RADIX PAPER NO 16
JULY 2020

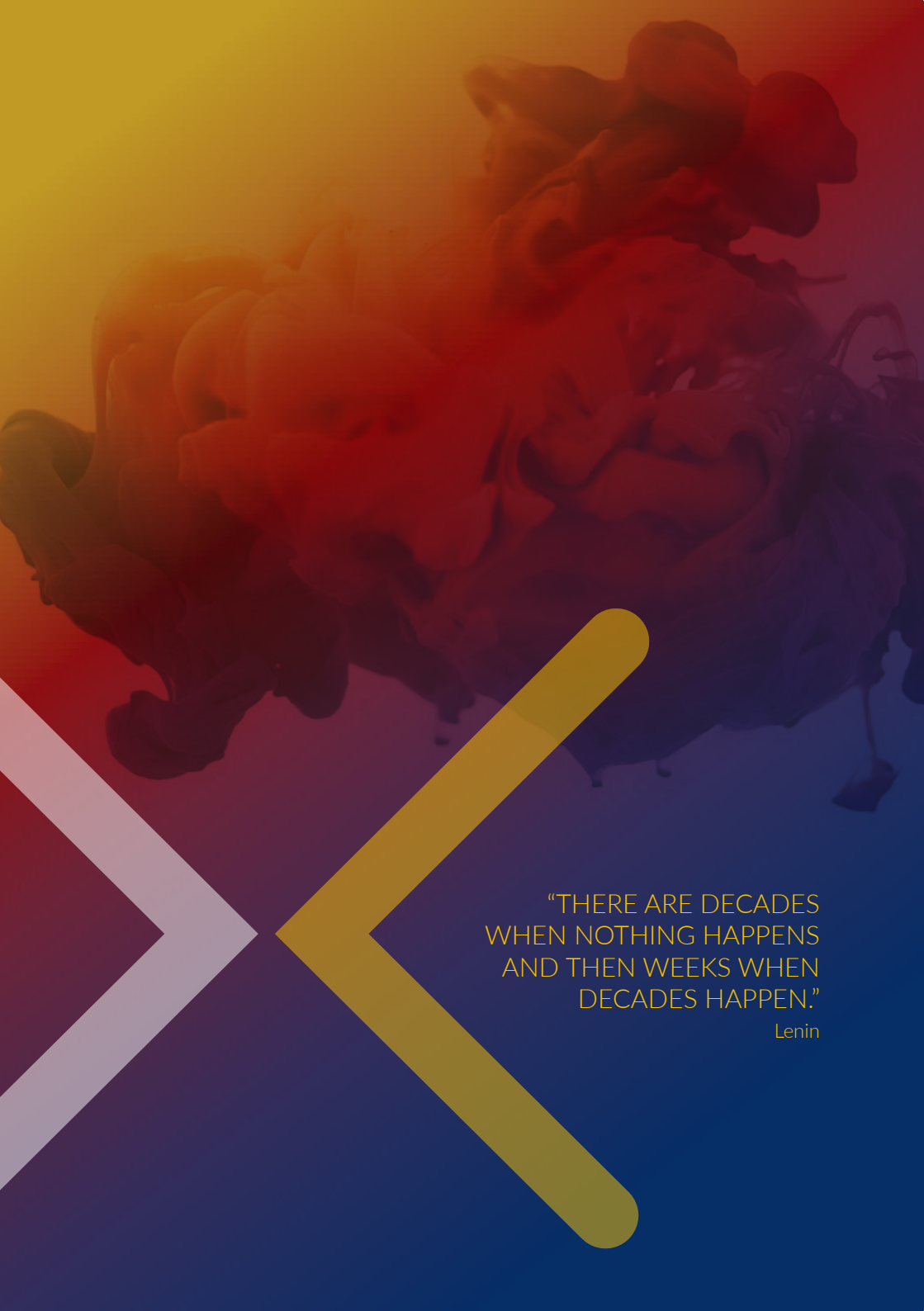
Dr Paul Goldsmith
Dr David Colin-Thomé
David Boyle

RADIX

THINK
TANK
FOR THE
RADICAL
CENTRE

LOCALISE, EQUALISE AND UNTICK

THE FUTURE OF HEALTH CARE POST-COVID



"THERE ARE DECADES
WHEN NOTHING HAPPENS
AND THEN WEEKS WHEN
DECADES HAPPEN."

Lenin

EXECUTIVE SUMMARY

Covid has shone a bright light on the strengths and weaknesses of the NHS.

In some regards the experience has been encouraging: the centralised, command and control structure of the NHS enabled it to achieve, in a matter of days, fundamental transformations which, in normal times, would have taken years. Hospitals were restructured and staff reassigned, consultations brought online, restrictive targets and bureaucracy overturned, field hospitals built and resourced in under a fortnight. As a result, the UK avoided the chaotic scenes seen in Lombardy, the service was not overwhelmed, and patients were treated.

Yet, in other respects, Covid highlighted long-standing structural weaknesses in the way the UK manages the health of the nation, and while international comparisons are far from watertight, our overall outcomes - in terms of disease management and excess deaths - appear significantly worse than many others, who were less well-prepared or resourced.

Some of these problems can be put down to specific emergency political or medical decisions which, with the benefit of hindsight, appear flawed, such as the timing of the lockdown or the failure to protect care homes.

PATIENTS AND THEIR REPRESENTATIVE GPS HAVE BEEN DISEMPOWERED,

Nevertheless, others are clearly a function of long-term structural issues:

- *The NHS is over-focused on hospitals and acute care rather than keeping people well, and this tendency has been exaggerated in areas of greatest deprivation leading directly to worse outcomes during the pandemic.*
- *Patients and their representative GPs have been disempowered, reducing individual responsibility and resulting in less coherent and more expensive care.*
- *Risk averse central planning, target-setting and measurement have generated bureaucracy, waste and removed resources from frontline care.*

Unless we learn from these failings, the UK's health provision will continue to under-deliver and risks ultimately being overwhelmed, not by a second wave or another pandemic, but by the daily demands of an ageing population in poor health, with unrealistic expectations, lacking the information or tools to take responsibility for its own wellbeing.

In response to these challenges and learning the lessons of Covid, RADIX sets out in this paper, to:

- *Decentralise both management and decision-making to make it responsive to local needs*
- *Tackle inequality both in health outcomes and services, through empowering patients and their representatives*
- *Reduce bureaucracy and red tape to maximise resources on the front line.*

Fundamental to all our recommendations is a shift in the lead responsibility for health care and promotion from hospitals and organisations which treat sickness, to the public and GPs, with a focus on keeping us all well.

ENSURING THAT WELCOME NEW INVESTMENT IN HEALTH INFRASTRUCTURE IS RESPONSE TO LOCAL NEEDS AND PLANNING, RATHER THAN TOP DOWN DEVELOPMENT OF UNINTEGRATED TERTIARY CENTRES.

