

Future Foundations



Towards a new culture in the NHS

By Bill Moyes and Paul Corrigan
Edited by Henry Featherstone



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About the Authors

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Until recently, Bill was the Chairman and Chief Executive of Monitor, the independent regulator for Foundation Trust hospitals, which he set up in 2004. Before that he was Director General of the British Retail Consortium from 2000 to 2004. He joined the Civil Service fast stream in 1974, and spent the first ten years of his career in Whitehall, including three years in the Economic Secretariat of the Cabinet Office. Between 1983 and 1994 Bill held a variety of posts in the Scottish Office, culminating in his post of Director of Strategy and Performance Management for the NHS in Scotland. He joined the Bank of Scotland Group in 1994, initially on secondment to establish a health care PFI team offering financial advice and raising debt and equity in the capital markets. Bill became a Director of the British Linen Bank in 1996, and Head of Infrastructure Finance for the Bank of Scotland in 1998. He has a PhD in theoretical chemistry from Edinburgh University, and is married with one son.

Paul Corrigan

For the first 12 years of his working life he taught at Warwick University and the Polytechnic of North London where he taught, researched and wrote about inner city social policy and community development. In 1985 he left academic life and became a senior manager in London local government and in 1997 he started to work as a public services management consultant.

From July 2001 he worked as a special adviser to Alan Milburn first and then John Reid, the then Secretary of States for Health. At the end of 2005 he became the senior health policy adviser to the

Prime Minister Tony Blair. Between June 2007 and March 2009 he was the director of strategy and commissioning at the London Strategic Health Authority.

Since then Paul has been working as a management consultant and an executive coach. He is working with a wide range of public services organisations and think tanks. As a columnist for the Health Service Journal and with his own blog “Health Matters” he has continued to argue the case for reform of the NHS.

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Executive Summary

Why is it proving so difficult to design and operate a healthcare, education or prison system that provides high and improving quality but also provides value for money when these are requirements that in other parts of the economy would be taken for granted?

Under successive governments, and given its importance, healthcare in England has inevitably been the object of reform of different ways of organising, funding and managing hospital, community and primary care services. But are Ministers the best people to run the NHS; decide how it should be organised, or where funding should go, and where facilities and services are located? And should Parliament seek to hold Ministers to account for every last detail of healthcare provided in each and every hospital in every Parliamentary constituency?

These perceptions and expectations that are heaped upon the NHS have sprung up from the way it has evolved over the last 60 years. Healthcare is a much more expensive business today than was foreseen when the NHS was created.

The ideology of the NHS – as a mutual insurance fund – that we all pay for ourselves and for each other in a large risk pool is a concrete part of the way in which the public think and feel about the NHS. But in the practical terms of experiencing NHS care there is no experience of cost to the public. And in terms of demand for more care and treatment, the money comes from somewhere else, so, of course we all want more.

These growing cost implications have been felt by HM Treasury, who have sought to exert their control over public expenditure all the way down through the many levels of the NHS. This has generated a culture in the Department of Health that has been simultaneously tightly centrist and controlling, and deliberately opaque.

Set against this background, it is easy to see why the creation of Foundation Hospitals was one of the most bitterly fought battles of the NHS reform programme under Tony Blair. Foundation Hospitals were to be truly independent of day-to-day Ministerial control, yet they were still owned by the NHS as public benefit organisations. Many people felt that, if you separated the ownership of the hospital from the elected Cabinet politician, the NHS could no longer really be a publicly paid for health service.

Foundation Hospitals would, of course, remain accountable to Parliament, but accountability would be wider and more direct with local involvement through a board of governors recruited from its patients, staff and the public it serves. The full system of Foundation Trust powers and governance contains the balance of incentives, sanctions and accountability that Ministers rightly judged necessary to give confidence that they would meet the needs of patients, improve quality and efficiency, respond to their commissioners, be called to account locally and not take risks they could not manage. And this system works well: the most recent annual health check for 2008-09 (published by the Care Quality Commission in the autumn of 2009) showed there were 38 trusts that were rated Excellent for use of resources and Excellent for quality of service and 36 of those were Foundation Trusts.

The policy of creating Foundation Trusts was designed to create a new set of structural relationships within the NHS. The development of the new structure was, amongst other things, an attempt to create a new culture. The old culture – the one that NHS managers and civil servants feel safest in – however remains dominant within the Department of Health.

There is still a belief in the minds of Ministers, and indeed Parliament, when reacting to public concern, that they can order

“Are Ministers the best people to run the NHS; decide how it should be organised, or where funding should go, and where facilities and services are located?”

Foundation Trusts to conduct exercises in hospital deep cleaning, or intervene in great detail in tragic episodes such as that at Mid-Staffordshire. In a crisis, or when pursuing an objective they regard as politically important, Ministers and Parliament still assume that the only approach is to exert managerial authority and issue instructions. The pressure to ‘do something’; even when you don’t have the power to ‘do something’ seems to be irresistible.

There are five key changes that must happen if we are to have any chance of creating the culture that is needed in Government to enable autonomy to flourish and with it creativity and innovation.

Developing real competition

First, true competition needs to be made a real part of the system, so that competitive pressures are brought to bear on managers and clinicians in order to incentivise them to improve safety, quality and the responsiveness of the services they offer. This competition needs to be between NHS providers and between NHS providers and providers from other sectors. Ministers should see themselves as the “patient’s friend” commissioning top-quality services on their behalf and driving out mediocrity, rather than, as now, the guardians of the status quo.

Developing a pricing framework that drives change

Second, we need to start using the tariff to drive change. The potential of a national tariff has not been remotely explored. Properly used, the tariff could define what the Government proposes to spend on different components of a care pathway, rather than simply reflecting average costs of different treatments as it does now. To achieve its full potential for improving services, the system for setting the tariff needs to be independent of political manipulation and properly resourced.

Foundation Trusts believing in and using the autonomy that they have

Third, NHS healthcare providers need to begin to relish their autonomy and to use it to develop their institutions. They ought to be well-placed to acquire weak providers and turn them into successes, and in the process build chains of strong institutions and services that are capable of resisting central control and rising above the pressures this seeks to exert. But so far these changes have been slow to emerge.

An industry, not an organisation or a system

Instead of letting the Department of Health reinforce its notion of itself as the headquarters of the NHS, the healthcare industry should be creating the structures to cooperate on devising and delivering the programmes it believes it requires, not passively accepting what is offered up by 'the centre'. At the moment the Department of Health pretends to 'stand for' the industry when in fact it 'stands for' Whitehall.

Developing real power of the payors

At the moment whilst enquiries may be made into the performance of a commissioner, neither the Department of Health nor the SHAs have created a risk-based national system of regulation for commissioning to match the regulatory framework within which Foundation Trusts operate. This is long overdue. Not only would it drive forward the development of commissioning, but it would begin the process of culture change that is so essential for the future of healthcare in England.

Commissioning needs to develop into the local driving force of service improvement, challenging providers to be more efficient and effective and to meet the needs of patients in the most clinically-

and cost-effective way. Commissioners need to develop different ways of assessing the real needs of the populations they serve, and effective methods to ensure that real needs are met and demand is properly managed. Above all, commissioners need to embrace the concept of being the patients' friend.

Conclusion

The policy framework is right, as is the service architecture. Resourcing is historically high (although the next few years will be difficult). But still the old culture of centralised control remains the dominant force and with it comes the politicisation of decisions and the undermining of the autonomy that is essential for change and innovation.

