University of BRISTOL

The English NHS needs changing: Policies and strategies to move forward a septuagenarian institution

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Birth of the NHS

- *December 1942* - Sir William Beveridge's Report: 'Medical treatment covering all requirements will be provided for all citizens by a national health service'
- *5 July 1948* - NHS established by Aneurin Bevan with 3 core principles:
  - Meeting the needs of everybody
  - Free at the point of delivery
  - Based on clinical need, not ability to pay
- Development of specialist services vs. family doctors (GPs) as self-employed, self-organising independent practitioners

NHS Facts and Figures

- 1.4 million patients treated every day
- People live on average 12 years longer than in 1948 (68→81)
- Budget £437 million in 1948 → £122 billion in 2018
- 11.2% of government overall spending in 1948 → 29.7% in 2018
- 34 deaths per 1,000 births in 1948 → 3.8 per 1,000 in 2018
- More than 1.2 million workers but 54,000+ staff shortfall*
- 89m outpatients, 16.5m hospital and 7m A&E admissions, 2.6m ambulance callouts*

Source: NHS England
*2017 figures England only

International comparison (18 countries)

- It does worse on:
  - Higher rates of people dying when successful healthcare could have saved their lives
  - Higher mortality rates for cancer, heart attack and stroke and child mortality at birth
  - Markedly few doctors and nurses (compare to population size) and fewer CT scanners and MRI machines
- It does better on:
  - Protecting people from financial costs and not being put off by costs
  - Managing long term illnesses, including diabetes
  - Lower administrative costs and use of cheaper generic medicine
  - Lower health care spending (% national income and spending per person)
- On par:
  - Waiting times for treatment and overall patient experience

Source: Dayan et al. (2018) *How good is the NHS?*
Based on OECD Data

Characteristics of NHS organisation: 1948-80

- Government control of overall expenditure through a system of ‘cash limits’ (especially from early 1970s)
- Control exercised through statutory bodies (from 1974: Regional Health Authorities, Area (later District) HAs and 192 Family Practitioner Committees). Highly devolved decision making
- Team (or ‘consensus’) based system of decision making at all levels. Equal status and veto power of different occupations (including administrators). strong focus on maintaining the status quo (incremental budgeting)
- ‘Clinical freedom’ of physicians to determine the delivery of services and therefore allocation of resources. In practice, medicine remained largely disengaged from management. Limited ability or willingness to challenge medical dominance

From Thatcher to New Labour

- *General Management (1983 - 1989):* Griffiths report (1983); resource management
- *Internal Market (1989 - 1997):* Purchaser-provider split; self-managing hospital trusts; clinical directorates; medical audit; GP fund-holding
- *Modernisation Agenda (1997 - 2010):* clinical governance; performance management; and the extension of markets through outsourcing of both provision and (most recently) commissioning

General Management (1983-1989)

A lack of individual management accountability. Consensus management resulted in confusion, 'lowest common denominator decisions' and delays.	"…if Florence Nightingale were carrying her lamp through the corridors of the NHS today, she would almost certainly be searching for the people in charge" (22).
A lack of effective machinery for implementing policies. General attitude of being reactive to problems rather than strategic and proactive.	"…there is no driving force seeking and accepting direct and personal responsibility for developing management plans, securing their implementation and monitoring actual achievement" (12).
A lack of performance orientation and no evaluation of the effectiveness of services. Most plans like 'shopping lists' focused only on expanding existing services.	"[The NHS] lacks any real continuous evaluation of its performance…rarely are precise management objectives set; there is little measurement of health output: clinical evaluation of particular practices is by no means common and economic evaluation of these practices is extremely rare" (10).
A lack of concern for consumer views and interests.	"Whether the NHS is meeting the needs of the patient, and the community, and can prove that it is doing so, is open to question" (10).

Source: Sir Roy Griffiths (1983) *NHS Management Inquiry*

The Griffiths report: what was prescribed?