A full list of the recommendations in this document are set out at the end of this report. Most importantly, however, we propose:

Centralism to localism

- *Making the existing Primary Care Network (PCN) model the base unit in responsibility for England's health care, led by empowered GPs acting in partnership with their patients and the communities they serve.*
- *Making the primary role and responsibility of specialists to be to advise GPs and plan and manage expectations on improvements, rather than see and follow up patients.*
- *Focusing the Regional NHS and local authority groups on providing organisational support, informing and promoting leadership and best practice, and resolving conflict, rather than target setting and enforcement.*
- *Ensuring that welcome new investment in health infrastructure is response to local needs and planning, rather than top down development of unintegrated tertiary centres.*
- *Ensuring the leadership of the NHS is bottom up, modelled on co-produced organisations.*

ORGANISE A CROSS-NHS BONFIRE OF TICKBOX, KPIS AND TARGETS

Tackling Inequality

- *Allowing variations in pay and conditions for healthcare professionals to reflect local demands and circumstances.*
- *Engaging a much wider group of local stakeholders in setting health goals and practices, with a particular focus on engaging disadvantaged and hidden groups.*
- *Financially incentivising local authorities to take responsibility for health promotion by using the NHS budget to reimburse local spending, and devolving personal healthcare and social care budgets to individuals.*

Targets and bureaucracy

- *Learning from the experience of the covid crisis, to organise a cross-NHS bonfire of tickbox, KPIs and targets*
- *Distinguishing between, on the one hand, tickbox targets which disempower health professionals and, on the other, checklists to support professionals*
- *Provide integrated and accessible data for quality assurance and also quality improvement*
- *Repealing the medico-legal aspects of the 1948 Act which govern compensation, and make the complaints system proportionate and care-focused*
- *Introducing academic undergraduate and postgraduate degrees in Healthcare management*

1. INTRODUCTION

COMMAND AND CONTROL

The big fear at the onset of Covid was the repeat of the scenes from Lombardy, Italy, with hospitals overrun by an exponential rise in severe cases. This led to an extraordinary reorganisation of NHS processes, staff and facilities to increase capacity for management of Covid. As it was, the April peak fell well under the newly created capacity but, even a few weeks earlier, this could not have been predicted. As a result, the NHS was on a war footing, for which the command and control style with which the NHS has traditionally operated is particularly well suited. It meant in a matter of days:

- *Elective procedures and routine appointments were postponed and cancelled.*
- *Wards were reconfigured to create extended intensive care units, Covid holding bays and recovery units (normally discussions on ward allocations to a particular speciality can take years).*
- *Staff under-went emergency training and were reassigned.*
- *Staff operated outside their silos, with far more collaborative working and team spirit.*

LARGELY EMERGENCY MEASURES TAKEN TO MANAGE THE IMMEDIATE CRISIS REFLECT A POTENTIALLY VERY DIFFERENT WAY OF OPERATING, LONG TERM

- *Many tickbox processes designed to protect against litigation or measure outputs were set aside.*
- *Specialists were providing consultations by video link or phone as standard, using technology familiar to the public, but hitherto not allowed or widely used in clinical practice.*
- *Nightingale hospitals created in weeks, supported by the military.*
- *Private hospitals were supplying beds and equipment on a previously unimaginable scale.*
- *Huge new orders for supplies were placed (albeit late), and emergency hospitals were set up across the country.*
- *Hundreds of thousands of volunteers were recruited.*
- *GPs emptied their surgeries and consulted patients by video call.*
- *Patients with chronic conditions were instructed in how to manage them themselves.*
- *Much more rigorous triage was introduced through the system, with the focus being on clinical need rather than patient plead.*

These are largely emergency measures taken to manage the immediate crisis, but they reflect a potentially very different way of operating long term.

The switch to arms-length management was one of the greatest changes, with 71 per cent of GP cases handled remotely (Royal College of General Practitioners figures[1]) and a similar dramatic switch for hospital cases. Decisions on digital technologies that had been stalled for a year were now pushed through in days. New system functionalities that would normally take years to develop and get approved were now happening in weeks.

There has been an extraordinary community activation, including WhatsApp groups linking together every household in a street, with broader co-ordination and links at parish or ward level, this being replicated across the country. We have also seen reflections from the public that 'things need to change'.

Could some of these practices feasibly be sustained after Covid? Might we see:

- *Patients being expected to play a far more active role in managing their own conditions and healthcare, whether covid-19 related or not?*
- *Communities actively supporting health and social care, whether at the individual patient level, or through altering the local environment to promote wellbeing (noting that healthy behaviour is profoundly influenced by surroundings)?*
- *Attitudes to risk management necessarily being reviewed, both in terms of bureaucratic processes and management of long term, lifestyle-related illnesses?*
- *The widespread use of volunteers to support the health service, transforming the relationship between professionals and the wider community who are also their patients?*
- *A shift in the cascade of activity from specialists to generalist health practitioners to less skilled ancillary staff to patients, with the focus of those higher up the 'specialism hierarchy' being on empowering and educating, rather than doing, with this activity done where possible at arm's length, using the efficiency of technologies, and through hub and spoke community links?*
- *A shift to more home working for clinicians, so enabling more equitable linkage of clinician location and clinical need?*

1. https://www.rcgp.org.uk/about-us/news/2020/april/around-7-in-10-patients-now-receive-gp-care-remotely-in-bid-to-keep-patients-safe-during-pandemic.aspx

CENTRALISATION V LOCALISM

ALTHOUGH THE CRISIS PRIMARILY HIGHLIGHTS THE NHS'S STRENGTHS, IT HAS ALSO EXPOSED THE WEAKNESSES OF ITS CENTRALIST, COMMAND AND CONTROL APPROACH

Although the crisis primarily highlights the NHS's strengths, it has also exposed the weaknesses of its centralist, command and control approach. For example, challenges with staffing, with NHS Nightingale London hampered by a lack of nursing staff, in part as a result of NHS pay and conditions which are not responsive to local market forces.[2] There may also have been a slow start to testing scale up versus those countries taking a decentralised approach.[3]

The most damming exposure may be in the UK's overall fatality rates. It is becoming increasingly clear that, although age, sex and ethnicity are important non-modifiable risk factors, other key risk factors are obesity, hypertension and diabetes. Detailed analysis will eventually give us a definitive answer, but it is likely that it would not be a better acute health service that would have improved Covid survival, but improved population healthiness.

The impact of lifestyle on health outcomes has long been known, although under recognised.

A third of NHS illness would disappear with healthier lifestyles. With a radical focus on determinants of health, 80 per cent of costs could go. So a lot of money is spent in a non-optimal way.

WITH A RADICAL FOCUS ON DETERMINANTS OF HEALTH, 80 PER CENT OF COSTS COULD GO

MOVING ON FROM A NATIONAL SICKNESS SERVICE

The question then is: whose job is it to try and address these broader factors? Are we paying for a National Sickness Service or a National Health Service? What role does Public Health England play? What role should society more generally play? And what about the role of local authorities?

This crisis is an opportunity to ask ourselves what we want from our health service and how it could function more effectively. In particular, we need to consider:

- *How do we better manage chronic care to improve health, reduce health inequalities and reduce pressure on acute services?*
- *How can we harness the goodwill towards the NHS to turn it into a bottom up organisation in which patients and communities are active participants, not passive recipients?*
- *How do we better use technology and newly learnt working practices to redirect professionals' time to maximise impact?*

2. There is London weighting, but this is limited in scope.
3. Although not universally true. East Asian countries have been quick and centralised, but had learnings from SARS. Other countries taking a centralised approach such as New Zealand are closer in size to a UK region or German state.

- *How do we better manage risk and focus on relative risk, so that outcomes are measured in ways that incentivise individual responsibility and health promotion and reduce the threat of litigation?*
- *What needs to be the role and attributes of the centre in order for local services to flourish?*
- *Is the nationalisation model still the best governance arrangement for the NHS and what could and should be the model relationship between the public, voluntary and private sectors?*
- *How do we achieve patient activation and encourage greater self-reliance and responsibility?*
- *How do we encourage and incentivise community action?*

These are just some initial issues raised by recent experiences. There are no doubt many more which can be considered. Nevertheless, what is certain is that, if – once this crisis is over – we simply revert to type, we will miss what might be a one-off opportunity to transform and update the way we manage health in this country to make it fit for the challenges of the 21st century.

The significant rise in the so called excess deaths that have occurred is a major concern, although the final numbers will not be known for maybe years ahead. Many of the excess deaths are not due to covid-19, many however may have been preventable and may have been due to people's reluctance or even fear to attend emergency services.