1. Introduction: why do the public want Ministers to think they have to run the NHS?

Politicians as managers

Both authors have spent much of the last six years building up the Foundation Trust sector in the NHS and in different ways trying to persuade the Government to implement with some enthusiasm three aspects of its health reform agenda – tariff, competition policy and devolution. In many ways much of this period has been spent in the detail of helping Foundation Trusts become and remain much more independent. But one of the puzzles of this work is often how hard it is to convince people who have spent their lives working in the NHS that this independence is a good idea. All the analogies of pushing water uphill are really explanations of what it feels like to take on – on a day to day basis – a strong culture. And that has been the experience of the Foundation Trust movement within the NHS.

What the NHS developed over the last 60 years has been a culture of dependence. Its culture (the way in which we do things round here) is one where people's eyes and attention are instinctively drawn upwards to the Department of Health and on top of that to the Secretary of State.

If we are to develop a new culture of independence, we will need to understand why the old one has such power.

A key feature of public services in the UK is the role played by national politicians and through politicians the role played by the State. We have a long tradition where Ministers decide not just the

overall architecture of the service and the resources to be allocated to it and perhaps the performance standards to be met, but also, in many cases, matters which are essentially operational and relatively detailed. It is easy to claim that they do this because they personally can't resist the urge to meddle, but they also do this because the public demand that they are accountable for the day to day activity of the service. The public want to 'write to their MP' and will do so in the expectation that their MP can get the Secretary of State to do something about the dirty toilet in their hospital. So, in assessing how the efficiency and effectiveness of public services might be improved one has to start by asking the question: **What is the correct role of politicians in designing and operating a healthcare system that meets the three requirements above?**

In the reformed healthcare system in England Ministers have a variety of ways in which they can decide or influence how healthcare services are designed and delivered.

Ministers:

1. **decide** on the total level of public expenditure to be spent on healthcare and how this should be allocated;
2. **decide** the price to be paid for specific treatments under the system of Payment by Results (PbR);
3. **decide** what treatments are outside the NHS, through their policies and their decisions on recommendations from The National Institute for Health and Clinical Excellence (NICE);
4. **decide** the terms of the contracts under which commissioners purchase care from providers (including the private sector);
5. **decide** pay levels and terms and conditions for all the staff employed by NHS organisations;
6. **decide** the shape of the secondary care sector through their decisions on major capital investments, their approval or rejection of controversial proposals to close services or buildings,

their approval or rejection of proposed mergers of non-foundation trusts etc.;

7. **decide** on the outcomes of all of the reconfigurations of hospital services if they are referred to them by local politicians;
8. **specify** the quality standards to be enforced by the Care Quality Commission (CQC);
9. **influence** the organisation, quality and delivery of primary care services through their negotiation of the national contract with GPs.

...and much more.

Why?

Many of these activities are not inherently political. Indeed many are essentially technical, requiring skills and experience possessed by few politicians, whose criteria for taking decisions is not technical but political and therefore partisan. Ministers are therefore inappropriately drawn into activities that concern the detail of managing a health service. They and the public draw them into the inevitable detail of this or that service and, when the NHS absorbs one-fifth of all public expenditure, collectively employs 1.3 million staff and has dealings with all of us at some time in our lives, this is not only inappropriate but simply not possible.

This looks to be common sense which intellectually almost every Secretary of State for the last 30 years would agree with. Yet inevitably, when they gain the position, Secretaries of State sometimes within days get drawn into this level of managerial detail. Before we deal with any analysis of structure we need to answer the cultural question: **Why do politicians think that they are best placed to lead and manage such a complex healthcare system?**

The answers to that question lie in the history of the creation of the NHS, and the culture that has developed in the Department of Health as the relationship between the public as voters, politicians and the NHS has evolved over the last 60 years.

The development of the NHS

What we refer to today as the NHS is actually two distinct, but closely intertwined systems both created simultaneously in 1948.

In order to secure the ability to give the public healthcare free at the point of delivery the Atlee government essentially nationalised all the different hospital systems that had developed piecemeal. Some were private companies, some were charities or local authority services that had their origins in Victorian or earlier benefactions, and some were major teaching and research hospitals. Most were funded by a combination of charges for services and the income from benefactions and charitable foundations. Their buildings and staff and equipment (but not their endowments) became the property of the employees of the State.

“The essential point was that the NHS was established effectively as a mutual insurance system, and remains so today. Everyone contributed and everyone would benefit, but the benefit and the timing of receiving it was not directly determined by the level and timing of contributions”

It is impossible to overestimate the impact of this on the NHS over the last 60 years. This was the model that the Atlee Government were implementing for most of their major interventions. The ownership of the coal industry and the railways were taken over by the State. As with the nation's hospitals this policy was not simply an ideological one supported by an electorate that wanted to support a new ideology. All of these industries and services had been effectively

nationalised during the Second World War.

During the war the Government not only ran large parts of industry but it also had the power to direct staff to go and work in certain industries and, through the rationing of food, had taken the market place out of that most necessary of services. Whilst there were a lot of grumbles about how the State had done this, for the majority of the population the experience of World War II was one where the creation and distribution of these services was an improvement on the pre-war period. This was why nationalisation

was such a straightforward intervention. And why the nation's hospitals being taken into ownership by the Secretary of State seemed a simple way of creating a new National Health System.

GPs, of course, remained self-employed operating under contract to the NHS, with access to the new NHS pension fund but retaining ownership of their practice premises. This was not in the original plan for the NHS but was the result of a compromise between the Government and the doctors which saw the 90% who voted against joining the NHS in February 1948 join enthusiastically within six months. This was an expensive compromise that has had repercussions throughout the history of the NHS and up to the present day.

At the same time as the NHS was launched in July 1948, the Atlee government also instituted the social security system funded by the new National Insurance Fund, based on the recommendations of Sir William Beveridge. This fund was created by the introduction of a new tax, separate from income tax, and calculated on a different basis. It was intended to provide the finance needed to fund the new, universal State old age pension and family allowances. In the mind of the general public the National Insurance Fund was also expected to meet the costs of providing free healthcare for all, although in practice the majority of the public funding of the NHS has come out of general taxation.

For both social security and the NHS those who had an income were obliged to contribute, either through their contributions to the National Insurance Fund or through income and other taxes. Those who didn't have an income had contributions to the National Insurance Fund credited through a variety of special arrangements, and had their healthcare costs met by the State.

The essential point was that the NHS was established effectively as a mutual insurance system, and remains so today. Everyone contributed and everyone would benefit, but the benefit and the timing of receiving it was not directly determined by the level and

timing of contributions. And at no point in his report did Beveridge suggest that ownership by the State of the assets of the NHS was necessary or even desirable. It was a matter on which he was completely silent in his report.

This mutual insurance system is what truly constitutes the NHS. It is the insurance system that enables care to be free at the point of delivery for everyone. It is this principle in practice that the public support and indeed love. The idea that we all pay for ourselves and for each other in a large risk pool is a concrete part of the way in which the public think and feel about the NHS. This is not an abstract political relationship but is an actual experience of paying taxes and receiving benefit.

