Meeting the challenge
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Contents

Summary ................................................. 2
What our members say .......................... 3
What needs to be done? ....................... 4
Changes at the frontline ...................... 5
Changes at organisational level .......... 6
Getting the local system right .......... 7
How can DH and SHAs help? ............. 9
The need for realism .......................... 13
There is no doubt that these changes should lead to significantly better services. Patients should get faster treatment in a more appropriate setting, and a more efficient and productive NHS will offer taxpayers better value for money. This will allow the NHS to build on the successes of the past few years. Implementing any one of these changes would be a challenge, but NHS managers will need to deal with them all.

The next two years will be among the most challenging the NHS has ever faced. As well as dealing with the current financial problems, managers will need to address:

- the 18-week treatment target, which will come into force from 2008
- the implementation of Payment by Results
- making the new primary care trusts (PCTs), strategic health authorities (SHAs) and ambulance trusts work when they come into operation later this year
- harnessing the power of practice-based commissioning
- the growth of a more pluralistic NHS with independent and voluntary sector providers
- managing the workforce changes required for successful delivery in the new environment
- an expectation that organisations will make significant year-on-year efficiency gains.

Summary
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Governance and leadership are key priorities. Information systems, high-quality middle management and clinical leadership are needed to support them. The lesson of the foundation trusts is that boards need freedom to lead and take responsibility. The lessons on governance are as significant for the Department of Health (DH) and SHAs as they are for other parts of the NHS. The key task is to create autonomy, a culture of improvement and communities of leadership rather than just telling other people what to do.

Commissioning must be strengthened to create productive relationships between new commissioners. This includes groups of practice commissioners and providers.

A focus on creating value for patients, designing the services and removing the blockages is a robust strategy whatever happens in terms of the reforms. It also means we can talk to clinicians and patients about the issues that are of vital concern to them. The reforms are not an end in themselves. Too much focus on each one individually is likely to mean we miss the interconnections and fail to focus on the ultimate goal.

Frontline staff can provide many of the solutions for improving services and developing better care pathways. They need a broad framework to guide them. They require autonomy and flexibility for this, but financial constraints can be a problem. Managers need to help staff to use their skills to deliver these changes.

What our members say

We have already seen a year of huge change, significant problems and a fall in public confidence in the service, so where do we go from here? We asked our members – at membership meetings, forums and through a number of detailed interviews – how we should respond to today’s challenges.

The responses were wide-ranging and thoughtful; a number of clear themes emerged:

We have a plethora of plans, but a shortage of strategy. The need to implement a daunting range of new policies has diverted managers from developing high-quality strategies for their organisations. All the policies are important, but dealing with them together is hard. They are not a substitute for a strategy that sets a direction and addresses how clinical services will change and develop.

Many of the poor encounters patients have with the health service are a result of operational management not working as planned. Therefore major attention must be paid to the detail of care delivery and the systems that support it. In particular, it will be crucial to make care more systematic and better organised.

Many of the issues we face can be dealt with only across whole health communities. The pursuit of individual organisational interest may work in some areas where choice will operate, but in many cases collective strategy is the only way to meet the needs of all patients. This conundrum of competition versus collaboration remains the biggest unresolved policy question.

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What needs to be done?

The high level of efficiency savings required this year and the low increase in the tariff are a sign of what the future holds. There will be lower growth and continued requirement to improve productivity and efficiency. In particular, there will be pressure to achieve benefits from the reforms and the investments that have been made.

However, the goal remains the delivery of a reformed NHS that feels radically better to patients and staff. The DH has described its vision for a reformed NHS in the white paper, ‘Healthcare reform in England’. This is a useful document, but it is a view from a high level and describes how the system appears from the perspective of central government.

The ambition is to create a ‘self-improving’ system, which is an appropriate aim for policy-makers. However, this is not how it will appear to frontline staff and organisations, who will have to do something different to deliver. The paper does not fully address this problem.

The reliance on incentives and implicit and explicit threats in the reform programme means that it has less to say about the action required across local health economies, in organisations or at the clinical frontline. Consequently, the policies have not been easy to explain to local staff or the public.

Many people have been alienated by the complexity of the reforms, their technical and detailed nature and some of the language of markets, competition and business. This seems to be confirmed by opinion polls that suggest staff are increasingly willing to speak negatively to others about the NHS and that the public often interpret modernisation as a euphemism for service cuts and privatisation.

