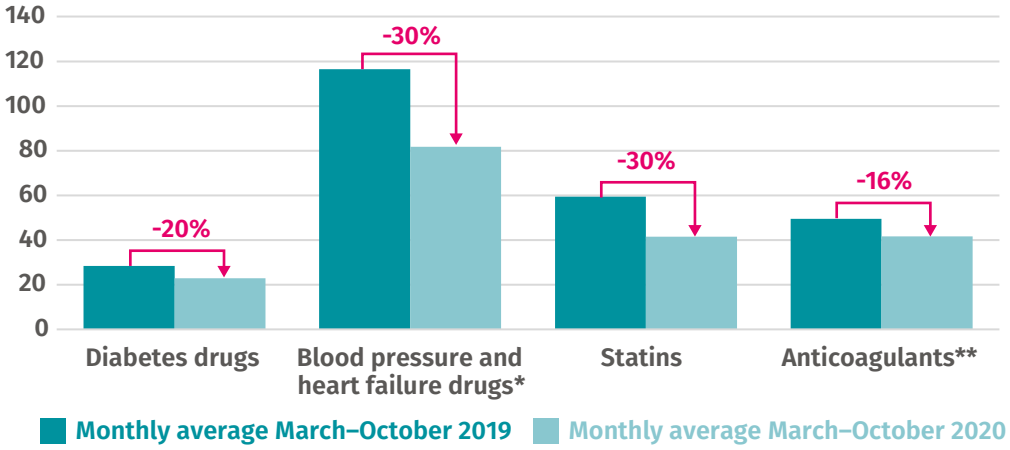
7 A minority will be directly attributable to Covid-19 pathology

8 There has been a reduction in new initiations of statins, antihypertensives, beta blockers, anticoagulants and oral diabetes drugs totalling 470,000 prescriptions. As some patients may have been commenced on multiple medications at the same time, the total number of patients missed may be lower than this. Based on CF analysis of LPD, IQVIA Ltd, incorporating data derived from THIN, a Cegedim database, Oct 2020

FIGURE 2.14

Opportunities to prevent heart attacks and strokes have been missed

Number of patients initiated on preventative cardiovascular disease drugs for the first time



Source: CF analysis of LPD, IQVIA Ltd, incorporating data derived from THIN, a Cegedim database, Oct 2020
***Includes beta blockers, calcium channel blockers, ACE inhibitors and diuretics**
****Warfarin and novel oral anticoagulants**

Additionally, we estimate the fall in echocardiograms (figure 2.12) means at least 23,000 missed heart failure diagnoses last year – a major setback to *The NHS Long Term Plan*'s goals to improve heart failure diagnosis and outcomes. Less than half of all people diagnosed with heart failure are alive five years later – a worse survival rate than most cancers – and early diagnosis is crucial to allow timely initiation of treatment (Taylor et al 2019).

If missed cardiovascular disease diagnoses, treatment initiations and elective procedures are not made up for, preventable cardiovascular disease deaths will continue to rise. A sustained reversal to cardiovascular mortality trends is a significant setback, not just to *The NHS Long Term Plan*, but to a number of Conservative party manifesto pledges.

Preventing more pandemic heart attacks

Finding the almost half a million missed patients and tackling the backlog of elective cardiovascular disease care is an urgent priority. Increasing the community care capacity in the most deprived regions of the country will help achieve this.

But if we want to avoid the pandemic causing lasting damage to health, addressing the care backlog alone is not enough. We need a radical rethink of our approach to health inequalities and prevention. Initiatives such as CVDPrevent, a new primary care audit to improve cardiovascular care quality, are helpful. But action outside of the NHS is required, too. Building on the prime minister's obesity drive, the government should improve the sequencing and co-ordination of wider policy functions to 'level up' health across the country – and deliver their manifesto pledge to increase life expectancy.

A more holistic digital health strategy is required too. The rapid shift to remote care comes with a warning about quality. Many patients do not have the medical training or self-monitoring equipment to clinically examine themselves. Vital clinical information therefore likely to be lost in the digital consultation and quality of care compromised. Indeed, the fall in cardiovascular medication initiation is steeper than the fall in the total number of GP appointments, implying digital consultations are leading to suboptimal treatment. Overcoming this will need investment in

remote monitoring training and equipment, but perhaps most importantly, ensuring patients and clinicians retain choice over the mode of consultation (in-person, telephone, video, etc).

Policy relating to digital care and public health is discussed further in chapter 3.

2.4 MULTIMORBIDITY

Our ageing population is driving rising levels of multimorbidity. More than a quarter of adults in England have two or more long-term health conditions (Cassell et al 2018), and one in three people admitted to hospital have over five underlying health conditions (Stafford et al 2018). The distribution is very unequal; those in the most deprived regions are more likely to become multimorbid – and do so 10–15 years earlier and with more functional limitations (Barnett et al 2012; Dugravot et al 2020). Multimorbidity also concentrates in several minority ethnic populations (Watkinson, Sutton and Turner 2021).

By 2035, one in six people will be living with over four long-term conditions (Kingston et al 2018). Our health and care system is not set up to handle this epidemiological shift. Care for most diseases is siloed into specialist pathways. And although patients do not separate their care needs into health and social, the system does. As a result of these divisions, the health and care system often struggles to see and support the patient as a whole (Taskforce on Multiple Conditions 2018).

Meeting these modern challenges requires integration of care: the NHS's main goal for many years now, and one that has proved difficult to achieve. *The NHS Long Term Plan* is the latest attempt. There are two broad aims: to better join up care around the individual; and to keep people and patients out of hospitals. This should, in theory, vastly improve both the quality of care for patients and the financial sustainability of the NHS.

Primary care networks (PCNs) are *The NHS Long Term Plan*'s main vehicle to deliver integrated care to patients, pulling together local GP practices to work together and with community, mental health, social care, pharmacy, hospital and voluntary services in their local area. Although multimorbidity isn't explicitly discussed in *The NHS Long Term Plan*, it is the focus of a key follow-up document titled 'Universal Personalised Care' (NHS England 2019).

Outside of the NHS, an underfunded and undervalued social care system has been one of the most significant barriers to integrating care. While official NHS documentation is light on social care services, chief executive Simon Stevens has been clear on the urgent need to reform and better resource social care for health system sustainability (*BBC News* 2020). This government has pledged a cross-party solution to social care (with work supposed to have commenced in its first 100 days in power), building on multiple previous manifesto commitments. A government white paper on health and social care reform published on 11 February 2021 provided minimal further information beyond stating proposals for social care will come 'later this year' (DHSC 2021a).

Patients with multiple long-term conditions have experienced Covid-19's impacts on primary care, social care and integrated care.

Primary care

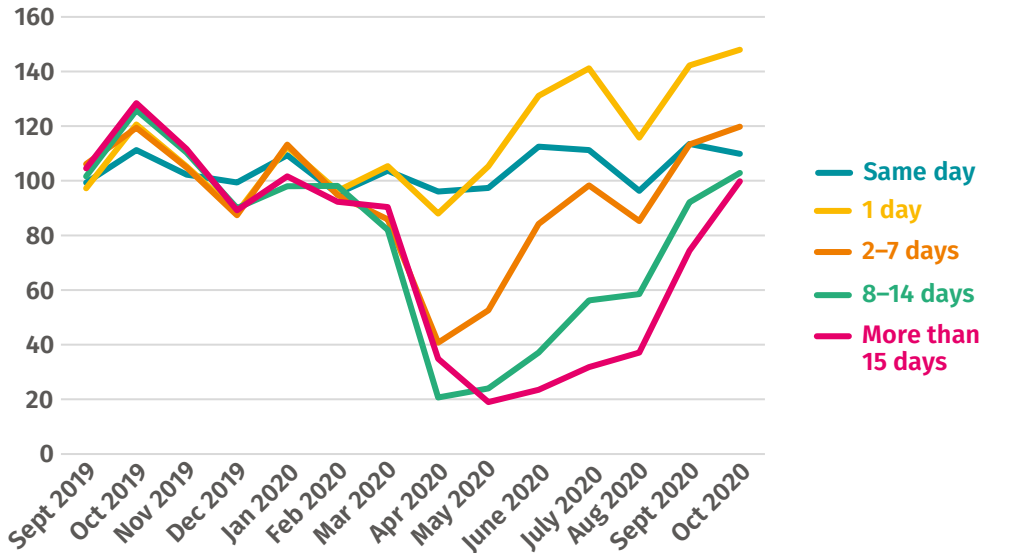
In primary care there has been great disruption and remarkable innovation. The almost five million people in England with over four health conditions usually see their GP once a month (Stafford et al 2018). They have suffered disproportionately from the over 31 million fewer GP appointments that occurred between March and December 2020 (compared to the same period in 2019). Most of these were non-urgent appointments, booked two or more days in advance, which are more likely to be for patients with long-term conditions (figure 2.15).

These falls would have been far worse were it not for the ability of primary care to adapt. There has been an incredible rise in telephone GP appointments (figure 2.16), and 88 percent of GPs feel this greater use of remote appointments should be retained long term (BMA 2021a). They have several potential benefits for patients (such as fast and easy access), for clinicians (such as freeing up time) and for the healthcare system more broadly (such as cost savings). But the shift to remote care amplifies digital inequalities in health: those with low digital literacy or poor mobile and internet access are left behind. Those digitally excluded are more likely to be older, poorer and from minority ethnic backgrounds (ONS 2019b).

