

A Proposal for National Health and Social Care Rationalisation and Accountability

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Summary

How much of the pressure on health and social care comes from insufficient funding, and how much from the way services are organised? Both may contribute, and each may make the other worse. Government needs a clearer basis for deciding what to change and what to fund.

I propose a coordinated national examination of health and social care in England. All organisations within its defined scope would be required to participate. The examination would identify duplication, avoidable delays, wasted resources and gaps in responsibility. It would assess both individual services and the connections between them, following the person's journey through care.

The work would use an adapted framework based on ISO quality-management principles. It would establish what better organisation could realistically achieve and calculate the resources needed to deliver a defined standard of care. Its findings would inform a national plan with clear responsibilities and timetables for action.

The framework and a report with the scope and ambition of the Beveridge Report would be developed together, with an 18-month target for a substantive draft report and national plan. This is a target for the report, not for completing reform. Urgent risks and resource shortages should be addressed while the examination proceeds.

Why examine the connections between services

A person experiences care as part of one life. Services may see separate appointments, assessments and episodes of treatment. Between them are referrals, decisions and handovers. If information fails to arrive, responsibility is unclear or the next stage is not arranged, care can be delayed even when each service has completed its own task.

Some delays also arise because services work in an unnecessarily rigid sequence. A patient may have to wait for one stage to finish before another begins, although assessment or preparation could safely proceed at the same time. This can delay diagnosis and treatment and increase the risk of avoidable harm.

The quality of the whole service therefore depends on its connections as well as its individual parts. Specialist expertise remains essential, alongside arrangements for sharing information, accepting responsibility and coordinating care.

The examination would establish where fragmentation and poor organisation occur, how extensive they are and what would help. Its guiding rule would be to preserve what works well and change arrangements where evidence reveals failures.

What the examination would cover

The scope would include GP surgeries, community health services, hospitals, mental health services, local authorities, commissioned social care providers and major external suppliers. It would also include organisations responsible for commissioning, funding, regulating and overseeing services, extending to the Department of Health and Social Care itself. Each organisation would explain what it receives, what it does, what it passes on and who is responsible for the quality and timeliness of those activities. Examining these accounts together would help reveal problems concealed when organisations are considered separately. The work would begin in England. Wider UK participation could be developed in cooperation with the devolved administrations.

Following care between services

The examination would cover referrals, test results, discharge from hospital, medication changes and continuing support. It would assess arrangements for sending information, confirming receipt, accepting responsibility and acting when delays remain unresolved. Where clinically appropriate, it would identify opportunities for assessment and preparation to proceed in parallel.

Making better use of staff time

Staff would help identify repeated data entry, duplicated assessments, avoidable meetings and time spent chasing missing information. Appropriate training and practical changes could release time for direct care.

Improvements must also prevent unnecessary work being passed to another service. For example, responsibility for acting on test results and arranging follow-up should be clear. Any increase in activity would be assessed alongside safety, outcomes and workload, so that efficiency did not depend on unsustainable working practices.

Including people whose needs are unmet

The examination would include people already receiving care and those awaiting it, whose requests have been declined or who cannot access services. Difficulties obtaining a GP appointment or securing onward assessment would form part of the picture. Funding and staffing would be compared with the capacity needed for safe and timely care, allowing for differences in the complexity of people's needs.

Who would put problems right

Responsibility for improvement would form part of normal management at every level. Managers would examine their services, address failures within their authority and refer wider problems to the level able to resolve them. These might include conflicting requirements, commissioning decisions, unavailable specialist capacity or funding constraints.

Each agreed corrective action would have a named person or body responsible, a timetable and a check that it had been completed and worked in practice. Senior leaders would formally review findings and decisions, including the resources required for improvement.

The Department of Health and Social Care would be examined in the same way as other participating bodies. Its processes, decisions and responses would be open to scrutiny. Local failures should be connected to the authority and resources needed to address them, including where responsibility lies nationally. Management review would be supported by independent assessment, service-user and staff participation, and public reporting. Documentation should be proportionate and useful to those delivering care.

How the examination would assess funding

A shortage of capacity does not, by itself, prove insufficient funding. Too few appointments might reflect a shortage of funded posts, recruitment difficulties, inefficient processes or a combination of these. A shortage of home care might reflect commissioning budgets, provider capacity or both. Delayed hospital discharge may require action across hospital, community and social care services.

The examination would first assess what could reasonably be achieved through better organisation without compromising care. It would then cost the resources needed to meet the remaining shortfall. Resource shortages may themselves create inefficiency, so the analysis would consider how the two reinforce one another.

Anticipated savings would need evidence before being used to justify funding reductions. Time released for staff to provide more care would not automatically be a cash saving. Financial effects should be considered across the system: moving costs from one public body to another does not establish overall value for money [6].

Comparing need with capacity

A structured comparison, or demand–resource matrix, would record the care required and the resources available at each stage. It would include current demand, backlogs and estimated unmet need. It would allow for differences in staff time, skills, equipment and facilities rather than treating all consultations or care packages as equivalent.

Bringing the information together

Existing information would provide a starting point. Integrated care boards could supply funding and commissioning information; NHS trusts, GP practices and community providers could supply staffing, workload, waiting list and capacity data. Local authorities could contribute assessments, outstanding requests, budgets and commissioning records. Care providers could report available staff hours, vacancies and capacity to accept referrals. Joint Strategic Needs Assessments and population data could help estimate wider need. Service users, carers, staff and Healthwatch would help identify needs missing from official records, including those of people unable to access services.

