ONE FOCUS

WHAT IF?

VIEWS FROM THE COAL FACE OF CHANGE IN THE NHS

MARCH 2019

PRACTICUS™

NHS

WELCOME

When the NHS celebrated its 70th Birthday in 2018, the government announced £20bn a year in extra funding by 2023. As NHS leaders announced their long-term plans at the start of January 2019, outlining how they will spend that money, we at Practicus thought we'd invite the views of a group of people seldom heard from, to see how they'd improve the NHS.

The group we spoke to are all Turnaround and Improvement professionals on the front line of making the NHS a better service.

We asked each of them the same question:

"PUTTING ALL POLITICS ASIDE, IF YOU COULD CHANGE ONE THING ABOUT THE NHS, WHAT WOULD IT BE?"

What follows are their individual responses. These professionals come from across the spectrum of NHS institutions and functions, from CCGs, Acutes, Mental Health Trusts and Community bodies. They cover operational as well as financial turnaround and improvement within every quarter of the service.

The report represents a broad church of views and touches on everything from funding to sustainability, from standardisation to taking politics out of healthcare. We are not presenting this collection of opinions as anything other than the honestly held views of professionals who are passionately engaged with improving our NHS.

Our purpose here is to create a platform for valuable insights from those who ordinarily you wouldn't hear from.

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COMMENTARY

There is not a single person or family up and down this country who has not at some time relied on our great NHS.

As CEO of an international business, I've had to do more than my fair share of travelling. I say from first-hand experience of talking to people in Asia and the Southern hemisphere, that the perception of the NHS could not be higher. They overwhelmingly see our public health system as the 'Gold Standard' in the world, an institution to be cherished.

Sometimes it's helpful to get an outside view, or a back to front perspective. Practicus has been supporting the NHS for 15 years. In that time, the professionals we represent, many of them improvement or turnaround specialists, have carried out in excess of 5,000 NHS assignments on our behalf.

In compiling this report, we wanted to bring to light the views of some of those professionals. There's no political angle here, indeed we've specifically asked the contributors to leave politics aside. Our genuine ambition is to bring a constructive and practical contribution to the debate about the future of an institution we all hold so dear.

Thank you for reading...

DARREN TOLHURST
CEO, PRACTICUS LTD.

STANDARDISATION OF FUNDING

PETER O'NEILL
TURNAROUND LEADER

Peter is a Turnaround professional with a background in NHS finance, and operational management. He's worked across a number of acute providers and CCGs on everything from CIP management and QIPP leadership to directing full-scale turnarounds.

IF I COULD CHANGE ONE THING...

I'd use the average income per specialty information to achieve standardisation of funding to providers across the NHS. National data exists or can be generated that would provide a basis for comparison to a peer group of similar providers at a specialty level. The proposal is that this would be driven at a national or at least regional level, to promote a consistency of approach. Providers where possible would be funded at this average, leaving the only commissioning decisions to be about volumes or known changes of mix due to service/pathway changes.

This would provide support for the development of stable and sustainable services – variances being based on cost of service delivery only. It would also provide a clearer and more consistent view of efficiency opportunities – as services could be benchmarked against 'normal' spend and income patterns of the peer group. Regulators would have the power to mandate health systems (through STPs) to manage any differences to within agreed tolerances. With the ability to freeze all or some of the CCG growth until any differences are addressed, STPs/Commissioners wouldn't be able to spend money on investments they couldn't afford.

The approach would contribute to the development of joined up health economies/STPs, avoiding the destabilising impact of financially challenged providers within those health economies. Clinical coding and activity monitoring and counting would be done through a single hub arrangement, managed by the STP and independent of providers. This would eliminate the differences in coding (up coding issues) and ensure consistency of approach. Indeed, centralised coding would make clinical and non-clinical comparison and benchmarking exercises more meaningful. Moving to one health economy wide coding/information department would generate significant economies of scale.

Mobilisation would require the STPs to have the ability to access contingency funding, either through existing growth or additional funding to phase any differences in over an acceptable timescale, avoiding destabilising providers.

MANAGING AT SCALE

CHRIS HUCKLE
TURNAROUND DIRECTOR + CONSULTANT

Chris is a turnaround and transformation senior executive who has worked across the NHS and Independent Healthcare. He specialises in helping organisations in difficult situations to achieve transformation, stability and success, whether it's an NHS Trust or a £2bn turnover corporate.

IF I COULD CHANGE ONE THING...

It would be with management structures. The great companies have one thing in common: a world-class management system. One that cascades from top to bottom of the organisation, allowing management of their business at all levels and a clear line of sight from board to shop floor. One that links organisational, operational and individual performance. One that looks forward, allowing management to intervene with support where risks are emerging rather than after they have hit.

One such great company is the IBM Corporation. IBM and the NHS are of a similar nature: the NHS runs with a budget of around £125bn, IBM one of $80bn. IBM has 380,000 employees, the NHS one million plus. The NHS has an inherent complexity with the separation of purchaser and provider and a plethora of separate organisations and arms-length bodies. IBM meanwhile has the challenge of operating, managing and reporting from 170 countries. Most importantly, both rely on and value immensely intellectual capital. Both have management systems in place that combine people, organisation and management information in a series of defined meetings and reports. Both bring great good to the world. However, they manage themselves very differently.

At IBM the management system is the very heart beat of the organisation. Its supportive and ubiquitous nature ensures that economics is a balancing consideration in all they say and do. Senior development engineers understand that a commercial focus ensures that more can be reinvested in primary, world-changing research and development. Account managers understand that less spent on airfares is more invested in developing customer-oriented solutions.

This powerful blend of culture and system is achieved through excellence in leadership, management and information. Executives ensure that quality and economics are both at the heart of every discussion. The majority of management meetings are one-to-one ensuring that both parties know their business intimately. Management understands they're accountable for delivery and that their primary role is to help their report be successful. The system is supported by up-to-date accurate information structured so that current performance and likely outcomes are balanced with risk highlighting areas that the management team need to focus

on. Meetings focus on how risks can be mitigated, and performance is improved with both parties contributing.

The NHS manages very differently. The reliance on committees and general meetings, many of which are statutory and limit individual accountability, creates a permafrost layer between senior management teams and operations, as well as limiting the essential transfer of knowledge and values that one-to-one meetings bring, a learning approach that is deeply embedded in its clinical approach. Locally developed solutions result in poor information and weak management reports that make it hard to manage and break the essential top to bottom management cascade. Lack of management training and experience allows the debate to gravitate to the crisis of the moment with few discussions focusing on the operational economics of the organisation.