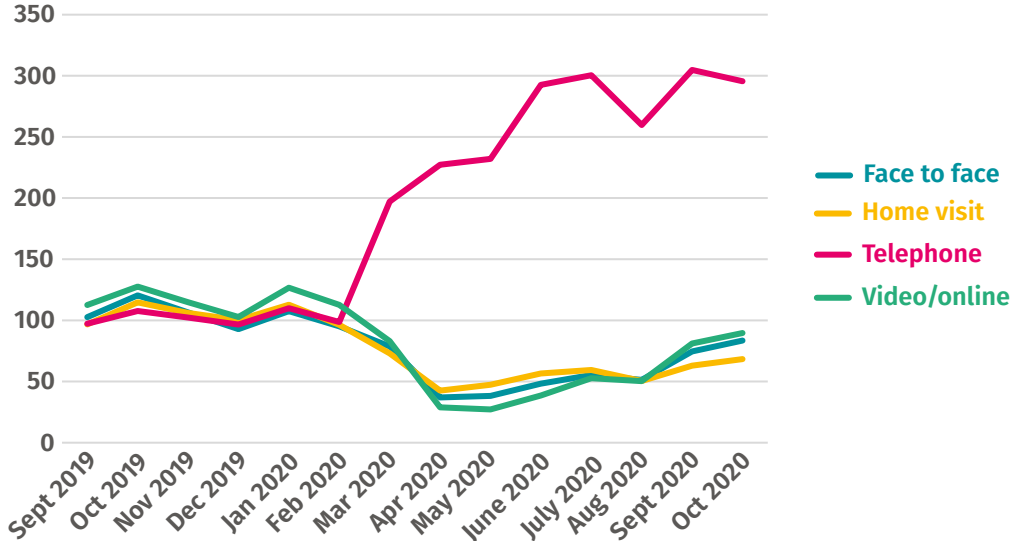
FIGURES 2.15 AND 2.16

The pandemic has led to big shifts in primary care

Primary care appointments over time compared to pre-pandemic levels, by time between booking day and appointment day*



Primary care appointments over time compared to pre-pandemic levels, by mode of consultation*



Source: IPPR analysis of NHS Digital 2020

*Pre-pandemic levels defined as average monthly consultations from March 2019 to March 2020.

Social care

Multimorbidity drives functional impairment, disability and frailty – and thus social care needs (Hanlon et al 2018). Over half of care home residents in England and Wales have medical problems in at least three out of six organ systems (Barker et al 2020). Covid-19 has preyed on these individuals.

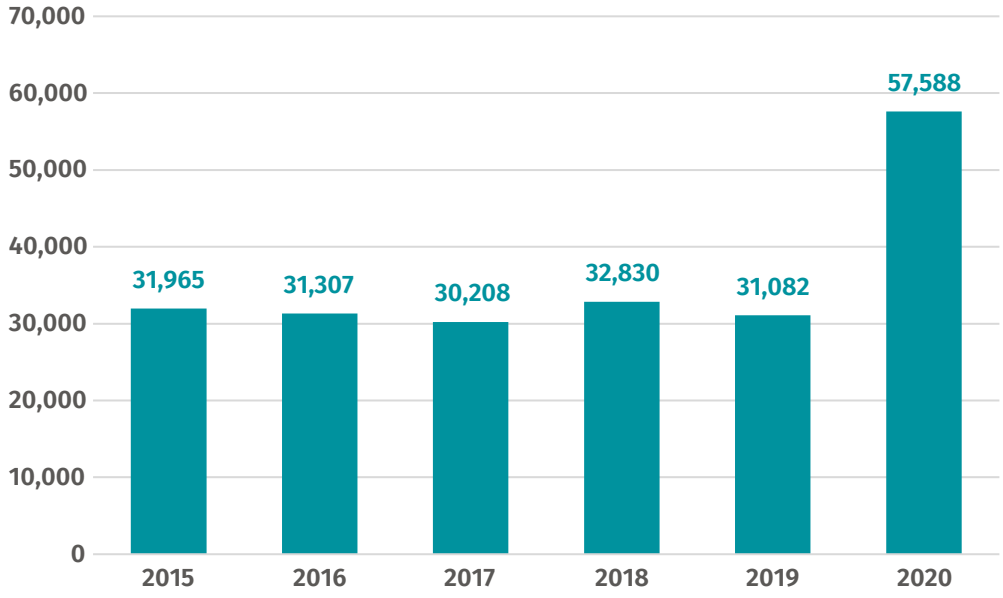
In the first wave, there were almost 30,000 more deaths among care home residents in England than we would have expected (figure 2.17) and a further 3,000 excess deaths in people receiving social care at home (ONS 2020d). This amounts to over half of all excess deaths in England during the first wave of Covid-19. Infection rates in residents were higher in care homes that rely more heavily on bank and agency staff, and lower in those where staff receive sick pay, highlighting how structural issues in social care contributed to the Covid-19 crisis (Shallcross et al 2021). It has been suggested that rapid discharges from hospitals to care homes, to help free up hospital bed capacity, may have shifted the epidemic into social care. The National Audit Office report a lack of Covid-19 testing capacity meant many patients were discharged from hospital to care homes with the virus (National Audit Office 2020a). Although it remains unclear to what extent this seeded the epidemic in social care, the poor co-ordination between hospitals and social care is evident.

At the time of writing, far fewer care home residents have died during the second wave of coronavirus. This is likely the result of care homes being better prepared, with vastly improved testing capacity and infection control procedures. It suggests the majority of care home deaths in the first wave of the pandemic were avoidable.

FIGURE 2.17

There were nearly 30,000 excess deaths among care home residents during the first wave of the pandemic

Number of recorded deaths in care homes between March and June per year



Source: IPPR analysis of ONS 2020d

Building back better

Despite the damage, the pandemic has shown us that better working together is possible. 'Enhanced health in care homes', a national specification for PCNs, was prioritised across England following the impacts of the first wave on care home residents. Internal NHS England and NHS Improvement (NHSEI) situation reports have found most PCNs are delivering on this, for example, by holding virtual multidisciplinary team (MDT) meetings for care home residents that involve practitioners from primary care, community care, social care and clinical pharmacy working together.[9] The purpose of these community MDTs is to provide more integrated and personalised care, and to reduce avoidable hospital admissions. Evidence evaluations are ongoing with regards to the latter, but it is clear that MDTs improve patient satisfaction and experience of care (Lloyd 2020).

Other PCN specifications, such as structured medication reviews and early cancer diagnoses, have been delayed. This is because PCNs do not have the resource, capacity or infrastructure to deliver these specifications on NHSEI's timeline, as reflected in the GP contract negotiations between the BMA and NHSEI (BMA 2021b).

THE COVID-19 VACCINATION PROGRAMME

The Covid-19 vaccination programme is perhaps the best example yet of integrated working in health and care. PCNs have been at the heart of this.

By the middle of February 2021, nine in ten adults over the age of 70 – approximately three-quarters of whom have multiple health conditions – had received at least one dose of a Covid-19 vaccine. By international standards, the UK is far ahead of most countries in terms of vaccinating its population.

Working together towards a shared goal (to reduce Covid-19 mortality in the most vulnerable populations by vaccination) required collaboration within and between GP practices, hospitals, community pharmacy, local authorities, voluntary groups and NHSEI.

Better and easier data sharing between these groups has been particularly important. The information governance framework flexed during the pandemic to enable rapid sharing of data while still maintaining proportionate safeguards. This involved an updated regulatory approach from the Information Commissioner's Office and a formal notice from the Department of Health and Social Care directing health and care organisations to share confidential patient information for purposes relating to Covid-19 (DHSC 2020b; ICO 2020).

The result of this integrated working has been a hitherto successful vaccination programme. This sets the precedent for integrated health and care going forwards.

Integrating out of crisis

The NHS must get integration right this time. Bottom-up integration has flourished during the pandemic as regulatory and financial barriers have been taken down. With more freedom, local organisations worked in systems by default. Learning from this, policy to facilitate integration should avoid command-and-control and instead focus on building collaborative culture, better data sharing and local partnerships. The legislative changes proposed in the government's recent white paper can facilitate this – but are only one piece of the integration puzzle (DHSC 2021a).

9 Information gained through expert interviews

Indeed, nearly all health and care leaders we polled said interoperable IT systems (between primary, community and mental health services) are important in enabling PCNs to deliver their national specifications – putting it slightly ahead of more funding, staffing and legislative change (figure 2.18).