Although some members have concerns about the process, the Integrated Service Improvement Programme (ISIP) contains a useful description of the principles that underpin the development of a new system. These have the advantage of talking about the goals of reform rather than the implementation of individual components (see Figure 1).

‘To enable the new NHS to thrive, the challenge is to ensure that the “market reforms” are complemented by a clear, compelling picture of the future, which is understood and owned across the NHS.’

John Bewick, Acting Chief Executive, South West Peninsula SHA

In discussions with members, there appear to be three levels of response to the challenges that NHS organisations must meet to make these principles real: changes at the frontline; strategy and operational improvement at organisational level; and health community approaches.

In addition, there are a number of actions that the DH and SHAs can take and ways in which they behave that will support these approaches.
Changes at the frontline

To meet the challenge, changes must begin at the clinical frontline. Organisations will need to create clinically based strategies to improve patient experience and outcome. These processes have to be led by clinical staff rather than imposed from above. They will need time, space and support to make these changes.

This will require the chief executives and boards of organisations to spend more time engaging with clinical staff and clinical processes, and thus less time dealing with external priorities. The 18-week target will be a catalyst, as this cannot be delivered without radical service transformation. Just running faster and more efficiently will no longer deliver.

‘Frontline managers and clinicians need the space to work on care pathways and demand management – but finding this space for development work is difficult within the current financial constraints.’

Kevin Barton, Chief Executive Officer, Lambeth PCT

A rigorous focus on what adds value to patients, the removal of the stages in the care process that fail to do so, improved safety, elimination of errors and the creation of more systematic processes are all vital. We will need to examine whether care is being delivered in the most appropriate setting, by the most appropriate professional.

The NHS Confederation has argued that we need to stop talk about shifting work between sectors as this sets up inappropriate conflict and behaviours. Instead, we must focus on designing integrated services wrapped around the needs of the patient. The primary/secondary split is an artefact of the ancient history of the NHS. Decisions about the model of care should be based on an understanding of cost-effectiveness and what patients value.

The form of ownership of out-of-hospital services should follow articulation of a clear view of what the model of care is going to be and what sort of services will be commissioned in future. A focus on value for patients must also ensure that population health is improved. This is a particular challenge for practice-based commissioners.

‘A key task for managers will be to help clinicians cope with the need to balance the individual with the community. Frontline clinicians are caught in this hugely difficult no-man’s land. Managers have to help them reconcile these two priorities.’

Martin McShane, Chief Executive, North Eastern Derbyshire PCT

Optimising the parts of the system necessary to hit a particular target will simply move the queue or bottleneck elsewhere. A lesson of the past few years is that care has to be redesigned right along the pathway. The current approach to performance management does not encourage this. The 18-week target undoubtedly requires this sort of end-to-end process redesign.

Brilliant clinical encounters can be ruined by poorly organised care, unpleasant facilities, disconnected and badly designed processes delivered with a lack of attention to detail. High-quality front-of-house and support services and the basic systems that good middle managers create and maintain are also essential. These have tended to be neglected in the pressure to meet targets. However, getting them right will be crucial in attracting patients and delivering better productivity. The public concern about hospital-acquired infection demonstrates the importance of rigorous management of clinical standards as well as infra-structure.

These frontline improvements require well-supported clinical leaders who can solve problems and have the authority to act. They also require organisations that are functioning well.
Changes at organisational level

Organisations need strategy and a focus on the detail of care delivery. This is difficult in an environment where the authority of boards can be undermined by top-down performance management. A key lesson of the past few years and of the foundation trust movement is that high-quality governance is an essential part of a successful organisation. Strengthening the board, supporting it with high-quality performance, planning, forecasting and benchmarking information and creating a culture of responsibility and constructive challenge will be crucial.

We need to replace the culture in which people are expected to look upwards. Instead we should be looking into the organisation, outwards at the patient, and across to similar organisations to compare performance.

Also key at organisational level is the development of strategies to deal with instability. The sort of clinical strategy referred to above – which provides a clear vision of what the organisation is trying to achieve – will certainly help here. It may also be necessary to become less reliant on high-cost fixed assets and to create a more flexible cost structure. Access to a banking function will be essential if providers are to be able to adjust smoothly to changes in referral patterns.

All of this will also need sophisticated strategies for changing the workforce that will need careful handling; staff will need to be closely engaged in this process. There will be a need to ensure that future workforce requirements are identified and that appropriate training and role design is put in place well in advance of the needs arising.