The solution is to establish a national management system that covers the length and breadth of the NHS, allowing global roll up and down. The defining of standard approaches for similar units, such as Trusts, would allow the adoption of best practice and make management transfers more effective. National standard formats for management information and reports, with the necessary investment in management information systems, would have the added benefit of improving management line of sight.

Great training for all line managers, with a focus on work-place coaching, is essential. As part of this programme all managers would be encouraged to meet one to one with their direct reports on a weekly, monthly and quarterly cycle. Also encouraging cross-industry learning through secondments and 'teach first' types of initiatives would greatly enhance the development of the management system.

Resource for health care will always be limited. Having a management system that can make the right economic and quality based decisions is essential if we are to have a thriving world class health care system.

IT WOULD BE WITH
MANAGEMENT
STRUCTURES.

INTEGRATED TALENT MANAGEMENT

CLARE STEWARD
PROGRAMME DIRECTOR

Clare is a successful and highly experienced senior System Leader, with more than fifteen years of senior NHS Board level experience, as an STP Programme Director and Advisor, CCG Accountable Officer, PCT Chief Executive Officer and numerous other Executive Director roles. She specialises in supporting the NHS and its partners to deliver highly complex strategic change programmes.

IF I COULD CHANGE ONE THING...

It would be for evolving health and care systems to have available the workforce they really require.

Fundamentally, we are in a place where the services that are there to support the health and care needs of individuals, do not have the key individuals they need to do so. For several years now, it has been well-recognised that professionals in key disciplines are in desperately short supply. This issue is prevalent across all areas of the health and care sector, resulting in an inability to deliver optimal care.

As part of the work that I typically do, whether it is bringing systems together, reconfiguring current service provision or within the world of primary care, there is a consistent need to try and re-orientate the way in which we attract, resource and optimise.

What might it be like if, instead of competing across organisations and sectors, we were to look towards establishing a workforce that coalesces around an integrated care system? A provision where the opportunity for our most valued assets goes beyond portfolio careers, to that of an enterprise model that promotes individual ownership, along with an employer commitment that engenders trust and commitment to those staff.

As leaders, we are only as good as our staff and therefore we need to take responsibility, invest and promote a dynamic culture of value and ambition.

BREAKING DOWN BARRIERS

KAREN WATKINS
PROGRAMME MANAGER

Karen is a programme manager with over 20 years' experience working within the NHS. She has worked across the acute, commissioning, community and mental health arms of the service – working on change programmes ranging from large PFI projects, implementation of national directives (e.g. Polysystems, MH pathways) and local change initiatives.

IF I COULD CHANGE ONE THING...

Aneurin Bevan, Minister of Health in the post-war Labour government, insisted that 'the self-contained, independent local hospital is nowadays a complete anachronism'. The implication was that the development of health services required a modern, integrated organisation with appropriate links between hospitals and primary and community services (The past and future of the NHS, John Mohan, 2003). Nearly 70 years later I believe we still haven't truly achieved this. Yes we have joined up technology, MDTs, system wide ops groups, patients groups, national conferences and confederations etc. But at a fundamental strategic level we still don't truly work together. Distrust between the various arms of the NHS remains and we never fully share information with our partners (and sometimes even within our own organisations), only 'giving up' what we absolutely have to. System wide decisions are made on half-truths and without the full picture and every five years or so we change everything simply because "it's not working". Projects and programmes are often disbanded after huge amounts have been spent on them, because priorities in one arm of the system changes and interest is lost.

If I could change one thing (politics aside) it would be to take a sledge hammer and open the whole lot up, take away the barriers, share information openly and work as a truly single organisation, only then will we be able to get to the root cause of our problems and solve them together.

'... TAKE AWAY THE BARRIERS, SHARE INFORMATION OPENLY...'

PERSONAL RESPONSIBILITY

GAIL NEWMARCH
TURNAROUND DIRECTOR

Gail is an interim director focussed on system resilience, turnaround and world-class commissioning. She has more than 15 years' experience looking across these challenges in very different health economies across the country.

IF I COULD CHANGE ONE THING...

If I could change one thing about the NHS, it would be to reduce its paternalistic culture in favour of real personal responsibility. The value and place of the NHS is not in question, nor is its contribution to the quality of all our lives. But something needs to change if policies on personal responsibility are to embed more widely.

Increased demands, workforce and service costs, create pressure at every point of health delivery. Yet analyse the data of any GP practice or Hospital and see the variations in diagnostic testing, emergency thresholds for admission or even prescribed medication. Our clinically led health system needs to shift in favour of patient led decision making. Do I need the chest x-ray my GP just prescribed? Does the frail elderly person picked up by Ambulance following a fall need to go to hospital when the paramedics have assessed there is no injury? But to be safe he/she will. Once there, diagnostics tests will find something wrong – or even just because it is late at night – a clinical decision to admit will likely follow.

Might it be better to find ways to have a different conversation with patients, with information and options to help them make and own the decision? I went out with an ambulance crew and heard first-hand the number of 80+ aged patients say they didn't want to go to hospital. But their voice is inaudible over the warnings and cautions and ultimately a decision is made for them.

End of life care is perhaps the pinnacle of this position. Most of us don't want to die in the current pathways of repeat emergency admissions or on a hospital ward. In pursuit of value, quality of care, but mostly personal responsibility – isn't it time we truly empower individuals and families to make informed decisions about their care?

HIGH-END ASSURANCE

AMANDA ALLEN
GOVERNANCE + RISK MANAGEMENT SPECIALIST

Amanda is a PRINCE2 qualified Senior Healthcare Leader & Clinical Governance and Risk Management Specialist. She is expert in transforming operational processes across Healthcare to strengthen regulatory compliance and clinical effectiveness.

IF I COULD CHANGE ONE THING...

The NHS is steeped in history and tradition, and has a strong surrounding infrastructure to support regulatory compliance, but sometimes this can lead to compartmentalisation of roles. I would change the way we think about clinical governance and how it sometimes gets separated out from operational and financial activity.

The return on investment to be gained from the implementation of a robust governance framework can get overlooked in times of competing financial priorities and strict budgetary controls. The commercial and reputational impact of poor CQC compliance ratings is well understood, but the strategic benefits to be gained from high-end assurance activity can be less well explored.