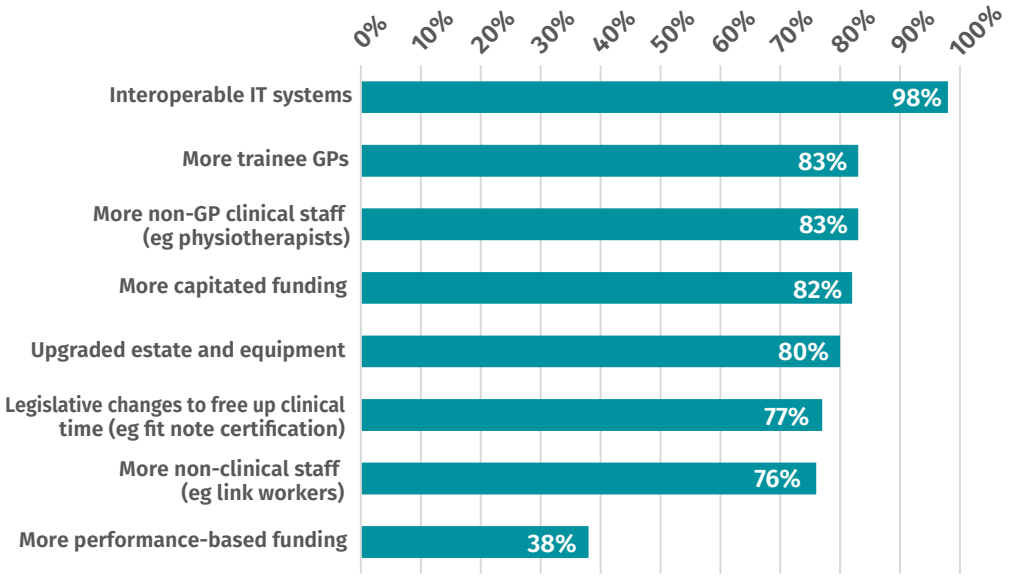
But delivering integration with a fragmented, underfunded, understaffed social care system will always be difficult. Despite pledging on a social care solution, the government once again kicked the can down the road in its latest white paper on health and social care reform (DHSC 2021a). A better, fairer social care system should be a legacy of the Covid-19 pandemic.

Policy relating to integration and social care is discussed further in chapter 3.

FIGURE 2.18

IT interoperability is at the heart of integrating services

Factors health and care leaders believe will enable PCNs to deliver on their national specifications (per cent rating each as important)



Source: IPPR/Savanta ComRes polling of 172 senior NHS and local government officials

3.
HOW TO BUILD BACK BETTER?

As our analyses have shown, Covid-19 makes it more difficult to deliver *The NHS Long Term Plan*. New IPPR polling finds four in five health leaders (81 per cent) across the NHS and local government agree.

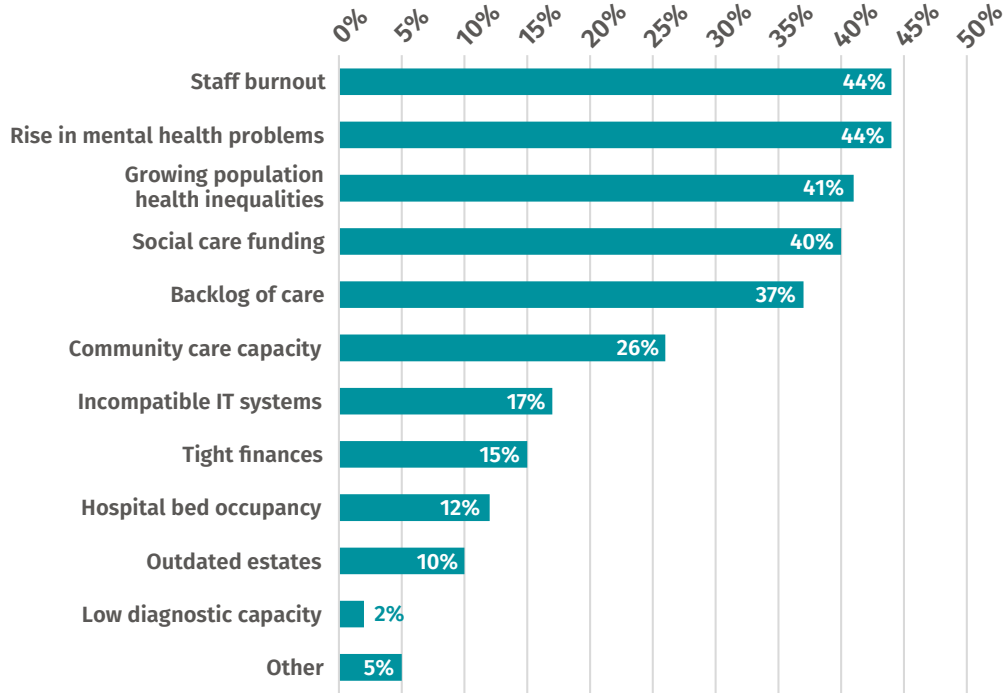
Given that we are just one year into the plan, the NHS finds itself at a crossroads – in terms of what it prioritises and how ambitious it is in the 2020s. Our polling finds the most important challenges amplified by the pandemic are rising mental illness, staff burnout, populational health inequalities, and social care (figure 3.1). Health leaders have ranked each of these as more important challenges to overcome than the pandemic care backlog.

***Four in five* NHS and local government leaders say the pandemic makes delivering The NHS Long Term Plan more difficult**

FIGURE 3.1

Staff burnout and rising mental illness are the greatest post-pandemic challenges

Most important challenges identified by health and care leaders to overcome in the context of the pandemic (per cent selecting each in their top three)



Source: IPPR/Savanta ComRes polling of 172 senior NHS and local government officials

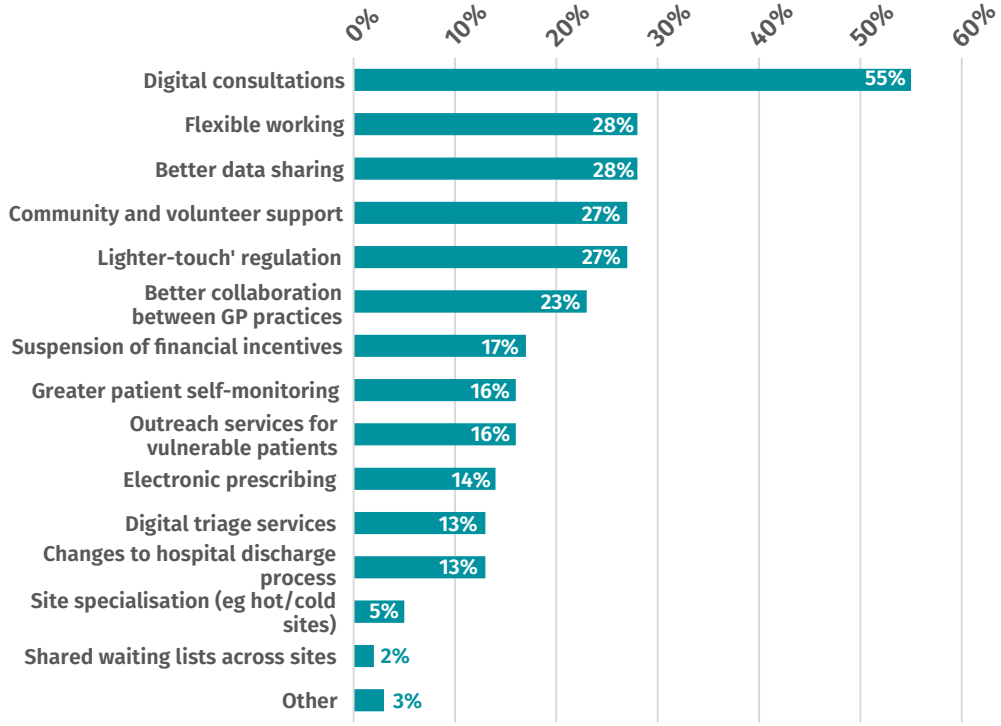
The pandemic has also shown us that better is possible. In particular, it has shattered long held beliefs about the slow speed of innovation in the NHS. The implication is that we do not need to confine ourselves to a trade-off between the care backlog and the ambitions of *The NHS Long Term Plan*. We should not simply focus on recovery, but on building back better. This will involve learning from the positive shifts that have occurred during the pandemic. Our polling highlights digital consultations, flexible working, lighter-touch regulation and better data

sharing as positive shifts health and care leaders want to see maintained (figure 3.2). Worryingly, 46 per cent of leaders polled report that beneficial changes which they saw occurring at the start of the pandemic are dissipating. Decisive policy action must now be implemented to capture them.

FIGURE 3.2

Digital consultations have been the pandemic's greatest innovation

Most important beneficial changes to maintain after the pandemic according to health and care leaders (per cent selecting each in their top three)



Source: IPPR/Savanta ComRes polling of 172 senior NHS and local government officials

Both recovery and increased ambition are only possible with policy change. Indeed, while clinical targets may shift, the policy that determines our ability to meet them do not. In this chapter, we explore what needs to change if we are to end the decade with a globally leading NHS.

But the NHS cannot 'build back better' health and care alone. An overwhelming 98 per cent of health leaders across the country believe *The NHS Long Term Plan* will be difficult to deliver without social care reform and cross-government action on health inequalities; a further 87 per cent believe changes to immigration rules are also important.

Bringing together these polling insights and our analysis of the pandemic's impacts on *The NHS Long Term Plan*, we have identified six key changes to 'build back better' health and care:

1. ensure a sustainable workforce
2. resource the NHS to deliver and sustain transformation
3. empower integration from the bottom up
4. upgrade the digital NHS
5. fund and reform social care
6. level up the nation's health.

Each is an area that has been highlighted as important by the pandemic, but that was also important to high quality health and care before Covid-19. They will define our attempts to do better on health in the years to come.

