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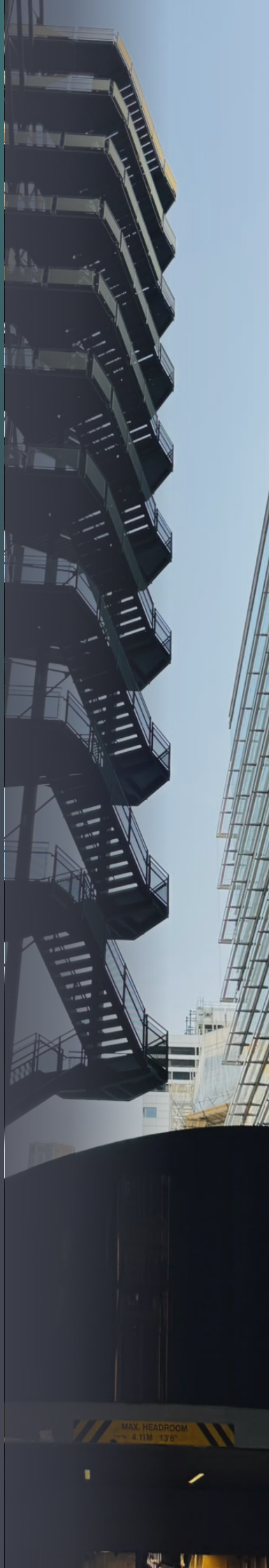
THINKING DIFFERENTLY ROUNDTABLE

Ready to decide

Power is moving closer to home. What has to be true before the NHS can use it?



Contents

THINKING DIFFERENTLY ROUNDTABLE

Foreword

The NHS has never been short of ambition. It has strategies, plans, ten-year visions and delivery frameworks. What it has lacked, until recently, are the political conditions to turn any of them into sustained delivery.

We brought together four NHS chief executives, a health economist, an improvement expert, health legal and governance specialists, a healthcare data leader, a decision intelligence leader and an atypical medical leader to test a single question. If there is no more money, and power is coming closer to home, what changes next?

Nobody in the room proposed another savings programme. What they described instead was an organisation that has spent a decade cutting away the very capability it is now about to need.

The discussion followed the Chatham House Rule. Views are reported without attribution.

CO-CHAIRS

Naeem Younis
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THINKING DIFFERENTLY ROUNDTABLE

Executive summary

The NHS is about to be handed decisions it has spent a decade dismantling its ability to make.

The service spends against a configuration that no longer matches the population it serves. The difference between what goes in and what comes out is rarely waste in the conventional sense. We call it trapped value, because the money is doing something, just not the thing the population needs.

Government now intends to move power closer to communities. Local leaders are about to be handed decisions of a size they have not held for a decade, and many will take them with the smallest analytical and commissioning teams their organisations have ever had.

Four barriers keep the value locked in place, and each one makes the next worse.

- Political and structural drag defends the acute hospital by default, so investment flows to the same buildings regardless of where outcomes are better.
- That default shapes the workforce, which has grown by activity and history while the capability to deploy it well was cut to pay for the growth.
- A workforce managed that way disengages, and fear of personal exposure does the rest.
- Disengaged organisations without analysts stop interrogating their own data.

Four conditions would let leaders act.

- Give them real freedom, and resolve the legal exposure that stops them using it.
- Redesign around populations rather than buildings.
- Rebuild management and analytical capability, which is the condition the other three rest on.
- Fund and govern outcomes over five years instead of activity over one.

The evidence for what works already exists. The job now is to create the conditions that let it spread beyond the organisation that invented it.

01

TRAPPED VALUE

The gap between what is spent and what is achieved

THE ARGUMENT

Releasing trapped value means changing the configuration, and that means someone local has to be able to decide.

During the resident doctors' strikes, hospitals did something they had spent years being told was operationally impossible. They put their most senior clinicians at the front door.

Participants described the result plainly. Empty waiting rooms, empty corridors, empty inpatient beds. Senior people at the front door appeared to change the flow of the whole hospital, on days when there were fewer staff in the building than usual.

Then the strike ended and the rota went back.

Strike days are not clean evidence, and that has to be conceded. Elective activity was cancelled, patients were told to stay away, and demand was suppressed as well as managed.