- Establishment of a Health Services Supervisory Board to take on a strategic role in directing resources and overseeing performance. Also, greater focus on patents and community opinion in the design and delivery of local services
- Introduction of a new cadre of general managers at all levels on fixed term, performance related contracts. New managers to have full executive authority accountable for achieving DHSS objectives
- Stronger emphasis on ‘cost improvement programmes’ at all levels
- Physicians (‘natural managers’ of the NHS) to become more involved in management with responsibility for ‘management budgets’ relating to clinical workloads

Internal Market (1989-1997)

- Establishment of a purchaser-provider split in the NHS (1991). Providers increasingly dependent on (non legally enforceable) contracts from purchasers (commissioners) for revenue
- Promotion of ‘self-governing’ NHS trusts, with executive boards (modelled on ‘commercial organisations’) and stronger management functions partly autonomous from DHA control (new freedoms to recruit staff and dispose of assets)
- Changes to GP contract (increasing capitation fees to promote patient turnover) and GP fund-holding. Volunteer GPs given powers to manage budgets for commissioning (mainly elective) services from health and community care providers
- Creation of Clinical Directorates, Medical Directors and extension of ‘resource management’ within NHS trusts

Sources: White Paper (1989) *Working for patients*
NHS and Community Care Act (1990)

Modernisation Agenda (1997-2010)

- Initial retreat from markets (with abolition of GPFH), but later strengthening the commissioning role of Primary Care Trusts (PCTs) becoming responsible for 80% of NHS budget.
- ‘Privatisation’ of commissioning: reintroduction of GP involvement through ‘Practice Based Commissioning’ (2005)
- ‘Corporatisation’: trusts judged to be capable of self managing are awarded independence from central control by becoming Foundation trusts (2003)
- ‘Privatisation’ of provision: the NHS Plan 2000 facilitated to growth of (NHS and privately owned) independent treatment centres (ITCs), paid according to the NHS ‘national tariff’
- Payment by results (2005) links resources for provider organisations (trusts, ITCs, GPs) only to services provided. Increasing accountability: performance management systems and clinical standards (NICE and clinical governance)

The rise of clinical leadership

- Lord Darzi (2008) *High care quality for all*
  - Clinicians involvement to be strengthened in decision making at every level of the NHS
  - All physicians need leadership skills to improve clinical care in their area

- King's Fund (2011) *No more heroes*
  - 'The health service has a long history of attempting to improve both management and leadership. Many reports have either touched on management and leadership or been specifically focused on it. The most notable include the Cogwheel report of 1967, which called for more involvement of clinicians in management, with clinical divisions taking more responsibility for the management of resources' (8)

- Abundant evidence that this is a good idea!

The 2012 Health and Social Care Act

- Coalition Government Programme (2010): “we will stop the top-down reorganisations of the NHS that have got in the way of patient care”
- Andrew Lansley (then Secretary of State for Health): ‘no more top-down reorganisation’
- Sir David Nicholson (then Chief Executive of the NHS): “Someone said to me ‘it is the only change management system you can actually see from space’ – it is that large’”
- ‘The British system maximises the temptation to reorganise but minimises political penalties for doing so’ (Pollitt, 2007)

The 2012 Health and Social Care Act

- Abolition of 152 Primary Care Trusts and creation of 211 Clinical Commissioning Groups (with involvement of patients and acute care providers)
- Power and budget for commissioning services to be transferred to GPs
- ‘De-politicisation’ of policy making with creation of Public Health England (an executive agency) and NHS England (an executive non-departmental public body)
- Increased role for local government (new Health and Wellbeing Boards)
- Measures to stimulate greater competition and private sector involvement

The 2012 Health and Social Care Act - Drivers

- Commissioning by GPs would improve care and efficiency
- Central government (through DoH) too big and dominant
- Need to eliminate intermediate levels of bureaucracy (Strategic Health Authorities and PCTs)
- Management expertise (not political interference) improves health services. Management needs to be insulated from politics
- Provider competition generates improved quality and efficiency

The 2012 Health and Social Care Act – Issues

- The official legal duties and structures make it (very) difficult to achieve (a great deal of) cooperation
- Substantial costs to deliver efficiency (£1.5 billion conservative estimate of the National Audit Office) including huge bills for management consultants' advice (£600m in 2012 – with no efficiency gains)
- Opportunity cost in terms of loss of leadership (SHAs and PCTs) and staff time to focus on (more pressing) problems
- Transformation programmes did not deliver (but neither negatively affected) improvements in safety and efficiency. Local commissioners struggled to bring about new or reshaped services
- *Did GPs really want to take on this role? BMA firmly opposed, others in favour (NHS Alliance, NAPC)*