Politicians, senior civil servants and NHS managers often disparage this analysis as reducing the NHS to “merely a funding system”. This is completely to misunderstand or misrepresent the nature of an insurance system and the power it can exercise. Operated properly this mutual insurance system – the NHS – could drive improvement in the design of services, in the quality and safety of care, in the physical environment, in the training and quality of staff, in productivity... indeed, in pretty much every aspect of the healthcare service, publicly and privately-owned. But in practice this part of the system – mutual purchase of health care – is neglected and often despised.

This mutual insurance system – the NHS – is the commissioner or payor. And, until recently it has been left ignored on the sidelines. Why?

The answer is that at the creation of the NHS – and ever since – the public didn't, and doesn't, see the new insurance company. As outlined above the ideology of the payment system – we all pay for ourselves and each other – is very strong, but how that has been turned into the practice of buying my hip replacement or my drugs is obscure. In contrast what the public saw, and therefore what they very quickly regarded as ‘the NHS’, was doctors, nurses, buildings, equipment and institutions.

The importance of mutual insurance as the fundamental component of the healthcare system was completely lost on the public and they have been offered no part in this throughout the history of the NHS. They weren't given the set of accountability relationships that would build the link between paying their taxes and their national insurance stamp (as it then was) and the availability of free healthcare, because to get free healthcare they didn't have to demonstrate a record of national insurance contributions or even membership of the National Insurance Fund. They simply went to the hospital or clinic or GP's surgery and got whatever treatment they appeared to need.

The national insurance stamp and having a complete and properly recorded history of national insurance contributions was important to the public, but only because this was the only way to get a full – or, in some cases, any – old age pension. There was a direct link and it was clear and constant in the minds of the public.

In contrast the public didn't link their national insurance contributions record to getting access to free healthcare. It was now free. This means that in practical terms there was no experience of cost to them. Only in an abstract way was it their money. (This is why if the public is asked "Should there be more money spent on the NHS?" the answer is always "Yes", even after record increases.) The money comes from somewhere else so, of course I want more.

So, the users of the healthcare system and the wider public – who were also the funders of the system – had no stake in improving efficiency and productivity or reducing the costs of care, because they saw no relationship between the taxes they paid and the cost or volume of care they received. Receiving healthcare free at the point of need became an entitlement. You did not receive free healthcare because you had been paying for it. You received it because it was a part of being British.

Within this context any attempt to close local services to concentrate clinical expertise and to reduce costs were regarded by the

public as attempts to reduce the scale and scope of the NHS and were generally fiercely resisted. And as new treatments became available the assumption was that they would be 'on the NHS' in other words available free to all. Even as the NHS came into being the stresses and political pressures this attitude would cause were very apparent. The Atlee government was divided over prescription charges and charges for some dental and ophthalmic services. Bitter political battles over the scale and scope of charging, or indeed its very existence as an integral part of the funding and rationing mechanisms of the NHS, were a regular feature of the Labour governments of the 1960s and 1970s. And in the minds of many of the public, the attitude to charging for elements of healthcare came to be a key issue that defined the difference between the Labour and Conservative parties.

The public and political perception of the NHS as being the hospitals, clinics, GPs' surgeries and the staff who worked in them had much wider ramifications. In 1948 the State took these institutions into its own ownership, not simply in an ideological sense but concretely. And since they were owned by the State there had to be some accountability for that public money and publicly owned organisation. If the public in some sense 'owned' these facilities, someone had to exercise the ownership function for the public and, given the accountability through the electorate, then Ministers must surely 'manage' them on behalf of the public and could be called to account for their stewardship. In that sense the Secretary of State for Health not only took the nations hospitals into 'public' ownership, but into 'personal' ownership.

Out of this reality of ownership and accountability grew the perception that:

- Ministers run the NHS... they decide how it should be organised, where funding should go and how it should be spent, where facilities should be located and what care they should and should not deliver... and a hundred other things;

- Parliament should call Ministers to account for their management of the NHS... Ministers should answer questions and be grilled by Select Committees, the details of the organisation and delivery of healthcare services should be subject to debate and challenge in the Houses of Parliament, much of the framework within which the NHS operates should be set out in law and MPs should individually represent their constituents' particular concerns about the NHS to the Minister who will be held to account for this detail;
- 'Clinical freedom' exists and should be preserved and extended. In other words clinicians – actually, doctors – can do as they please and are not subject to challenge by the Secretary of State, his officials or anyone else on grounds of cost or quality or appropriateness.

These three perceptions – all of them have sprung from the way in which the NHS was set up and yet all of them are highly questionable – have shaped 60 years of the NHS, and seldom for the better.

2. The NHS as a corporate entity

Of course given the million people who interact with the NHS every 36 hours it is just not possible for Ministers to carry out all this activity. Ministers themselves do very little of what is required of them by legislation or attributed to them by the public and the media. Mostly, their government departments – the Civil Service – formulate the decisions for Ministerial approval, and often take and implement the decisions with little or no involvement of Ministers or Parliament. This is not to say that this is inappropriate given the scale of the enterprise – how could it possibly be otherwise?

But to understand how the NHS has developed, we have to give some thought to how the Civil Service thinks and behaves as it tries to manage the NHS. It carries out this task on behalf of successive governments with very different political philosophies about the role of the State, the management of the economy and what might be the legitimate expectation of the citizen, the taxpayer and the current user of the healthcare system. We also need to remind ourselves of the context in which the NHS has developed –the economic and political context, and the development of healthcare technology - and of the attitude of the public to the NHS.

Since the end of the Second World War the UK has had to rebuild its economy after the immense financial burdens created by fighting prolonged and expensive wars in Europe and in the Far East. Along the way the country has experienced periods of high inflation, which successive governments have tackled through tight controls on public expenditure and borrowing, on the levels of pay settlements throughout the economy and on the growth of the money supply. In parallel the UK has moved from a nation deferential to authority and grateful for whatever level of public services

governments made available, to a nation with a strong consumer attitude and high expectations, determined to have their rights respected and their needs and wants met. Whilst this is a gross simplification of the economic and social history of the post-War period and omits many key changes, it does recognise the considerable impact that the twin themes of the impact of economic crises on public expenditure and the rise in public expectations have together had. These are the key developments that have shaped the evolution and management of the NHS.

For much of the period up to the early 1990s the Civil Service was grappling with how to control public expenditure and inflation, while simultaneously responding positively to public expectations of more and better public services, especially health-care. The NHS was a particular headache. When the NHS was created the assumption was that, as the population had easier access to healthcare, their health would progressively improve and therefore demand for healthcare would decline. We now know that this was flawed logic.

What Beveridge and Bevan and the creators of the NHS could not have foreseen was the growth in medical technology and its impact on demand for healthcare services and therefore on the cost to public expenditure of providing an apparently free service. The main drivers have been:

- The development of diagnostic technology from simple X-ray machines to the MRI scanners and other technologies of today has enabled much earlier and more extensive diagnosis, and therefore treatment, of conditions that were previously never diagnosed or identified only well after effective treatment was realistically possible;
- The development of anaesthetic drugs and techniques has enabled more extensive and complex surgery to be performed on a wider range of patients than ever before. Elderly patients

can now be operated on and recover fully from major surgery, when twenty or thirty years ago they would have been kept as comfortable as possible as they died;

- The development of immuno-suppressive drugs and surgical techniques has enabled a large and growing range of transplant operations to be offered as routine treatments to a wide range of patients;
- The improvement of prostheses has made joint replacements a treatment of choice for those with arthritic conditions, and the subsequent replacement of the prostheses when it begins to wear out has created new and growing areas of need or demand;
- The fact that all of these and rising standards of living have increased life expectancy so that nearly everybody now will spend the last 20 years of their life with one, two or three long term conditions that need some form of regular medical intervention.