3.1 ENSURE A SUSTAINABLE WORKFORCE

In 2019, when *The NHS Long Term Plan* was released, there were an estimated 100,000 shortages in the NHS workforce as a whole (King's Fund 2019). Workforce shortages are commonly cited as the single biggest barrier to delivering *The NHS Long Term Plan*.

It has direct impacts on the quality and capacity of care (CQC 2020: 113). For example, half of all mental health staff are already too busy to provide the level of care they would like to (BMA 2020), but *The NHS Long Term Plan* wants a further 2 million patients to be accessing mental health services by 2023/24. Without the staff to deliver it, *The NHS Long Term Plan* will fail. While the government did focus on this in their manifesto, their commitments were inadequate even before the pandemic (Buchan et al 2020).

The pandemic has made workforce issues worse. It has put severe strain on staff, with challenging clinical situations, gruelling shift patterns, redeployment, unequal access to tests and PPE, inadequate childcare provision and low pay all issues. The result is burnout, moral injury and mental illness. Without action, this is likely to see more people leave the NHS – an IPPR poll in April 2020 found one in five healthcare workers were more likely to leave the sector because of the pandemic (Thomas and Quilter-Pinner 2020). Any plans to improve health and care will be severely constrained if action is not taken to: prevent catastrophic staff loss; address the shortages that existed before the pandemic; and ensure the workforce is fit for the future.

Improve retention and recruitment with a pay rise and a new benefits settlement

Greater alignment between contribution and reward is at the heart of addressing the NHS staff recruitment and retention crises. Better pay is the main driving force of that alignment.

In March 2021, the Department of Health and Social Care submitted evidence to the Doctors' and Dentists' Pay Review Body and the NHS Pay Review Body, who in turn will make recommendations to the government on NHS staff pay. The Department has suggested a one per cent pay rise for all staff. That is half of the pay rise (2.1 per cent) previously budgeted under the *NHS Long Term Plan* funding settlement. It is a post-pandemic austerity measure and out of touch with a macroeconomic consensus that is encouraging greater government spending in the recovery from Covid-19 (Jung, Dibb and Patel 2021).

The 'agenda for change' NHS pay deal (which covers nurses, midwives and most NHS staff who are not doctors) is set to end in 2021 and a new multi-year deal will be drawn up. Anything below the previously budgeted 2.1 per cent rise would be woefully inadequate. Most nurses have endured a 10 per cent real terms pay cut in the last decade. A respectable salary increase will only go some way to reversing that and is a fair reward for staff who have gone above and beyond during the pandemic.

A higher pay rise will also reduce post-pandemic workforce attrition. A majority of clinicians are now exhausted and in need of a break (RCP 2021); many will not return without added incentive. Indeed, the exodus of junior doctors from the UK has been gaining momentum for several years and is now at breaking point (Wilson and Simpkin 2021). And the migrant healthcare workers the NHS is so reliant on, who have been disproportionately exposed to Covid-19, will seek other destinations – particularly as the UK tightens its migration rules (Morris 2020).

Table 3.1 shows the estimated costs of three pay rise scenarios for: all NHS staff; all staff excluding consultant doctors and senior managers; and all staff excluding senior doctors and managerial staff. Improvements in workforce productivity and the fiscal multiplier effects of increasing the pay of 1.5 million working people in England (almost 5 per cent of the entire English workforce) will eventually more than offset much of the increased expenditure. It will also support a strong and fair economic recovery after Covid-19 (Jung, Dibb and Patel 2021).

Crucially, it is patients and the public who ultimately benefit from a better paid NHS workforce that is less stressed about financial problems, more motivated at work and more productive (Rankin and Parkes 2020).

TABLE 3.1

Costing scenarios for NHS staff pay rises (£billions)

Scenario	All staff	Excluding consultant doctors and senior managers	Excluding senior doctors and managerial staff*
1% pay rise	£0.3	£0.3	£0.2
2.1% pay rise (previously budgeted)	£0.7	£0.6	£0.5
5% pay rise	£1.7	£1.5	£1.2
7.5% pay rise	£2.6	£2.2	£1.8

Source: IPPR analysis

***Senior doctors defined as those at specialty registrar grade and above; managerial staff defined as managers, personnel, IT, legal and finance staff (specifically does not exclude catering, maintenance, porters and domestic staff).**

Note: Expenditure estimates based on cost of a base salary rise plus resulting pension costs, minus tax receipts (income tax and national insurance contributions).

Pay is not the only way to improve recruitment and retention. The people plan (NHS 2020b) has a stated ambition to make the NHS 'the best place to work'. Data from the health leaders we polled suggested greater professional autonomy (see section 3.3), flexible working, and mental health support are all at least as important as improving pay (figure 3.3). This is in keeping with IPPR polling of on-the-ground health professionals in 2020, which highlighted the importance of similar benefits and support beyond better pay (Thomas and Quilter-Pinner 2020).

A precedent has been set during the pandemic, as staff mental health support has been expanded, flexible and remote working permitted, and benefits such as free meals at work rolled out. Although planned as temporary measures, they show that better care for NHS staff is possible when there is a will. This should now be made permanent and expanded to improve staff morale and retention long term.

Reform health education, enable progression, and create the roles and skills we'll need in the future

The immediate sense of crisis should not distract from the need to reform education and training – so we not only have the right number, but also the right kind of staff with the right skills.

The NHS is tasked with three broad planning functions: service, finance, and workforce. It separates these, inevitably leading to mismatches between service plans and sufficient staffing to deliver them. The creation of largely unused NHS Nightingale hospitals, which are forecast to cost over £500 million (Carding 2021), is just one

example of this mismatch. Moving forwards, these planning functions should be joined up. The NHS should develop plans based on questions such as: what skills mix is needed for ICSs to improve population health and reduce inequalities?

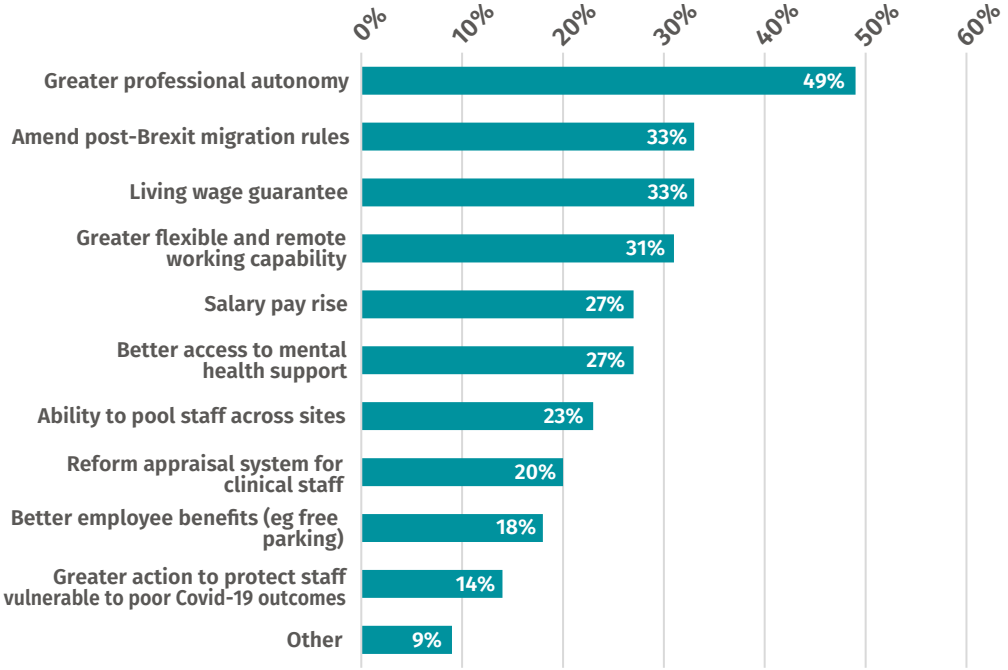
Growth of new roles, from link workers to data scientists, is key to tackling workforce challenges in the long term, as identified by leaders (figure 3.4). But so is reforming education and training more generally, such that all staff have a broader range of skills (including digital skills) that enable them to work across different care settings. Widening entry routes to clinical professions, shorter training requirements with greater emphasis on skills, and increasing access to learning throughout careers should be all be considered. These reforms will increase the quantity and diversity of the workforce in the long term. Retaining it will require taking down barriers to progression and dismantling the institutional racism that stains the NHS.

The 2020 spending review announced a one-year £260 million boost to Health Education England's budget, far short of the additional £580 million required, according to the King's Fund (King's Fund 2019).

