My speech about reforming the NHS

Like others, I warmly welcome the workforce plan. I am grateful to my hon. Friend the Member for Winchester (Steve Brine) and his Committee for producing a detailed and interesting report that highlights many of the things we need to study.

I suspect most of us in this Chamber, of whatever political party, accept the broad principles that we need to train more medical staff in this country and that we need to expect to recruit more people to deal with the rising workloads and rising population in the years

ahead and to clear the current backlogs. And who would not want progress on better working conditions and decent levels of remuneration, so that many more people are proud to remain in these jobs?

It is not as if we have not had these issues before, and it is not as if the workforce has not been expanding. As the report reveals, the number of full-time equivalent staff in NHS England has expanded by 263,000 since 2010, which is a very substantial increase. It is rather more than 263,000 people, because it includes part-time arrangements too. Of those, some 55,000 are nurses and 42,000 are doctors, which means that more than 160,000 are not in those two leading medical professions. NHS managers, who have increased substantially in number during that time, need to demonstrate that they are recruiting the right kinds of support staff, administrative back-up and IT help so that medical professionals are better able to concentrate on treating people and doing a good job.

In the past, I have led a couple of large industrial groups, and in the days before we had an elected Assembly to run the Government of Wales, I was responsible for the very substantial public sector workforce in Wales, including the NHS workforce, as Secretary of State, so I have some experience of the complexities and difficulties of helping to supervise or run large workforces. I freely confess that none of those workforces was on the scale of NHS England, which is another degree larger, with a workforce of 1.5 million. None the less, whether it was tens of thousands or hundreds of thousands, I understand the complexities of dealing with large workforces.

I have reflected on what worked and on my experiences. My first reflection reinforces the point we have heard from the Committee. If I had experienced a 9.1% rate of turnover each year, I would have been quite alarmed. Had that been added to by a 6% or 7% absence rate, as is reported in some professions and areas of NHS England, I would have been even more alarmed. Although I had lesser problems with absence and loss of talent, I regarded them as a challenge that the leadership and management teams had to take on. To deal with the frictions, there were nearly always things that could be done to improve conditions of employment and to improve the understanding between management and those trying to execute policy.

The frictions were not always about pay. Of course, increasing pay is greatly

helpful, and I welcome the results of the independent review—I was one of the many voices saying the independent review had to be implemented—but we now need something for something. We need to complement pay by making good decisions so that people feel they have a worthwhile, feasible job.

The one thing on which I disagree with my hon. Friend the Member for Winchester is his point that, with an organisation this big, it might be rather difficult to do the right kind of mentoring and individual treatment. The NHS is a series of small organisations under a general umbrella. There have been endless arguments, not particularly on party lines, about how much should be decided by experts and well-paid people at the centre and how much should be decided in the hospitals and surgeries—about how much delegated power there should be.

There is certainly management at all levels. As my hon. Friend reminded us, there are chief executives and other senior staff in hospitals, and there are practice managers and others in GP surgeries. Quite a lot of the

mentoring, understanding, and evolution of a person's role or job must occur in those local places, where one of the local management's main tasks must surely be ensuring that their staff are looked after and well motivated. This service is a great example of a people-led service. It has millions of potential patients and a million and a half staff, and it is the interaction between them that matters. The quality of service is almost entirely dependent upon the skills, attitudes and approach of the medical professionals and their support workers in delivering a good quality of service to those who turn up as patients.

We need to say to the 36,000 managers of the NHS England system that they have an important task; that surely they know their staff and what some of their staff's problems are; and that it is in their hands, not in the hands of Ministers, how the jobs are described and made into realistic jobs, with tasks that people want to do and can do. It is for those managers to work out how staff are rostered and how people become eligible for a promotion. Good staff management is about managing all those things.

Let me further the debate on this. We talked to the trust chief executive about this yesterday. She said that she does good exit interviews with people who leave her trust. They leave for varying reasons, but often it is because they have got a different job in a different part of the country, and their family circumstances have changed—they are not always off to Sydney. So this comes down to leadership. The Secretary of State would talk about the Messenger review—I assume the Minister would concur—which talks about leadership in trusts and integrated care systems. That is not as good everywhere as it might be.

That is right. I hasten to add that there are many examples of good practice in the NHS. In the hundreds of trusts, units and management commands in the NHS, there are some very fine examples. In a large organisation such as this, part of the skill lies in spreading the best practice from the places that

know how to do things and are doing them well to those that need help or support. They may not be aware of what is feasible, given the resource to which they are committed. I have found whenever I have been involved with something that was not working well that bad management have often made a mistake and appointed some good people but not in the positions of influence and power where they can really make things happen. Where someone is trying to recover something that is not running well, it is often about identifying the people who are good but who may be sidelined, frustrated or not being used properly, and then transferring them into different roles, to give the idea to the others that the organisation can be a good one.

My hon. Friend was hinting at where someone wants to get to if they are leading any organisation. They want success, because success breeds success; people want to work for a successful and happy organisation. If morale is allowed to sink, performance starts to get poorer. If performance sinks, really good people perhaps do not want to be associated with it or they are frustrated that they are not given the power to sort it out. The organisation could then get into a downward spiral, which it needs to avoid.

Let me move on to a slightly tougher message and spoil the party. I take as my text the work that the Chancellor of the Exchequer and his team have been doing and his recent big speech at the Guildhall on productivity. His research revealed that productivity in crucial public services, particularly the NHS, is considerably below its 2019 levels. We are all sympathetic to the fact that there was a major disruption of the NHS's work for the period 2020-21, and probably we would also expect there to have been difficulties in in 2022 after the impact of a major diversion of effort and activity into tackling the pandemic. We are all very grateful to those brave and talented staff who did what they needed to do to see people through. However, over that period a large additional amount of money was provided, not just for the pandemic, but now on a continuing basis, along with some additional staff, as we have been commenting on, yet we are still not back to the productivity levels we were at in 2019.

