Good Governance Institute

Goldberg II: Delivering on strategy in the NHS

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This report is part of a growing series of reports developed by the Good Governance Institute (GGI) that consider issues contributing to the better governance of healthcare organisations. GGI is an independent organisation working to improve governance through both direct work with individual boards and governing bodies, and by promoting better practice through broader, national programmes and studies. We run board development programmes, undertake governance reviews and support organisations develop towards authorisations.

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Thanks

I was able to write this report because the work of the Good Governance Institute (GGI) now involves so many different individuals in so many parts of the NHS and social care worlds. Whilst we focused my final interviews in South London, the report draws on time with boards and healthcare leaders in many parts of the country – some as part of my formal time with GGI and some over many dinners and drinks with colleagues I now consider friends. I would like to thank all concerned for their candour and passion, and for sharing their thoughts and perspectives with me.

I secondly would like to thank my colleagues at GGI for giving me the platform to complete this work, and for placing me right at the heart of the debate about the future shape and inner-workings of the NHS.

Finally and most specifically, might I also thank Donal Sutton and Christopher Smith, researchers at GGI, who have patiently helped with the editing of this report and who have dutifully expunged various Americanisms and errant 'Zs' (zees as I would call them, zeds to them). Donal and Chris have also generally organised the report, checked the references and prepared it for the printers. I would also like to thank Dr. John Bullivant and Andrew Corbett-Nolan for their counsel over the shape of the report as it developed and for their introduction and concluding remarks.

David Goldberg
Portland, Oregon
April 2014

Introduction

The Red Queen shook her head, "You may call it nonsense if you like," she said, "but I've heard nonsense, compared with which that would be as sensible as a dictionary!"[1]

I have spent most of my working life in healthcare – around 33% in each of the NHS and the commercial and third sectors; but I have always considered this part of the 'same mission'. From early days as a management accountant at St. Anne's House, Hastings Health Authority in 1989 through to returning to the very same building a few years back to evaluate the Board of the current East Sussex Healthcare NHS Trust, I have seen a cocktail of both enormous change and at the same time absolute stasis. My return to St. Anne's house was almost as if I had made the journey using Dr. Who's Tardis – I was in the same place with the same taupe paint on the walls and even many of the same staff making coffee for me as I waited to see one of the directors (probably from the same mugs!), but at the same time this was a different universe with everything fundamentally changed. My former management accounting colleagues Steve and 'Barrell' were still carefully producing the monthly figures, but the numbers they deal with are now a quantum leap from the amounts we used to wrestle with, and the way in which their reports are used has exponentially changed too.

Most of my career in the NHS itself was as a planner. In those days, if asked at a party by a stranger what my job was I usually ducked the issue for two reasons. Firstly, the reputation of NHS management was pretty low, with TV programmes such as 'Casualty' portraying us as at best buffoons, at worst malevolent money-grabbers intent on subverting the efforts of the clinicians to provide decent patient care. Secondly, the word 'planner' meant to most that I was some kind of architect helping to build hospitals or clinics.

My first NHS project as an NHS planner was to close the casualty department at Rye, Winchelsea and District Memorial Hospital. I later did the planning work to close this cottage hospital entirely, and develop a clinic in the town centre that is still used today. Rye was the town where my father had been a school-teacher and near to where I had grown up. I remember arriving one hot summer's afternoon to start the discussions with Miss Linda Pemberton, the nurse in charge, who greeted me with tea and a cake. It was a Thursday and apparently a local lady always made a cake for the hospital on a Thursday. Above Miss Pemberton's desk a rather nice Victorian portrait of the hospital's founder smiled benevolently at me. It was Lady someone or other who had endowed the hospital after her son had been killed in an accident and, there being no hospital in Rye at the time, she had felt his life had been needlessly lost. The hospital had been built at some distance from the town because that's where Lady Whoevershewas had had some land that she donated for the building. There was no nursing home in Rye, and amongst the hospital myriad services was bathing, with a local baronet coming in for his weekly bath.