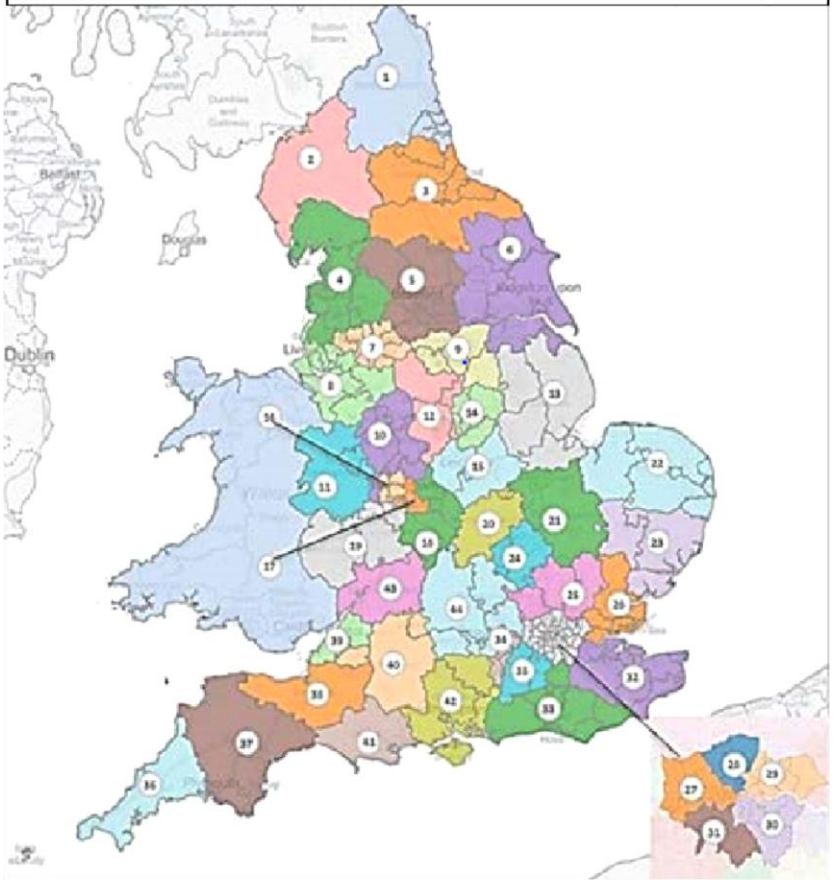
Integrated Care

- Known drivers: funding constraints, rising demand from growing and ageing population, technological advancements, outdated hospital-based model of care
- Objective: breaking down barriers to better co-ordinate the work of general practices, community services and hospitals to meet local needs of people (including prevention)
- NHS five year forward review (2014) introduces new care models: 44 geographical footprints areas Sustainability and Transformation Plans/Partnerships (STPs) plus evolution of some STPs into integrated care systems

‘Our aim is to use the next several years to make the biggest national move to integrated care of any major western country’ (NHS England, 2017)

STPs

Map of 44 STP Footprints (source: NHS England)



STPs

- Partners: NHS organisations, local authorities, charities and others
- Collaboration vs. competition (HSCA 2012) to respond to the challenges facing their local services (‘place-based planning’)
- Average population size 1.2 million (300,000< >2.8 million)
- Three main goals:
  - Improving and developing new models of care
  - Improving health and wellbeing
  - Improving efficiency of services
- Access to NHS transformation funding

Source: The King’s Fund (2017)