The list is long and growing. Care has progressed from palliative (relief of pain & symptoms) to curative and is now increasingly about improving personal performance and quality of life rather than curing life-threatening conditions.

These developments presented successive generations of politicians and civil servants with acute policy and managerial dilemmas. But the NHS was comprehensive and free. Rationing or extensive charging was politically unthinkable. And clinical freedom meant that decisions on what treatments to make available and to which category of patient were taken by the clinicians themselves, and their judgements were generally based on the benefits to the individual patient with no thought for the wider consequences for the NHS or indeed for the Country.

Taken together these forces generated the potential for unconstrained growth in demand and cost. Yet this was taking place in a

system where resource could only be generated by increases in taxation, at times when the imperative was to control and then reduce public expenditure and inflation across the economy. In the absence of mechanisms to control demand and cost, and to manage clinical and public expectations and with politicians seeking (and then offering) reassurance that the NHS was indeed “the best healthcare system in the world”, the Department of Health adopted the only strategy it could think of – tight central control over the operation of the healthcare system and subterfuge to persuade politicians and the public that the service was good and improving. This tight central control was the only way in which the Civil Service could think of to control public expenditure. In fact it was the form of public expenditure control that had always been typical of the Treasury. They felt that they had to have sight of every pound that left the Treasury and was spent by public organisations and, having sight of that pound, they could at any stage withdraw that expenditure. Public expenditure control was based upon being able to intervene all the way down the service and – the theory went – you could only intervene if you had the control to do just that.

It is probably not correct to describe the Department’s approach as a ‘strategy’ – thought through, objective, optimised against defined criteria and persisting over many years and successive governments. Rather the Department’s approach was the accumulation of many individual decisions designed to manage short-term pressures for more or better services. What seems irrefutable is that the Department of Health’s main purpose came to be to avoid a general recognition emerging of the gap between what the Country appeared to want from the NHS and what the Country could afford at different times, so that the consequences of this gap did not become politically unmanageable for the government of the day.

“Care has progressed from palliative to curative and is now increasingly about improving personal performance and quality of life rather than curing life-threatening conditions”

This in turn generated a culture in the Department that was simultaneously tightly centralist and controlling, and deliberately opaque.

The highly centralised bureaucracy and tightly planned system that was progressively created to 'run' the NHS from Whitehall was founded on a number of assumptions:

- Capacity – beds, buildings, staff and equipment – could be planned precisely, and by this means supply and demand could be brought into equilibrium and kept there;
- Competition was wasteful. It required some spare capacity to enable competitive forces to drive change. The spare capacity represented poor value for money, because it was not strictly required in a world where supply and demand could be brought into balance;
- The profits made by the private sector were money the taxpayer need not have spent because they didn't buy anything for the taxpayer. Profits were, therefore, poor value for money. The aim should be a minimum cost system, which could best be achieved by a system that did not require profits or dividends to be paid to shareholders – a State-owned system. It was in the interests of the taxpayer to cut the private sector out of the NHS;
- The public could not make choices in such a technically-complex system as healthcare. The doctor (sometimes nurse) knew best what care to offer. The views of patients were irrelevant. Whitehall knew best where services should be located, how buildings should be designed and equipped and staffed, and how services should be organised. Patients' preferences were irrelevant. The taxpayers could not be expected to fund 'frills' such as attractive and comfortable surroundings, customised services and care etc. Within this particular view of value it was required that the service be basic and utilitarian because best value was synonymous with minimum cost;

- Best value for money could be most sensibly defined centrally. Outside of the clinical sphere, Whitehall could and should specify the design of buildings, the pay and conditions of staff, how services should be designed, which buildings should close and which should remain open... and a host of other, essentially operational matters. Intrinsicly these were decisions that generally could and should be taken locally, but allowing this risked local managers acceding to pressures from the public or clinicians for more services or higher standards, which would expose the inherent strains in the system between improving quality and constraining cost.

The approach had several unforeseen but important consequences.

First, since the Department of Health was a Department of State with a politician accountable to Parliament for its activities, what the Department did was essentially political. This meant that the public and the healthcare professions and backbench MPs came – rightly – to believe that all important decisions about the NHS were essentially political rather than managerial decisions. The way to get what you wanted from the NHS was to lobby the Minister and create political pressure on the government through debates in Parliament, have petitions presented to No10 with as much publicity as possible, organise marches with the public and nurses in uniform, and as much negative press coverage as it took to get the Minister to cave in... which they did with depressing regularity, irrespective of their political colour.

This attitude, and the results it generated, encouraged those in the NHS not to be managed by it but to use the politics of lobbying to try and influence their management. In turn, this placed the senior management of the NHS in a very difficult position; they are meant to ‘control’ the NHS, but the fact that they are within a democratic political system means that NHS employees can and do appeal to the public for support against that management.

Second, administrators and subsequently managers (who were late to emerge in the NHS) learned that their over-riding objective was to keep the political noise down. Challenging orthodoxy to improve the effectiveness and reduce the cost of services, tackling poor clinical performance, promoting innovation in the design and delivery of services and in the utilisation of labour and assets... these were fine so long as they did not lead to political controversy and embarrassment for the Minister or the Government.

Pictures in the media of the Queen or the Minister cutting the tape to open a new building or gazing in wonder at some puzzling new machine or greeting happy smiling patients sitting up in well-made beds with Matron hovering in the background... these were smiled upon. If there was public disagreement from staff or the public were in the press trying to stop change, the manager was seen to have failed. This created in managers a culture of what counts as success being a lack of confrontation and stopping any changes that might lead to confrontation. Successful managers made sure that nothing got in the papers, even if this was at the cost of very little challenge and change.

Third, this combination of weak management and political pressure being the easiest way to secure a desired outcome gave the clinicians no encouragement to take any responsibility for managing the services they delivered. Clinicians professed loyalty to their individual patients or to the requirements of their professional bodies. They would do what they felt they had to do to secure the resources they required to treat their patients, even if this meant criticising publicly and lobbying against the managers of the institutions in which they worked and the organisation that paid their salaries. There was no appetite or incentive to take on a leadership role, and very few routes by which this could be accomplished.

As a consequence, it wasn't clear, beyond a simple desire for everything, what the public was entitled to expect from the NHS in return for its taxes, and there was no desire or incentive to make it

clear. Accountability within the NHS was diffuse and financial pressures were managed through using long waiting times to manage demand. For the most part, poor clinical or managerial performance often went unchallenged. Clinical and managerial decisions were often based on pressure rather than objective criteria and good information, and the outcome was often the lowest common denominator dressed up as a clinical/managerial/political consensus.

3. Challenging and changing NHS corporate

Twenty years of reform

The successive Conservative administrations of the 1980s and 1990s embarked on major reforms of the organisation, management and funding of the public sector. In the public trading sector, industries were privatised. In the public services reliance was placed on a combination (which evolved over time) of more professional management, better identification and control of costs, tighter cash budgets and independent scrutiny (the National Audit Office, the Audit Commission). In time a degree of user choice would creep in, especially in education.

The reform agenda was perhaps weakest in the health sector. In the face of incredulity from the Department of Health that any form of market-like reforms might be contemplated and conscious that the public had a strong attachment to free, apparently un-rationed, healthcare and strong suspicions that the Conservatives could not be trusted to maintain this status quo, Mrs. Thatcher lost her nerve.