In this one reminiscence we have the entire strategy dilemma of the NHS. An expensive, inappropriate and possibly unsafe hospital-based service built in the wrong place, adored by the local residents and needing replacing by a sustainable and more useful service where the patients need it. It look several years to engineer the hospital closure. The site is now a sheltered housing and care scheme caring for many, and the Rye Clinic in the town centre a GP practice offering extended services and a minor illnesses service. The journey from the old cottage hospital, complete with baronet-bathing service, to the new town-centre clinic and care home was lengthy and fraught. The local population, galvanised by a strong-minded lady who took to phoning me at home on Saturday mornings in order to personally berate me, included a famous pop star who funded a smart firm of London management consultants to build the case against the health authority. All in all this was a hard change to achieve and, I may add with some feeling, an entirely thankless task. But it was the right thing to do and the care services for the people of Rye are the better for it.

[1] Lewis Carroll, *Through the looking glass, and what Alice found there,* 1871

We now don't have the luxury of taking several years to change one small element of patient care services. The chips are down and as a country we must quickly complete the debate about the kind of care services we need, and get on with implementing the massive changes needed to improve the health of a population that is getting older, sicker and fatter. The NHS has always been great at developing plans and strategies, but the challenge now is to implement change at scale and in double-quick time, and do this in a way that keeps on board the NHS and primary care staff who we need to go on providing the patient care itself, and the people of the UK who use the NHS and pay for it all.

As you read through David's latest report, the clarity of the visiting man from Mars (well, Oregon in this case) is brought to bear on the situation we find ourselves in here in the UK. David has had three spells of working in the UK. The first was in the 1970s. He then returned for lengthy periods in the early noughties, and again in 2012 and so he brings the insight of a favourite cousin who we see just at weddings and funerals, but who is very much part of our family, loves us dearly, knows our foibles and little ways and who can spot both the changes and the things that remain the same.

David's career has taken him across the USA, through a period of commuting to New Zealand and of course back again and again to the UK. For more than 30 years he has advised the leaderships of top healthcare organisations, as well as developing and running rural healthcare services and significant primary care systems at scale. His passion around clinician leadership of both care services and change comes through in his latest report, and his insight developed over many years helps us understand what needs to be done, and how we can complete this task best.

David and I conceived this latest report last autumn. After a year spent with both challenged NHS Trusts and the emerging CCGs it became clear to us that the pace of change needed to pick up. GGI was developing fast, and we needed David to look at the strategy challenges facing the NHS. We are already in the silly season in the run up to the general election next year, and we see very apparent and significant challenges facing Boards and governing bodies of NHS organisations these next 24 months.

Although tapped into GGI's work around the country, we needed to gain insight from one area where David could talk to all the key players – the CCGs, the NHS providers, patients' representatives, the Health and Wellbeing Boards, Local Authority leaders and clinicians and managers working to make everything simply work day to day. As David and I part-time share a flat in Elephant and Castle we chose South London. There was no other logic that it was a place where we knew all the key players and David could get a view of how one whole system was working. But I emphasise, this isn't a case study and David's report is pitched at a much higher level than simply critiquing the unique and sometimes troubled story of healthcare in South London.

This report, once again, lays out things very much as they are. We are just 500 years on from the publication of The Prince, a misunderstood manifesto that actually encouraged the reader to see things for what they really are, and not what they are dressed up to be. This is what David's latest report is: the state of NHS strategy without the blather, and his thoughts on what needs to be done right now. It is encouraging too, because he suggests the right things are happening and he is encouraged by the first year of CCG working. Only we need now to move on from discussing what we know needs to happen to getting it done. The road ahead is perilous too.

The themes of leadership, sustainability, having the right metrics and genuinely engaging stakeholders are all at the heart of the governance mission. Five years into the GGI story this report confirms to me that GGI is on the right track, and really helping to build and support excellent NHS Boards and governing bodies that will deliver the most complex and crucial changes in the history of healthcare. I can't think of a better reason for getting up in the morning and coming to work.

Andrew Corbett-Nolan, Chief Executive
Good Governance Institute
London
April 2014

Policy context

"Current providers are organised to provide fragmented episodic care. New contractual forms are essential. These should enforce integration and incentivise keeping patients out of hospital."
Professor Paul Corrigan

When then Secretary of State Andrew Lansley announced the massive change in commissioning from Primary Care Trusts (PCTs) to Clinical Commissioning Groups (CCGs), I was frankly surprised. It is unusual to see a central Government seemingly devolve such power to local leaders. In this case, it was even more surprising, as the devolution was to local independent GPs without a clear democratic mandate. I am a keen advocate of having local clinicians at the heart and core of commissioning and so I was warily supportive. I was, however, astonished that instead of taking administrative action to require PCTs to have GP Board Chairs and perhaps to have a super majority of clinicians on PCT Boards, a whole reorganisation was planned and passed by Parliament. We will never know the true costs of this reorganisation, but my experience tells me you will be looking hard to find real savings.