One significant change for organisations is that, for many years, success in the management of provider services has been defined by the speed and size of growth. The rules have now changed. How effective the organisation is in delivering high-quality safe care and the extent to which it is financially viable are now far more significant measures of success.

Creating flexible, innovative and responsive organisations that provide excellent care, even if they are smaller at the end of the process, will be a much more successful strategy than creating ever larger but less flexible organisations that never quite manage to achieve the promised economies of scale or increased market share.

‘Some long-standing pressures are coming to a head that will mean we must look at the existing configuration of general hospital services – for example, the working-time directive and higher specialist training reforms. Reviewing the configuration of hospital services may also be one of the major ways we can address the current financial difficulties.’

Mike Deegan, Chief Executive Officer, Central Manchester and Manchester Children’s University Hospitals NHS Trust

‘It is about developing a culture in the NHS which is about shared leadership. Managers need to invest time in helping clinicians become effective leaders.’

Alwen Williams, Chief Executive, Tower Hamlets PCT
Getting the local system right

A well-designed pathway will fail if the rest of the system does not work, and a dysfunctional system can undermine the best-run organisation. While the shape of elective surgery and diagnostics may be determined by the operation of a market, a number of other services require collaboration, networks and joint working. In many health communities, if there is not a shared approach to the development of strategy and each organisation pursues what appears to be its own best interest the results could be disastrous. The only solution to some of the hardest challenges will be through reconfiguration that cannot be achieved through the operation of market forces. A plan will be required, along with some very mature behaviour and significant courage at every level, including the political.

Systems need to find ways to work together to solve problems, but without removing the edge that the other mechanisms in the system are designed to create.

They must overcome some of the disincentives to ‘doing the right thing’ – for example in the management of long-term conditions where hospitals that help to improve disease management lose income. They will need to work together to define and develop the networks required to deliver cancer, emergency care and a number of specialist services.

They will need to understand capacity and demand to know whether a shortage of capacity or delays in the flow of patients are causing problems in meeting the 18-week target. They will need to have a comprehensive view of how pathways work across the system to be able to manage demand. There will have to be ways to share the risks and benefits when participants come together to manage patients in new ways. Simply unbundling the tariff is unlikely to be sufficient.

‘Some of the internal efficiencies trusts have made will have to expand into the whole system pathway. This is problematic when financial incentives are not in place to help achieve this and there are inherent problems in the system that could prevent it moving towards more efficient ways of working. The NHS needs close and collaborative relationships – where partners can see past [the] disincentives to co-operate – more than ever. This sort of mature market management will have to be encouraged – and that would be the role of SHAs.’

Julian Nettel, Chief Executive, St Mary’s NHS Trust

‘We must increasingly look at how we provide services across organisations and look to develop a series of incentives for collaboration, to sit alongside the push for greater contestability. Handled well, this can help us move the debate on from a sterile one around closing individual institutions to one focused on using our hospital stock flexibly and fluidly to support the broad direction set out in the white paper.’

Mike Deegan, Chief Executive Officer, Central Manchester and Manchester Children’s University Hospitals NHS Trust
Perhaps the most crucial set of changes is the development of high-quality commissioning. Making practice-based commissioning work is seen as a key part of this. Efficiency and reform are not just about getting the detail of each clinical encounter right. It is also important to ensure that the entire system operates efficiently.

Beyond this, there is the even more challenging question of how to allocate resources efficiently so they are used in the most cost-effective way across the range of options. Key stakeholders, the practices, the public and patients must be fully engaged in these decisions.

Of all the good commissioning ideas being developed, two components stand out as being essential to support this type of strategic approach: programme-budgeting approaches and a quality and outcomes framework that covers the whole system. Commissioning for the future and creating the strategic framework to make the most of practice-based commissioning will require commissioners to be given space and time to develop their own approaches. SHAs will therefore need to adopt new styles of leadership and facilitation.

‘Commissioners need to be clear about what they actually want to commission and to have proper service level agreements... good commissioning is the key to resolving the financial problems.

Commissioners may also need to make tough decisions about disinvesting in some services: this needs to be well articulated and supported by evidence, and to engage the public, other individuals and organisations, such as MPs and overview and scrutiny committees. This will be a major challenge.’
Anthony Marsh, Chief Executive, West Midlands Ambulance Trust

‘Practice-based commissioning offers a two-way track for finance to flow between the acute and other sectors. This will need a greater maturity of relationship between providers and commissioners. Primary care has to accept responsibility for how it manages resources and the quality of services that are being delivered – although the quality and outcomes framework for GPs is a useful start. There will also be the need for a continuing dialogue with the public at all levels, which practice-based commissioners are well placed to deliver alongside PCTs.’
Martin McShane, Chief Executive, North Eastern Derbyshire PCT

All these changes will continue to require investment in the workforce and information systems and new and more appropriate buildings and equipment. These investments need to be driven by the clinical strategy and vision for the system, not the requirements of a centrally set policy. NHS Employers, acting as the agent of local employers, has a key facilitative role in this process.
How can DH and SHAs help?