The internal market was created but with none of the characteristics of anything approaching a market. So-called self-governing NHS Trusts were created, but these organisations had little or no real autonomy. NHS Trusts had their budgets set and board members appointed centrally, and capital expenditure was allocated centrally. The buildings, as had been the case since 1948, were owned by the Secretary of State, who claimed the proceeds of the sales of any surplus land or buildings.

With no tariff there was no price for services and therefore no incentives to do more work, since you were paid irrespective of output, or to reduce costs or improve productivity. Patients had no

real choice of GP or hospital, and therefore service providers had no incentives to improve service quality or patient experience (then an unrecognised concept) and purchasers had no levers to drive change or improvement. NHS contracts defined services but they were not legally binding and in practice were often little more than lists of services to be delivered.

The Department's culture of a centrally planned and tightly controlled publicly-owned service had triumphed over Mrs. Thatcher's strategy which was transforming the cost and performance of huge parts of the wider economy – telecommunications, energy utilities, even parts of the Civil Service. And unlike in these industries, where existing and new managers and investors had seized the opportunities offered to them, in the NHS many managers and clinicians united in their opposition and refusal even to contemplate change.

Culture ate strategy for breakfast.

Under John Major, public services were expected to be more consumer-focussed. The Citizens' Charter rewarded local attempts to define and meet the expectations of service users. But in health it was little more than window dressing. After a decade the health reform agenda quietly petered out.

Things can only get better

We are now well into the second major attempt to reform the NHS, launched by Tony Blair (but only in his second term as Prime Minister) and carried forward, hesitantly, by Gordon Brown. Two Prime Ministers, five Secretaries of State for Health and seven years of relative stability in the policy framework coupled with the largest ever injection of cash into the healthcare system... has the culture been overturned and strategy triumphed? Or is the culture simply catching its breath before it consumes another hearty breakfast of toasted strategy?

After a wasted first term Tony Blair eventually got a lot right. The Government asked the people who used different healthcare services what they really wanted. Not surprisingly two major elements of the answer were shorter waiting times and being treated as human beings with feelings and points of view, and not simply cases who received passively whatever treatment was offered them. Blair's Government also accepted the public's desire to see significant investment in the healthcare system, but recognised that this had to be deployed as a lever to secure significant and lasting improvements in labour productivity and, ideally, to create pressures and incentives for productivity and efficiency to improve year on year.

The solution adopted was to start where Thatcher left off, but this time to apply the levers of change with some power:

- The internal market was created under the guise of commissioning and provision;
- A national tariff was introduced to set a defined, non-negotiable price for a wide range of secondary and tertiary treatments;
- Patients were given the right to choose – progressively widened to an unconstrained right to choose any hospital or provider for their treatment;
- With money following the patient and the tariff now defining the price of treatment, hospitals had real financial incentives to attract patients and cut costs;
- Competition not collusion was the ethos, with a deliberate programme of encouragements to the private sector to enter the market and create the competitive pressures the system had so far lacked;
- Commissioners were encouraged not to assume that their traditional provider was necessarily the best but to seek bids for services from any willing provider who could meet the NHS's standards (which were not yet well-defined) at the tariff price;

With the price fixed, competition was on quality of service – better, safer treatment delivered in ways that best met the preferences of the service user;

- And, through the creation of Foundation Trusts Ministers took the first tentative steps to get out of central, operational control.

4. Foundation Trusts – the beginning of the end of the NHS as corporate?

The creation of Foundation Trusts was one of the most bitterly contested reforms introduced by Tony Blair. The legislation was finally passed in 2003. As Antony Seldon records: “Nine separate rebellions occurred during the six month passage of the Health Bill threatening its survival all the way through to the final vote. In total 87 Labour MPs voted against it at various points. At 5 pm on 19 November 2003 the Commons finally agreed with a majority of just seventeen.”¹

Now, six years on and with Foundation Trusts the majority of hospitals and widely regarded as one of the real successes so far of the whole reform programme, it’s hard to credit some of the criticisms and concerns voiced during the Parliamentary debates. Claire Short argued that “giving them [Foundation Trusts] greater authority and more privileges will lead to growing inequality”. Other MPs expressed concerns that the ability of Foundation Trusts to “poach staff” would “increase health inequalities”. For Frank Dobson, the creation of Foundation Trusts would be “damaging and divisive”. In 2003 during the passage of the legislation the idea that Ministers would completely relinquish any control or influence over the operation of a hospital ‘owned’ by the NHS was an almost unthinkable challenge to the concept of the NHS as an integrated healthcare corporate and to the culture of centralised control and subordinate management that this had bred.

In many people’s minds the link between the Secretary of State actually owning the hospital and the principles of the NHS seemed

¹ “Blair Unbound” Antony Seldon, Simon and Schuster 1007 (Page 246)

one and the same thing. These people felt that, if you separated the ownership of the hospital from the elected politician, the NHS could no longer really be a publicly paid for health service. There is of course no straightforward logic in this position, but it did have nearly 60 years of experience behind it.

Yet, Foundation Trusts were an inevitable consequence of the reform agenda. Without them reform would have been short-lived. As Alan Milburn discovered it was one thing to make promises to the public in the form of defined maximum waiting times, but quite another to get these delivered. The formidable Ministerial pressure that he could exert could 'persuade' the most recalcitrant hospital chief executives to improve their organisation's performance. But, without real incentives, effective accountability and serious consequences for failure, the integrated, corporate system was incapable of delivering the Government's promises of shorter waiting times, and there were simply not enough hours in the day and not enough telephones in the country for the Secretary of State personally to intervene in every case when a target was not being met.

So the powerful challenge of requiring the system to meet minimum waiting times meant that the Government was forced to look at incentives that would drive more activity within the system. And, if the leadership of organisations were to be incentivised to do more work, then the organisation needed some freedom to be able to both maximise that activity and secure the incentives that had encouraged them to do that extra work.

Moreover, the more the public was encouraged to regard the Secretary of State as, in effect, chief executive of the hospital system, the more likely it was that he – and therefore the Government – would be blamed for every failure – real or perceived – by a demanding public, whose attitudes to public services were increasingly consumerist (following the encouragement of the Thatcher, Major and Blair Governments).

The Secretary of State could not win. The doctors and nurses got the credit when services were perceived to be good (even if, in reality, they were mediocre). He got blamed for the slightest failure, even when in reality it was often incompetent or unwilling managers who were at fault. There must have been many times when he felt he was the only person with any public accountability in the whole NHS. And in fact in many people's eyes he was.

What Alan Milburn came to realise, implicitly, was that the right policy framework was not enough. The culture of centralised control to deliver what Ministers wanted had to be altered permanently to make the patient and the service user much more the focus of service planning and delivery, and they had to have the ability to influence the service managers and clinicians.

So, it should be no surprise that the statutory and operational framework for Foundation Trusts involved incentives, sanctions and local public accountability.