The concession makes the sequence worse. The service saw a materially better result, could not work out what had caused it, and never tested the promising explanation under normal conditions. Whatever share of it came from the change at the front door is still unmeasured today, and still unavailable to any board now working out how to staff its own.

That is what we mean by trapped value: the difference between the resources a trust puts in and the outcomes it gets out, where the difference comes down to how services are configured, how staff are deployed and how decisions are taken. It is recoverable in principle.

Spending less on the same system does not change where the money goes.

Releasing it means changing the configuration, and that means someone local has to be able to decide.

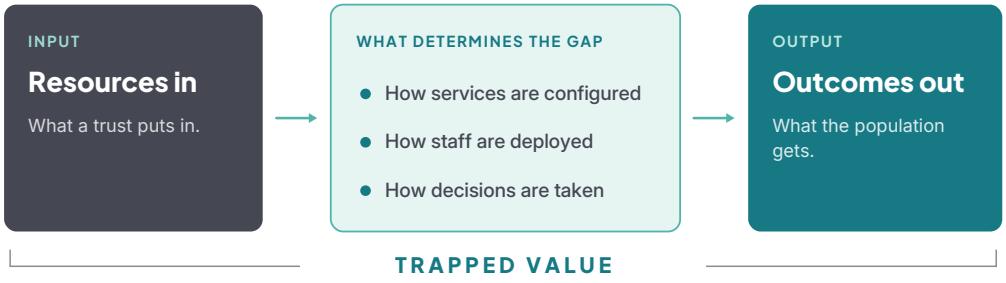

Figure 1. Trapped value sits between what a trust puts in and what its population gets out. This paper attaches no monetary figure to it.

02

43

places running the national neighbourhood health implementation programme

THE ARGUMENT

Devolution changes who holds the decision. Whether they can then make it well is a separate question.

THE POLITICAL MOMENT

Why now is different

For the first time in a decade, government is proposing to let them decide.

Andy Burnham became Prime Minister having previously held the health brief, and has committed to what he calls the biggest rebalancing of power the country has seen. Yvette Cooper took health and social care in July 2026 with real political weight behind her. Social care sits in the government's first rank of priorities for the first time in years.

The delivery architecture is already moving. The Neighbourhood Health Framework published in March 2026 set out ten core steps for local government and integrated care boards during 2026/27. A national implementation programme is running across 43 places[7], and government has committed to 120 neighbourhood health centres by 2030.

Figure 2. The delivery architecture is already moving.

The room supported the direction, but one consistent concern emerged. Devolution changes who holds the decision. Whether they can then make it well is a separate question, and one the discussion kept returning to.

THINKING DIFFERENTLY ROUNDTABLE

The four barriers

Four barriers keep the value locked in place, and each one makes the next worse.

03

BARRIER ONE

Political and structural drag

THE ARGUMENT

If investment flows to the same institutions regardless of outcome, so does recruitment.

Political considerations shape organisational choices in the NHS to an extent that would surprise most people outside it. Recent reforms have blurred accountability, producing a system where responsibility is shared without always being clearly owned.

The ambitions of the 10 Year Health Plan are widely supported and remain largely aspirational, because nobody has been clear about how any of it actually gets done. Chief executives are expected to deliver transformation while working inside constraints they do not control. Neighbourhood working still has no agreed definition of what a neighbourhood arrangement has to be able to do, which leaves 43 places each interpreting it locally.

A system designed to do what it does

The NHS has usually responded to financial pressure by cutting capital, prevention, social care and community services first, with demand "shuffling back up to the acute door." Power stays weighted towards acute hospitals, which makes it hard for commissioners to move investment towards prevention even where the evidence is clear.

Underneath that sits a financial mechanism most business cases price wrongly. A hospital's cost base steps rather than slopes.[1] Close a ward and the estate, the overheads and the on-call rota all stay where they are while the income falls, so the cash released comes nowhere near the figure in the plan. The genuinely variable share of a bed day is small. That is why moving care out of hospital looks affordable on paper and so seldom releases money in practice, and why a trust doing the right thing by its population can end up carrying stranded costs for it.

