LESSONS FROM THE CORONAVIRUS CRISIS

The NHS takes control: consequences for health policy in England

Steve Iliffe

The public health response to the pandemic has been shaped by rapidly shifting strategies and many years of underfunding and austerity. But the NHS has stepped up to the task and taken control. Many of the changes in organisation and management style that have taken place as a result are likely to be difficult to reverse.

The new coronavirus that arrived in the UK in January 2020 has triggered changes in the NHS which will be difficult to reverse, at least in the short to medium term.[1]

In the beginning, the place and funding of public health as a discipline became a hot topic in the coronavirus debate as experts gave differing views of how to manage the pandemic. The 'herd immunity' view (building up a protective sub-population of the immune) was favoured initially, on the grounds that testing as many as possible of the whole population was impractical. The 'herd immunity' view gave

way to the World Health Organisation's strategy of selective testing in mid-March, but there were political as well as scientific reasons for this change.

Public Health, taken into the NHS from local government in 1974, was restored to local government control in the Lansley Reforms of 2012. Like the rest of local government, it has experienced substantial cuts in its budget over the last decade. Public Health has been under-resourced, and the adoption of the 'herd immunity' strategy reflected the inability to mobilise the resources needed for mass testing and contact tracing. National government therefore opted for the second-best option of mitigating (but not controlling) the effects of Covid-19, in a country in which successive governments have deliberately underfunded Public Health services.

Changing strategy

Although it still has its advocates, the herd immunity strategy failed. The government then turned to selective testing combined with containment measures (social distancing and the closure of public spaces) as the optimal method for containing the pandemic. The change in strategy did not alter the problem of limited resources. Accident and Emergency departments were struggling with high levels of demand before the pandemic's arrival; there were (by one estimate) 100,000 job vacancies across the health service; and historically the NHS had spent relatively little on intensive care facilities or staff.

An attempt to mitigate the impact of the virus by promoting voluntary action by individuals reflected not only the Conservatives' ideological hostility to 'big government' but also a belief that most people could be nudged (but not coerced) into following public health advice. This optimism ignored the evidence that people in affluent and individualistic societies easily adopt an 'eat, drink and be merry' culture, breaching social distancing (and other health-preserving) rules as they do so.

The epidemiological modelling of Covid-19's spread then began to alarm politicians. They abandoned voluntary restraints on movement and gathering and imposed a more stringent 'lockdown', designed to slow virus spread and reduce demand for hospital care for those whose infection became life-threatening.[2]

A shambles

A seven-week delay in introducing containment measures – a delay described by one academic as 'near criminal negligence' and 'obfuscation' – resulted in recurrent shortages of Personal Protective Equipment (PPE), which provoked angry responses from NHS staff.[3] The TV image of the Health Secretary loading boxes into a van

showed what a shambles NHS supply had become. The Health Care Supply Association admitted to a 'system' failure, but without naming names or pointing fingers. According to the *Health Service Journal* some trusts turned to alternative suppliers to source protective kit, including DIY shops. Staff working in central purchasing teams reported particular difficulties in getting hold of PPE; these included a lack of UK-based manufacturers; the restriction of exports by other countries in order to meet their local demand; the supply of poor quality products as buyers worked in a hurry; and some unjustified price rises introduced by suppliers. In some places protective kit was delivered to the NHS by army lorries.

Similar problems appeared once the government had changed strategy and promised widespread screening: screening tests were not available and university laboratories that could have contributed to test analysis had been mothballed and their staff sent home as part of university lockdowns.[4] NHS plans to test were poorly executed. On 2 April, *The Times* ran the front page headline 'Virus testing plans in chaos', over an image of a large drive-through testing centre at Chessington World of Adventures in which nobody was being tested.

NHS takes control

The NHS then demonstrated what a real command-and-control management style could look like in a huge institution made up of intertwined and sometimes competing bodies. Some of its management actions may prefigure or bring about future changes, as discussed below.

Commissioning

NHS England took over commissioning services from Clinical Commissioning Groups (CCGs), which had anyway failed to transform the ways in which the NHS worked over the preceding decade. It seems unlikely that the CCG form of commissioning will be restored.