Let's look at the CQC Domain Effective. Many people limit the definition of 'clinical effectiveness' to patient outcome, and debate on this is often consigned to the clinical directorates, but an integrated approach when discussing effectiveness of a service or intervention across finance, operational and clinical departments enables this concept to be explored more holistically.

For example, business cases for introduction of new technologies frequently cite research-based outcome data to secure funding. However, this does not mean that the same outcomes might be achieved by that organisation. What is the population health profile like? What environment will the technology be deployed into? How would the patient outcomes impact be measured financially? What other innovations might need to be abandoned to enable the business case to succeed? When we think 'clinically effective', should we not also think what would be most 'operationally and financially efficient' for the patient, the healthcare organisation, and the wider population together?

STUCK AT THE BORDER

JAYNE TUNSTALL
HEAD OF SYSTEM RESILIENCE

Jayne has over 26 years' senior management experience, including as an NHS Acute Trust Executive Director, and is known for taking troubled Acute Trusts from a struggling position to one of high performance. She's run hospitals in both the NHS and the independent sector and has specialised over the last few years in system-wide resilience and urgent care transformation across primary, acute and community service providers.

IF I COULD CHANGE ONE THING...

It would be around the "connectivity of care" and effective seamless "handovers" – or dare I say it, have no "handovers" at all!

It is widely known that with every "hand off" at least 1-2 days delay are inbuilt into the patients journey – which can lead to more mistakes, confusion around who has done what already, deterioration of the patient, re-reviewing patients and Community out-of-hospital staff having difficulty locating and receiving patients. The result is that patients remain in hospital unnecessarily, putting them at considerable risk.

From personal experience, I know how vital it is for patients to get home as quickly as possible and for doctors and Nurses not be so risk averse when discharging – it's amazing what people can do once they are back home in their own familiar environment.

However, the support network required is vital upon initial discharge – maybe a couple of nights 'night-sitting', just to give patients and their relatives a chance to gain some confidence, so that they don't resort back to dialling 999 when they feel unable to cope. If the care and support is front loaded and then the appropriate care given thereafter (but reviewed regularly), it can promote independence.

It might seem an expensive approach, but I can guarantee many savings can be made further down the line, together with the ability to speak to someone who is familiar with the patient (not 999).

My dad is 89, has dementia and lives on his own with family support and carers twice a day for 1 hour. He is happy, safe, clean and in some ways quite independent. Usually, we are too quick to put in "heavy" packages without fully assessing what people can actually do in their own home.

So, how could this be achieved given the financial constraints?

The way I think this continued seamless care could take place successfully is that every patient who is not self-caring, be assigned a Care Pathway Coordinator who is with them in Hospital and then follows them home. Care can decrease quickly if not needed, releasing care givers, or increased if it avoids the need to attend hospital. Nothing new you might say, but nowhere

I know does this happen consistently and sustainably.

Adopting this would definitely keep more patients safe at home - reducing demand on care establishments, promoting independence and providing assurance to loved ones who do feel the stress of ever changing patient care plans. Having confidence that the service is responsive, rapid, appropriate and timely, could prevent major financial losses, but more importantly, prevent patients going into care unnecessarily.

We thought Dad wouldn't be able to stay at home after losing mum. Oh how he has proved everyone wrong...! He has been given personalised appropriate care tailored to his individual requirements (what he wants), that can be responsive and adjusted as required.

It's priceless to see someone having a good quality of life. If only a bit more time was given to the individual in our business - what a difference we could make.

STUCK AT THE BORDER

JAYNE TUNSTALL
HEAD OF SYSTEM RESILIENCE

RESTRUCTURING FUNDING

STEVE BURKE - TRANSFORMATION + TURNAROUND PROFESSIONAL

Steve is a qualified Chartered Accountant who has worked for both larger international groups and smaller entrepreneurial companies. Over the last 12 years, he's used his commercial, corporate finance and business turnaround experience from the private sector, to help drive significant improvements in financial and operational performance in public sector healthcare. He provides expert consultancy support in transformation and turnaround, strategic planning, financial management, project management and has helped a number of Trusts significantly improve their financial position.

IF I COULD CHANGE ONE THING...

Having spent over 12 years in the NHS in a variety of consulting roles – mainly focused on transformation and turnaround challenges – I have seen huge change. Some of this has been progressive but unfortunately, a lot has been unsuccessful, failing to deliver both sustainable benefits for patients and staff, or efficiency gains and financial improvement.

A key factor, which I believe is causing sub optimal and inefficient delivery of healthcare, is "Silo working". I refer to organisational structures that lead to poor integration of working practices, resulting in inefficient allocation of resources and also in conflicting objectives and priorities. This is most obvious at the Macro level. Examples of this are the major reforms in 2012 and more recently, the development of artificial structures, including STPs and ACSs, in an attempt to improve integration and allocation of resources. These initiatives are simply a reshuffle and re-badging of existing resources and fail to address the root cause of the problems, often creating new barriers to joined-up thinking and coordinated healthcare delivery.

A major cause of the inability to develop effective integration of services and coordinated working across the wider Health Care Systems, including the NHS, is the way in which resources are allocated and financial budgets are set. Financial budgets follow artificial organisational structures from the top to the bottom of the whole system and the achievement of these is seen as the key measure of "success" and "efficiency" in today's financially challenged times. This often leads to resources being allocated in an illogical and inefficient manner, sometimes resulting in perverse human behaviour, simply to hit targets that are not aligned with the delivery of successful patient outcomes.

As a Finance Professional, I completely understand the need to operate within existing budgets. However, it is time to examine how the allocation and delivery of funding can be structured in a way which incentivises best practice and coordinated actions from the bottom up.

QI TRAINING

SHARON JEFFREY
QUALITY + INNOVATION CONSULTANT

Sharon has been dedicated to the NHS for 32 years, working in many senior managerial roles across various areas (secondary care, commissioning and regional). The last 18 years have been dedicated to quality improvement and innovation - working at local, regional, and national level. This includes delivering many transformational redesign programmes. Her work has been presented at national forums, including the Institute for Health Improvement (IHI).

IF I COULD CHANGE ONE THING...

After training over a thousand leads and clinical staff in the use of Quality Improvement (QI) tools, I am passionate about skills and capability building for NHS staff. If we always do what we have done, we will get the same results. I have come across far too many staff who know, or have heard of an improvement approach, but without coaching and support they are just tools. So, my change would be to have QI skills programmes for all staff, with coaching to deliver well in all organisations.