Several participants questioned whether the district general hospital model is still fit for purpose. One described it as "like running McDonald's and a Michelin-star restaurant in the same building."

The default has consequences well beyond the estate. If investment flows to the same institutions regardless of outcome, so does recruitment.

04

70%

of what the NHS spends is workforce

THE ARGUMENT

The NHS now employs more clinical staff than at any point in its history, and its ability to work out where to put them has gone backwards.

BARRIER TWO

A workforce shaped by growth

The Nuffield Trust puts employee costs at around three-quarters of what NHS providers spend.[2] There is still little discussion about changing the shape of that workforce to match what the population now needs.

Staffing decisions have too often followed activity levels, historical patterns, or whoever had the loudest voice in the room. The system responded to pressure by hiring rather than by redesigning the service those staff were being recruited into.

An eroded management pipeline

The bigger loss came alongside that growth.

Restructure after restructure has stripped out experienced staff and specialist expertise, in some organisations reaching core capabilities such as management accounting. Management development was among the first things cut when money got tight. Commissioning expertise thinned. Analytical capacity was filed under back office.

The focus on cost reduction did most of this damage, which is the part that never appears in the savings return. Several participants had watched management accounting capability disappear from trusts that then could not model the consequences of their own service changes.

A decade of reducing cost has left NHS organisations leaner in the functions that produce this year's savings and weaker in the functions that produce next decade's value.

So the NHS now employs more clinical staff than at any point in its history, and its ability to work out where to put them has gone backwards. That is the gap devolution is about to be poured into.

It is also, predictably, a way of managing people that wears them down.

05

BARRIER THREE

A disengaged and fearful workforce

62.8%

of staff would be happy with the care their own organisation gave a friend or relative, the lowest that measure has ever been

THE ARGUMENT

Leaving the service exactly as it is carries no exposure, and it is the option her successor will inherit.

The 2025 NHS Staff Survey recorded many engagement and morale measures at their lowest on record. The share of staff who would be happy with the care their own organisation gave a friend or relative fell to 62.8%, the lowest that measure has ever been.[6] Scores on freedom to speak up, and on whether speaking up leads to anything, both declined.

The NHS has leaned heavily on a particular kind of manager, the one who in a participant's phrase would "lay down in the road for you and do anything." That group is shrinking, and nothing is replacing it.

Alongside disengagement sits fear, and the fear is well founded. Think about what a chief executive is actually weighing when she proposes moving a service. The clinical risk and the financial risk, certainly. Also gross negligence manslaughter at common law, prosecution under section 37 of the Health and Safety at Work Act, the fit and proper person test, CQC enforcement, and a coroner's report to prevent future deaths.