Many postponed services are now being restarted as the pandemic wanes and the NHS critical care services are thankfully, for the time being, under less severe pressure. But those delays to reviews of serious conditions may take a toll, for example with increasing evidence emerging of delays in cancer diagnosis. We have an intra-epidemic crisis that must be addressed now.

This paper reviews the longer term health of our nation through the Covid prism. A key observation we will make is that healthcare is highly complex and to achieve optimal outcomes requires different levels of organisation – central, region and local. A missing ingredient has been a systematic engagement of, and integration with, non-traditional healthcare actors and activation of the public as co-producers and problem-solvers. These challenges also occur in other areas of government, and therefore some of the solutions outlined in this paper apply equally to societal problems beyond health.

IF – ONCE THIS CRISIS IS OVER – WE SIMPLY REVERT TO TYPE, WE WILL MISS A ONE-OFF OPPORTUNITY TO TRANSFORM THE WAY WE MANAGE HEALTH

2. THE CURRENT STATE OF THE HEALTH SERVICE

The perennial challenges of the NHS are inherent to its structure, culture and governance. A very early Minister of Health (equivalent to a current Secretary of State) described the system of finance in the NHS as one that 'endows everyone providing, as well as using it, with a vested interest in denigrating it'.[4]

WE HAVE AN NHS WHOSE STRUCTURE, GOVERNANCE AND CULTURE ARE COUCHED IN THE PAST

The most visible debate always centres on money - always 'underfunded, under-staffed', with low morale, increasing health inequalities, access inequalities and pressures from a growing and ageing population. The latter is a more recent development, but the first two issues are perennial. The health inequalities issue is now headlining, with the Marmot report (2020) highlighting the dropping life expectancy and massive gap in healthy years lived in deprived areas. Covid has served to emphasise this discrepancy.

The poor health of the UK population is compounded by poor NHS outcomes magnified by the UK's poor educational attainments.

We have an NHS whose structure, governance and culture are couched in the past, professionally mediated, hospital centric, with marginalised community-based services and a statist public health system that is not 'of the public', all set in the prevailing centralising and disabling un-participatory national governance culture.

EXISTING EVIDENCE

'When compared internationally, the UK has seen similar changes in mortality for the older population. However, relative to our closest comparators, outcomes for under-50s are worse. There has been no improvement since 2011 for the younger (under 50) population as a whole and mortality has actually increased for 45–49 year olds'.

Mortality and life expectancy trends in the UK: stalling progress Louise Marshall, David Finch, Liz Cairncross and Jo Bibby, published by the Health Foundation, 2019.

This paper's focus is on current NHS policy development in England, but most research and the dominant backdrop for the authors is the whole UK where there are two overarching problems: the health of the population and NHS health outcomes. These need to be considered separately.

4. Powell, 1966

NHS health outcomes may be measured in a discrete way, for example time to thrombolysis for a stroke, 30 day survival from a heart attack. The overall health of the population is much broader than this and is primarily driven by lifestyle and societal factors. Indeed, an area of the country can have good NHS outcomes but poor overall health outcomes. An example is the north of Tyne health area, where the hospitals are all rated outstanding by CQC, but the population suffers ill-health and dies young. Poor health and health inequalities are reinforced by the pattern of deaths from Covid.

The Global Burden of Disease Study 2017 (GBD 2017) (Seattle, United States: Institute for Health Metrics and Evaluation (IHME), 2018), shows that England's health has improved over the last 30 years, but improvements in mortality rates have slowed in the last decade. This is not unique to England and has been seen in 20 of the 22 countries compared. It is largely due to a slowing in the rate of improvement in cardiovascular disease mortality and to some extent cancer. England outperforms the other UK countries in most areas of disease burden with lower rates of mortality and morbidity (death, illness or disability). Internationally, England outperforms the USA (when the entire US population is taken in aggregate), but lags behind Scandinavian countries, the Netherlands and Spain.

The poor health of the UK population is compounded by relatively poor NHS outcomes. The Commonwealth Fund is a private US foundation whose stated purpose is to *"promote a high performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable and the elderly".* Its analysis of healthcare systems in 11 nations in 2017 found the UK to be the best, safest and most affordable, but the very same report ranked the UK 10th on healthcare outcomes, a category that measures how successful treatment has been – a significant weakness that was also identified in 2014 – so we have to ask, what is the measure of success?

AN ANALYSIS OF HEALTHCARE SYSTEMS IN 11 NATIONS FOUND THE UK TO BE THE BEST, BUT THE SAME REPORT RANKED THE UK 10TH ON HEALTHCARE OUTCOMES – SO WE HAVE TO ASK, WHAT IS THE MEASURE OF SUCCESS?

The underperformance of the UK in health outcomes – illustrated by Covid - has generated much support for *'healthcare reform'*, a focus for successive UK governments from 1990 of all political hues, although there are many other drivers for reform from those with varied philosophies. For those on the progressive side, the words of the 'founding father' of the NHS, Nye Bevan, remain inspirational: *"Illness is neither an indulgence for which people should have to pay, nor an offence for which they should be penalised, but a misfortune, the cost of which should be shared by the community."*

IN EVERY SINGLE INDICATOR LOOKED AT, HEALTH CARE IS WORSE FOR PEOPLE EXPERIENCING THE GREATEST DEPRIVATION

New analysis has found that people living in the most deprived areas of England experience a worse quality of NHS care and poorer health outcomes than people living in the least deprived areas. These include spending longer in A&E and having a worse experience of making a GP appointment. The research, published in 2020 and undertaken by Quality Watch, a joint Nuffield Trust and Health Foundation programme, has looked at 23 measures of healthcare quality to see how these are affected by deprivation. In every single indicator looked at, health care is worse for people experiencing the greatest deprivation.

Using NHS and the Index of Multiple Deprivation data, the researchers found that for 11 out of the 23 measures, the inequality gap was widening. In general, for indicators where the quality of care has deteriorated over time, the inequality gap between the most and least deprived has widened too. For many of us with long experience of the NHS, it is simply further confirmation of a prevailing fact. And yet much had been achieved. The Department of Health Annual report 2017 showed that in key areas the gap has widened since 2010 after narrowing over the previous decade.

THE GRAND CHALLENGES FOR THE UK'S HEALTH

So, whatever successes the NHS has had, outcomes remain patchy and unequal, the service and form unaffordable and the institutions unsustainable. But the lessons of Covid potentially point to three ways to begin to address these problems, and move from a National Sickness Service to a Health Service.

To this end, we propose:

- *Moving from centralism to localism*
- *A focus on tackling inequalities*
- *An overhaul in the approach to bureaucracy and targets*

We argue that the NHS must transform to a community-centric service based on building local resilience, confidence and co-production.

We argue that the overarching priority for health and wellbeing is to enhance social capital, community solidarity and sustainable development for individuals and communities and the NHS plays an important stakeholder role.

We argue that moving forward the focus should be on the underlying determinants of poor health, rather than taxpayers' money going to the far more expensive and far less effective task of trying to patch people up as they accumulate diseases.

And to achieve this, we argue that we need both an operational system and an incentive system that aligns with these outcomes.

3. FROM CENTRALISM TO LOCALISM...

"The Primary Care Home is the precursor to current national policy."

Dom Hardy, Director of Primary Care and System Transformation, NHS England and NHS Improvement until November 2019 at NAPC conference, October 2019.

The UK is by tradition a centralised state and only relatively recently devolved some powers to constituent countries. The introduction of local mayors during the Blair government was a step toward more devolved local power and responsibility. The 2011 Localism Act, introduced under Cameron's coalition government, had a key premise: "The time has come to disperse power more widely in Britain today."

The Act solely applied to local government and was a general policy commitment. At the same time, Greater Manchester was designated a functional city region on 1 April 2011 in which healthcare has a key part in the overarching aim, creating employment.