New organisations and a new system mean that it is time for a new relationship between the centre, SHAs and the NHS. Members have identified a number of changes in the way this should operate to facilitate the development of strong organisations capable of operating independently and confidently as a part of local systems.

Perhaps the most significant issue relates to leadership style. The service needs the new SHAs and the DH to find ways of working that reflect the new system that is being created. The key changes might include:

• developing leadership locally rather than dictating to communities. Leadership should be collective, and the expertise and commitment of all organisations in a health system need to be used. This means resisting the temptation to second-guess local leadership, and ensuring that any interventions are really going to be helpful

• supporting responses across whole health systems. SHAs need to become more strategic and concentrate less on performance management. The development of a sophisticated market-management function will be essential in achieving this. There must be appropriate behaviour at all levels

• defining success more clearly but in less detail. This will involve developing light touch, proportionate monitoring and recognising that organisations are starting from different points and have different constraints. This will require the skills of managing diversity and the proper use of discriminatory data to allow incipient failure to be identified and prevented. The failure of an individual organisation must be seen as the failure of the entire community, including the SHA

• helping to bringing commissioning to the fore. The risks around practice-based commissioning must be balanced against stifling innovation

• creating mechanisms to allow more flexibility of capital and workforce, for strategic readjustment, double running and for organisations to shrink their cost base when their income changes. A strategic banking function will be essential

• ensuring organisational stability. This is important in the next few years and structural reorganisation should be avoided

• ensuring the key values of honesty and mature behaviour. These will need to be reflected in everything NHS management does.

‘We have to stop the culture of bullying, performance management by shouting and telling people to just do it, even when the person telling you has no clue about how to, and the task may even be impossible. In the past, we have been asked to sign off plans that we knew were beyond heroic. The people telling us knew it too, but still insisted. Some hard questions need to be asked about where this sort of behaviour comes from and why it is tolerated.’

A PCT finance director (with 15 years of break-even or surplus budgets)

‘The NHS needs a culture that allows frontline staff and organisations to devise their own solutions to problems rather than adopting a prescriptive, top-down approach. Helping to foster that approach is partly a task for the new SHAs as they performance-manage organisations, but PCTs also need to give clinicians a framework to work within as well as latitude and flexibility to devise appropriate solutions for their areas. This is particularly important with performance-based commissioning.’

Alwen Williams, Chief Executive, Tower Hamlets PCT
In particular, further work is required on the design of the tariff. It does not effectively support delivery of care through networks. Neither does it support the management of specialist services where capacity is needed irrespective of patient flows (for example in burns units). Capitation methods may be better than episodic payments for a number of services. Unbundling is unlikely to be the comprehensive answer that some seem to believe.

Creating coherent policy means addressing some of the difficult trade-offs and dilemmas that have been ducked or left ambiguous. In particular, the balance between competition, incentives, planning and system management should be made much clearer. Market mechanisms have their limits as a way of achieving change – but what is the correct balance? Decisions will have to be made about the fragmentation that can come from some versions of choice and new provider models and the integration and continuity that some types of service require. There are decisions to be made, too, about how much stability can be created without undermining the force of the reform programme. We will need to consider how failure will be dealt with while maintaining local services, particularly for emergency services.

We will have to learn to deal with multiple simultaneous relationships with other players in the local economy – as competitors, collaborators and partners. The commercial sector has had to deal with this complexity and now the NHS must learn to do the same. In addressing these issues, the service must be closely involved in the design of policies. It can then ensure that incentives are not perverse – only those on the ground can properly predict the outcome.
The centre also needs to provide clarity about the way forward and the planned balance. This should happen as soon as possible to avoid any repetition of this year's problems when the late tariff-setting, changes to the purchaser parity adjustment and the top-slice led to sudden, unexpected financial pressure on organisations, which nullified all planning. In the short term, early publication of the tariff and planning assumptions will help. In the longer term, an independent tariff-setter could assist.