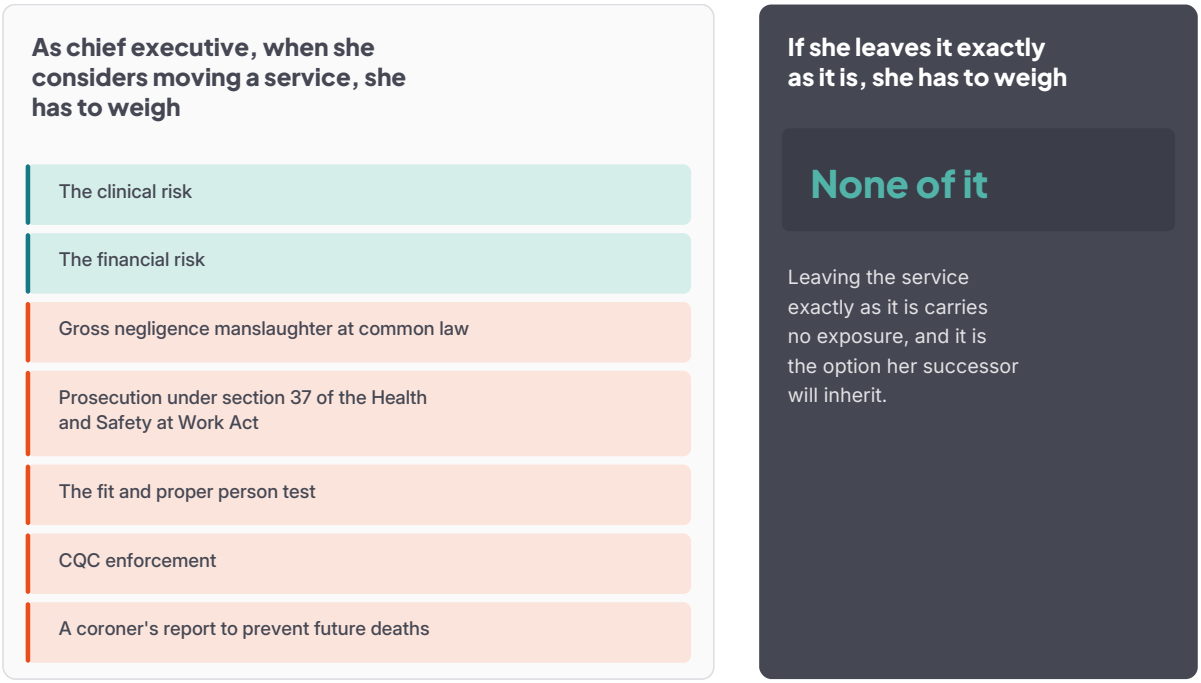

Figure 3. An illustrative scenario: the exposure comes from acting, not from leaving things as they are.

No adviser can tell her with confidence where the line sits, because nobody has drawn it. Leaving the service exactly as it is carries none of that exposure, and it is the option her successor will inherit.

The more likely obstacle is quieter than any of it. Section 242 of the NHS Act 2006 requires that people who use a service are involved in developing proposals to change it, at the formative stage rather than once a decision has

taken shape, and the greater the impact of the change the more involvement is required.[3] Reconfigurations are judicially reviewed on precisely that ground. Prosecution of a chief executive is rare. Having a service change stopped in the Administrative Court is not, and that is the risk they actually plan around.

A workforce in this condition will use devolved freedom to avoid blame rather than to redesign anything, and it will stop asking hard questions of its own performance.

06

BARRIER FOUR

Data and social care

THE ARGUMENT

Boards cannot see their own unwarranted variation, and cannot test a redesign proposal against evidence before committing to it.

The NHS's use of its own data is a significant missed opportunity. Volume is not the problem. As one participant put it, "the data is there, but not available in the right format and the right questions are not being asked of it." Boards cannot see their own unwarranted variation, and cannot test a redesign proposal against evidence before committing to it.

This is the work decision intelligence does. It takes information an organisation already holds and puts it in front of the decisions the organisation is currently unable to make. It runs on the analytical capability described in barrier two, which is the capability that got cut.

Social care reform is treated as the precondition for everything else: "before you get to reimagine healthcare, you have to sort out social care." The observation is fair and the reform is necessary. Meanwhile the acute sector remains a substantial source of its own bed pressure.

Productivity policy has made this worse. Vacancy freezes and the removal of non-clinical roles have cut the support available to clinical teams, which moves the work onto the most expensive staff in the building.

Consultants doing their own typing is not a productivity gain.

The four barriers

1

BARRIER ONE

Political and structural drag

Investment flows to the same buildings regardless of where outcomes are better.

That default shapes the workforce.

2

BARRIER TWO

A workforce shaped by growth

The workforce grew by activity and history while the capability to deploy it well was cut to pay for the growth.

A workforce managed that way disengages.

3

BARRIER THREE

A disengaged and fearful workforce

Fear of personal exposure does the rest, and the exposure attaches to acting rather than to leaving things alone.

Disengaged organisations stop asking.

4

BARRIER FOUR

Data and social care

Organisations without analysts stop interrogating their own data, so the next investment decision is taken blind.

And the next round of cost reduction cuts the analysts again.

Figure 4. Each barrier makes the next one worse, which is why none of them can be fixed on its own.

THINKING DIFFERENTLY ROUNDTABLE

The four conditions

Four conditions would let leaders act. Rebuild management and analytical capability, which is the condition the other three rest on.

07

SOLUTION ONE

Freedom and air cover to act

THE ARGUMENT

None of it required new money. It required somebody senior to say yes.