Type of NHS Healthcare Trust	
Acute Hospital Trusts	168
<i>of which</i> Foundation Trusts	88
Mental Health Trusts	58
<i>of which</i> Foundation Trusts	38

The key features of the Foundation Trusts and the regime within which they operate are:

The Foundation Trust

1. is run by its board of directors ('the board'). The board is accountable under statute to Parliament (via its chief executive as accounting officer), to its regulator and to its governors;

2. earns income from legally-binding contracts with its commissioners (mainly Primary Care Trusts). If it can deliver services more cheaply than the tariff, it can make and retain surpluses to invest in developing its services;
3. can borrow commercially, retain the proceeds from the sale of assets and can fail financially;
4. has a membership recruited from its patients and staff and from the public it serves. The members elect a board of governors and in addition governors are nominated by key stakeholders.

The governors’ main duties are

1. to appoint the chair and non-executive members of the board and determine their terms of service;
2. to appoint the auditors and receive their report;
3. to call the board to account.

The Secretary of State has no power of direction over Foundation Trust. His influence comes via the commissioners – the Primary Care Trusts – with whom the Foundation Trust negotiates contracts for the provision of services. Oversight and scrutiny of the Foundation Trusts is performed by Monitor:

The Independent Regulator of NHS Foundation Trusts (“Monitor”)

1. assesses applicants to be Foundation Trusts according to criteria it determines;
2. specifies the terms of the Foundation Trust’s Authorisation;
3. intervenes, if a Foundation Trust should significantly breach the terms of its Authorisation. To secure renewed compliance with the Authorisation, Monitor can replace any or all the members of the board or the governors, require the appointment of advisers, instruct the Foundation Trust to do, or not to do specified things (which covers all aspects of its operations, clinical and non-clinical).

4. Controls borrowing by each Foundation Trust and the income each can earn from private patients;
5. Defines the reporting requirements and the audit code for Foundation Trusts;
6. Publishes a wide variety of financial and performance information;
7. Approves a merger with another Foundation Trust or a major acquisition.

This system contains the balance of incentives, sanctions and accountability that Ministers rightly judged necessary to give confidence that Foundation Trusts would meet the needs of patients, improve quality and efficiency, respond to their commissioners, be called to account locally and not take risks they could not manage.

“There is still a tendency for boards to treat governors as ambassadors for their hospital rather than recognising the governors’ legitimate right to call boards to account”

The tariff and patient choice, coupled with the ability to make surpluses and retain them, give Foundation Trusts powerful incentives to secure and retain contracts from commissioners, pursue opportunities to increase market share profitably, improve

productivity and efficiency and deliver services in ways that reflect the preferences of those who use them and those who refer patients.

Monitor’s high standards for authorisation and robust assessment process generally ensure that Foundation Trusts start with strong boards and good governance, that their business plans are initially robust and that the organisation has the capacity and capability to meet its various obligations. The compliance regime has demonstrated that Monitor can identify risks to financial viability or service delivery and is increasingly confident in its ability to forecast likely future serious risks of failure in time for them to be dealt with. Monitor’s considerable powers of intervention, and its proven ability to use them effectively, generally

ensure Foundation Trusts adhere to the terms of their Authorisation.

Foundation Trusts were designed to be more responsive to the needs and wishes of their local communities. Anyone who lives in the area, works for a Foundation Trust, or has been a patient or service user there, can become a member of the trust. By the end of 2009 there were roughly 1.5 million members. These members elect the board of governors of which at the end of 2009 there were 400 governors of the 126 boards. Foundation status is granted to high performing trusts after successfully completing an application process administered by Monitor. Foundation Trusts are different from NHS Trusts because:

- they are not directed by Government so have greater freedom to decide their own strategy and the way services are run;
- they can retain their financial surpluses and borrow to invest in new and improved services for patients and service users; and
- they are accountable to their local communities through their members and governors, their commissioners through contracts, Parliament and to Monitor as their regulator.

Local public accountability is perhaps the area where the system is taking longest to develop. There is no shortage of interest. All boards of governors had exercised their statutory functions to different degrees – appointing or re-appointing chairs and members of boards of directors, receiving audit reports, commenting on the annual plans of their Foundation Trust. But there is still a tendency for boards to treat governors as ambassadors for their hospital rather than recognising the governors' legitimate right to call boards to account. And governors are too often willing to be ambassadors.

5. Does the system work?

Up to a point it does.

Evidence about service quality and the clinical performance of public-sector healthcare bodies is currently very patchy. However, it is all that is available. For Foundation Trusts it offers a generally positive picture, both about the performance of individual institutions and about the effectiveness of independent regulation. Successive annual health checks published by the Healthcare Commission and its successor the Care Quality Commission (CQC) have shown Foundation Trusts to be consistently the best performers. The Royal Marsden Hospital, for example, has been rated Excellent for both its quality and its use of resources in four successive annual health checks. In the most recent annual health check for 2008-09 (published by the CQC in the autumn of 2009) there were 38 trusts that were rated Excellent for use of resources and Excellent for quality of service and 36 of those were Foundation Trusts.

In part this reflects an improvement in the calibre of the boards, and specifically the non-executive directors. The removal of the Secretary of State's power of direction, which means the board of a Foundation Trust is truly in charge, appears to have made membership of a board much more attractive to a wide range of people with experience of running large and complex organisations, and with the skills to set strategy, monitor performance and call management to account effectively. It may also reflect the impact of the tariff and patient choice. Boards populated by people who have run businesses whose success depends on satisfied service users, and clinicians who want to be able to secure investment in service improvement, appear to be responding to the incentives and pressures created by

giving patients freedom to choose, allowing money to follow the patients and enabling hospitals to benefit from improved efficiency by generating and retaining surpluses for future investment.

However, it would be hard to demonstrate convincingly that there are truly world-class hospitals in England. In contrast, most people would agree that there are several world-class English or UK universities in any list of what are regarded generally as the world's best. In part this difference reflects the very poor data available to assess the true quality of hospitals as measured by the safety and effectiveness of their clinical services and their responsiveness to patients. This is changing, but very slowly. There are better measures for universities, and these have become more important as the UK's higher education system has had to market itself across the world and as individual institutions have had to compete in the global and domestic markets to attract students. That said, the fact that universities clearly are in charge of themselves and each institution has a different relationship between itself and government is important.

Foundation Trusts have many features in common with universities. Although constitutionally the two types of institution are statutorily protected from direct Ministerial involvement in their management or operations, in practice the involvement with Foundation Trusts remains much closer. It isn't obvious from the relative performance of the two sectors that this brings benefits in the quality of services delivered.

There have of course been some under-performing Foundation Trusts, in relation to both finance and clinical or service quality. This is regrettable, but is probably inevitable. The fact that failures occur does not of itself demonstrate that the policy is a failure. Far from it. Contract monitoring and performance reviews by commissioners, independent regulation by Monitor and the publication of data on service quality by the Healthcare Commission and now CQC

means that problems are openly acknowledged, however politically embarrassing they might be, and have to be tackled speedily and effectively.

This system puts great pressure on boards to recognise their organisation's problems, to devise effective plans to remedy them and to show that these plans have had the desired impact. Boards that can't or won't solve their problems can and are replaced by Monitor using its statutory powers of intervention. The fact that Monitor has used its powers on a small number of occasions, either because its own data has identified serious under-performance or because of the concerns of a Foundation Trust's commissioner, means that Foundation Trusts take seriously and respond to Monitor's concerns about performance or governance.

The days are not yet over when hospitals would use political pressure to transfer their problems elsewhere or have inefficiency unnecessarily subsidised, and when under-performance was hidden from public view and dealt with quietly (if at all) to minimise political embarrassment, but they seem to be coming to an end.