Since 2016, health and care organisations have been working together in every part of England, initially in Sustainability and Transformation Partnerships (STPs). These morphed into the Integrated Care Systems (ICSs) which accelerated their work.

The first 14 ICSs were confirmed in 2018, including two areas with healthcare devolution agreements (Greater Manchester and Surrey). ICSs cover a range of urban and rural geographies, with wide variation in population size and system complexity.

NHS England and NHS Improvement have worked with locally based organisations to develop a consistent approach to how systems are designed, and the NHS Long-Term Plan set this out highlighting three important levels at which decisions are made:

- *Neighbourhoods (populations circa 30,000 to 50,000 people) served by groups of GP practices working with NHS community services, social care and other providers to deliver more co-ordinated and proactive services, including through Primary Care Networks (PCNs), of which more in the next section.*
- *Places (populations circa 250,000 to 500,000 people) served by a set of health and care providers in a town or district, connecting Primary Care Networks to broader services including those provided by local councils, community hospitals or voluntary organisations.*
- *Systems (populations circa 1 million to 3 million people) in which the whole area's health and care partners in different sectors come together to set strategic direction and to develop economies of scale.*

This is now happening. The neighbourhoods which NHSE talk about are now in effect the Primary Care Networks. Most are nascent in their development, apart from those 19 per cent that were the voluntary Primary Care Homes who have demonstrated joint working and varying degrees of community engagement. The PCNs are managed by NHSE in a largely supportive and permissive manner, but once the current NHSE chief executive moves on, or a faster pace of progression is demanded by politicians with an anxious eye on fulfilment of their promises by the next election, this current (and unusual for the NHS) enabling environment may disappear.

Historically, NHS political and management leadership is dirigiste and the commitment to primary care, especially within the NHS 'skin deep'. For example, while a new hospital building programme as part of the Government's Health Infrastructure Plan is to be welcomed, it should not simply be imposed from above. It is unclear what local input there has been in the choice of the initial six large sites or how the range of services to be provided are to be integrated with local priorities.

In contrast, the well-meaning who support the bottom up principle, can load too much, too hastily onto the Primary Care Networks and damage the energy and commitment of the enthusiastic. Centralism and structuralism pervade the NHS, with a dominance of transactional thinking.

A NEW HOSPITAL BUILDING PROGRAMME AS PART OF THE GOVERNMENT'S HEALTH INFRASTRUCTURE PLAN IS TO BE WELCOMED, BUT SHOULD NOT SIMPLY BE IMPOSED FROM ABOVE

The health of the public is usually viewed in terms of tasks to be delivered, like smoking cessation, rather than enabling people to have more sense of self-control and self-fulfilment.

Even when the NHS moves beyond the medical model, it struggles to shrug off its paternalistic attitudes, for example with the term 'social prescribing', highlighting how professionals will prescribe what you, the patient, should do. Health is as much about a feeling of self-worth, resilience and knowledge, but does the NHS or even local government recognise that? The local neighbourhood PCN must be given time and support to foster local relationships and to create for local people a feeling of it being their organisation. The history of localism suggests that this won't happen, given the pervasive culture of the NHS and local authorities. Indeed, devolution to local authorities risks just replacing one set of 'doing to' professionals with another a bit closer to home. We must instead go hyper-local and change the culture.

WE MUST INSTEAD GO HYPER-LOCAL AND CHANGE THE CULTURE

RECOMMENDATIONS

- *All key stakeholders should be included within the PCN as soon as their maturity allows, such as community police, teachers, local councillors, both parish and county, third sector representatives, youth and religious leaders.*
- *The parent organisations of local stakeholders, whether these be local authorities, police or NHS organisations, should be responsive to the local intelligence gathered from the PCNs. Mechanisms should be put in place to influence the parent organisation. Reasons for not responding to change requests should be open to public scrutiny.*
- *Regional NHS and local authority groups should provide organisational support, inform good practice, provide leadership training and resolve conflict blocks. But they should not performance manage imposed PCN-specific targets.*
- *The progress of PCNs should continue to be assessed against a Maturity Index which should not being used as a controlling performance management tool, but instead for support.*
- *Data should be provided to the PCNs so they can better understand their local challenges and the impact of proposed solutions. Public Health England and the ONS should provide data that is relevant locally.*
- *The functional units making up new local hospitals or clinics, should integrate different healthcare contributors, so reconciling the desire for the physical hospital with specialist skills and support necessarily residing in tertiary centres.*

4. TACKLE HEALTH INEQUALITIES EFFECTIVELY

"For the NHS Long Term Plan to succeed, we must keep all that's good about our health service and its place in our national life. But we must tackle head-on the pressures our staff face, while making our extra funding go as far as possible. And as we do so, we must accelerate the redesign of patient care to future-proof the NHS for the decade ahead. This Plan sets out how we could do that'.

NHS Long-term Plan, 2019

PCNS ARE POTENTIALLY A HOME FOR MANY CURRENTLY WORKING IN HOSPITALS

A key anthropological principle is that humans can only handle a certain number of relationships, in the order of 150, the Dunbar number. Beyond this and more complex structures need to be put in place. That is how we need to go about tackling the health inequalities in the UK – because it explains how to bring healthcare decisions closer to people and how to make them more effective.

It may seem counter-intuitive to claim that health inequalities have anything to do with this failure to consider human relationships, but our argument is that – by fatally undermining relationships in places where health is poor – this is the major cause of health inequality in the UK.

This insight into the local and relationship-based approach led to the experiment of the Primary Care Home, now being rolled out nationally as the Primary Care Network (PCN), where the number of core relationships probably don't go above 150. The population of each Primary Care Home was set within the range of 30-50 thousand general practice registered patients. The Dunbar number reflects the number of key health and care staff who work within the 'Home' and who would thereby maintain and enhance existing working relations in this voluntary reorganisation of their work place. When NHSE proposed PCNs to be the building block of the NHS, the principles and size of the PCH was retained.

The NHS Long Term Plan was preceded by several and varying NHS 'Vanguard' sites to provide an evidence base for more radical service re-design and by publications such as the also well received 'NHS 5-Year Forward View' and a 'General Practice 5-Year Forward View' NHSE 2014. This embraced a more developmental approach to inform policy than customary practice, and a refreshing emphasis on primary care.

The Plan offers the best opportunity in living memory to deliver and further develop the aspirations of this paper, with the Covid-19 emergency response shaking away some of the traditional blockers, providing the understandable immediate calls for more hospital beds are appropriately filtered.

As we have seen, the concept of the PCNs arose from a Primary Care Home (PCH) programme originated by this paper's co-author David Colin-Thomé in 2009 and brilliantly advanced by the National Association of Primary Care (NAPC). PCNs are potentially a home for many currently working in hospitals, in particular those who have a responsibility for long-term conditions care, for rehabilitation and re-ablement, and for the surgeons who in particular specialise in 'office based' procedures.

The potential for PCNs, as demonstrated by PCH accomplishments, is to fulfil the originating principle for PCH - 'a population based (GP registered list) community provider possessing its own budget and ultimately providing an alternative to current NHS hospital centricity'. The potential is to then run a surplus and invest savings made by more effective health care and better health outcomes in social care and wider public health. Primary Care Networks must view themselves as a system: they require system leadership and governance that breaks from the past if they are to achieve their full potential.

By contrast, a growth of larger scale GP and primary care organisations carries an inherent risk of them becoming the new 'they' - distant, impersonal and controlling. Not the recipe for success if the aim is to enable the involvement of all locally based clinicians in conjunction with the population based general practices, so they can better tackle inequality.