The past eighteen months has been an eye-opener. Local GPs across the country have taken on commissioning with rigour, vigour, and thoughtful reflection. Indeed, there have been mistakes, and relationships between CCGs and provider trusts have been strained, as have relations between CCGs and Local Authorities. Yet, GPs have contributed greatly to ensuring the debate is realistic and focused on the health needs of their patients and their patch. In spite of multiple NHS reorganisations, local GPs have steadfastly served their patient populations since the founding of the NHS 66 years ago.

At the same time, budget pressures persist in the NHS, and whilst everyone is speaking about the integration of health and social care, the budgets for social care have also been slashed. So, if one were sceptical about the motives of politicians, one might surmise that there was a grand scheme to shift responsibility and authority to local CCGs at the same time funding for health and social care was being reduced differentially. This places the onus of dealing with cuts, rationing and cost-improvement planning right in the laps of local GP leaders, rather than on Government officials. I will let you reach your own conclusions.

This dramatic reorganisation comes to an already very disintegrated playing field. Many of the GP leaders I spoke with stated that the NHS is more fragmented now than it was before. With NHS England responsible for commissioning GPs, CCGs responsible for commissioning secondary care, and relationships with social care and community care and NHS England responsible for commissioning tertiary and specialist care, there is considerable confusion in the marketplace. Many hospital, community services and mental health trusts are having to deal with multiple CCGs and Commissioning Support Units (CSUs) and, unsurprisingly, some patients are being caught in the fray.

CCGs are just one-year old. During this time they have had to self-organise, hire staff, develop their commissioning intentions and five year strategic plans, start collaborating with their local Health and Wellbeing Boards (HWBs), establish relationships with other stakeholders, work with their CSUs and the NHS England Area Teams and complete a year of commissioning on budget. Most have done a credible job. I note that just twenty-four CCGs (a little more than 10% of the CCGs) are expected to produce financial deficits this first year.[2]

The time commitment on the part of CCG GP leaders has been impressive. Is it sustainable? I am not certain, but I do feel that if the political control of the government switches in 2015; and the Health and Social Care Act is significantly changed and local GPs are disenfranchised from commissioning, then the United Kingdom will deservedly lose a generation of GP leaders. The NHS will be worse for it.

[2] HSJ, *Revealed: the 24 CCGs forecasting deficits in their first year,* 2013

The state of strategic planning and system levers

When asked who is responsible for assuring improvements to the health of the population? He said "I am." Andrew Eyres, Accountable Officer, NHS Lambeth CCG

It has been 18 months since my initial report on strategy in the new NHS.[3] Much has happened since December 2012. CCGs have now replaced PCTs, CSUs have come into existence, and HWBs have formed and started their work. During this time, GGI has reviewed many attempts at strategic planning, including the Welsh Health Boards and Trusts, CCG commissioning intentions, NHS Trust Integrated Business Plans (IBPs) for NHS Foundation Trust status, HWB plans, and Better Care Fund plans. The quality of these plans has been incredibly varied. Many are still as I described in 2012 at my presentation launching the Goldberg report – aspirational with little ability to track progress delivering outcomes, and with no ability to assure Boards that progress is being made and that there is value for money in what is being commissioned. Strategic priorities have been imposed, or seem to have been, according to some from newspaper headlines. Whilst outcomes were perhaps discussed, only outputs or processes were being measured and considered.

But there are increasingly bright lights. As talented and energised GPs take the helm of local commissioning and with many good NHS managers being retained by CCGs, the plans have become more realistic and grounded in what can be measured and delivered. Examples of this strength can be seen at NHS Lambeth CCG and Central Manchester CCG, where strategic objectives are aimed at achieving measurable outcomes and positive impact on the health of their populations. I am certain there are excellent examples of well-conceived plans at other CCGs across the country and my colleagues at GGI report seeing some. In many ways, the locus of the real challenge lies not as much in identifying strategic priorities but initially in developing programmes, commissioning them, and assessing their value for money. However, surely this is only the first step to the real integration of care.