The aim is the widespread improvement of delivery for sustainable change. As a key component of this, we still only hear a tiny amount of the patient voice at local QI delivery. Patient focus groups, feedback, questionnaires, friends and family surveys are all helpful. However, truly engaging patients in the QI workshops and/or rapid improvement events is essential.

I know it can be unsettling for staff "airing problems in front of patients", but in my experience the input has been invaluable and promotes a balance of positive feedback versus improvement opportunities. Patient experienced-based design methods have been available from NHS Institutes for over 10 years, but in my experience have limited utilisation. Using video feedback clips via a booth/room, or even a taxi! (Yes, I have experienced the results) is so empowering. The material/knowledge can be used as part of sharing with QI rapid improvement teams, system-wide events and engaging clinicians/nurses and management.

In summary I would enhance support and development of QI skills programmes for all staff, alongside coaching, specific goals and use of the skills on local work, which must have executive backup. A key component is to engage patients directly in local/frontline work and truly hear their voice, both the positive feedback and the improvement opportunities.

'... QI SKILLS PROGRAMMES FOR ALL STAFF...'

SUSTAINABLE LEADERSHIP

OBI HASSAN
TURNAROUND + TRANSFORMATION DIRECTOR

Obi helps NHS Trusts and private sector organisations facing financial challenges to turnaround, transform and improve, and to sustain those improvements for the long-term. He has been doing it within the NHS for over 12 years and he puts his success down to a belief that sustainable organisations require a balance of inspiring leadership, sound finances, excellent quality of care and strong operational performance. He is strongly opposed to 'slash and burn'.

IF I COULD CHANGE ONE THING...

It would be the approach to recruitment, retention and development of leaders and leadership teams at all levels of the NHS. Transformational change requires inspirational leaders. We need to transform the way the NHS attracts, develops and supports leaders to deliver change, by giving them the autonomy to make things happen and allowing them to lead the way through uncertainty on the long journey to sustainability. The NHS is struggling to meet the needs of an ageing population and the increasing prevalence of long-term conditions that requires fundamental changes to how health and social care are delivered.

Whilst additional money is essential, it alone will not solve the funding crisis. The investment must be used effectively to transform services that deliver short-term stability and-long-term sustainability. This means balancing both quality and finance. Yet many Trusts who are facing financial and quality challenges, or find themselves in special measures, often focus on short-term fixes. Too often, these Trusts emerge from a turnaround and struggle to sustain those short-term improvements.

We need to empower Trusts by equipping their management and staff with the skills, knowledge and resources necessary to not only overcome their challenges, but sustain the improvements delivered. Often, Trusts know what the problem is but lack either the capacity, capability, energy, drive or skill-set to deliver above and beyond the 'day job'. They look for short-term financial fixes – often responding to pressure from the system – to what are so often longer term problems and don't support staff to give their best, nor manage those out that don't.

Sustainability is about behaviour and culture change, not learning more advanced technical skills.

This approach will be more cost effective, quality focused and develop the required skills within the NHS. And it will deliver sustainable financial and quality improvements, by driving real efficiencies and transformation in new models of care, to make the NHS, as we know it, affordable again.

LONG-TERM PLANNING

KEITH DIBBLE
ASSOCIATE + DIVISIONAL DIRECTOR

Keith has worked as an interim for five years, prior to which he was substantively employed in the NHS at Associate and Divisional Director level, primarily in the Midlands. The bulk of his experience has been in the area of Planned Care – Surgery and Women and Children's Services – although he has other medical specialities as well. This pattern has largely continued in his Interim work, although his focus most recently has been around Mental Health transformation.

IF I COULD CHANGE ONE THING...

Apart from the obvious wish for enhanced funding to arrive, the greatest limitation I have found with the NHS is the inability to plan service delivery (and thereby cost savings) over a long period.

Short-termism stymies innovation and compromises true service transformation. I have seen too many sound medium to long-term strategies either cut short or watered down, so that achievements are greatly restricted. Changes in work-force models, for instance, can provide not only long term sustainability, but also greater economies of scale.

To give an example, in Ophthalmology, widespread use of optometrists and nurse practitioners will create a robust workforce for the future at a lower cost, as well as make better use of scarce medical resources. But this requires a minimum of a two-year lead-in, which in itself is likely to involve some double-running while staff are recruited and trained. The result then is often a scaled back version of the plan, with insufficient staff being brought into the frame, and therefore a less than sustainable solution being put in place.

If the NHS genuinely wants to follow three, five or ten year plans, funding needs to be made available to support longer term developments with genuine strategic direction, where evidence of real transformation can be provided. There are limited numbers of examples of this where excellent progress can be made, but generally the requirement to achieve the current year's QIPP or CIP target prevails at the expense of the real change.

I felt this to be the case when employed substantively, but it has become even more apparent when I have been brought in to an organisation specifically with a transformational remit, only to find that the reality demands transactional change only.

This is beginning to change as Trusts are forced to work together to deliver health economy-wide improvements, but some of the entrepreneurial spirit within each organisation is often being repressed. To make real and lasting change, it needs to be unleashed.

UNNECESSARY VARIATION

LUKE O'BYRNE
PROGRAMME MANAGER

Luke has a broad range of experience in Strategy, Nursing, Operations and Governance roles in CCGs and Trusts, as well as senior experience from CSU, Education, Council and SHA environments. He specialises in developing community-based services, improving clinical and wider governance systems and working in partnership to deliver sustainable improvements.

IF I COULD CHANGE ONE THING...

About the NHS it would be its lack of consistency.

I spend time in a lot of different organisations and there are significant variations in practice that can mean less than optimal clinical care for patients, as well as additional unnecessary expense.

One example of this is that in some areas people are given injections of an anti-coagulant after an operation and in others they are given oral medication. If a person is unable to do their own injections, a community nurse may be required to do this (with all the additional expense of multiple visits). In some areas, this is sorted out following discussions with surgical teams. In others, the much pressured community nurses struggle on. And elsewhere, it is sorted out for some patients but not as a protocol for everybody.

This lack of consistency is different in other sectors where unnecessary variation is recognised as the enemy and considerable effort is made to standardise systems and processes.

While I understand that all patients are different and that we do not want to stifle individual clinician's freedom to act and innovate, the important thing is to reduce the unnecessary variation.