GPS ARE MUCH BETTER AT MANAGING RISK THAN HOSPITAL SPECIALISTS

THE PRIMARY CARE PUSH

There has also been a recent push of activity to GPs, mainly as GPs were seen as cheaper than secondary care. Some of this is an illusion as it is comparing apples with pears. GPs were not doing as many tests and did not have the overheads, nor the emergency work provided by specialists but usually not accounted for. Nevertheless, the desire to move activity to GPs is a very sensible one, key reasons being:

1. *GPs are much better at managing risk than hospital specialists. Indeed, this ability to make extremely difficult calls on what to do with a particular patient is quite phenomenal.*
2. *GPs are the only clinicians with a holistic overview of multiple factors. This is not only medical but non-medical factors too.*
3. *GPs have the best view over social drivers of ill-health. Some of this is because they have built long-lasting relationships with patients, know their families and their background. Hospital notes are siloed. In particular, mental health trusts are usually completely separate from general medicine. The only bridge between the two is the GP.*

4. *GPs are population based. They are (more or less) responsible for a defined geographical area and everybody living within. The introduction of the ability to choose any GP has only slightly altered this, most still have a tight geographical tie.*

There is therefore a strong logic in moving activity to primary care and also moving management to primary care. The challenge is one of scale and complexity. One of the problems which beset Clinical Commissioning Groups was an 'anti-goldilocks' problem. CCGs are too small to meet the challenges of more complex medical care operating at a region wide level. Conversely, they are too big to be sensitive to the local needs at primary care level which require greater local coordination. And they were commissioners rather than providers.

One solution to the health equalities conundrum therefore is to provide a greater coverage of effective GPs.

MANAGEMENT SILOES

Health management is siloed. There have been multiple drivers behind this. First of all, the creation of NICE has inadvertently pushed the expansion of specialist care. NICE has been very successful at rationalising treatment allocation, gradually expanding or restricting treatments to those with an evidence base. But it has also made recommendations regarding access to specialist treatment. NICE guidelines have gradually morphed into NICE mandates, with failure to follow guidelines being a key argument used by prosecution lawyers in medical litigation. The majority of NICE guidelines for many years were for single condition states, with a dearth of recommendations for situations where there are multiple interacting factors. The rapid production of practical advice during covid-19 has been welcomed.

COVID-19 HAS CHALLENGED OVER-SPECILAISATION, WITH A TEMPORARY RETURN TO MORE OF THE COLLABORATIVE WORKING FROM DECADES EARLIER

In parallel to the growth of NICE, the General Medical Council (GMC) introduced much more stringent training and revalidation requirements to maintain medical practice. The aim was to drive up quality, or more particularly, to weed out the weakest. It has probably been successful in this, but at considerable cost. One major cost is that, with the burden of demonstrating proof of competency, including costly acquisition of continuous professional development points through lecture attendance, clinicians have become increasingly narrowed in their specialism and indeed have been actively warned by the GMC not to act outside of competency.

Covid-19 has shaken this, with a temporary return to more of the collaborative working from decades

earlier, with specialists mucking in, including a Middlesbrough cardiothoracic surgeon manning an ICU ventilator. The GMC, in keeping with the extraordinary times, have been pragmatic and supportive of much more adaptive and broad working.

Before Covid-19, the combination of these two factors had led to the demise of the general physician and the deskilling of the general practitioner, both of whom were historically the lynchpins of general medical care. This has occurred at the same time as co-morbidity in patients has greatly increased. Now, with a combination of an ageing and less fit population, more obese and inactive, multiple chronic interacting conditions are the norm. Unfortunately, with the siloes of specialisation, this means one patient now visits multiple different specialities. This is very expensive and, worse, can lead to conflicting treatments.

CONDITIONS FOR HEALTHCARE PROFESSIONALS SHOULD BE SENSITIVE TO LOCAL NEEDS

SPECIALIST BEHAVIOUR

Specialists investigate for their speciality. Because they see problems related to their specialism more frequently, they will often assume that a new symptom is more likely to be related to their specialism. There is also an embarrassment driver, not wanting to miss something which is their home territory. Thus, for the same symptoms, a rheumatologist will request rheumatology tests and a neurologist, neurology tests. Tests cost money and also pick up coincidental changes that then require further investigations and follow ups, all contributing to cost.

Specialists follow up many patients. Much is "just in case" monitoring. Some reflects the culture of paternalism in the NHS, that patients cannot be trusted to manage their own symptoms and report back should certain parameters be breached. There is also an element of, if something changes and it is not picked up, I will be sued or criticised. This leads to a culture of 'doing to' the patient, rather than empowering the patient, or indeed educating and empowering the GP.

RECOMMENDATIONS

- *Conditions for healthcare professionals should be sensitive to local needs. Market forces should be used to pay relatively less in leafy environments where physicians would be prepared to work for relatively lower pay, with the opposite driver for nurses and lower paid staff.*
- *PCNs must not be allowed to become too big. If they need to expand beyond 150 individuals when including non-medical stakeholders, then fission should occur to keep the size of the group at a manageable number. General Practice must retain its autonomy within the PCN.*

- *The output from a hospital-based consultation should include an explicit statement about what the patient and their GP should look out for relating to their condition and what should trigger referral back, and should also explain why the hospital is following the patient up if they maintain the need to do this. The default should be to discharge patients to community care.*
- *Specialists should move to a primary advice and guidance service rather than a direct automatic, and bookable consultation. Thus, if specialist support is required, the GP can ask a specialist for advice, which might be recommendations for actions by GP or patient, organisation of a test or organisation of a consultation. Learning from the Covid period, the percentage of appointments made should be peer reviewed to make sure that as many cases are dealt with virtually as possible.*
- *Clinical opinions, such as provided in clinic letters, should explicitly state the functional level possible for the given structural constraints. This will be within the limitations of the condition, including anatomy and associated pathology, at the level of function which would be possible if all patient-directed measures were enacted, with a description of those actions. For example: 'Mr Johnson can currently only walk 10 metres. With weight loss and a graded exercise program he would be able to walk 1 mile. However, it is unlikely he will ever be able to walk further or run'. This would have a profound effect on the way many medics practice, including often different specialities being pitted against each other and failure to holistically address drivers.*
- *Representation should be included in the PCN from community facing physicians such as elderly care physicians. The move to hub and spoke working for specialists should be encouraged, with a distinction made between buildings and their location and the functional happenings within. This allows specialist input to happen in the locality with all the support and quality assurance associated with a specialist unit, but integrated into the locality and delivered locally. Continuing the increased use of digital consultation under covid should be used to facilitate this.*
- *The development of the concept of Primary Care Networks should be a template for future policy and service of government development in other non-health areas, co-produced and service owned.*

5. TARGETS AND BUREAUCRACY

"Decisions that used to take months or even years because of endless, pointless form-filling and meetings are now made in less time than it takes to boil a kettle."

The new NHS under Covid-19 according to Dr Max Pemberton, writing in the Spectator.

ONE DOCTOR WAS TOLD NHS STAFF ARE "ADULTS" AND CAN BE TRUSTED TO MAKE THE RIGHT DECISIONS ON THE SPOT

One doctor we know was told by managers that this sudden freedom was because NHS staff are "adults" and can be trusted to make the right decisions on the spot. We can probably all agree with the sentiment. Yet, we believe, NHS staff were adults before Covid-19 and will be adults after. And if decisions can be made in minutes now, why not always?

There is no doubt that, in some cases, the intelligent use of targets successfully brought down waiting lists and times, though all of them also had a cost even then: they increased the imperial sense among staff that they were pawns in a greater game, and that neither their ideas nor their common sense were required.

Now, when KPIs and targets have so much increased, it makes absolute sense to lift the burden of tickboxing targets – 30,000 of which constrain the efforts of staff in north-west London alone – and which have caused such wastage of time and money in the health service in recent years.