No single organisation should be assumed to hold the complete picture. Integrated care boards and local authorities could coordinate this work jointly with providers. Before combining information, they would check its completeness, consistency and reporting periods, and record remaining gaps. Service-user and staff experience would help test whether the findings reflected practice.

Calculating the funding requirement

A costing team would work alongside the examination. It would include health and social care finance specialists, health economists, clinicians, care providers and service-user representatives. Independent scrutiny would test its assumptions and calculations.

The standard of care used for costing would be stated explicitly. It would draw on applicable clinical guidance, statutory duties and agreed expectations for quality and timeliness, with professional and service-user participation.

The calculation would follow five steps.

1. Establish the need. Estimate how many people require each service, the complexity of their needs and the quality and timeliness of care required. Include waiting lists and unmet need.
2. Identify the resources. Calculate the staff time, skills, premises, equipment, supplies and supporting services needed under a realistically improved organisational model.
3. Price those resources. Use full employment costs, realistic recruitment costs, purchasing prices and other operating costs. Calculate investment and transition costs separately.
4. Account for efficiencies once. Include only evidence-supported improvements, allowing for the cost and time needed to achieve them. Distinguish cash savings from capacity released to provide more care.
5. Compare cost with funding. Use the same service scope and time period, avoiding double counting between organisations.

In simplified form, the annual funding gap would be the annual cost of meeting assessed need under a realistically improved model, less the annual funding available.

The estimate should be a range with explicit assumptions. Recurring expenditure and one-off investment would be reported separately.

Developing the framework and national plan

The adapted framework and the national report would be developed in parallel. Findings from applying the framework would inform the report, while emerging findings would help refine the framework. The target would be a substantive draft report and proposed national plan within 18 months, for public and parliamentary scrutiny.

Implementation would require its own timetable, responsibilities and resources. Essential care and action on urgent risks should continue throughout; people should not have to wait for the report before pressing problems are addressed.

Reviewing progress and changing needs

The resulting framework and plan would include annual reviews at NHS trust and local authority level, with earlier reviews when significant changes required them. Reviews would check whether improvements had been achieved and sustained, and reconsider priorities as needs, staffing, costs, funding, technology and provision changed.

Financial review would compare actual expenditure, demonstrate savings and remaining funding gaps with the resources needed for safe and timely care. Service users, carers and staff would contribute to the assessment.

Local reports would be published in accessible formats, identifying who was responsible for further action and by when. The Department of Health and Social Care would bring findings together in an accessible national report and publicise them through national media.

Success would be judged by improvements in care: fewer avoidable delays and failed handovers, less duplication, better use of staff time, improved outcomes and service-user experience, and transparent financial accountability.

Why use ISO quality-management principles

ISO 9001 provides requirements for quality-management systems [1]. Its principles offer a structured way to define processes and responsibilities, monitor performance, correct failures and improve services. The proposal would adapt these principles to a connected care system, while retaining existing clinical, professional and regulatory standards.

ISO 9001 certification is already used in complex scientific and healthcare-related organisations. Examples include the National Physical Laboratory, whose stated scope covers scientific research and development and internal services [4], and The Health Informatics Service, hosted by Calderdale and Huddersfield NHS Foundation Trust [5].

These examples show applicability within individual organisations or services. They do not demonstrate equivalent arrangements throughout health and social care or establish the benefits of this proposed national approach. Those benefits would need testing during development and application.

ISO certification is voluntary. This proposal instead calls for mandatory participation in the defined national examination. It does not assume that requiring every organisation to obtain a certificate would, by itself, improve connected care. The purpose is a continuing process of investigation, corrective action and review.

Related standards

ISO 7101:2023 provides requirements specifically for quality management in healthcare organisations. It addresses people-centred care, dignity, equity, patient and workforce safety, and clinical and non-clinical performance [3]. It could help shape the examination alongside ISO 9001's broader principles. ISO 14001 addresses environmental management [2]. Its approach could complement the work by examining energy and water use, clinical waste, pollution, purchasing and transport. Coordinating these activities could support improvements in service quality, environmental performance and resource use.

What government is asked to do

Government is asked to commission a coordinated national examination with mandatory participation within its defined scope, designated leadership, service-user and staff involvement, and independent scrutiny.

The examination should produce a national plan that preserves effective services, addresses failures within and between organisations, and identifies where better organisation, additional resources or both are needed. The plan should assign responsibility for corrective action, publish timetables and monitor results.

The purpose is lasting improvement in the quality, timeliness and continuity of care, with a clearer evidence base for public spending and accountability for decisions.

Sources

- [1] ISO. ISO 9001 explained.
<https://www.iso.org/home/insights-news/resources/iso-9001-explained.html>
- [2] ISO. ISO 14001 Environmental management systems.
<https://www.iso.org/standard/14001>
- [3] ISO. ISO 7101:2023 Healthcare organization management.
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- [4] National Physical Laboratory. Quality.
<https://www.npl.co.uk/quality>
- [5] The Health Informatics Service. About THIS.
<https://www.this.nhs.uk/about-this>
- [6] HM Treasury. The Green Book 2026. Chapter 6, Public sector financial impact.
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