Those involved in designing policy must also:

- remember that incentives are high-powered and must be carefully designed
- recognise that contracts, while important, are a safeguard when trust and relationships fail. In most markets, however, tariffs are a guide and high-quality relationships between people with the initiative and intelligence to make things work are more likely to succeed than a set of rigid rules designed at the centre
- help the public understand that some of the fundamental changes – for example that the implication of shorter lengths of stay is fewer beds – are improvements in patient care
- provide political support for unpopular moves, such as altered roles for some hospitals because of manpower and technological changes
- get rid of the blame culture, which can end good managers' careers and is deterring potential leaders from aspiring to become chief executives
- recognise that the benefits of structural changes and mergers are as elusive as those from economies of scale. It is important not to try to solve problems by resorting to organisational change
- understand that not everything can be achieved in one year and that implementation that delivers sustainable change will take longer than the design of the policy
- experiment and pilot new approaches and recognise that some of these will fail if we are to be ambitious. Pilots must not move to phase-one implementation without evaluation.

“There is an urgent need for the DH to help change public perceptions on, for example, bed numbers, by trying to educate the public that shorter hospitals stays are good news.”

Claire Perry, Chief Executive, Lewisham Hospitals Trust

“I would like to see an independent tariff-setting organisation like the Bank of England. It would remove tariff-setting from political interference, which is important in a mixed market.”

Mike Cooke, Chief Executive Officer, South Staffordshire Healthcare Foundation NHS Trust, a mental health trust

“The DH needs to think through the results of its policies and ensure there is clarity across policies. There are real benefits in involving the people who have to implement the policies in assessing their risks. I want to see more sophisticated thinking about markets. Different parts of the NHS face different market challenges, and that should feed back into commissioning.”

Stuart Bell, Chief Executive, South London and Maudsley Trust
A third category of action includes dealing with some of the rough edges on policy. Members want to address the perverse incentives and rough edges in the reforms as quickly as possible. They want guidance on key areas quickly, as well as clarity on the roles of the different levels within the system. This means:

- revising the system of accounting that ‘double counts’ past deficits and finding a way for longer-term payback to be made
- removing the disincentives to collaborate in Payment by Results, and the penalty of having new capital investments and private finance initiative
- sorting out the regulatory arrangements for the new system
- ending the long wait for a failure regime.

‘[We need] better-modelled policy that looks at its effect on the whole NHS system. If the DH, under pressure to see change happen quickly, is unable to see the relationships between different policy strands, then that is very dangerous. There really is an issue not just about seeing the impact of individual pieces of policy, but aligning different aspects of policy.’

Kevin Barton, Chief Executive Officer, Lambeth PCT

‘There is a mismatch between apparent DH perceptions that change locally is slow, whereas at the grass roots, the opposite is felt.’

Claire Perry, Chief Executive, Lewisham Hospitals Trust
The need for realism

The scale of the reforms is still enormous. Realism is required about how all the changes are to be managed together in a system that external, informed commentators regard as under-managed. In small organisations, policy developed by many different sections at DH requires implementation by a single manager in a PCT or trust. The challenge is to ensure that changes are properly managed and not rushed, otherwise error will creep in. Success needs to be measured, not by ticking the boxes to say that the policy has been implemented, but by the results of a reformed health system for patient care.

The dogmatic pursuit of targets should be replaced by more direct measurement of patient experience and outcomes. This should focus on value for patients, population health and inequalities and the whole system of care. The danger remains that we chase targets, hit them, but miss the point and fail to make care better.

Just achieving any one of the challenges facing the NHS would be a major achievement for any organisation in another industry. One issue is that the pace of reform has meant some changes have been mechanistic rather than real, and the NHS now needs to move towards real reforms.’

Julian Nettel, Chief Executive, St Mary’s Hospital Trust.

This document represents work in progress and we would be very interested in hearing members’ views about how the Confederation’s work programme could be developed. Contact nigel.edwards@nhsconfed.org
Meeting the challenge

The next two years will be among the most challenging the NHS has ever faced. As well as dealing with the current financial problems, managers will need to address:

- the 18-week treatment target, which will come into force from 2008
- the implementation of Payment by Results
- the growth of a more pluralistic NHS with independent and voluntary sector providers
- managing the workforce changes required for successful delivery in the new environment.

This report explores how we should respond to these challenges, what changes need to be made at the frontline and at organisational level, and how we can get the local system right.

The NHS Confederation believes that this report is important reading for all those involved in ensuring NHS organisations are effectively run and supported in delivering high-quality healthcare.