STPs – early evidence

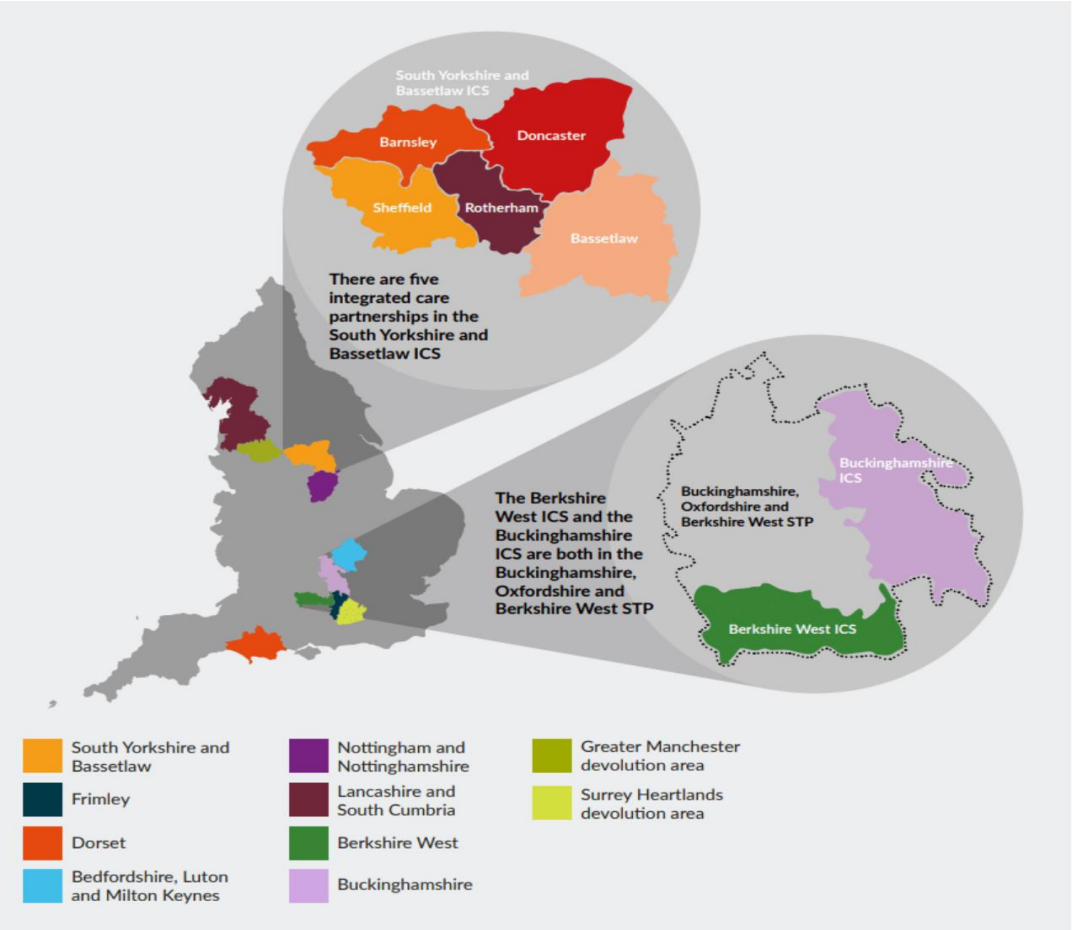
- Difficulty to involve all parts of the health and care system in developing the plans (especially clinicians and front line staff)
- Wide variation in terms of involvement of local authorities
- Patients and public generally absent in the early stages of planning process
- The NHS environment is not designed for collaboration, in particular considering the fragmented complex organisational arrangements created by the 2012 HSCA

Source: The King's Fund (2017)

Integrated Care: Organisational Forms

- Integrated care systems (ICSs) have evolved from STPs and take the lead in planning and commissioning care for their populations and providing system leadership. They bring together NHS providers and commissioners and local authorities to work in partnership in improving health and care in their area
- Integrated care partnerships (ICPs) are alliances of NHS providers that work together to deliver care by agreeing to collaborate rather than compete. These providers include hospitals, community services, mental health services and GPs. Social care and independent and third sector providers may also be involved
- *Accountable care organisations (ACOs) are established when commissioners award a long-term contract to a single organisation to provide a range of health and care services to a defined population following a competitive procurement. This organisation may subcontract with other providers to deliver the contract*

ICSs



Source: NHS England (2018)

ICSs – What they are expected to do

ICSs have no statutory basis and rest on the willingness of NHS organisations to work together to plan how to improve health and care, with no national blueprint. As they develop, it is expected that they will:

- agree a performance contract with NHS England and NHS Improvement to deliver faster improvements in care and shared performance goals
- manage funding for a defined population by taking responsibility for a system 'control total'
- create effective collective decision-making and governance structures aligned with accountabilities of constituent bodies
- demonstrate how provider organisations would operate on a horizontally integrated basis, for example, through hospitals working as a clinical network
- demonstrate how provider organisations would simultaneously operate as a vertically integrated system linking hospitals with GP and community services
- deploy rigorous and validated population health management capabilities to improve prevention, manage avoidable demand and reduce unwarranted variations
- establish clear mechanisms by which residents can exercise patient choice over where they are treated

Source: The King's Fund (2018)

ICSs – What they gain out of it

- the ability for the local commissioners in the ICS to have delegated decision rights in respect of commissioning of primary care and specialised services
- a devolved transformation package from 2018
- a single ‘one-stop shop’ regulatory relationship with NHS England and NHS Improvement in the form of streamlined oversight arrangements
- the ability to redeploy attributable staff and related funding from NHS England and NHS Improvement to support the work of the ICS