In spite of the attention expressed about the need for better integration of care (more than 80% of CCG commissioning intentions say they will create integrated care), *integration* is being approached as if it were a separate programme or project. The Integration Pioneers or the Better Care Fund programmes are laudable, however these efforts are being offered as add-ons or special experiments. Everyone I spoke with identified "integration" of health and social care as a critical underpinning of being able to effectively and efficiently deal with the challenges presented by the frail elderly, patients with multiple long-term conditions, the range of outpatient and inpatient mental health needs, and squaring-up to behavioural issues such as smoking, alcohol use and obesity.

Integrating resources and data, eliminating unnecessary duplicative overheads and bureaucracy, and coordinating care are all necessary to deliver improved population health outcomes, particularly at a time of decreasing resources. Nevertheless, simply getting all of the stakeholders into a room and trying to sort out a new way of working is not enough. Integration is a means to the end of delivering appropriate and timely care to individuals and improving population health outcomes. Indeed, it might be said to be supply chain management.

[3] David Goldberg, *The Goldberg Report: Strategy and the New NHS,* 2012

So what is necessary for real integration of health and social care? I suggest the following:

- **Trust over time:** Sound commissioning is based on relationships and shared experience. The national Government has to stop changing the rules and altering commissioning relationships. It is critical to give CCGs at least five years to demonstrate whether they can produce improved health outcomes and better value for money, doing so with fewer resources. Further, any integration solution cannot add bureaucratic work to GP practices or to the management of social care, as this is not sustainable. Population health improvement does not happen in 12 months.
- **Brave commissioners who will take on the status quo:** It is clear that continuing the fragmented episodic commissioning of care will not lead to integration and improved care for those who utilise services the most. Commissioners must be brave and challenge the status quo. I believe GP leaders in CCGs have the insight and grip to do this. When clinical leaders in primary and secondary care are in front of reform (even if it means closing or altering a service) there is much greater likelihood of success. Politicians are afraid of disagreeing with local clinicians on issues of patient care, quality and safety. Taking on the status quo will also mean taking risks to embrace new technologies such as telehealth and other technologically supported approaches to care.
- **Linked data:** If one looks at the NHS and at social care, one finds myriad borders, boundaries, jurisdictions and funding sources. During my many interviews I asked, "who is responsible for assuring improvements in the health of the British People?" Only one person (a CCG Accountable Officer) gave a clear and unambiguous answer: "Me", he said. Further, when I asked what is preventing you from delivering outcome improvements and real impact, without exception I was told the problems are to do with:
  - tools for connecting patient data
  - reviewing clinical variation
  - real-time feedback on performance

  At the same time, one must be very sensitive to ensuring patients know and approve of their data being shared. Given recent debate and miscommunications over *Care.data,*[4] it is clear that getting patients to buy into the value of shared data will be an uphill battle.
- **Aligned funding and financial incentives:** The present funding mechanisms will not support integration. First, health and social care budgets must be integrated and protected (ring-fenced). Second, episodic funding of health care must be changed. There are ample models around the world and some form of risk-based capitation makes sense. The COBIC (Capitated Outcome-Based Incentivised Commissioning)[5] discussion is rich with ideas. Capitated approaches will require shared data.
- **Co-located health and social care:** The current separation in the provision of primary care GP services and social and community care is confusing and difficult for patients to navigate. The creation of neighbourhood health centres where many primary care, community care, mental health and social care services are co-located will go a long way to advancing an integration agenda. Expanding this approach to include community-based secondary care clinicians and services makes sense. Community geriatricians for example, co-located and working with GPs, would certainly add value and convenience for patients.
- **Keeping an informed patient at the centre of care:** It is critical to both understand and embrace the notion that the patient of the present and future will be better informed and involved in their own care. Patients must have access to their medical records and be co-producers in their health and wellbeing.