NHS leaders need more autonomy, and they need to be told plainly that they have permission to make hard decisions. Central control has eaten the freedoms originally designed into the system. Leaders need room to try things and to learn from what fails, including through new organisational models such as Advanced Foundation Trusts.[8]

Air cover has a legal dimension that usually gets left out of the policy conversation. The chief executive in barrier three is not asking for immunity, and no minister is going to hand it to her. She is asking for something simpler: tell me what a properly evidenced decision and a defensible consultation look like, and tell me what following them is worth if a regulator, coroner or court examines the decision two years from now.

It has a financial dimension as well. A leader who closes a ward on a plan built at average cost is left holding the stranded overhead on reduced income, and looking as though she failed. Until the money follows the change at something closer to the real rate, the safest thing any chief executive can do is leave the configuration exactly as it is. That is a rational response to how the system is built, and the system gets it every time.

Where staff have been given time, permission and better information, the results have been significant. One paediatrician working alongside primary care cut referrals substantially. Other trusts have brought down waiting lists, sickness absence and bank staff costs by making room for workforce-led improvement. None of it required new money. It required somebody senior to say yes.

08

SOLUTION TWO

Populations and prevention

THE ARGUMENT

Reallocation fails when somebody has to lose for somebody else to win.

Real change needs a much stronger focus on population health needs and prevention. Instead of continuing to respond to illness as it arrives, the NHS needs a population-based approach that works with other agencies on the things that actually generate demand: poverty, housing, isolation, work.

Segmenting a population by need, rather than by whichever service happens to see them now, is the practical starting point. It is a method we use in our own work. Success depends on pooled budgets, shared risk and closer integration between mental health, primary care, community and acute services.

Brazil's Family Health Strategy gives community health workers a defined set of households and targets solutions at what those households need, with better health arriving as a consequence rather than as the goal. Closer to home, Hackney's primary care, voluntary sector and acute partners moved resources between them because they were united by one vision for their population. That last point is the whole trick. Reallocation fails when somebody has to lose for somebody else to win.

09

SOLUTION THREE

People and capability

THE ARGUMENT

Capability and authority should move on the same date and out of the same settlement.

The biggest opportunity lies in the staff already there, and in the skills they need to lead change. The NHS concentrates on the tangible levers of process, structure and finance, and pays much less attention to the people and capability that decide whether pulling any of those levers moves anything at all.

Figure 5. People and capability: the condition the other three rest on.

This should never become a national readiness test. The NHS has run that experiment through foundation trust authorisation and earned autonomy, and each time a capability gate designed to protect standards turned into a mechanism for keeping power at the centre. Capability and authority should move on the same date and out of the same settlement.

Managers need to be taught to manage. The NHS Leadership Academy already exists, and the gap it has not closed sits at operational and administrative grades. A band 6 service manager can end up running the flow of a 40-bed ward having had no formal training in how to do it. That is where an accredited academy with a real career path would earn its keep.

Analytical and commissioning capacity has to be treated as core rather than overhead. These are the functions that turn a devolved budget into a decision somebody can defend.

Staff also need to feel safe enough to say what they think. Change holds when people find their own voice and their own ownership in it, rather than when somebody outside supplies the momentum.

10

8

months before Cambridgeshire's UnitingCare contract collapsed

THE ARGUMENT

Annual cycles cannot buy multi-year results.

SOLUTION FOUR

Funding and governing outcomes

Funding and accountability both need rethinking to support better outcomes. Annual cycles cannot buy multi-year results. Participants pointed to a five-year outcome-based contract covering community services and elements of social care, tying funding to population health outcomes rather than activity alone. It gave providers room to move and still gave commissioners something to hold them to.

Two attempts of this kind failed. Cambridgeshire's UnitingCare contract, worth £800m over five years, collapsed eight months in and left £16m of unfunded costs behind it.[4] Two years later Staffordshire abandoned a £687m cancer procurement when the last bidder standing could not show its offer was financially viable, having spent around £840,000 to reach that point.[5] The idea survives both. What sank them was handing contracts of that size to commissioners who had been stripped of the capacity to price them.

The wider task is scaling what already works. Proven approaches to cutting waiting lists and improving care too often stay locked inside the organisation that developed them, while the rest of the system "limps along" rather than learning from what succeeded fifteen miles away.