As a patient, I want the best possible treatment and as a taxpayer I want to ensure that a pressured NHS budget is spent as effectively and efficiently as possible.

THE PRIMACY OF PRIMARY

RIAN LAMPRECHT
ADVISOR + PROJECT MANAGER

Rian has provided services to the NHS for more than twenty years, has a PhD in psychology and an MA in clinical psychology. He has seen how leaders step away from intuitive strategy, mission goals and meaningful change by becoming bogged down or exasperated with national policy overload. His passion is to bring clarity of thinking, maintain the distinction between true strategy and operational solutions and support senior leaders to prioritise with prudence and take their people with them. He draws on experience in clinical, director and business advisory roles within healthcare, as well as wider experience in financial services, central government and higher education.

IF I COULD CHANGE ONE THING...

For three decades our health and care policies vacillated between three competing needs, with the third priority having an increasingly dominant run:

1. Best clinical practice possible (NHS Beacon programme, Commission for Health Improvement, NICE, Variation in care, Keogh Review, Getting It Right First Time)

2. Patient centrality (Choose and Book, Expert patient, PROMS, Compassion in Practice)

3. Integration and aligning delivery and resources (the Acheson inquiry 1998, Health Act 1999, Health Improvement Programmes/HImPS, Joint Investment Plans/JIPs, Health Action Zones/HAZ, Kaiser NHS Beacon Sites, Ten Care Trusts by 2008, all aiming to shift the balance on Vertical-Horizontal integration, and on Centralisation-Decentralisation).

Looking to the future, two layered scripts could help us get out of a repeating pattern:

- The size of funding: rather than reducing funding pressure, with inevitable short term political and major structural solutions. Instead, increase funding through taxation

- How we spend the funding: providing a long-term commercially sustainable solution (though we have never successfully embedded past attempts, e.g. primary care-led health and care services).

In support of the latter, the one thing I would change is for access to all health and care services to be systematically controlled by primary care, with each referral to secondary pathways being bespoke clinically-led commissioning decisions.

To enable this, we implement a 'patient-level funding model' where primary care has direct access to clinical pathway activity data. Tariffs for all healthcare activity are predetermined for set lists of treatments. For pre-agreed services the population is covered as a constitutional right, whilst other specific secondary services require prior authorisation. Funding is based on capitation. A limited number of regional tertiary hospitals provide highly specialised clinical care funded nationally, and provide no other services. The resource requirement to fund the administration of these functions comes from a significant reduction of current informatics, performance and commissioning infrastructure.

THE PRIMACY OF PRIMARY

RIAN LAMPRECHT
ADVISOR + PROJECT MANAGER

PSYCHOLOGICAL INTERVENTION

NIKI CARTWRIGHT
DIRECTOR

Niki has worked in the NHS for 30 years. When people ask her what she does, she usually says, 'I sort out the mess'. It's the best way to describe her skills set, which is looking at a problem and seeing how solving it can improve an outcome or situation. Her job titles have been varied, Director of Strategy, Chief Transformation Officer, CEO, Programme Director, Director of Delivery... it goes on. She looks at it from the impact on the patients – that is her driving force and is still what makes her get up in the morning with passion and joy.

IF I COULD CHANGE ONE THING...

It would be to recognise the emotional impact and cost that ill-health has on the individual and, consequently, society.

We invest billions every year in pills, potions, treatments and surgery and yet we invest little in psychological support. And I don't mean counselling – I mean psychological support delivered by highly-skilled clinicians.

Over the course of my NHS career, I have met many people who have received the best physical care that can be provided at a huge cost to the tax payer. And yet they consistently fail to take their medication, do their physio exercises, stop smoking etc.

So why is that?

In some cases, it's because the impact of being over-weight or having a long-term condition, is so emotionally crippling that they feel they have little control over their life, so they think, what is the point?

What we need is to reduce our investments in pills and potions and use that money to fund a swathe of psychological interventions by professionals who can build relationships with people who are frightened and in need of a friendly guiding hand.

But not delivered remotely in a hospital setting, instead delivered by walking alongside the person in their daily life, by nurturing small changes, by helping them to understand the impact they can have on their health, by giving them back control.

That investment would off-set the wasted billions in unused medication and failure to comply with treatment. We would have a happier and healthier population living rather than existing.

CURING PREVENTION

JOHN WICKS - CHIEF EXECUTIVE + MANAGEMENT CONSULTANT

John Wicks is a Chief Executive-level healthcare management consultant, with twenty years Director / Accountable Officer experience in Acute Hospital, NHS Commissioning and Social Care organisations, as well as experience of national policy-making and implementation at the DH / NHS England. Since becoming a freelance consultant five years ago, he has supported CCGs across the country with leadership, governance and financial turnaround challenges. Most recently he led the mental health transformation programme for North West London STP. With expertise in commissioning and contracting, John prides himself on his ability to forge effective partnerships across organisational boundaries to achieve common goals.

IF I COULD CHANGE ONE THING...

I'd restore 'Prevention of ill-health' as a key priority for the NHS.

One of the less controversial aspects of the Health and Social Care Act 2012 reforms at the time, was the transfer of public health commissioning from the NHS to local authorities.

However, as a result, there are large swathes of the NHS that no longer regard prevention of ill-health as the NHS's business. The rhetoric remains intact. Sustainability and Transformation Plans (STPs) – the five year strategies for health and social care for large geographical areas – identified 'health and well-being' as one of three key objectives (alongside quality and financial sustainability). And yet, many STPs have struggled to muster a coherent programme of work.

The even greater risk has been the decline of preventive action among CCGs. The financial constraints in the NHS have largely squeezed preventive schemes out of commissioning plans. Where they do feature, schemes are expected to deliver a return on investment, often within the same year, or are deemed unaffordable. This sets a higher bar than almost any other form of NHS healthcare commissioning. We accept the necessity to fund the care people need in A&E or hospital at a realistic level of demand. But a proposal to employ, say, a team of alcohol liaison nurses to support people whose reason for attending A&E is alcohol-related and prevent them returning in the future has to navigate a world of business cases, investment panels and risk aversion.

And so we remain on the hamster wheel chasing ever higher levels of activity while focused, well-evidenced interventions remain unimplemented.

The emerging 'Integrated Care Systems (ICSs) hold great promise. If they identify 'prevention of ill-health' as a key purpose, ICSs can help the NHS rediscover its mojo for prevention and help the NHS become a worthy partner for local authorities in improving population health.