At the end of the day, when the chips are down, performance indicators and KPIs get in the way. They act as a huge demotivator, infantalising staff who don't need them. And they achieve very little except a false semblance of control. As we have seen, the NHS is one of the most centralised organisations in the world. It is run by managers and politicians who fall into the centralised mindset – they need to believe the figures because they are the only information they have, insulated as they are from the frontline. They are particularly blind to how local managers and staff will manipulate the figures to their own advantage – a process known as Goodhart's Law *('When a measure becomes a target, it ceases to be a good measure.').*

But there are other reasons why modern services have been overwhelmed by tickbox processes. Most of these derive from American contract culture which has always been at the heart of the New Public Management. Much of the paperwork and recording in the NHS is driven by fear of litigation. As claims on the NHS have grown, there has been a push to make sure that everything is documented in case it is required for court cases. If NHS staff had done the right thing, but it was not documented well, cases would be lost.

The tickbox approach is designed to manage people and organisations from a distant centre, with a minimum of human intervention. And within that objective, it is designed to reassure, to make sure that the endeavour is transparent or safe, that it lives up to its social obligations – that the right people are employed, that someone has made sure the cladding is safe or that their medical skills are up to scratch. Or, perhaps more usually, to provide an official imprimatur on this reassurance, even when it is completely hollow (as in Grenfell Tower's cladding).

Tickbox systems appear to offer reassurance, but they don't deal with variety very well. When you manage a range of people, then every other case will find you wishing there was another box to tick. Everyone has their particular issues and peculiarities, which a tickbox system will miss unless there are an infinite number of boxes to tick.

Any system designed to manage people or human life in any way, or to process them, tends either to be ruinously expensive or to cost so much to run that it really isn't worth it.

Finally, the fluidity of language is exactly why NHS managers want to run a less ambiguous system, which is perfectly understandable. So, like bureaucrats before and since, they choose numbers over words. They choose targets or key performance indicators, because these feel objective and hard-nosed, though in fact they are even more unreliable than words, because at least we are on our guard against words.

It is worth looking more closely at the idea of tickbox, and distinguishing it particularly from checklists – which clearly have an important safety role.

The medical writer and doctor Atul Gawande describes in his book The Checklist Manifesto the beginning of checklists, which date back to air accident prevention measures in the 1930s. But the purpose of checklists, as a safety device, is very different from tickbox. Checklists put the power back into the hands of professionals: nobody will know but them whether they have been used properly. Tickboxes are designed to achieve the opposite: to look over the shoulder of professionals from central headquarters, to remove their power and responsibility in the name of transparency or central control.[5]

5. See David Boyle (2020), Tickbox, Little Brown, London.

RECOMMENDATION

- *Organise a cross-NHS bonfire of tickbox, KPIs and targets – perhaps organised along the lines of the 'scrap sessions' at grassroots level in the Dutch NHS.*

COMPENSATION CLAIMS

According to the BBC, the NHS receives 10 000 new claims for compensation every year. The total cost of outstanding compensation claims is estimated at £83 billion. In contrast, the total budget of NHS England in 2018-2019 was £129 billion.

Bizarrely, if someone is injured maliciously, they get a much smaller payout, as these cases fall under the Criminal Injuries Compensation Scheme. This is far less generous than civil pay outs, sometimes to the tune of a 50-fold difference, given the criminal compensation cap is £500k, but civil pay outs now reach the £20-30m per case level. Therefore a baby with a lifelong disability from an obstetric accident may receive £25m, but still use NHS care; a baby with an identical disability resulting from being battered across the head by a step uncle will get £500k (criminal scheme) and NHS care; and a baby with identical disability resulting from a genetic condition will get no pay out at all, but NHS care, hopefully of the highest standards. The reason for this is that civil injury litigation falls under an obscure, flawed and outdated piece of legislation, the Law Reform (Personal Injuries) Act 1948.

A further consequence is the jeopardy of complaints and litigation cause GPs to work less and retire early. They avoid out of hours and emergency work, these being the areas of medicine most in need of doctors, but also the riskiest in which to work. A typical GP may be sued three times in their career and each case can drag on for many years, meaning a GP can spend a major part of their professional career with litigation hanging over them. Additionally, as with other clinical professionals, they may be curtailed from working when under investigation, thus placing further work load pressure on their colleagues.

An example case is an outstanding GP who was the pillar of his rural community and who was sued by one of his patients. In the end, it became too much for him and he took early retirement. The local community do not know why they lost their excellent GP.

CHECKLISTS PUT POWER BACK IN THE HANDS OF PROFESSIONALS. TICKBOXES LOOK OVER THEIR SHOULDERS FROM THE CENTRAL, TO REMOVE POWER AND RESPONSIBILITY IN THE NAME OF TRANSPARENCY

That the NHS is free is one of its most wonderful things, but a consequence is patients do not see the trade-offs. Indeed, they have been actively hidden by politicians over the decades with slogans such as "my health, my NHS" rather than "our NHS". A fair and equitable service means that the actions of individuals should not disproportionately impact negatively on others, something which the current system allows.

MEDICO-LEGAL REFORM SHOULD BE UNDERTAKEN URGENTLY WITH REPEAL OF THE 1948 ACT AND THE COMPLAINTS SYSTEM SHOULD BE PROPORTIONATE, WITH VISIBILITY ACROSS INSTITUTIONS TO TACKLE THE VEXATIOUS COMPLAINANT

It is often assumed complaints and claims correspond to the same cases, but there is surprisingly little overlap.[6] The introduction of the Patient Advisory and Liaison Service (PALS) has been a very effective rapid response system to deal with the majority of complaints. For those that progress, there is an established process including dispute resolution and Ombudsman referral. Unfortunately the system is not flexible enough to deal with the small minority of patients who abuse this and create disproportionate cost and distress to the NHS and its staff.

RECOMMENDATIONS

- *Medico-legal reform should be undertaken urgently with repeal of the 1948 Act. Principles should be enshrined that if a patient accepts care on the NHS, they accept the NHS will also look after them in the same way it would anybody else with identical disability and employment support if something goes wrong.*
- *The complaints system should be proportionate, with visibility across institutions to tackle the vexatious complainant. Complaints which are about disagreement diagnosis and over treatment should be recorded separately from those where there are actual errors.*

COMPETITION VERSUS COLLABORATION

Competition, in general, drives up standards. People respond to incentives; the trouble is that both require numerical bureaucracy.

There was limited introduction of market forces by the Thatcher and Major governments, but then a massive expansion by the Blair government which introduced widespread centrally set targets, and then expansion of the market. This improved efficiencies and standards because of competition. But this came at a cost of chasing financial targets and other centrally dictated performance measures, sometimes at the expense of care quality, exemplified by disastrous failings in some trusts.

An additional problem is that competition hinders collaboration. Healthcare is exceedingly complex. Some trusts engage in behaviour which may enhance their own performance metrics, but at the expense of optimal patient care more broadly. Someone needs to police this and co-ordinate a response. Historically, this role was performed by the Regional Health Authorities. When these were dismantled, NHS England attempted to maintain co-ordination through their regional teams, but with limited success.

6. https://www.emerald.com/insight/content/doi/10.1108/IJHCQA-06-2015-0081/full/html

The historic structure is now being put back, but now named Integrated Care Systems, effectively Regional Health Authorities by another name.

More sophisticated thinking would be less binary – compete in some areas and collaborate in others, as in the motor industry – but in the NHS such thinking is uncommon. The challenges of NHS organisational co-ordination are highlighted by the fact that a talented CEO, Simon Stevens, has been trying to achieve this for six years. Then Covid came and co-ordination happened. No longer the petty squabbles and dysfunction. "This hospital does this, you're in charge of that." The corona enemy focused minds and most definitely led to need trumping want.

Competition between organisations works best where population density is high and large, making choices between multiple providers easy. This does not work in other areas of the country, and in particular more rural areas. The introduction of competition was meant to reward the best organisations, which it did. Turnover soared for the prestigious Shelford Group Teaching Hospitals, those institutions which were always going to be the most desirable from a patient choice perspective with turnover for each trust rising above £1bn (£1.6bn for Guys and Thomas' NHS Trust).