As the managers of the NHS go about creating a more contented and happier workforce, in the way I have been describing, they need to say to people, "You are going to be better paid, but we can also look at your promotion, grading and job specifications," because the good ones should be able to get additional pay and go up the scale into more important jobs. There has to be something for something. The managers have to help the staff to deliver more treatments, consultations and diagnoses, which must be possible because we are not even at the levels we were at in 2019.

I have met scores of people working in the NHS at different levels; I am sure the right hon. Gentleman has too. When I talk to them about the productivity gap, they give me two or three clear examples of why there is a productivity problem. One is that there are more sick days because of burnout and exhaustion. It is unfortunate that the Government are cutting funding for mental health hubs, which have been a huge source of help for staff, particularly in hospital settings.

The NHS workers I have spoken to also talk about scanners that are way past their use-by dates and take far too long to get going, and about IT systems that do not speak to each other. They have to use eight or nine different IT systems between wards, or even on one ward, and old computers take too long to set up in the morning. It is that kind of tiresome daily grind. We sometimes know about that here in Parliament, when computers do not start in the morning and things do not work, and people end up getting frustrated.

Does the right hon. Member recognise that the productivity problem is not just about rotas, but about investing in technology, IT and scanners that work, making sure that water is not coming through the ceilings and giving mental health support?

I agree with all that. I have been very careful not to criticise the staff; I am talking about a management problem. If there are too many agency staff, then time has to be spent explaining to them how that particular hospital or department works, which would not be necessary if the regular staff had turned up. If there are gaps because of staff absences or people having resigned, that puts more strain on people and the system does not work efficiently.

All my remarks are made in the context of what I said at the beginning about trying to make these jobs more worthwhile and feasible. We need to look at how that can be done, and managers have to answer questions about whether some of them are imposing too many requirements on people that are not directly related to them performing their tasks better. There have to be limits on how much other general management information or other management themes they want to pursue, when the main task is to clear the backlogs and to treat the patients. The patients should come first, second and third, and that is not always possible if managers are making many other demands. So that is where the management teams need to take the organisations.

I was coming to the other good point that the hon. Member for St Albans (Daisy Cooper) makes, which is also well made the workforce plan. We are living through an extremely exciting digital revolution. It may even be speeding up with the developments in artificial intelligence, which could be dramatically helpful. There is a continuing task in the NHS, which sometimes thwarts those attempting it, to make sure technology is applied in the right way and is understood and friendly to use, so that hard-pressed and busy medics can find it a support, rather than a tribulation or a barrier.

Given the NHS’s huge range of data and experience, artificial intelligence should be an extremely valuable support, aiding diagnosis and decisions on treatment. I am not one of those who think that computers can do these things on their own or are about to take over the world. In the model we are talking about, the computer is an extremely important assistant that can do research and produce first drafts—that kind of thing—in a way that speeds up the work and effectiveness of the professional. However, it has to be controlled and guided by the medical professionals, who have the judgment, wider experience and expertise. The quality and speed of what they do could be greatly enhanced with the right kind of AI backup. For example, if they are facing a

condition they do not know much about because it is rare, the computer would be able to give them immediate access, one assumes, to the details of what has happened in similar cases, what it looks like and how it might be treated.

We have the time, so let us explore that briefly. My right hon. Friend is right to talk about technology and AI in particular. We produced a report a couple of weeks ago on digital NHS. We are struggling with first base on digital. Medics talk to us about having to log in to multiple systems in order to do one very simple task. I worry that, while we are talking about 21st or 22nd century technology on assistive AI, we are struggling with first base. We were at the Crick Institute yesterday. Teams there were talking to us about the challenges of bringing together all the datasets that exist across the NHS to assist in their research, and they cannot even do that. This should be an assistive help to the workforce, but we have a long way to go on that. I know the Secretary of State is very seized of this opportunity, but my right hon. Friend knows that there are problems.

Yes, indeed. Wishing to be optimistic, I was pointing out, as many will do, that there is huge opportunity in this area. None the less, my hon. Friend is quite right that there are all sorts of issues and

questions, such as: what the existing technology delivers; whether the systems talk to each other sufficiently; and whether it has data in a format that can easily be transferred to a more common and modern system. We are obviously back into arguments on—I do not have a strong view on this, but experts should—how much has to be laid down centrally, so that there is an England-wide, or NHS-wide, system that is freely interoperable, and how much is best determined by local units, which know their own needs and will be organising the training and will want things that their own staff find helpful to them and fit into the sometimes differentiated approach that an individual hospital or a GP surgery may have.

It is good news that we are taking future manpower requirements seriously. It is good news that we are having an informed conversation about what might be possible. It is good news that most people, I think, agree that technology is part of the answer. Having better motivated and happier staff is clearly fundamental to the answer. I hope that, when the Minister sums up, she will have a few thoughts for me on what actions the senior management of the NHS and its various trusts are taking so that they can get those absence rates down, so that they can get the loss of staff substantially reduced, so that they have fewer staff saying, “This is not feasible,” or, “I am burned out,” and more staff saying, “I am really proud to work here,” or, “This is going extremely well; we cut our backlog last week,” and, “Did you know that many people are now getting over this condition because of our treatments?”

That is clearly what we want. We want high-morale organisations. That takes money and the right number of staff. It also requires great leadership, but it is not just leadership from the political top; it must be, above all, leadership from the very senior managers at the top of NHS England

percolating down to the very important senior managers that we have in every trust and every major health institution under the framework of NHS England.