MONEY IS NOT THE ANSWER

RICHARD DODDS
DIRECTOR & STRATEGIC ADVISOR

Richard is a career senior healthcare executive manager with a unique blend of experience in strategy, tactical and operational management and executive leadership roles. He specialises in health and social care integration and transformation, often operating within complex and challenging structures and organisations that are 'situationally sensitive'. He has delivered at Governmental, national policy, corporate and operational levels.

IF I COULD CHANGE ONE THING...

You posed an interesting question: "Putting all politics aside, if you could change one thing about the NHS, what would it be?" The obvious 'one thing' that most would choose would be more money! But I am convinced that would not be the solution and would actually compound the already lopsided current system.

However, I am of the view that the full integration of social care with healthcare to create a "universal access" model which is free at the point of delivery to all and based on a social insurance model building on Dilnot 2 may well ease the pressure.

The main blockers are the repeal and replacement of parts of primary legislation in National Assistance Act 1948 and the NHS Act 2006. Public engagement would be key as would Party Politics. Setting up a cross party expert review group now is essential so that the legislation changes can be implemented in 2022, which is the first time there will be the necessary available Parliamentary time after all the 'Brexit' legislation and regulations should be concluded.

CREATE A UNIVERSAL ACCESS MODEL

DEMAND MANAGEMENT

TIM TEBBS
DIRECTOR OF FINANCIAL SUSTAINABILITY

Tim has held a number of CFO roles for PCTs and CCGs – on a substantive and then an interim basis - and has gained a wealth of experience from working with organisations and health systems across the country. Recently, Tim has focused on supporting financially challenged CCGs. Whilst financial recovery is often perceived to be cost cutting and punitive, Tim's approach is to use financial pressure as a lever to deliver much needed transformational change. Though it adds to the challenge, Tim believes it is important to pursue demand management on a mutual benefit basis to take cost out of the system. Part of that challenge is persuading providers that this is possible...

IF I COULD CHANGE ONE THING...

We've been talking about integrating health and social care for many years now – and yet evidence of meaningful progress is rarely seen.

Truly joined up services means seamlessly integrated clinicians and service professionals, working efficiently and effectively together - as one team, communicating freely across primary, community and secondary care, embracing technology and treating patients and their families as respected and valued 'customers'. It's part of a vision that we all sign up to. And yet despite STPs and the like – this vision often seems as elusive as ever.

What stands in the way? Well many things I'm sure – but in my view one 'culprit' is the clumsy and ineffective way that funding is allocated via the 'contracting process'. Having observed several adversarial lose:lose contracting rounds, this is the one thing I would change in an instant.

Systems need to recognise the affordability envelope that they are given – and all parties within that system need to own this. Fruitless hours are spent arguing and the debate achieves nothing – not to mention the industry surrounding contract management that then perpetuates the energy sapping arguments for the remainder of the year. If only the public knew what went on behind the scenes...

Where energies should be focused is on working together to create modern, integrated services. Jointly working to manage demand, jointly agreeing where finite clinical and physical resource is prioritised, and jointly identifying and taking out excess costs driven by excess demand. None of this is easy – and structured turnaround discipline is needed to make any complex change happen. But let's help ourselves by finding a better way of allocating resource – sharing control totals – putting an end to mistrust and suspicion. It's in our gift to do so. And let's redirect our energies to making meaningful progress towards that vision of integration that all of us should feel it is our duty to deliver.

DYNAMIC USAGE

PHIL CHURCH
TURNAROUND + TRANSFORMATION DIRECTOR

Phil has been active in all areas of healthcare, public and private for over 12 years now. During that time, usually operating as a Turnaround or Transformation Director, Phil has supported Acute Trusts, PCTs and latterly CCGs, Community and Primary Care organisations, Care Trusts, CSUs and several private healthcare providers. He is originally finance-trained but has spent a good part of his career in sales and business development roles.

IF I COULD CHANGE ONE THING...

The amount of NHS footprint that goes unused on a routine basis borders on the criminal and needs to change. Sadly, recent changes have taken away much of the local incentive to be proactive around use of estate, and costs are rising and management fees are increasing. 'Use of estate' is a measure nobody in the NHS is currently monitoring, even though the technology to do so cheaply, in real time, has been available for some time now.

I would pull everything related to estates and estate management out of NHS Property Services and hand it back to the Providers and Commissioners. I would then task them with making far better use of their estate than they do today. As part of that I would institute dynamic usage surveys; would set targets for building occupancy and usage; mandate the ratio of desks to employees to drive more flexibility around working practices; pull the bulk of middle and senior managers out of offices into more open plan environments; and review availability across the health (and maybe local government) asset stock rather than looking at individual organisations in isolation.

Proposals for innovative approaches to improved usage would be pump primed and shared across the sector. The freed up estate identified would then be sold at commercially favourable prices and the cash retained by health and social care economies.

ALIGNING INCENTIVES

PETER BULLIVANT
PROGRAMME DIRECTOR

Peter is an enabler and leader with experience of facilitating, developing and delivering change in many systems within the NHS. He has a particular passion and ability to turn data into pathway and behaviour change through working across professions and organisations using effective programme management.

IF I COULD CHANGE ONE THING...

I would change the financial incentives so that all organisations are rewarded for the achievement of patient-determined outcomes.

This would facilitate the design of healthcare as a value-based system and not archipelagos of isolated organisations with competing priorities, driven through perverse incentives. Organisations do not deliver healthcare, people deliver healthcare and we do not currently work together as a system.

Aligning incentives would enable application of systems theory used in other sectors such as that espoused by Senge and Nonaka. We could develop systems that operate across organisations to promote feedback and communication around common goals; we need to change how we support people and populations not just where.

The shift in incentives would create an environment where everyone, including CFOs, are focused on patient outcomes to ensure support that is high value at both the personal and population level. It is also achievable.

Having worked with many clinicians in developing optimal designs, there are two central tenets that emerge on nearly every occasion once we are able to de-tribalise their thinking and enable them to focus on their common goal: supporting the people they see every day.

The first is the lack of communication between clinicians throughout the patient journey that leads to silo thinking and creates a culture of blame.

