

OPINION · STRATEGY

# If the NHS was a patient, what treatment would you prescribe?

*Stravinsky had it right: creativity comes from the constraints. The NHS needs to stop fighting them — and trust the people closest to the work to find the answers within them.*

By [Steve Moore](#) Former NHS Chief Executive

We know the diagnostic. Tight finances and a national fiscal position that means the cavalry is not coming. A tired, overstretched workforce. Estates and equipment that are threadbare and often in the wrong places. An acute-focussed model poorly suited to the complex health and social care problems our demographics demand we tackle.

We know the prognosis if treatment fails too. Accelerating decline. An involuntary drift toward private care. The slow rending of the social contract that underpins the NHS itself. If not an end, then a fragmentation that will deepen health inequalities that are already on the rise.

So, what is the treatment?

Railing against the constraints is futile because the world is as it is. Crucially, it may also be missing a vital opportunity to unleash our combined creativity. Let's stop

fighting the constraints and start using them.

When *The Rite of Spring* premiered in 1913, it scandalised Paris — a ballet so brutal in its primal modernism that the audience rioted. Stravinsky later moved in the opposite direction: back into the strict constraints of an earlier era. From within those self-imposed obstacles, he wrote some of the most original music of the twentieth century. As he reflected:

*My freedom will be so much the greater and more meaningful the more narrowly I limit my field of action and the more I surround myself with obstacles.*

For the NHS, the creativity to find new answers will not come from another

national programme, structural reform, or consultancy slide deck. It will come from the people who actually deliver and use the services — released, trusted and given a framework to work within.

In nearly four decades in the NHS, I have watched plan after plan land with ambition and too often disappear without trace. A prescription left unfulfilled.

This failure of the way we plan is caused by the fact that we usually lock the people who really understand the service out of the very work that needs them most.

There have been a few times when we did really engage – none more pronounced than during the pandemic. When the constraints were absolute, the system found a clarity of purpose it had lost in other times and, as a CEO leading a large integrated provider I saw an unleashing of the most remarkable creativity. Of course, this period was unprecedented, but I learnt more about being a CEO in those two turbulent years than I had over the whole of the previous decade. Beneath the pandemic urgency, sat a discipline I think is worth recovering — the thread from intent to accountability was visible, and somewhere over the last decade that thread has frayed. This is good practice we have allowed ourselves to forget.

For Boards, three changes would make the difference.

**Begin with what is true.** In the pandemic whilst there was huge uncertainty about transmission, incubation periods, treatment pathways and recovery, there was, nevertheless a clear shared understanding of the nature of the challenge – we needed beds, oxygen, equipment and PPE. In our more multi-dimensional business as usual environments, this clarity needs to come from a structured, honest diagnostic. We need to look through four different lenses. We need to *look back* at what the organisation already knows. *Look in* at what the data and service landscape reveal. *Look out* at what is working elsewhere. *Look forward* at what needs to be true to make the strategy a success. Boards also need to bring the real population into the room, not as deprivation deciles, but as people.

A child worrying about their mother's dementia.

A lorry driver trying to lose weight before it is too late.

A young person with severe mental illness who has fallen between every service meant to catch them. When a Board can see the person the strategy is for, the strategy stops being abstract and engages the emotions.

### **Design with the people who will live with it.**

Strategy stalls when it fails to set out a future enough people can rally behind. It needs to describe a connected architecture spanning clinical pathways, workforce, digital, estate, finance and on-going engagement. This cannot be done in a Board's back room. It must be done with the staff who deliver services and the people who experience them. Co-production is not a stage in the design process, it is the process.

### **Deliver through named accountability.**

If a Board successfully navigates the design phase it usually fails in delivery. Every commitment should answer three plain questions. The Why — the human difference it will make. The What — measurable and specific, but open enough to invite innovation in delivery. The When

— a date the Board can mark against. Each commitment should have a single, named Executive lead, a clear timescale, and a direct line into the Board Assurance Framework. This discipline means the Board can be proactively correcting its course in pursuit of its desired strategic objectives.

Boards must be willing to slow down before they speed up. Executives must be willing to accept named accountability. And, most of all, frontline staff and patients must be trusted to find the answers within a clear framework of constraints.

That is where the creativity is, in the people who really understand services. This treatment has a welcome side effect too — it engenders hope.

*Let's focus on People first, not problems*

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