The promotion by Monitor of service-line management is enabling hospital clinicians, for the first time in the history of the NHS, to understand reliably the economics of the services they deliver and also how to assess not just the clinical outcome and safety of their services but also the views of patients and staff. This means that clinicians have the data to take managerial responsibility for improving efficiency and effectiveness, and the incentives to do so. And increasingly boards can have the confidence to delegate to clinical leaders decisions on reshaping services to improve quality or efficiency, decisions on investment etc. This in turn enables boards to spend more time on strategy and less on operational issues that can best be settled by those delivering services.

Foundation Trusts have also been at the forefront of developing and publishing quality reports: the so-called quality accounts. In

2009 the first reports, which dealt with performance in 2008-09 necessarily used existing data and current quality indicators. However, for the first time boards have published their objectives for improving quality during the following year (i.e. 2009-10) and in their annual reports for that year they will set out what has been achieved, and what has not. Because the reporting framework is set by Monitor, these quality reports are not mere advertising. Their scope may be quite limited, but they are designed to offer an honest account.

There is now more, and more accurate, data on financial and non-financial performance of hospitals than ever before, and its coverage and ease of access by patients is constantly improving. But the cultural obstacles remain, and if anything they are becoming more robust in the face of challenge.

The policy of creating Foundation Trusts was designed to create a new set of structural relationships within the NHS. The development of the new structure was, amongst other things, an attempt to create a new culture. However, the old culture – the one that NHS managers and civil servants feel safest in – is still dominant within the Department of Health. And sadly the current and immediately previous Secretaries of State have acted in ways that strengthen this out-dated and inappropriate culture, rather than challenging it.

As explained above the public, political parties and the NHS itself expect the Secretary of State to be responsible for everything that takes place within the NHS. This expectation of the Secretary of State's responsibility for the NHS is a belief also held by many IN the NHS itself. Legally the Secretary of State is withdrawn from this position with regard to Foundation Trusts by the legislation passed by Parliament in 2003. If something goes wrong inside a Foundation Trust the Secretary of State has no legal duties or powers unless Monitor chooses to de-authorise the Foundation Trusts using the powers given to it in the Health Act 2009.

However, this is not how Secretaries of State or Members of Parliament actually act. Ministers still operate as if they were responsible for most significant operational decisions – in effect, Group Chief Executive of a corporate hospital system.

Two of the most public examples illustrate how the reality and the legal position are not currently aligned.

First was the row over whether Foundation Trusts should be told by the Department of Health to deep clean wards to combat MRSA. In September 2007 the Prime Minister decided that this was an appropriate response to public anxiety, that hospitals might be “dirty”. He pledged that all hospitals in the NHS would be deep cleaned by a certain date. This may or may not have been a correct idea to make hospitals clean, but it is clear from the Foundation Trust legislation that he had voted for that the Prime Minister did not have the actual power to make all Foundation Trusts do this. He can ask them, but he cannot tell them. This did not stop the Department of Health from expecting that the Foundation Trusts would fall in and obey orders alongside all other hospitals that can in fact be told what to do. But Foundation Trusts acquiesced and the deep cleaning was carried out across the NHS estate.

Parliament also behaves as if it had not passed the legislation that it did. They believe that the Secretary of State for Health can be questioned on, and invited to appear before the Health Select Committee to discuss, any aspect of the performance of hospitals, including those – Foundation Trusts – over which he has no jurisdiction.

In mid 2009 there was a clear report that standards of care in some parts of Mid-Staffordshire NHS Foundation Trust had fallen well below what the public has a right to expect. The then Secretary of State seized the opportunity to make an oral statement to Parliament and to commission a range of enquiries, investigations and interventions. He did so without apparently recognising that Parliament had passed a law which did not give him the locus to do

so or the power to impose any of the resulting recommendations. And he acted in this way despite the fact he had voted for the legislation which withdraws those rights from himself. But the Independent Inquiry went ahead, although without the statutory powers under the Inquires Act, and its report was laid before the Secretary of State in February 2010.

In any other organisation operating so far beyond the legal remit would have been thoroughly criticised. But Parliament was receptive itself, positively encouraging the Secretary of State to flout the law that Parliament had passed. It wanted to revert to the familiar assumption that healthcare and the NHS are subject to detailed political control and demanded that Parliament was regularly updated by the very office holder from whom Parliament had withdrawn the right to do anything.

In a crisis, or when pursuing an objective they regard as politically important, Ministers and Parliament still assume that that the only approach is to exert managerial authority and issue instructions. The pressure to ‘do something’; even when you don’t have the power to ‘do something’ seems to be irresistible to Ministers and Parliament.

This means that it is irresistible to the officials in the Department of Health. They could say to the Secretary of State that they are sorry but legally the law that Parliament passed means that all the Secretary of State can say in a statement to Parliament is that this is shocking and a number of other organisation have this in hand and will report in due course. But their culture is also one where they feel they ‘should’ be in charge so act as if they are.

What the Secretary of State is entitled to do is to ask why commissioners are spending taxpayers’ money buying poor quality care from apparently badly-run or dirty hospitals. In the reformed

“The pressure to ‘do something’; even when you don’t have the power to ‘do something’ seems to be irresistible to Ministers and Parliament”

system the Secretary of State is the patient's friend, not the chief bureaucrat. His job is to ensure that commissioners buy the most cost- and clinically-effective care to meets the needs of the community that the commissioner serves, that the commissioner knows what is being delivered and tackles a provider offering unacceptably poor care. How service deficiencies are remedied is a matter for the provider.

If the commissioner can't or won't get better value for money, the Secretary of State has the powers to change the commissioner. The Secretary of State, working through the Strategic Health Authority (SHA) has the power – and the duty – to regulate commissioning. However, although enquiries may be made into the performance of a commissioner, neither the Department of Health nor the SHAs have created a risk-based national system of regulation for commissioning to match the regulatory framework within which Foundation Trusts operate. This is long overdue. Not only would it drive forward the development of commissioning, but it would begin the process of culture change that is so essential for the future of healthcare in England.

So far in England no serious attempt has been made to recast in this way the relationship between Government and the healthcare system. Culture is still eating strategy for breakfast – more slowly than in the past, and with occasional bouts of indigestion. The question is: how can we finally turn the tables so that strategy defines culture?

6. Towards a new culture

Five key changes must happen if we are to have any chance of creating the culture that is needed in Government to enable autonomy to flourish and with it creativity and innovation.

Developing real competition

First, true competition needs to be made a real part of the system, so that competitive pressures are brought to bear on managers and clinicians in order to incentivise them to improve safety, quality and the responsiveness of the services they offer. This competition needs to be between NHS providers and between providers from other sectors. The speech to the King's Fund by Andy Burnham on 17 September 2009 – in which he stated that NHS organisations should be the preferred provider of State healthcare services – and consequent referral of that policy to the NHS competition and co-operation panel has left the policy entirely unclear. If Andy Burnham's personal preference were to become the practice of every NHS commissioner, no NHS provider would feel under any competitive pressure to improve. They would know that the commissioner would have to buy healthcare from them and no one else.

As far as the Secretary of State's personal preference for NHS providers, no longer are commissioners expected to commission the best quality that the tariff price can buy. The switch to the NHS as the 'preferred provider' places the maintenance of existing services and buildings above the best interests of patients and gives mediocre clinicians and managers cause to hope that they will be allowed to continue as before with no real threat.

Even before this, competition was often no more than piecemeal tendering of parts of services.