FIGURE 3.3

Greater professional freedom is key to making the NHS the best place to work

Short-term solutions to workforce challenges identified as important by health and care leaders (per cent selecting each in their top three)

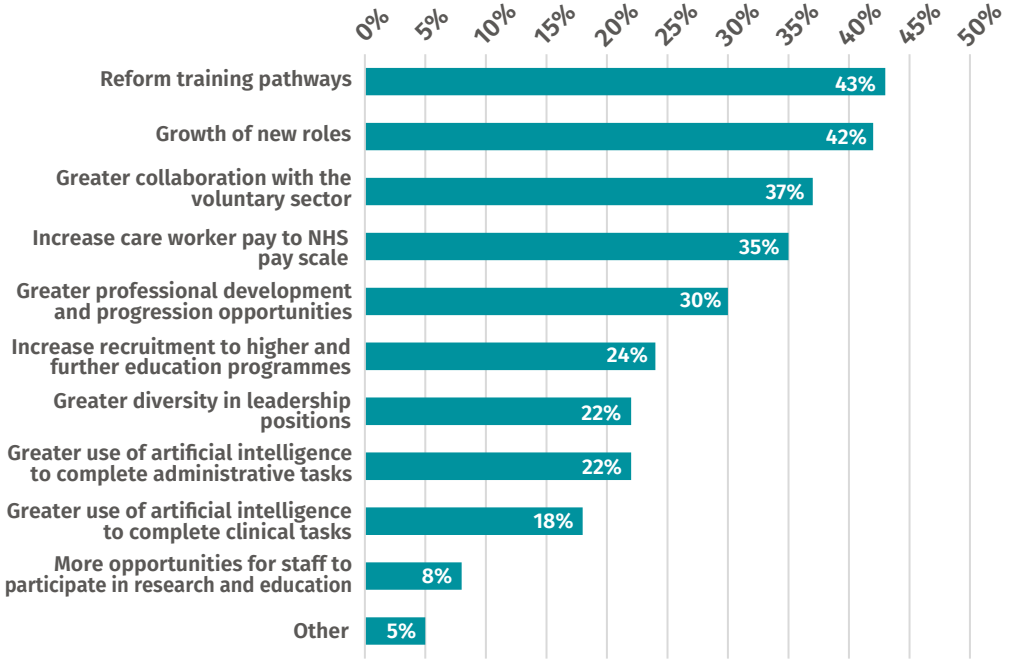


Source: IPPR/Savanta ComRes polling of 172 senior NHS and local government officials

FIGURE 3.4

Filling long-term workforce gaps needs a shake-up in training

Long-term solutions to workforce challenges identified as important by health and care leaders (per cent selecting each in their top three)



Source: IPPR/Savanta ComRes polling of 172 senior NHS and local government officials

3.2 RESOURCE THE NHS TO DELIVER AND SUSTAIN TRANSFORMATION

After a decade of focussing on cost-efficiency, the UK spends substantially less on health than the G7 average (OECD 2020b). In lieu of new money, the NHS has often been asked to fund services out of 'efficiency savings' – such as the £20 billion efficiency drive instigated between 2012 and 2015. This has come at the expense of resilience, transformation and sustainability.

The NHS Long Term Plan funding deal was welcome but came with many oversights. It did not cover capital or workforce training spend (both of which were severely cut during austerity), making it a plan without sufficient equipment or staff to deliver it.

Moreover, Covid-19 has led to substantial new direct and indirect costs for the health service. This has led to special Covid-19 financing for the NHS as well as changes to the core budget.

For the past year, Covid-19 costs to the NHS have been financed relatively freely with £18 billion allocated in 2020/21. This funding allowed hospitals and ICSs to plan, adapt and care for over 400,000 patients admitted to hospital with Covid-19. This Covid-19 funding arrangement is now being reviewed by the Treasury. Given Covid-19 pressures on the NHS remain high, this review is premature and conflicts the chancellor's commitment to give the NHS 'whatever it needs' to get through the pandemic. Such cliff-edge financial uncertainty obstructs service planning – ICSs do not know the funding available to them from April 2021. This funding arrangement should come under review later this year, but in the immediate term, the NHS ought to have certainty that it will receive what it needs to look after people with Covid-19.

The indirect costs of Covid-19 are large, too. The reduction in non-Covid healthcare activity has led to an enormous care backlog, pent-up healthcare demand and new healthcare demand. These will hijack money from the core NHS budget that was allocated in 2019 to evolve the healthcare system and deliver *The NHS Long Term Plan*. A one-off £3 billion has been added to the core budget to mitigate this. This is welcome, but it is not commensurate to the scale of the challenge. Without sustaining the additional funding, resources to improve the long term will instead be used to support the short term.

To 'build back better' health and care, there is a need to make sure the NHS has sufficient resource to both recover from Covid-19 and deliver *The NHS Long Term Plan* priorities. Not doing so will only cost more in the long run, as damage embeds, inequalities entrench, and productivity gains stagnate.

Meeting the backlog of elective care and rise in mental illness needs a multi-year funding settlement

Over 200,000 people have now waited more than a year for treatments and operations they need – a hundred times the pre-pandemic figure (NHS Digital 2020d). Millions more have experienced delays to planned operations (ibid). It will take far longer than one year to tackle this; funding must reflect that. This is why four in five health leaders – who are in charge of local service and finance planning – say more funding is required beyond the top-ups announced in 2020. People living in the most deprived regions of England are more likely to have experienced these cancellations (Propper et al 2020). Without adequate funding, healthcare inequalities will continue to grow.

The NHS needs a pandemic settlement worth £2.2 billion per year until 2025/26

The other major impact of the pandemic that requires financing is the rise in mental health service usage. As described in chapter 2.2, the pandemic has led to a surge in mental illness. This will lead to large rises in the demand for mental health services, which need financial support to expand. Without it, hundreds of thousands of people – particularly young people – will be left mentally scarred by the pandemic. This impacts not just individuals and families, but also the post-pandemic economic and labour market recovery.

The 'NHS Recovery Package' commits a one-off £3 billion to meet these extra costs. This is welcome, but a one-off fund will not suffice. We estimate that adequately resourcing the elective care backlog and the rise in mental healthcare demand will cost an additional £2.2 billion per year until 2025/26 (see appendix for further details). In effect, this is similar to maintaining the core NHS budget at the level it has been brought up to, rather than allowing it to counterintuitively drop off next year.

Capital investment should grow at the same rate as the NHS budget

There has been a significant increase in health capital spending this financial year to £11.1 billion (of which £1.8 billion is for Covid-19 adaptations), representing a doubling of the budget in five years. This is welcome – the NHS has historically spent less on capital, and has fewer MRI and CT scanners per person, than most comparable countries (OECD 2020b).

Most of this capital funding will be needed for the maintenance and repairs bills on NHS estates, which sits at £9 billion (NHS Digital 2021b). These works are important to patient care – clinical incidents relating to facilities are up by 22 per cent year on year. But they leave little spare for capital investment to fund the digital transformation and purchase equipment needed to expand diagnostic capacity, which would drive large productivity gains and help meet the care backlog quicker (Richards 2020).

Despite this increase, the capital allocation to the Department of Health and Social Care (which allocates in turn to the NHS) remains lower than most comparable countries. Analysis by IPPR in 2019 found that the budget would need to hit £12.5 billion by 2021/22 to meet the OECD average (Thomas 2019). We recommend the government continue their trajectory towards at least this, and then maintain capital budget growth at the same rate as the NHS budget.

As important as the increase in funding is the ability to plan. Capital projects are often long-term and multi-year and therefore require certainty in budgets. But capital allocations often run to 12-month time horizons. The government should use this year's comprehensive spending review to give a long-term security on the capital settlement, improving capacity to plan transformative projects.

3.3 EMPOWER INTEGRATION FROM THE BOTTOM UP

Integrated care is a long-standing goal in health policy – it is patient-centred and population-orientated. Structural NHS reforms in recent decades have made it their key objective. It is once again at the heart of a new set of reforms proposed by the government this year (DHSC 2021a).

Despite the focus, progress on integrating care has been limited. This is due to an overly top-down approach, which assumes integration must be commanded as opposed to fostered. This assumption has impacted our approach to regulation and governance, financial incentives and legislation. The result can be counterintuitive, such as the greater fragmentation resulting from the Health and Social Care Act 2012.

Better integrated care is paramount to progress on the clinical priorities discussed in this report. But if that is to happen, a different approach is required – one that seeks to develop local leadership and learning culture.

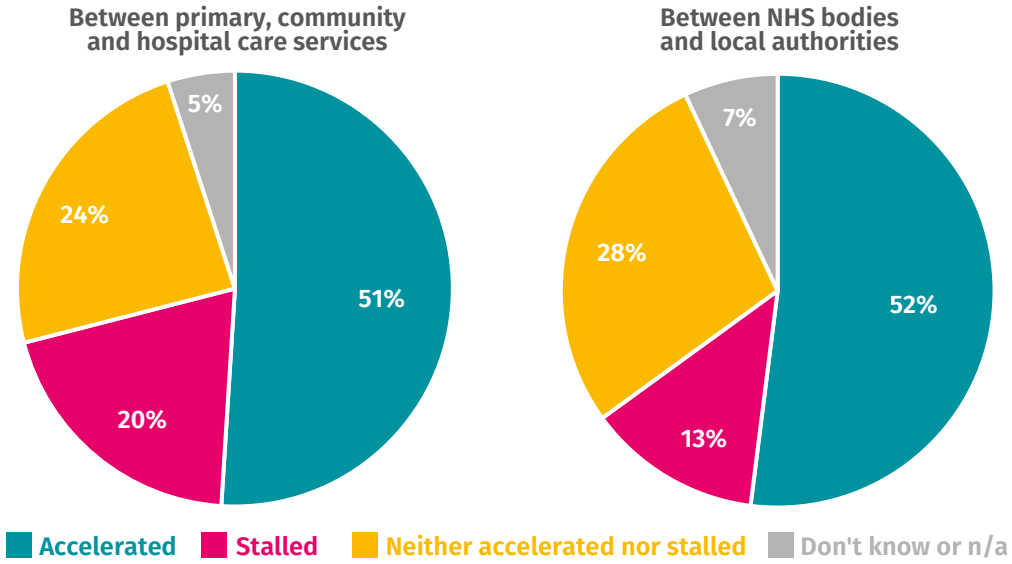
The pandemic has shown an alternative route to integration is possible. Half of health and care leaders we polled believe the pandemic has accelerated integrated working between the NHS and local government, and between primary, community and hospital care services (figures 3.5 and 3.6). Key to this was a better balance between local and national bodies. The latter provided a clear mission and resource – and then got out of the way (through regulatory, financial and legislative changes) to allow empowered local decision-making and delivery. This resembles the 'mission based' approach IPPR outlined in *The Innovation Lottery* (Thomas et al 2020a). It is vital this approach embeds beyond the pandemic – fewer than one in six leaders polled believe the national-regional-local relationship had been working well.