11

8

recommendations: five for government in priority order, three for boards

EIGHT RECOMMENDATIONS

Policy recommendations

The room was clear that the answers largely exist, and that the work is in creating the conditions that let proven solutions be implemented, scaled and sustained. It did not set out to write a policy programme, and it did not produce one.

The recommendations below are ours. Strasys and Hill Dickinson have drawn them from what we heard across the discussion, and they should not be read as positions agreed by participants or by the organisations they work for.

FOR GOVERNMENT, IN PRIORITY ORDER

1 **Fund the capability, and fund it from the transfer.**

Devolution has a delivery cost nobody has costed. Every settlement moving budget or commissioning authority to a local system should carry a proportion for the analytical and commissioning capacity to run it, drawn from the same envelope rather than found locally by an organisation under a break-even duty. It is the cheapest thing on this list and everything else depends on it.

2 **Set out what good process looks like for a reconfiguration decision, and make it count.**

Leaders do not need immunity and no minister will grant it after the last five years. They need to know what a properly evidenced decision looks like, and to be confident that following it will weigh in their favour if the decision is later examined. Publish the standard. Say what following it buys. This costs nothing in cash and a great deal in political attention, which is why it keeps getting deferred.

3 **Publish one operating definition of neighbourhood health, with a capability specification attached.**

43 places implementing 43 interpretations will not produce learning that scales. Standardise what a neighbourhood arrangement has to be able to do, and leave how it does it alone.

4 **Stop setting in-year cost reduction targets that can only be met by removing next year's capability.**

This is the single change that would do most to protect what remains. It also removes the excuse for cutting the people who find the savings.

5 **Extend five-year outcome-based contracting to at least ten systems, with the commissioning capacity attached.**

Fund the analytical capability to price the risk transfer before the contract is let, which is what Cambridgeshire and Staffordshire lacked. Publish the results so the model can be assessed rather than admired.

FOR SYSTEM AND TRUST BOARDS

6 **Know your capability position before the decision arrives.**

Work out what you actually hold across management accounting, commissioning, population analytics and service redesign, and share it with your integrated care board. This is an assurance conversation between partners, and it should shape what support you ask for rather than whether you are allowed to proceed.

7 **Ask how the decision was made, as well as what was decided.**

Boards report finance, activity, safety and workforce, and none of them report decision quality. Fold it into the assurance framework you already have: for the significant decisions of the quarter, what evidence was used, over what horizon, and when will it be reviewed.

8 **Target the next round of cost reduction at the largest gap, not across the board.**

Ask where the distance between resource in and outcome out is widest, and design against that. A uniform percentage across directorates takes most from the services with least slack.

Figure 6. Eight recommendations. These are ours, drawn from the discussion, and are not positions agreed by participants.

THINKING DIFFERENTLY ROUNDTABLE

Conclusion

The focus on cost reduction has run out of road. The next round will deliver the same savings return and the same erosion of the capability needed to avoid having to do it again.

Government is about to offer local leaders something the service has asked for consistently: power closer to the decision, freedom to act, permission to design services around the people who use them. The offer is genuine and the evidence for what works already exists.

Whether any of it lands comes down to something that sits below policy. When a board is handed the authority to redesign a pathway, close a service or move investment from acute to community, does it hold the analytical capability, the management capability and the psychological safety to make that decision well and defend it afterwards?

For most organisations in this country the answer today is no.

It is fixable, and fixing it costs less than leaving it.

Devolution is welcome. The work now is making sure that when the decision arrives, somebody in the building is ready to take it.

Acknowledgements

With thanks to all participants for their insights and contributions to the discussions that informed this paper. The roundtable was held under the Chatham House Rule, and views are reported without attribution.

Co-chaired by Naeem Younis, Founder and CEO, Strasys, and Robert McGough, Partner, Head of Health Commercial and Regulatory, Hill Dickinson.

The Thinking Differently Roundtable, London, July 2026.