The trade-off was that other places became weaker. The logical consequence would be that these organisations would close and patients travel further to the higher performing units. But local populations do not like closure of their hospitals and local MPs are highly motivated to achieve re-election by fighting against such closures.

This has led to years and in some cases decades of paralysis. Hospitals without the critical mass to staff key specialities limp on in a powerless state and with expensive locums used to maintain rotas and lack of critical mass of specialism support structures severely undermining quality.

ACTIVITY VERSUS OUTCOMES

Payment by results – an inevitable by-product of competition – was a key market driver behind the Blair reforms, and it was bound to have numerical targets at its heart. The more units of clinical activity carried out, the greater the payments.

Unfortunately, this was payment by activity rather than payment by outcomes. Getting more patients in, pushing more patients through, enriched the hospitals. The simpler the cases the better, so perversely maintaining ignorance of GPs was desirable and unfortunately practised by some clinicians. Follow-ups also attract a tariff, so the more of them the better. There was no incentive for patient empowerment or indeed to make patients better long-term. The system has perpetuated a national sickness service, patching people up, rather than tackling the determinants of ill health and activating patients to look after themselves.

Hospitals argue, wrongly, that they have little impact on some of the broader healthcare determinants, such as obesity, exercise or smoking, and that it is somebody else's job.

It is certainly a challenge, but hospital clinicians are highly influential (from a patient perspective). However, when they do try and impact patient behaviour, it is impossible to measure how much of the eventual improvement was down to the hospital rather than somebody else and so how to incentivise this behaviour?

We have seen a 20-year push to streamlining NHS services and improving efficiency. In many areas this has been successful. Yet, whilst the factory mentality works well for widgets and also for some routine aspects of healthcare such as knee replacements, many areas of healthcare are highly complex, nuanced and variable. The move from a relationship based to a transactional economy, with the de-professionalisation of medics who were deemed not to be trusted, has led to a capability gap in dealing with complex integration and difficult situational judgment.

WE NEED TO SUPPORT THE NHS CEO IN TAKING A CO-PRODUCED, BOTTOM UP APPROACH

RECOMMENDATIONS

- *We need to support the NHS CEO in taking a co-produced, bottom up approach. And any future successors should be chosen for their wide experience. Until the present incumbent, NHS CEOs have come from the acute hospital sector - even though 90 per cent of all NHS care is community based and 80 per cent of clinical consultations occur in primary care.*
- *An academic undergraduate and postgraduate degree in healthcare management should be introduced, not least to encourage a wider entry into NHS management*

AN ACADEMIC UNDERGRADUATE AND POSTGRADUATE DEGREE IN HEALTHCARE MANAGEMENT SHOULD BE INTRODUCED

6. FINAL REFLECTIONS: THE COMING OF COVID

'Progressive politics must find a way of integrating the schism between the individual as consumer and the individual as citizen.'

Philip Gould

In any NHS 'pyramid' denoting influence, power and resource availability, hospitals would be at the top and patients and the public at or near the bottom, even though well meaning missions, strategies and plans place patients and public at the top.

Why is this? Some of it is historic, reflecting an overweening dominance of bio-medical professionals whose focus over time is increasingly on treating and cure. What happened to the doctor as a teacher who serves as a nurturing or fostering influence?

A compounding issue: does an NHS derived from a state nationalisation model of ownership further leave the individual - whether patient or carer - with little influence? The NHS ensures at a national level a socially just service, but - as so often with state-funded organisations - little influence and even less power for the individual. To address that problem, the concept of the 'Third Way' became fashionable, led by USA President Clinton and UK Prime Minister Blair with academic underpinning by Anthony Giddens. That progressive concept died a death under pressure from populism, but intellectually and practically it remains as relevant now.

Most critically, a statist model hides from the citizen the trade-offs pervasive in our search for improved health and well-being, the functioning of the NHS and the wider determinants of health.

A pandemic is raging around the world. Can the UK-wide societal and NHS changes either directed at us or developed locally in response to the potential overwhelming of our healthcare system bear any long term benefit once the crisis is over? The pros and cons seem balanced. The NHS has sharpened its efficiency by using technology for direct patient contact, lessened the need for follow-up for many clinical conditions and increased volunteering. On the other hand, there is a hugely increased focus on hospital care, although necessary during this pandemic. Ceasing follow up of patients, even though much is traditionally excessive, may be an abandonment rather than an enabling of patients.

Much more fundamentally, a crisis requires centralising control and often command. This isn't the future style that is required. Worse, for authoritarian minded leaders, it might provide an opportunity to maintain draconian measures. How do we nurture the former and eliminate the latter?

7. POLICY RECOMMENDATIONS

LOCALISING

1. Divide PCNs when they need to expand beyond 150 individuals (including non-medical stakeholders) and General Practices should retain their autonomy within PCNs.
2. Make the role of the Regional NHS and local authority groups to provide organisational support, inform on good practice, provide leadership training and resolve conflict blocks, rather than performance manage targets.
3. Make specialists a primary advice and guidance service for GPs rather than a direct automatic consultation being bookable.
4. Peer review the percentage of appointments made to ensure as many cases as possible are dealt with at arm's length.
5. Include in the outputs from a hospital-based consultation, an explicit statement as to what the patient and their GP should look out for relating to their condition, what should trigger referral back and also explicitly state why a hospital is following the patient up if they maintain the need to. The default should be to discharge patients to community care.
6. Ensuring the leadership of the NHS is bottom up, modelled on co-produced organisations.

EQUALISING

7. Make pay and working conditions for healthcare professionals sensitive to local needs. (Market forces should be used to pay relatively less in leafy environments where physicians would be prepared to work for relatively lower pay with the opposite driver for nurses and lower paid staff.)
8. Include key stakeholders - such as community police, teachers, local councillors, both parish and county, third sector representatives, youth and religious leaders - within each PCN, as soon as their maturity allows. Representation should be included in the PCN from community-facing physicians such as elderly care physicians.
9. Encourage the move to hub and spoke working for specialists, with a distinction made between buildings and their location and the functional happenings within.
10. Require clinical opinions, such as provided in clinic letters, explicitly to state the functional level achievable by patients if advice is followed, within the limitations of their condition.