The challenge is recreating that sense of mission – driving integrated working towards a joint goal – without a pandemic. Doing so relies not just on defining the mission (for example, to reduce inequalities in mental illness), but on better defining the structures that determine integrated working: regulation, financial incentives and legislation.

FIGURE 3.5

Around half of health and care leaders believe the pandemic has accelerated integrated working

The effect the pandemic has had on integrated working between NHS bodies and local authorities, and between between primary, community and hospital care services, according to health and care workers



Source: IPPR/Savanta ComRes polling of 172 senior NHS and local government officials

The regulatory approach should nudge system working

Health and care regulation in England encompasses:

- inspecting the quality and safety of care – undertaken primarily by the Care Quality Commission (CQC), who measure provider performance against national standards and legal requirements
- assessing the operational performance and financial sustainability of providers – undertaken by NHS England and NHS Improvement (NHSEI)
- information governance and data protection – undertaken by NHS bodies and the Information Commissioner's Office (ICO).

Regulation of this nature is there to protect patients, and is widely accepted to play a role in quality improvement (Scally and Donaldson 1998).

However, there is growing consensus that it is time for regulation and governance in England to evolve (Edwards 2016). 'Lighter-touch' regulation and easier data sharing were two of the most popular positive changes identified during the pandemic that leaders polled would like to see maintained (figure 3.2). It is likely they permitted the step change in integration observed (figures 3.5 and 3.6).

Provider regulation, focussed as it is on individual providers rather than systems or place, tends to re-enforce rather than repair the fragmentations in the system. The CQC has started to address this by piloting place-based regulation which sees national bodies hold systems rather than individual providers to account, and NHSEI have expressed their plan to move from organisation-level to system-level regulation (NHSEI 2020c). This is the right approach and must be taken further as PCNs, provider collaboratives and ICSs grow in importance.

It is also increasingly clear that regulation can create excess bureaucracy and perverse incentives to the detriment of patients (DHSC 2020a). This is particularly true of the information governance framework which usually leads to defensive data sharing practices. It is patients who suffer from this (especially people with multiple health conditions) as their different care providers struggle to connect the dots, and quality of care is compromised as a result. Better data sharing is the bedrock of better integrated care, as the pandemic has shown.

Ultimately, we must recognise that excellence cannot be mandated from the centre. This means regulation and national intervention must be seen through a capabilities lens. They should be designed to enable the primary determinants of integration: distributed leadership, collaborative culture, and staff motivation. As the pandemic has demonstrated, a culture change at the bottom requires a culture change at the top. The CQC, NHSEI and ICO must seize this opportunity to review their approach to national intervention.

Financial incentives should reward population outcomes, not activity

Our polling finds that 80 per cent of leaders believe the current financial incentives are counterproductive, and 63 per cent support moving away from activity-based payment. This is because activity-based payment (also called the 'payment by results' system) incentivises activity over outcomes, with a particular focus on hospital treatment over care in the community or prevention of illness. Recognising this, NHSEI are planning a large-scale shift to a new blended payment model (NHSEI 2020d).

This is welcome, but the proposed payment model still incentivises higher volumes of activity (through the variable payment element, which pays providers a tariff per healthcare activity performed, similar to payment by results). For systems, it means performing a hip operation will pay more than preventing the fall that leads to a broken hip. It risks contradicting *The NHS Long Term Plan*'s stated aim to focus resource on improving population health. Indeed, pausing payment by results during the pandemic contributed to better system working.

NHSEI should move as quickly as possible to remove these incentive blocks on system working. Financial incentives should relate only to patient and population health outcomes – addressing inequalities in each.

Legislation can permit, but not prescribe, integrated working

Legislation cannot command integration, but it can help. ICSs such as the West Yorkshire and Harrogate Partnership have successfully navigated legislative hurdles to achieve a high degree of integration. Many others however could benefit from the extra support and acceleration provided by legislative changes. Our polling finds 69 per cent of health and care leaders believe the NHS will struggle to deliver *The NHS Long Term Plan* without legislative change..

In February 2021, the government set out legislative proposals for a new health and care bill, with the salient goal of achieving greater integration of services in health and care. These proposals amount to three key changes.

First, they undo many of the reforms of the Health and Social Care Act 2012 enacted by David Cameron's government. These changes are in keeping with the recommendations made by the Health and Social Care Committee in 2019 (HSCC 2019: 59) and will take down existing legislative hurdles to collaborative working. This marks the end of a 30-year experiment of market-orientated reforms in the NHS that have largely failed to drive improvement in outcomes.

Second, the government propose formalising ICSs as statutory NHS bodies that subsume commissioning responsibilities from clinical commissioning groups. This mirrors the legislative changes NHSEI wants, and bears strong resemblance to the changes suggested by IPPR in 2018 (Darzi 2018). There are clear benefits to this,

such as accountability, democratic oversight and greater powers for systems to integrate services. For example, our polling finds only one in five leaders currently report having any pooled health and social care funds in their area (22 per cent). The risk of these structural changes are that ICSs become NHSEI outposts, rather than genuine partnerships between local authorities, NHS agencies and voluntary organisations. This fear is reflected in our polling, as although around half (54 per cent) of leaders polled support making ICSs statutory bodies, a quarter (26 per cent) are sitting on the fence and 16 per cent oppose (there were no significant differences in views between NHS leaders and local government leaders). It is imperative, therefore, that ICSs are given genuine ownership and freedom to implement national priorities, something supported by 74 per cent of leaders.

Third, the white paper proposes greater ministerial control of the NHS. Given its expenditure amounts to almost £150 billion a year, the NHS ought to be more democratically accountable. But attempting this through greater powers for the health secretary comes with risk. The pandemic is used as a justification for these changes, but cronyism in procurement and contracting during the pandemic has set a dangerous precedent and goes against ambitions of democratising healthcare (National Audit Office 2020b). The proposed legislation also opens the door for further unilateral institutional reorganisation by the health secretary such as the poorly solicited abolition of Public Health England. Ultimately, these proposals will further increase the salience of electoral cycles in health policy making, to the detriment of long-term action to improve public health. Instead of concentrating ministerial power, the NHS's accountability to the public should be strengthened by a more direct relationship between Parliament and senior NHS officials.

Overall, the reforms set out in the government's white paper are the right changes proposed at the wrong time. NHS legislation is only one piece of the integration puzzle, and reforms to social care, for example, are both more important and more urgent (chapter 3.5).

3.4 UPGRADE THE DIGITAL NHS

The pandemic has delivered digitally enabled care much faster than *The NHS Long Term Plan* had anticipated. Patients and healthcare workers think digital consultations are here to stay (BMA 2021a). Leaders agree – it was the most popular positive shift to be maintained identified by our polling (figure 3.2).

There are plenty of benefits to digital care. It can provide faster and easier access to care. It can lessen the care burden for millions living with long-term conditions. And it can free up time for clinicians to care and open up new ways of sharing knowledge, improving productivity in the NHS and outcomes for patients.

But when we move fast, things can break. Digital inequalities (which intersect with age, deprivation and ethnicity) are magnified, making internet access and digital literacy important determinants of health. Similarly, if patient preferences about how they want to engage with new technology are not understood, then quality of care will fall. Rather than improve access and quality, the digital shift risks the opposite. Only with policy to mitigate these risks can the rewards of the remote revolution in health and care be realised.

The government should make sure everyone has access to the internet to realise the full potential of digital health

Seven per cent of UK households, and 29 per cent of the most deprived households, lack internet access (ONS 2020e). The NHS is a universal health service free at the point of need; a digital NHS is not. The government should ensure everyone can participate in digital health and care. The alternative is to widen health inequalities and allow digital exclusion to limit the health and cost-saving benefits of digitally enabled health.

Reliable internet access should be viewed as a basic need in the post-pandemic world. Several broadband companies stepped in during the pandemic to provide free internet to low-income households with children. This is commendable, but not sustainable – it is due to expire at the end of the school year. The government will need to bridge the digital divide.

The cost is not prohibitive. IPPR estimate it would cost £300 million per year to reimburse internet access to the over 1 million households without it – a drop in the ocean compared to the billions it could save the NHS (Darzi 2018).

In the first instance, a means based reimbursement scheme should be developed to reduce inequalities in internet access. In the medium term, collectivised provision is likely to be cheaper and more effective. The pandemic has accelerated the shift toward digital ways of living and functioning, making the case for public ownership of digital infrastructure even stronger.