The second is the opportunity of increased non-clinical support for patients, to educate and coach, to create shared understanding and shared decision making that reflect patient preferences. This shift ensures that resources are focused on what really matters and we reduce all low value activity that exists today. This requires a change in thinking and behaviours from both patients and clinicians, which system thinking with common incentives can enable. This shift in culture is key to a sustainable health service that uses the resources available to provide the best outcomes for patients.

ART OF THE POSSIBLE

AMANDA RAMSAY-DUNN
TRANSFORMATION + TURNAROUND DIRECTOR

Amanda has significant experience and knowledge across the health sector and her key skills are focused around transformation, service design and end to end pathways re-design. Amanda is an approved Turnaround Director and has led large-scale transformation programmes across several organisations, both from a commissioning and provider perspective. She has managed complex partnerships and is an experienced Board level director.

IF I COULD CHANGE ONE THING...

Whenever I support an organisation with the development of their savings programme, it is very rare to find an associated commercial strategy that demonstrates how the Trust will develop and grow other income streams. This seems to be an area that some larger teaching hospitals have developed very well. For example UCHL are a prime example of a Trust that is consistently innovating and growing. It is developing a specialist treatment centre using alternative ways of working, such as Special Purpose Vehicles or Joint Venture arrangements. It has a research facility that develops new strategic partnerships with big commercial organisations. It is also a member of Healthcare UK which is a DH department that help UK healthcare providers to do more business overseas, through the promotion of the UK healthcare sector to overseas markets and by enabling healthcare partnerships between the UK and overseas healthcare providers.

Now this may be fine for a large Trust such as UCHL but each Trust could apply smaller ambitions and goals to their ways of working. For example, strategic alliances with outside commercial partners can assist with reviewing current ways of working, sharing of resources and accessing some of the latest advances and current thinking. Joint working with other health providers to "sweat assets" can reduce waiting lists. It could simply be the hiring of rooms and premises (where appropriate) to the commercial sector for meetings and training course provision. Other possibilities include expanding any innovation that has been developed, such as apps, to create additional revenue sources or the sharing of good practice around joint working with clinicians to develop private patient clinics or facilities. These don't have to be inpatient facilities but could include cosmetic clinics that could run over the weekends.

If each Trust worked with their clinicians to discover the "art of the possible", it would engender new ways of working and the creation of transformed service provision that may stretch far and wide and will enable the creation of a continuous improvement culture, which in turn will lead to a more efficient organisation.

SIMPLIFY BEFORE ADDING

ALEX ROBERTSON
TURNAROUND + PROGRAMME DIRECTOR

Alex has an extensive background in turnaround and change management in both the commercial and public sectors. Over the last five years, he has operated as programme director with a number of CCGs and more recently with integrated health and social care organisations, leading complex change programmes. Alex's main area of focus is supporting organisations in the design and delivery of effective out-of-hospital models of care.

IF I COULD CHANGE ONE THING...

it would be that out-of-hospital services, provided by a combination of acute hospitals, community health & social care organisations and the voluntary sector, are frequently disconnected. They often overlap and aren't effective as a system. Our patients struggle to know which services to access, and often aren't aware of which services are available - and it's confusing for health & social care professionals too. Patients default to what they know – an 8am call with fingers crossed to their GP, or a trip to A&E – rather than making use of other available services.

And in CCGs and Local Authorities, there can be a temptation to commission a "new shiny service" which adds to this complexity, confusion, and cost.

Instead of dashing to a solution, be clear on the problem(s) we are trying to solve – based on hard evidence not just gut feel. Take time to understand the data, patient and front-line staff insight, and the existing service makeup. Spend time with patients and the professionals and volunteers who look after them.

Create a clear milestone picture and write task-level plans. Write down what we'll do, and when, so everyone can see them. Simple yet effective.

Work out what the future model is – the blend of professionals, volunteers, etc., working together to look after patients out of hospital whenever appropriate, meeting both planned and unplanned needs. Co-design the future model with them. Make every contact count – make sure patients have the same messages about which services they can access, and when.

Lastly and most importantly – implement and embed brilliantly. Deliver projects that actually move the dial. Focus relentlessly on the outcomes. This is the time to go all in. Turn up the effort and see our patients benefit.

Too often projects stop at the completion of the task (launching a new service, for example) rather than when the problem has been solved and we can see what's better for our patients, their families, and our clinicians. Resist the urge to dash to the next task – the next "new shiny service" - before we deliver the benefits.

EMBED COLLABORATION

ANDREA O'CONNELL - TRANSFORMATION LEAD + IMPROVEMENT CONSULTANT

As a registered General Nurse, Andrea is passionate about the NHS and has spent the majority of her career working for the NHS and arms-length bodies, rising to Director of Nursing & Quality in a CCG before becoming a consultant.

IF I COULD CHANGE ONE THING...

It would be to ensure collaboration and cooperation are embedded into every aspect of the NHS. I have seen first-hand, the power that collaboration has in delivering sustainable high quality services.

There is a significant amount of evidence supporting collaboration to meet the challenges faced by health and social care providers, with Integrated Care Systems leading this work and focusing on developing strong partnerships. However, I still observe organisations focusing on their own interests, isolating themselves from the wider system.

Collaboration comes out of trust, and it requires all parties, at all levels to communicate respectfully, breaking down any barriers that have built up.

The NHS and wider care sector is full of amazing people, doing absolutely incredible things. The pressures on all parts of the NHS are unrelenting, yet despite this, care is being transformed, organisations are delivering high quality care. Those Hospitals and Systems have the same challenges as everyone else, yet they manage to overcome them.

It was a real privilege recently to observe individuals from health, care and education as well as service users openly embrace joint-working to improve the outcomes for children with speech, language and communication difficulties. There was such passion and dedication to make a real difference for these children!

There was mutual respect at all levels and organisational and professional boundaries were broken down in order to make the current pathway more accessible. This will, I firmly believe, ensure better outcomes whilst also making efficiencies to make the service sustainable for the future. The child, their families and carers were all at the centre of discussions. Rediscovering the importance of relationships should never be underestimated and this situation demonstrated to me that anything is possible when the right people collaborate.

If I were to offer one piece of practical advice on how to begin to improve the culture in the NHS, it would be to enter into every interaction with an open mind, to listen to others, be willing to have a true learning conversation, be curious. Put preconceptions aside and see what you can achieve in one conversation. Small changes in your behaviour can lead to far bigger changes across organisations and systems!