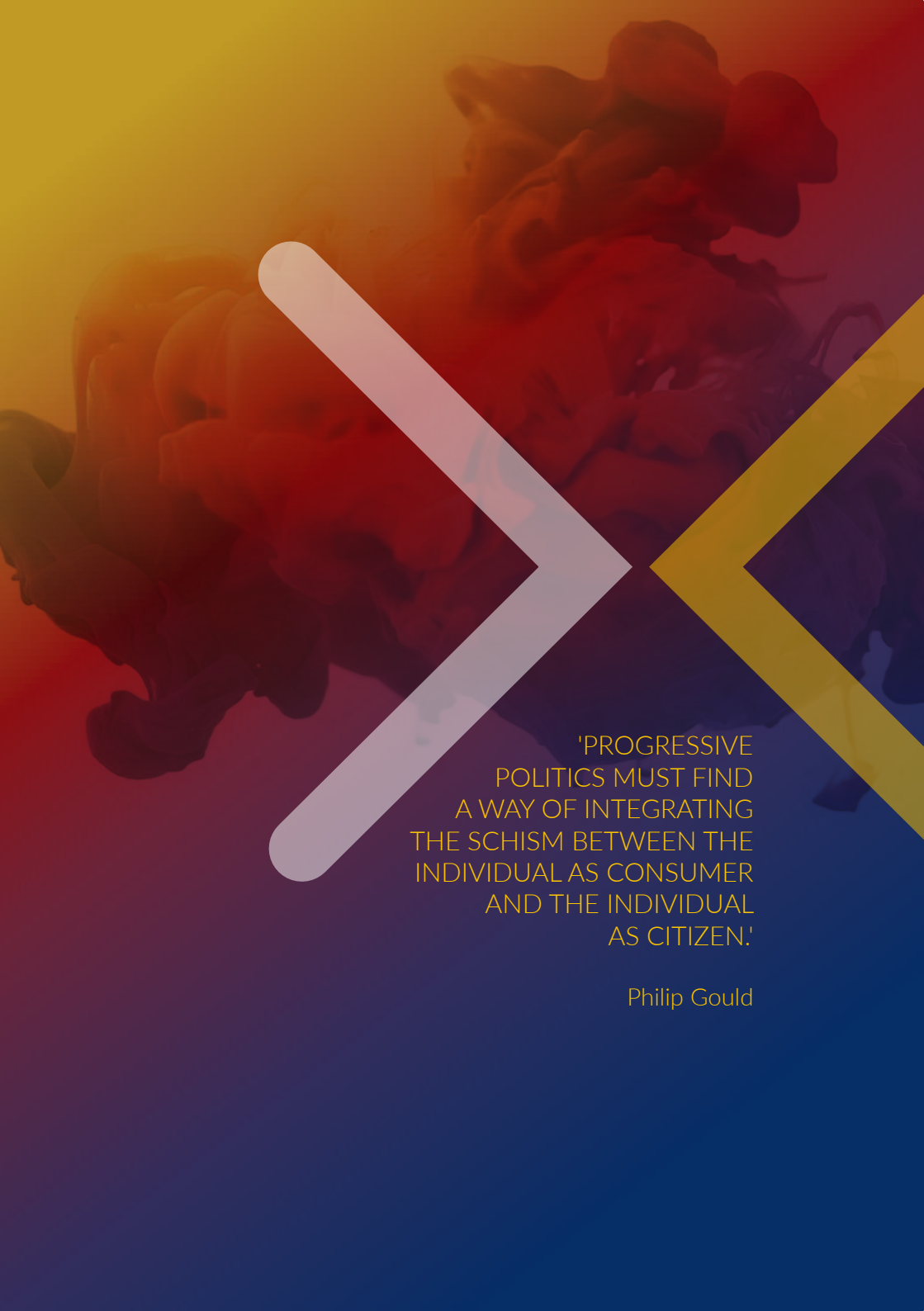
UNTICKBOXING

11. Organise a cross-NHS bonfire of tickbox, KPIs and targets – perhaps organised along the lines of the 'scrap sessions' at grassroots level in the Dutch NHS, learning from experiences during the Covid crisis.
12. Embed group problem-solving within all PCNs with upskilling of staff and emulating best practise in co-production to engage patients, the public and outside groups.
13. Repeal section 2(4) of the 1948 Act governing medico-legal practice to enshrine the principle that - if a patient accepts care on the NHS - they accept the NHS will also look after them in the same way it would anybody else with identical disability and employment support if something goes wrong.
14. Make the complaints system proportionate, with visibility across institutions to tackle the vexatious complainant
15. Develop the concept of Primary Care Networks as a template for future policy and service development in other non-health areas, co-produced and service-owned.
16. Launch an academic undergraduate and postgraduate degree in healthcare management to encourage a wider entry into NHS management.

Dr Paul Goldsmith, *MA BM BCh MRCP PhD* is a life sciences entrepreneur and consultant neurologist, with an interest in evolutionary medicine and complex systems strategy. He has held NHS Clinical Networks, Vanguard and Senate roles. He is chair of the Big Tent Foundation, President of Closed Loop Medicine and a Non Exec Director of the MDU.

Dr David Colin-Thomé *OBE, MBBS, FRCGP, FRCP, FFPH, FFGDP (Honorary), FQNI* is an independent healthcare consultant and formerly a GP in Castlefields, Runcorn for 36 years, the National Clinical Director of Primary, Dept of Health England 2001-10, and visiting Professor Manchester and Durham Universities.

David Boyle is policy director of Radix UK and the author of a number of books including Tickbox and The Human Element.



'PROGRESSIVE POLITICS MUST FIND A WAY OF INTEGRATING THE SCHISM BETWEEN THE INDIVIDUAL AS CONSUMER AND THE INDIVIDUAL AS CITIZEN.'

Philip Gould

LOCALISE, EQUALISE AND UNTICK

The future of health care post-Covid

Dr Paul Goldsmith
Dr David Colin-Thomé
David Boyle

ABOUT RADIX

RADIX is a non-aligned think tank for the radical centre. We welcome people from all parties and none. We challenge established notions and work to re-imagine our societies. We focus our efforts on policy initiatives that can drive towards system change rather than putting sticking plasters on the existing system. Our goals are to revitalize our liberal democracies, re-define capitalism, and re-build cohesive communities and societies. We want all citizens to live securely, with dignity, be active participants in society, and be free to pursue their own interpretation of the good life.

ABOUT RADIX PUBLICATIONS

Radix exists to challenge established notions and to re-imagine societies. As such, we welcome the opportunity to publish original papers which promote political, economic and social system change. The opinions expressed within any Radix papers are those of the named authors and publication does not imply agreement by the Radix Group Ltd or any of its Trustees with specific conclusions or recommendations. We hope nevertheless that all our publications provoke more informative, intelligent and thoughtful debate.

ISBN (ePub) 978-1-912880-16-4

Radix Brand and Layout:
Mark Huddleston

CONTACT US

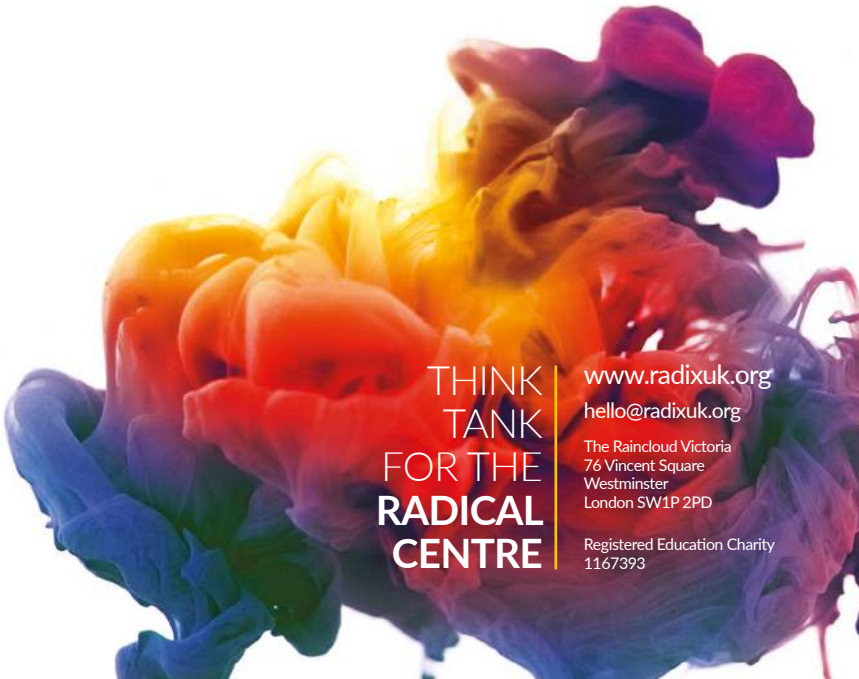
RADIX,
The Raincloud Victoria,
76 Vincent Square,
Westminster,
London SW1P 2PD

hello@radixuk.org

Published in July 2020
by Radix Group Ltd

www.radixuk.org

RADIX



THINK TANK FOR THE **RADICAL CENTRE**

www.radixuk.org

hello@radixuk.org

The Raincloud Victoria
76 Vincent Square
Westminster
London SW1P 2PD

Registered Education Charity
1167393