Access and quality of digital care should be part of NHSEI's system oversight framework

NHSEI's system oversight framework will set specifications that ICSs are expected to deliver on. Given the new salience of digitally delivered care, this framework should include measures of digital exclusion and digital care quality. ICSs should co-design solutions to digital exclusion with patients, which may include reimbursement, digital training and the provision of tablets as medical devices.

Most importantly, patients and clinicians should retain choice over the mode of consultation (such as in-person, video or telephone). Not all care can be delivered effectively remotely, and there is no systematic way to categorise what can and cannot occur digitally. Although the health secretary wants all GP appointments to be remote by default (Hancock 2020), the best way to ensure high quality care is simply to let patients and clinicians choose the most appropriate mode of consultation.

High-quality digital health relies on the infrastructure to deliver it

The pandemic has taken down cultural barriers to digital care, but infrastructural barriers remain. The remote revolution will not sustain, or deliver higher quality care, without infrastructural upgrades. Our capital investment deal (chapter 3.2) costs for these digital infrastructure upgrades.

Improving IT interoperability between the hundreds of applications and records used across health and care is a long-standing problem that is urgent and solvable at the ICS footprint level. It has innumerable beneficial knock-on effects (Wachter 2016). Our polling with health and care leaders suggests that IT interoperability is even more important than additional funding and staff if PCNs are to deliver on their national specifications. While NHSX (the digital transformation arm of the NHS) ploughs ahead with plans for cutting-edge artificial intelligence technologies to personalise care (DHSC 2021b), patients are still being asked for the same information over and over again. Getting the basics right is the first step in high-quality, data-driven healthcare.

Remote care relies on remote monitoring. Patients, particularly those with multiple long-term conditions, will need to be provided with health technologies to ensure the collection of vital clinical information is not sacrificed.

3.5 FUND AND REFORM SOCIAL CARE

A solution to social care is a clear priority after the pandemic. For over 20 years governments have fallen short on their social care commitments. Social care cuts are difficult to understand from both quality of care and financial sustainability perspectives: the cuts between 2010 and 2018 explain up to half of the increase in A&E visits by over-65-year-olds (Crawford et al 2020).

Now structural problems in social care have amplified the spread of Covid-19. Care homes more dependent on temporary staff and on staff not entitled to sick pay had higher rates of Covid-19 infections among their residents (Shallcross et al 2021).

Sir Simon Stevens has called for a social care solution by the middle of this year. He is supported by 80 per cent of NHS and local government leaders we polled who believe social care funding and reform is 'very important' if the *The NHS Long Term Plan* is to be delivered. The public would also see failure to deliver a social care solution as a major breach of trust (Quilter-Pinner 2020a). Solutions to social care will need to address access, quality and workforce problems.

Make social care free at the point of need for everyone aged 65 or older

Extending this principle from the NHS to social care is the public's favoured solution to problems in social care access (ibid). Getting older should not mean getting poorer. But care needs are not just determined by age. Long-term conditions, and in particular multimorbidity, increase risk of social care needs. Free personal care means people are not forced into financial precarity by their care needs (Quilter-Pinner and Hochlaf 2019).

Making social care free at the point of need would mean a direct welfare payment to those meeting the threshold for nursing and/or personal care, as exists in Scotland. This would cost £5 billion per year (Idriss et al 2020), although much of this would be offset by savings in the NHS.

Develop an NHS-style long-term plan to improve the quality in social care

Free at the point of need should be the starting point for reform, not the conclusion. An NHS-style long-term plan for social care should address provider reform, quality of social care and workforce problems.

This plan for better, fairer social care should involve a move to ethical commissioning (a set of standards to drive low quality providers out of the market), a cap on accommodation costs, and a provider shift back to public and voluntary sector ownership (Blakeley and Quilter-Pinner 2019; Quilter-Pinner 2019).

A living wage guarantee for care workers, eventually bringing pay in line with NHS pay scales

Before the pandemic there were over 120,000 shortages in the social care sector. Pay is currently the greatest barrier to the recruitment and retention of care workers. Almost three quarters of care workers are paid less than the living wage, and at least one in four is on a zero-hour contract (Dromey and Hochlaf 2018; Gardiner 2020). In the first instance, care workers – who are three times more likely to be single parents than the overall workforce (Resolution Foundation 2020) – should receive a living wage guarantee. This is the minimum they should be given for putting their lives on the line to care for others during this pandemic. This can be funded immediately through government wage subsidies, as has been occurring in Scotland, and we estimate it would cost £1 billion.

Longer term, the government's social care taskforce has advised that social care staff pay is brought on par with the NHS pay structure. As with improving the quality of social care, achieving this will require a shift to ethical commissioning and a provider shift back to public ownership (Quilter-Pinner 2019).

Amend post-Brexit immigration rules to maintain the supply of social care workers

Almost four in five employees working in social care from the EU would not qualify under the new migration rules (Morris 2020). In the context of poor funding and low wages, the new migrations rules are 'particularly difficult to understand' for the social care sector according to the government's migration advisory committee (MAC 2020). Data from the health and care leaders we polled suggests amending

migration rules is equally as important as a living wage guarantee to address the immediate social care workforce crisis.

Putting care workers to the shortage occupation list alone does not solve these problems. The government should also exempt care workers from the new migration skills requirement, scrap the general salary threshold and require employers to pay the living wage in all sponsorship licences.

3.6 LEVEL UP THE NATION'S HEALTH

Covid-19 has run along society's unequal grooves, exposing and amplifying structural inequalities. Pakistani, Bangladeshi and black men and women are two to three times more likely to die from Covid-19 than white men and women, while people in the most deprived regions of the country are twice as likely to die from Covid-19 compared to those in the least deprived (ONS 2020b).

Sir Michael Marmot has concluded that existing population health inequalities explain why England was the worst affected country in Europe (Marmot 2020). The pandemic has shown how much we value our health. Health inequalities should now become commonplace measures of broad social and economic progress. Policymaking should reflect this and attempt to deliver on the ambitious goal of extending healthy life expectancy by five years by 2035 (Marteau et al 2019).

Although a key aim of *The NHS Long Term Plan* is to improve population health, health care determines only 15 per cent of our health (Davies and Pearson-Stuttard 2021). That is why 98 per cent of health leaders IPPR polled believe that cross-government action to address health inequalities is important to achieve the *The NHS Long Term Plan*.

Set up a national public health council cabinet committee

Improving population health should be at the heart of the government's levelling-up agenda. Indeed, addressing health inequalities will by virtue mean levelling up by most other measures, given the sheer range of social and economic factors that determine our health. A national public health council (chaired by the prime minister and the health secretary) should be set up as a cabinet committee. Its purpose would be to sequence and co-ordinate policy functions across Whitehall such that they improve population health and reduce inequalities, on issues ranging from obesity to injury prevention (Rankin and Parkes 2020). In particular, coordinating health and climate policy in the green recovery after Covid-19 will be important, given the significant benefits to both from action on housing insulation, clean energy and healthy urban planning.

Provide greater funding and powers to local authorities to address health inequalities

Local government is the delivery vehicle to level up public health. Spending on education, skills, employment, housing and local economic development all determine health. Austerity has had a severe impact on each of these over the past decade; the pandemic laid bare the impacts of this. Powers to act on these determinants of health are also centralised in Westminster and Whitehall. The abolition of Public Health England was ill-advised, but it creates an opportunity to devolve greater population health improvement responsibilities – with commensurate funding and powers – to local government (Thomas et al 2020b).

As part of this, the government should restore the public health grant (cuts to which have fallen disproportionately on the North, the poor and minority ethnic communities) to its 2014/15 peak with a subsequent annual growth rate in keeping with the NHS budget.

4. CONCLUSIONS

In this inaugural *State of health and care* report, we have revealed the impacts of the Covid-19 pandemic on *The NHS Long Term Plan*, and assembled policy to 'build back better' health and care. This is the first report that shakes out the detail of what the pandemic has meant for *The NHS Long Term Plan*'s targets for cancer, mental illness, cardiovascular disease and multimorbidity care.

Overall, we show that these leading causes of death and disability have been sidelined and/or amplified by the pandemic. This has disrupted delivery of *The NHS Long Term Plan* in its first year and put achievement of its long-term aspirations in doubt.

Building back better means two things.

First, it means taking the opportunities for innovation that have emerged in the last 12 months. As often during crises, innovation has flourished and better ways of working together have transpired. Many of these must now be embedded. Table 4.1 is a summary of the Covid-19 pandemic's disruption and innovation to *The NHS Long Term Plan*.

TABLE 4.1

The impact of the pandemic on *The NHS Long Term Plan*'s key priorities in cancer, mental health, cardiovascular disease and multimorbidity

Major health condition	*The NHS Long Term Plan* target	Pandemic disruption	Pandemic innovation
Cancer	75% of cancers diagnosed while still highly curable (by 2028)	Fall from 44 to 41% of cancers diagnosed while still highly curable, leading to 4,500 avoidable cancer deaths attributable to the pandemic	Community diagnostic and treatment hubs
Mental illness	2m more people accessing mental health services (by 2024)	Access reduced and over 1.8 million new referrals expected by 2024, cancelling out planned gains on 'parity of esteem'	24/7 crisis line Voluntary and community support networks
Cardiovascular disease	Prevent 150,000 heart attacks, strokes and vascular dementia cases (by 2029)	Highest cardiovascular mortality in a decade, with a further 12,000 avoidable heart attacks and strokes expected by 2025 if missed treatment initiations are not made up for	Digital care Electronic prescribing
Multimorbidity	Integrate and personalise care by expanding primary care (by 2024)	Over 31m fewer GP appointments than expected since the pandemic began	Digital care Integrated working

Source: IPPR analysis

Secondly, it means committing to bold new policies.