A proper policy framework is needed that enables high-quality providers, who can deliver services to the standards specified by commissioners within the tariff price, to be able to enter the market and displace services of poorer quality. Ministers should see themselves as the ‘patient’s friend’ commissioning top-quality services on their behalf and driving out mediocrity, rather than, as now, the guardians of the status quo.

Developing a pricing framework that drives change

Second, the tariff should start to be used to drive change. The potential of a national tariff has not been remotely explored. Properly used, the tariff could define what the Government proposes to spend on different components of a care pathway, rather than simply reflecting average costs of various treatments as it does now. The tariff could make clear what constitutes, say, upper quartile performance (quality and cost) and offer real incentives to providers to achieve this level of performance and efficiency. And, by defining tariffs for care pathways rather than individual Healthcare Resource Groups (HRGs – groups of similar treatments), the Government could indicate where it sees a need to invest in improvement to secure better care for particular categories of patient.

Used in this way the tariff could drive change and innovation and identify those providers incapable of meeting the high standards required to sell services to the NHS. Instead, the Operating Framework for 2010-11 gives the SHAs the ability to set aside the tariff and “temporarily suspend contractual arrangements between PCTs and providers.” In effect, the policy of a national tariff is progressively being abandoned. SHAs are being allowed to decide how much surplus a particular hospital will be allowed to make by

turning the tariff off and on. This removes the discipline of the tariff from those hospitals that are precisely those that need to have that discipline. Instead of penalising SHAs for not being able to commission effectively within the tariff, they are being allowed to pass to providers all the risks associated with the tariff.

To achieve its full potential for improving services, the system for setting the tariff needs to be independent of political manipulation and properly resourced. Instead of being a technical backwater of a Government department where careers are made in policy development and implementation, the system needs an independent organisation devoted solely to structuring a tariff within a defined envelope of public expenditure and staffed by technical experts with experience in the wide range of tariff-based systems around the world. And the tariff should be made to stick, and not be subject to local manipulation by SHAs.

General elections are not won or lost on such proposals, but their importance to the development of a high-quality healthcare system cannot be over-stated.

Foundation Trusts believing in and using the autonomy that they have

Third, NHS healthcare providers need to begin to relish their autonomy and to use it to develop their institutions. It is increasingly recognised that some NHS Trusts are intrinsically weak organisations, unlikely ever to be strong enough to be granted the autonomy of being authorised as a Foundation Trust. There can be many reasons for this: poor leadership or management; small scale creating a cost base incommensurate with any realistic income; inappropriate reconfigurations in the past creating organisations with no strong identity or culture. Foundation Trusts should see opportunities here. They know the risks they can take and those they can't. Service line management has given them an understanding of

the economics of the services they provide and an ability to assess the consequences of expanding services or adding new ones.

Foundation Trusts ought to be well-placed to acquire weak providers and turn them into successes, and in the process build chains of strong institutions and services that are capable of resisting central control and rising above the pressures this seeks to exert.

“ Foundation Trusts ought to be well-placed to acquire weak providers and turn them into successes, and in the process build chains of strong institutions and services that are capable of resisting central control and rising above the pressures this seeks to exert ”

But so far these changes have been slow to emerge. Only one real take over has occurred where the Heart of England hospital took over Good Hope hospital. This must and will become a feature of the hospital landscape in the next few years.

A key requirement for the development of local autonomy is its exercise. Too often Foundation Trusts – especially those who are under-performing – are very ready to let Ministers and their officials step over the line and try to take back control. Too often

Foundation Trusts feel they have to be included in the SHAs attempts to performance manage the NHS. Too often they feel that when they are told to by an SHA or the DH they have to agree to take someone from their Board to prop up another non-Foundation Trust hospital. This isn't to say that Foundation Trusts should not engage with the other components of the NHS. Of course they should where doing so helps them improve the services they deliver. But they should do so as the equal partners the legislation describes, not as subsidiaries.

An industry, not an organisation or a system

In parallel with this – the fourth change that is needed – is for the provider sector to behave more like the industry it is. In the wider economy competitors have learned to co-operate to

strengthen the industry in which they operate and advance its interests. In some cases this is mainly through trade bodies. In other cases joint ventures are created to take forward industry-wide initiatives.

Too often in healthcare this is still left to Government and the assumption is that this is where cooperative activity belongs. So, the National Leadership Council drives initiatives to help young managers and clinicians acquire the skills and exposure they need to progress to the most senior levels. In the process it expands into board development initiatives and schemes to identify likely candidates for what it defines as the most challenging roles. All of this the industry itself could do, and do better. Instead of letting the Department of Health reinforce its notion of itself as the headquarters of the NHS, the healthcare industry should be creating the structures to cooperate on devising and delivering the programmes it believes it requires, not passively accepting what is offered up by 'the centre'.

Developing real power of the payors

Finally, and perhaps most importantly, commissioning needs to develop into the local driving force of service improvement, challenging providers to be more efficient and effective and to meet the needs of patients in the most clinically- and cost-effective way. Commissioning isn't simply a funding mechanism. Commissioners need to develop different ways of assessing the real needs of the populations they serve, and effective methods to ensure that real needs are met and demand is properly managed. Above all, commissioners need to embrace the concept of being the patients' friend.

Their role isn't to protect their local hospital, simply to exist in its present form. If the hospital is uneconomic the chances are the service quality may be poor. The job of the commissioner is to

negotiate with providers what should and can be delivered in hospital and what can best be delivered elsewhere – in the community, or in a different secondary care provider – and then ensure that this happens.

Commissioners should never be satisfied. There is always room to improve quality or achieve better value. How that is done is for the providers. But the commissioners have a legitimate role in ensuring that quality and value constantly improve. If the existing provider can't or won't improve, the effective use of competition will enable new providers to show what they can do for patients.

To be most effective, commissioners and providers have to work together closely, as happens between suppliers and purchasers in other similar industries. But the relationship needs to have a strong element of effective challenge by the commissioners, if the needs of patients are to be met in the most effective way. Foundation Trusts may not like it, but it was never the intention of the policy to featherbed them.

Conclusion

The policy framework is right as is the service architecture. Resourcing is historically high (although the next few years will be difficult). But still the old culture of centralised control remains the dominant force and with it comes the politicisation of decisions and the undermining of the autonomy that is essential for change and innovation.

The only part of the system that has scarcely changed in 60 years in the Department of Health, itself the source of so many reorganisations of the rest of the system. The time has come for it to reinvent itself as the driver of change through commissioning not management. Can it seize the opportunity?



Given its importance healthcare in England has inevitably been the object of reform of different ways of organising, funding and managing hospital, community and primary care services. But are Government Ministers the best people to run the NHS? And should Parliament seek to hold Ministers to account for every last detail of healthcare provided in each and every hospital in every Parliamentary constituency?

The policy of creating Foundation Trusts was designed to create a new set of structural relationships within the NHS. The development of the new structure was, amongst other things, an attempt to create a new culture. But the old culture of tight central control – the one that NHS managers and civil servants feel safest in - still remains dominant within the Department of Health.

In this pamphlet, Bill Moyes and Paul Corrigan, the architects of Foundation Trusts, argue that the NHS needs to adopt more of the changes that allowed Foundation Trusts to flourish. They suggest 5 key changes that must happen if we are to have any chance of creating the culture that is needed in Government to enable autonomy to flourish, and with it creativity and innovation.

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