REMOVE THE POLITICAL REIGNS

PHILIP KEMP
NURSING + GOVERNANCE SPECIALIST

Philip is a Deputy Director of Nursing and governance professional with over 25 years' experience. Emergency nursing in particular has been a career-long interest for him and he led a number of departments before specialising in his other great passion, governance.

IF I COULD CHANGE ONE THING...

I'd love for the NHS to be removed from political change. I know this is a Nirvana-like state but we can all dream. Over the past 25 years that I have known the NHS, there have been so many changes that have altered, abolished, re-organised or just shaken what is an amazing institution. Some of the changes the NHS has undergone have been well intentioned, like the introduction of general management in the 1960s, but others have been damaging, brought about in response to political fashions or to capitalise on the perceived public mood.

Most have been poorly thought out and have lacked the long-term understanding of the real impact that implementing the policy of the moment has on the people who really know the NHS inside out, its staff.

And it's those people, the NHS staff, who have been the ones most affected by these changes. Great skill and experience has been lost through petty and unnecessary re-organisation. It has set this brilliant institution back so many years and has done untold harm to staff and their patients. This is not a swipe at government of any particular colour but at our system of a politically-led Healthcare as a whole. If we want to have an NHS as good as it is now in another 70 years, not only do we need to fund it properly and avoid the constant draining and unsettling annual battle for funds, but we need to remove its political reigns. We bend and change like the grasses in a summer meadow seemingly without disruption or impact. But the impact is very real, long lasting and damaging. Leave the NHS to the clinicians, managers and admin staff who love it for what it is - the best healthcare system for patients in the world!

GOOD GOVERNANCE

CHRIS DAVIES
TURNAROUND + PROGRAMME DIRECTOR

Chris is a programme director operating at board level in public sector and blue chip organisations. He's a transformation specialist with a wide portfolio of skills ranging from workforce redesign, delivering complex IT and business programmes to Business Change.

IF I COULD CHANGE ONE THING...

It would be to make governance more consistent. To my mind, governance should be like a game of premier league football; the play takes place within a defined space with named players in each position and a referee to ensure fair play, in the presence of the stakeholders, the owners and, last but not least, the spectators – or in this instance the patients and their families.

My very first turnaround assignment involved introducing proper governance under National Audit Office scrutiny, and it proved so effective that I have used this governance approach ever since.

Governance structures are rarely a riveting read but what they lack in thrills they more than make up for in keeping the programme safe. Here's mine:

- Context
- Programme scope
- Arrangements
- Terms of reference for the following:
  - Senior Responsible Officer (SRO)
  - Programme Board
  - Programme Director
  - Clinical Reference Group (CRG)
- Named individuals
  - SRO
  - Programme Director
  - Board members including CRG Chair
  - Stakeholders
  - Clinical Reference Group
  - Core
  - Workstream Leads and their Sponsors

It's really important that the CRG Chair is a Consultant or Senior Nurse. The core team is usually composed of Clinical Directors from the affected Directorates, together with the Programme Director. Workstream Leads are responsible for the deliverables and the corresponding Workstream Sponsors are responsible for generating benefits from the deliverables.

All programme deliverables are confirmed by the CRG Chair at the Programme Board. Sponsors are 'locked into' the Workstreams, so that they participate in raising requirements and the acceptance testing. There can only be one SRO and subordinate roles are disallowed. The SRO is not a member of the CRG to satisfy 'adequate separation of duties'.

Named individuals means that specific names only apply and that substitution is not

permitted; in other words, responsibility is only vested in the named individuals and no one else.

Finally, back to the football.

The defined space is provided by the Context and Programme Scope; the rules are defined in the Arrangements; the Referee is the SRO; the Stakeholders are as described and the Customers are the Workstream Sponsors.

Deviation from the governance structure always leads to problems. Properly structured governance that is understood and adhered to by all involved provides audit-proofing, which is the ultimate goal.

TO MY MIND, GOVERNANCE SHOULD BE LIKE A GAME OF

PREMIER LEAGUE FOOTBALL

CONFLICTING STANDARDS

ANDREW KENT
OPERATIONAL LEADER

Andrew Kent is an operational leader, his last role was Managing Director of a Care Group in the North West. He has specialist expertise in operational leadership, flow and service improvement.

IF I COULD CHANGE ONE THING...

As an operational leader in the NHS, I would want to change the number of opposing constitutional standards. To deliver the service to the patient, we need to re-align the standards to be meaningful to the patient's journey and not be in conflict with each other. The foundations are there, for example cancer standards have shown a significant improvement in care but maybe we have not got the early detection and prevention right.

The changes in the 18 week RTT standard were an opportunity to improve pathways for patients with benign conditions, but it has led to confusion and longer wait times. The diagnostic standard does not include reporting times and therefore is misleading and causes bottlenecks in the system. The emergency care standard gives an indicator of the pressure within the system but does not help to alleviate it, in fact it has the potential to be a catalyst for investment such as A&E departments but the reality is funding may be required elsewhere. We should now move towards social care, delayed discharges and medically fit for discharge, this could be more welcome, thus allowing flow to improve through the health economy. I guess what I am saying is that the amount of standards has caused bottlenecks and conflicts in the system, "we are what we measure."

A full review needs to be undertaken and more meaningful standards should be put in place that allow the goal - which is flow with improved outcomes for the patient. Let's be serious then about tackling variation and bottlenecks, by changing this element, this would give us significant improvement.

CONCLUSION

There is no doubt that our NHS faces a myriad of challenges, some potentially existential. How will we deal with an ageing population? How do we tackle health inequalities? How can we build a sustainable public health system for all?

The good news is that we have exceptional talent within the NHS, people like the professionals represented above who are committed to finding solutions.

If we at Practicus could change one thing about the NHS...we would create a national 'change learns system', where the diverse views of the professionals that are responsible for delivering change within the NHS can learn from each other. Only in that way can we turn the collective hindsight of so many NHS change programmes into foresight for the future.

If we could better guide the leaders of change around the bear traps, the financial and efficiency dividends for all would be significant.

Please feel free to send us your thoughts on the one thing you'd change.

PRACTICUS™

HEAD OFFICE

RIVERSIDE BARNS
REMENHAM CHURCH LANE
HENLEY-ON-THAMES
RG9 3DB

01491 577122

LONDON OFFICE

WORK.LIFE
33 FOLEY STREET
LONDON
W1W 7TL

020 7374 8886

BRISTOL OFFICE

1 TEMPLE BACK
BRISTOL
BS1 6FL

0117 922 1777