Source: The King’s Fund (2018)

Devo Manc (ICS)

- Based on £6 billion of health and social care to Greater Manchester in April 2016. Greater Manchester, with a population of 2.7 million, has ten ‘local care organisations’ (or ICPs), which remain responsible for the direct provision of care
- Long-established public sector partnership lead by local authorities
- The ‘umbrella’ organisation is responsible for strategic planning, aligning commissioning to the plans, exercising regulatory functions, managing performance, and providing leadership across the system
- Outcomes: improved access to GP services and investment in mental health services, changes to acute and specialised hospital services (e.g. Our Care Together programme), and greater emphasis to prevention and population health

ICSs – Early evidence

- Great variation in size and complexity and the level at which they operate (neighbourhoods, places and systems)
- Strengthening and integration of primary care and community services and improvements in information sharing
- Strengthening of collaborative relationships and trust including with local authorities
- Evidence of tangible improvements and outcomes still limited to date

Source: The King's Fund (2018)

ICSs - Barriers

- The legislative context does not support system working
- A legacy of competitive behaviours
- Regulation and oversight is not aligned behind ICSs
- Frequently changing language and the lack of a clear narrative
- Leaders face competing demands
- Funding pressures can both help and hinder progress

Source: The King's Fund (2018)

Other Care Models

2 models that focus on places and population rather than organisation to integrate care and improve population health:

- Primary and acute care systems (PACS)
  - Hospitals take the lead in joining up acute services with GP, community, mental health and social care services. Salford Royal NHS Foundation Trust provides acute and community care *and* adult social care services in collaboration with the Mental Health trust. Developing engagement with GPs
- Multispecialty community providers (MCPs)
  - GPs work at scale to forge closer links with community, mental health and social care services. Encompass in east Kent comprises 13 general practices collaborating to improve care for a population of 170,000 via multidisciplinary teams of GPs, community nurses, social care workers, mental health professionals, pharmacists, health and social care co-ordinators and others