Attendees

- Sarah Tedford, former Chief Executive Officer, Hillingdon Hospitals NHS Foundation Trust
- Robert McGough, Partner, Head of Health Commercial and Regulatory, Hill Dickinson
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- Naeem Younis, Founder and CEO, Strasys
- Louise Ashley, Regional Chief Nurse, NHS England East of England
- Laura Yearsley, Associate Director of Insight, Horizons NHS
- Kate Shields, former Chief Executive, Royal Cornwall Hospitals Trust and Cornwall and Isles of Scilly ICB
- Jez Tozer, Director, Arqis
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- James Sumner, former Chief Executive, Liverpool University Hospitals NHS Foundation Trust
- Dr Nadeem Moghal, Chief Innovation Officer, Strasys
- Andi Orlowski, Director, Health Economics Unit

Sources

Figures in this paper are drawn from published sources rather than from the discussion. Views attributed to the room are reported without attribution under the Chatham House Rule.

[1] Bed-day costs comprise a high proportion of fixed and semi-fixed costs. Semi-fixed costs move in steps rather than continuously, so reducing activity releases the variable element as cash while the fixed element is redeployed at best. The cash-releasing share of average cost varies materially by service and by trust, and published estimates differ, so no single percentage is used here.

[2] Nuffield Trust, *The NHS workforce in numbers*, which puts employee costs at around three-quarters of NHS providers' expenditure. The King's Fund separately puts staff costs at around half of total NHS day-to-day spending. The two measure different things, provider expenditure against the whole system budget.

[3] Section 242 of the NHS Act 2006, as amended. Case law establishes that involvement must occur at the formative stage and in advance of a final decision, and that the requirement is proportionate to the impact of the proposed change.

[4] National Audit Office, *Investigation into the collapse of the UnitingCare Partnership contract in Cambridgeshire and Peterborough*, 2016, and the Committee of Public Accounts report, 2016-17.

[5] Staffordshire cancer and end-of-life care procurement, abandoned 2017. The cancer element was valued at £687m within a combined ten-year programme of around £1.2bn.

[6] NHS Staff Survey 2025, national results published March 2026. 62.84% of staff said they would be happy with the standard of care provided by their organisation if a friend or relative needed treatment, down from 64.26% and the lowest recorded. Measures on freedom to speak up also declined.

[7] Neighbourhood Health Framework, Department of Health and Social Care, 17 March 2026. The National Neighbourhood Health Implementation Programme covers 43 places. Government has committed to 120 neighbourhood health centres by 2030 and 250 by 2035.

[8] 10 Year Health Plan for England, *Fit for the Future*, July 2025, and the NHS Medium Term Planning Framework, from which the advanced foundation trust route and the integrated health organisation model derive.

About the Thinking Differently Roundtable

Strasys, the decision intelligence engine for healthcare, and law firm Hill Dickinson teamed up to host this invitation-only roundtable for ICB leaders, regional teams and NHS Trust boards.

THINKING DIFFERENTLY ROUNDTABLE

Further reading

STRATEGIC BRIEFING · JUNE 2026

Securing the future of NHS paediatric services

Dr Nadeem Moghal & Naeem Younis · Strasys Academy

Commission the network, not the site. ICBs are the first commissioners large enough to build paediatric networks that work.

strasys.uk/securing-the-future-of-nhs-paediatric-services

FURTHER READING

The Decision Intelligence Hub.

Evidence-led research, insights and strategic frameworks for healthcare leaders who make better decisions.

strasys.uk/decision-intelligence-hub

VALUE & PERFORMANCE

There Is No More Money. But There Is Trapped Value.

Dr Nadeem Moghal · Apr 2025

STRATEGY & TRANSFORMATION

Integrated Neighbourhood Teams Will Fail If We Let Hospitals Run Them

Dr Nadeem Moghal · Jun 2025

WORKFORCE AND LEADERSHIP

Fewer People Die During a Doctors' Strike. Nobody Wants to Talk About Why.

Dr Nadeem Moghal · Nov 2025

VALUE & PERFORMANCE

A better approach to close the NHS performance gap: CIPs do not work

Naeem Younis · Nov 2024

STRASYS®

Strasys works with health systems on the decisions that are hardest to get right. Where to put scarce resource. Which services to change, and which to stop. How to know afterwards whether it worked.

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Hill Dickinson

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Its health and social care team works across the NHS, independent providers, primary care, mental health, social care and healthtech.

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