It is a tall order to recover from Covid-19, deliver *The NHS Long Term Plan* and make good on manifesto commitments – all at the same time. There is a need to prioritise.

But it is not clinical targets that we should be prioritising. There is no trade off to be made between recovering the care backlog and improving cancer outcomes. Instead, the conversation on prioritisation should centre around the policy that determines our ability to deliver any of these goals.

As such, we have categorised our recommendations into those that should be actioned immediately (table 4.2), and those that can be considered medium- and long-term targets (table 4.3). This comes with a caveat. Our report has already distilled policy into those we deem critical to 'build back better' health and care. The below tables inform prioritisation among them; they should not be taken as an argument to abandon any policy recommended in this report.

TABLE 4.2

Immediate policy priorities to 'build back better' health and care

Theme	Policy	Impact	Ease of delivery
NHS workforce	**A pay rise for NHS staff**	Improve staff recruitment and retention; improve morale and productivity; improve quality of patient care	**High** – the current NHS pay deal for most staff is set to expire this year. A 5% pay rise would cost between £1.1bn and £1.7bn
NHS funding	**One-off pandemic settlement of £2.2bn per year until 2025/26**	Prevent the care backlog hijacking *The NHS Long Term Plan* funding, such that the health of future generations is not scarred by the pandemic	**High** – at least two fiscal events are due in 2021, including a comprehensive spending review
Digital	**Universal internet access by government reimbursement**	Address digital exclusion; maximise benefits of digitally-enabled care	**Moderate** – reimbursement of internet costs can be made available to all those in receipt of universal credit. This would cost £300m
Social care	**Free personal care for adults ≥65 years** **(making social care 'free at the point of need')**	Address old-age poverty and inequalities; reduce avoidable acute hospital admissions; improve quality of life	**Moderate** – a direct welfare payment to those meeting a needs threshold for nursing and/or personal care, as exists in Scotland. This would cost £5bn, although much of this will be recouped in savings to the NHS
	A living wage guarantee for all care workers	Improve staff recruitment and retention; improve morale and productivity; improve quality of care	**Moderate** – again following the precedent set in Scotland, the government can top up care worker pay against the real living wage, using a similar operational process to the job retention scheme. This would cost £1bn
	Amend migration rules to increase care worker labour supply	Prevent Brexit exacerbating an already significant care worker shortage	**High** – exempt care workers from the skills requirement, scrap the salary threshold and require employers to pay the living wage in all sponsorship licences
Public health	**A national public health council cabinet committee**	Improve populational health and reduce inequalities	**High** – establish a cabinet committee to sequence and co-ordinate policy functions across Whitehall such that they improve population health
	Restore public health grant to 2014/15 levels and grow it at the same rate as the NHS budget	Improve populational health and reduce inequalities	**High** – at least two fiscal events are due in 2021, including a comprehensive spending review. Restoring the public health grant to its peak would cost £1bn

Source: IPPR analysis

TABLE 4.3

Medium- and long-term policy priorities to 'build back better' health and care

Theme	Policy	Impact	Ease of delivery
NHS workforce	**Reform health education, training and progression**	Develop a workforce with the right skills mix to meet future health needs; improve recruitment and retention; improve productivity; address workforce inequalities	**Low** – requires significant reform to clinical and non-clinical education programmes and training pathways
NHS funding	**Increase capital expenditure to OECD average and grow it at the same rate as the NHS budget**	Increase productivity; increase community care capacity; address the backlog of care; improve quality of care	**High** – at least two fiscal events are due in 2021, including a comprehensive spending review
Integration	**Reform the regulatory system to nudge integrated working**	More integrated care; improve population health and reduce inequalities; reduce waste	**Low** – requires a significant change from CQC, NHSEI and ICO
	Remove perverse financial incentives that reward activity over outcomes	More preventative care; more integrated care; improve population health and reduce inequalities	**High** – end activity-based financial incentives, instead only incentivising population health and patient outcomes
	Make ICSs a statutory NHS body with commissioning responsibilities	More integrated care; strengthen accountability; improve population health and reduce inequalities; reduce waste	**Moderate** – the government's health and care bill will need to be proposed, debated and passed through Parliament
Digital	**Monitor access and quality of digital care at the ICS level**	Address digital exclusion; ensure quality of digital care; maintain patient choice	**Moderate** – although easy to incorporate into the NHS system oversight framework, the metrics used will require careful deliberation
	Upgrade digital infrastructure across health and care	Vastly increase productivity; improve access and quality care; greater integration of care	**Low** – IT interoperability is tricky, but solvable at the ICS footprint level and vital to data-driven health and care
Social care	**Create a 'long-term plan' for social care**	Drive low quality providers out of the market; improve quality of social care; address accommodation problems; improve sustainability of the workforce	**Low** – widescale provider reform and returning ownership to the public and voluntary sector will require significant political will and investment
	Raise care worker pay to NHS pay scales	Improve staff recruitment and retention; improve morale and productivity; improve quality of care	**Low** – it will require a combination of provider reform and a shift back to public and voluntary sector ownership
Public health	**Greater funding and powers for local authorities to address health inequalities**	Improve population health and reduce inequalities	**Moderate** – a long overdue devolution white paper is awaited, but meaningful devolution of funding and power will require political will, investment and legislative change

Source: IPPR analysis

These policies amount to a £12 billion blueprint to 'build back better' health and care. Table 4.4 is a summary of the investment required. In the immediate term, the macroeconomic climate encourages the spending to be initially funded through borrowing (Roberts and Jung 2020). In the long term, tax revenue will have to rise to meet this permanently greater level of spending.

TABLE 4.4

Summary of the investment required to 'build back better' health and care

Policy	Additional expenditure (£bn)
5% NHS staff pay rise (excluding consultants and senior managers)	1.4
NHS pandemic funding settlement	2.2 (until 2026)
Capital investment	1.4
Internet access reimbursement	0.3
Living wage guarantee for care workers	1
Free personal care for ≥65 years	5
Restore public health grant	1
Total	12.3

Source: IPPR analysis

The pandemic has shown us that we value our health above all else. Now is the time to re-invest in our health and care system, not just to recover the damage that has been done, but to build it back better and stronger for generations to come.

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APPENDIX

DESCRIPTION OF THE NHS PANDEMIC FUNDING SETTLEMENT FINANCIAL MODEL

Our model is based on the two most salient costs of health service disruption caused by the pandemic: the elective care backlog (due to delays and cancellations) and the surge in mental health service utilisation (due to rising mental illness incidence).

The elective care model, developed by CF, estimates financing the predicted backlog of elective operations and procedures the pandemic ultimately creates. It is based on matching elective cancellations to the Covid-19 epidemic profile, therefore permitting estimates on the impact of the second wave of Covid-19 on electives. It also incorporates a small number of additional delays caused by a further wave of Covid-19 in the winter of 2021/22 (we have assumed this wave is significantly smaller and less disruptive than preceding epidemic waves due to high levels of population immunity from vaccination).

As the NHS is better prepared than it was during the first wave of Covid-19 (for example, the separation of 'hot' and 'cold' sites), the relationship between the epidemic and elective cancellations is weighted at 50 per cent of that observed during the first wave. Even with high usage of independent sector capacity in addition to NHS capacity, the fastest this backlog of care can be met is likely to be 2026 (primarily due to workforce limits).

Our mental health service calculations are based on a published system dynamics model developed by The Strategy Unit, which estimates the surge in mental health service utilisation from the pandemic (The Strategy Unit 2020). It based on data from the first wave of Covid-19; we have not attempted to incorporate additional mental health impacts of the second wave as, at the time of writing, it is difficult to differentiate the impacts temporally, and it is unclear whether the second wave is sustaining or amplifying the mental health impacts of the first wave.

DESCRIPTION OF THE POLLING SAMPLE

Savanta ComRes interviewed 172 health and care system leaders (director and executive level) online between 11 December 2020 and 15 January 2021. Data were unweighted. It is a sample with good representation across NHS agencies and local government, and good geographical representation across England. Sample characteristics are summarised in table A.1.

TABLE A1

Summary characteristics from the Savanta ComRes health and care leaders polling sample

Group		Number	Per cent
Setting of work	NHS	98	57%
	Local government	70	41%
	Both equally	4	2%
Areas involved in leadership role	Local authority or council	76	44%
	PCN	66	38%
	Health and wellbeing board (HWB)	61	35%
	Public health services	44	26%
	CCG	42	24%
	ICS and/or STP	40	23%
	Acute/hospital NHS trust	37	22%
	Adult social care services	36	21%
	Children's services	31	18%
	Community NHS trust	26	15%
	Mental health NHS trust	26	15%
	NHS England and/or NHS Improvement	21	12%
Region of England	North West	27	16%
	North East	13	8%
	Yorkshire and Humberside	14	8%
	West Midlands	23	13%
	East Midlands	17	10%
	South West	17	10%
	South East	22	13%
	Eastern	13	8%
	London	26	15%

Source: IPPR/Savanta ComRes polling of 172 senior NHS and local government officials

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