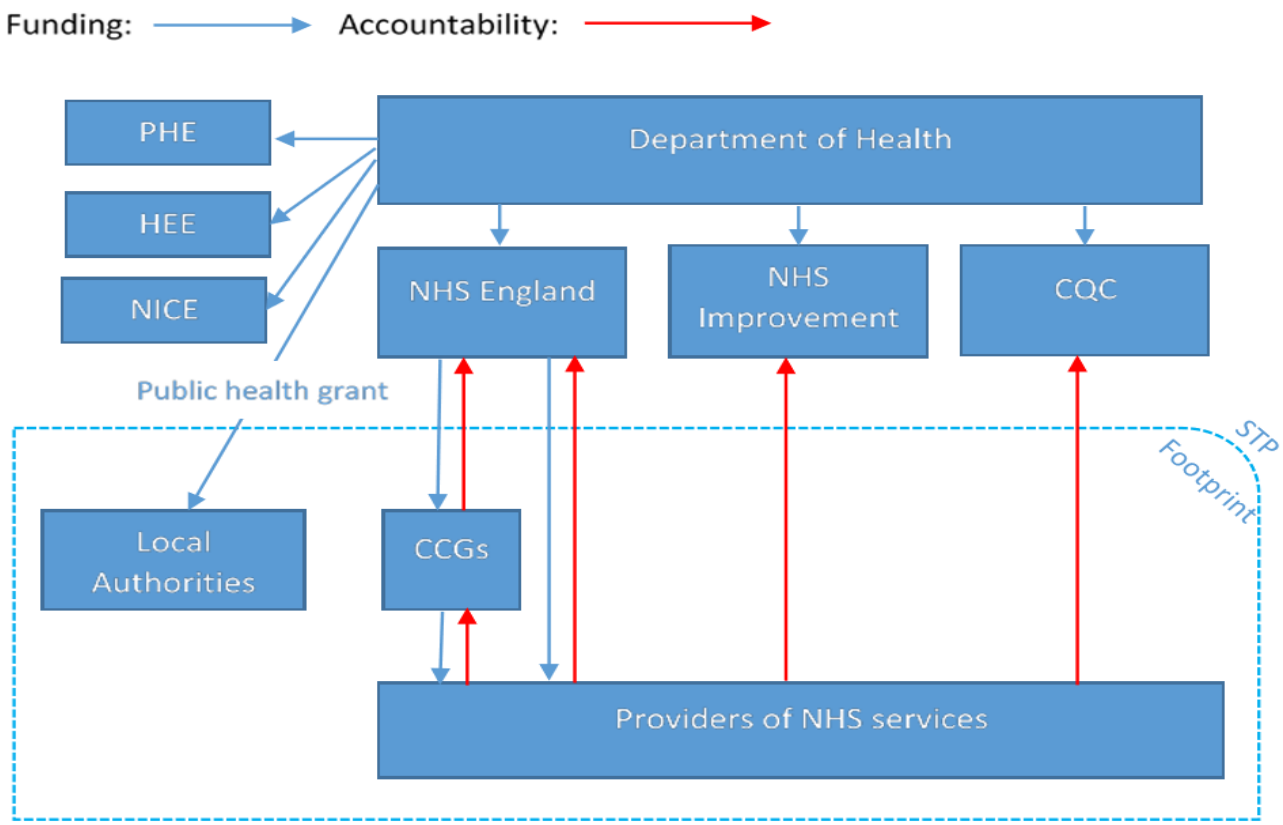
2019 NHS Long Term Plan

- Commitment of further £20.5 billion of funding for 5 years with an average annual 3.4% real-terms increase in NHS budget
  - There is already a growing funding gap, some of this money will be used to ‘plug the hole’ plus suggestion was for a 4%
- Identified a clear set of clinical priorities (including cancer, cardiovascular diseases, stroke, diabetes, maternal health, etc.)
  - The priorities are all worth and relevant, but they will not be easily achieved. And what does this mean for patients with multiple long-term conditions?
- Improvement of care outside hospitals via creation of primary care networks with dedicated funding and incentives (e.g. reduction in A&E and hospital admissions) and integration with community-based health care
  - Follows the existing commitment but it will take time to be delivered (leadership, shared vision and strong relationships needed) and the model is relatively untested

2019 NHS Long Term Plan

- Reducing pressures on A&E departments via clinical streaming, same day emergency care, and rolling out of urgent treatment centres (GP-led) and of NHS 111 services
  - Consistency with aim to change acute services, dependent on delivering technological improvements and uncertainty about overall benefits
- Address workforce gap and (exponential) increase in the use of digital technology
  - Training budget and immigration policy (especially for nurses) are crucial factors. Most patient-facing targets (e.g. outpatient care) are dependent on digital infrastructure
- Increase in productivity and changes in funding control and the payment system (from activity-based payments to population-based payments)
  - Productivity growth has been a key priority for some time. Decreasing dependence on central funding will be beneficial for NHS providers

The structure of the NHS in England (as at June 2017)



NHS reforms running themes

- Market-like forces and local purchasing power can generate widespread improvements
- Providers can become self-improving entities (but being accountable for their decisions and actions)
- Management of healthcare should be insulated from political intervention to make effective use of resources
- Decentralised decision making is needed to meet local needs
- Integrated care provision is paramount to achieve a sustainable health (and social) care service (demise of commissioning?)

Some lessons from NHS reforms

- Large-scale, system-based re-organisation (especially if half-baked) end up having less impact on the delivery of care than expected. Organisational forms cannot improve care in isolation, they are there to support who are doing (*and receiving*) the caring
- Healthcare is fundamentally about relationships between clinicians, managers and patients. A tradition of centralised, hierarchical rule is bound to create barriers rather than enabling relationships. Buy-in from physicians (or relative opposition) is essential
- The logic of care (Mol, 2008) relies on a long-term, frequently open-ended relationship between clinicians and patients (*and managers*). ‘Major change emerges from aggregation of marginal gains’ (Bohmer, 2016). Multi-disciplinarity must underpin incremental, small-scale work redesign
- Funding and financial incentives, performance management systems and staffing levels have been more effective policy levers. Re-organisation without reform?

Sources: Greener et al. (2015), Exworthy et al. (2016)

Reform fatigue (?)

- 26 years for first major reform, then 8 years, then 9 years, then…
- 26 Green and White papers and 14 Acts of Parliament during the Labour Government (1997 – 2010)
- 20 reorganisations between 1974 and 2010 (BMJ, 2010)
- 2012 Health and Social Care Act perhaps the turning point?
- Local models of care allowed to autonomously develop… for the time being