General Practice

The NHS increasingly dictates the terms under which the public contact their GPs, encouraging doctor-patient communication via video consultations and email. The technologies for virtual consultations that took the commercial provider Babylon years to establish in two cities became established across general practice within weeks. General practitioners are beginning to look like doctors working in a salaried service, instead of being sub-contractors. There is growing interest in a salaried option, especially among younger GPs.[5]

Spare capacity and labour direction

Not only has the NHS taken up direction of professional labour, encouraging forward movement of specialists into A&E departments and seconding nurses to work in field hospitals, but it is also mobilising 'returners' from among the recently retired. Volunteers have also come forward in large numbers to provide temporary support for isolated people staying at home without family support. New capacity was created by conversion of existing premises into infectious disease wards with ventilation capacity, and by construction of large field hospitals like the 4000-bed Nightingale Hospital in London. The NHS bought almost all spare capacity (in terms of beds and staff) in the commercial medical sector. These acquisitions may not be permanent but there will be a backlog of postponed surgery and cancer treatments to work through, and spare capacity in theatres and beds will help this.

Integrated health and social care

By contrast, the NHS has failed, despite decades of talking, to reach agreement with local government social services, and so is still handicapped in transfers of mostly older people with multiple problems out of hospitals into community settings. Retired social workers are not being called back into action. This historic mismatch may yet change, but it will probably do so slowly. There are accounts of some Integrated Care Organisations (which depend on collaboration between local government and the NHS) developing quickly, because managers who would often act as brakes to progress are absent, dealing with Covid-19 planning. Others report that the NHS and local government operate with the same distrust and disregard for each other as usual. This is a deeply entrenched problem that successive governments have promised to uproot, but without much actually happening. One suggestion that may offer employment opportunities during the coming recession is the formation of a community health worker service staffed by young people who have gone through a crash training programme.[6] And smaller changes may also make a difference. For example, the NHS response to Covid-19 might have been very different if Advance Care Plans had been in place for vulnerable older people like those living in care homes. Such plans should contain the option for us to decline ventilation, just as we may decline resuscitation.

Market mechanisms

The government has abolished payment by results and payment by performance in the NHS, and suspended payments for target achievement in general practice. It has also written off the debts that hospital and community trusts have run up with the Department of Health, a 'haircut' that has been talked about for two years.

These are blows to the marketisation of the NHS, and will reinforce the existing enthusiasm for direct control of the NHS from the centre. The NHS is beginning to look like a service that is clinically-led rather than target-driven. The supply failures suggest that it is time for the NHS to grow its own PPE and diagnostic testing kit manufacturers, in-house.

Public engagement and case mix

Constant encouragement to relieve pressure on the NHS seems to have had an effect; attendances at A&E departments fell by one third in March 2020, the biggest fall being among young adults. With hospitals being depicted as dangerous, infectious places, potential A&E users are understandably avoiding them. Supplier-induced demand may also be reduced, as doctors and nurses prioritise those with infections and pay less attention to others, reducing follow-up or onward referral to outpatient clinics of patients who do not have Covid-19.

These are only the most salient of examples of possible long-term changes in the NHS being initiated by short-term responses to Covid-19. Not all changes will take root. But overall the old order of the NHS will be shaken.

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Notes

1 Matthew Taylor, 'How the coronavirus crisis could change the nature of government and democracy', The Policy Institute, Kings College London, 3 April 2020.
2 Sarah Dalglish, 'Covid-19 gives the lie to global health expertise', *The Lancet*, 26 March 2020.
3 'The lockdown and the long haul', *The Economist*, 21 March 2020.
4 Joe Buckley and colleagues, 'A science-based socialist response to Covid-19', Scientists for Labour, March 2020.
5 Jacqui Thornton, 'How coronavirus will change the face of general practice forever', *BMJ* 2020, p369: m1279.
6 Andy Haines and colleagues, 'National UK programme of community health workers for Covid-19 response', *The Lancet*, 24 March 2020.