[4] BBC, *Critics of giant NHS database 'are scaremongering',* 2014

[5] Professor Paul Corrigan and Dr Nick Hicks, *What organisation is necessary for commissioners to develop outcomes based contracts? The COBIC case study,* 2012

Meeting the challenges head-on is not a done-and-dusted deal. I am hopeful, but not yet totally convinced, that the NHS is currently organisationally fit for the purpose of delivering population health improvement. We need to get to a place where it is. I see some of the crucial problems to solve, and critical challenges for the key actors, as follows:

- **Primary care:** GP practices are too small. If services are to become better integrated and removed from hospitals, then the co-location of a broad range of services need to be achieved. Neighbourhood comprehensive health and social care centres, where at-risk patients can receive a range of medical and social care services close to their homes, is an answer. The challenge will be how to aggregate GPs. The solution may be with the work now being done by NHS England in crafting a set of GP standards. If completed and adopted, these GP standards would address how lists of retiring GPs will be reallocated. There will likely be few, if any, single handed GPs and those getting the lists will have to demonstrate their organisational abilities. This comes at an opportune time, since in the coming ten years many GPs will be retiring. CCGs also provide a fertile ground for a federated model wherein practices join forces without merging. Such federations or networks could be a strong base for dealing with clinical variation, and even for joint ventures that might also reduce overheads.

  Furthermore, GPs must work 'smarter'. Presently, GPs see patients who queue up at their practices on, basically, a first-come-first-served basis. We need to increase the value of the GP clinical expertise. This should involve reducing the non-clinical activities GPs currently are engaged in, and establishing protocols so that patients with the greatest risk are prioritised in the GPs' daily schedule. Services to lower-risk patients should increasingly be delivered by nurse practitioners, practice nurses, and even healthcare assistants under the guidance and supervision of GPs. Innovative technologies such as telehealth and telecare must be considered.

  According to the Royal College of GPs, funding for general practice in England has fallen £400m in real terms over the past three years.[6]

- **CCGs**: The new clinical commissioner landscape has been designed to mimic the boundaries of Local Authorities. There are 211 CCGs (32 in London alone). CCGs are responsible for populations smaller than those that PCTs commissioned for. It is becoming increasingly clear that CCGs must merge and cover a larger population. Already we are seeing formal and informal alliances and federations of CCGs. In north-west London, several CCGs have the same management team and this model is replicated elsewhere, such as in Bradford and the Dartford area of northern Kent. In south-east London several CCGs are forming a common south-east London strategy. I am certain other such alliances, or similar practical ways of working together, are forming around England. The idea of matching CCG boundaries with Local Authorities has some merit in terms of managing public health and HWB focus. However, to have impact on population health, I believe CCGs must have responsibility for larger populations.

  During my many interviews and observations over the past year, I have heard numerous GPs mention their frustration of not knowing what is happening with their patients once they are referred for testing or consultant care. I have suggested developing very specific KPIs regarding access, service and timing into contracts. So, for example, if a CCG were commissioning for outpatient scanning services (CTs and MRIs), then the contract should specify *that from the point of receiving a GP referral, the provider must complete the scan within X days, and deliver to the referring GP the radiologist report in a specified electronic format within X + 1 or 2 days. If these access and report criteria are not met, payment reductions will occur.* The CSU must then monitor performance against these contractual KPIs.

[6] Royal College of General Practitioners, *Patients bear the brunt as GPs reveal a shocking £400m 'black hole',* 2014

- **HWBs:** These new 'Boards' are very puzzling. At once they are charged with creating a local health plan utilising public health leadership (which now resides within local government) and reviewing the CCG's commissioning strategy. However, HWBs have no direct staff, no budgets, and perform much like committees of local government. There are significant cultural and rule differences between the NHS and local government. These have strained many CCG/HWB relationships. Local Councillors are elected and feel accountable to the populace. CCG Boards are appointed (or elected from their GP membership). Executive directors do not vote in local councils, whereas in the NHS, executive directors have equal vote to the non-executives. Local councillors are legally accountable for not overspending their budgets, whereas NHS organisations frequently operate in deficit with little or no consequence. In fact, one finds NHS organisations with "planned" budget deficits, something that could never happen in local government. There are many examples where HWBs work well with CCGs. This occurs when there is a respectful relationship among members of the HWB, and where leadership from the Council and from the CCG work well together.
- **CSUs:** These are often in practical terms the intermediary between CCGs and provider Trusts and organisations. CSUs are expected to become commercial entities that compete in the marketplace for CCG and other business. There is a growing trend of CSUs merging and becoming larger so as to address CCG needs at a commercially viable scale. It will be interesting to see what happens in 2016 when NHS England ceases to host CSUs, and they are meant to become independent commercial businesses. I wonder about the economic viability of CSUs once Government support is withdrawn.
- **Acute Care Trusts:** Acute Care Trusts (both NHS Trusts and NHS Foundation Trusts) have not fared very well under the new commissioning arrangements. According to the Trust Development Authority (TDA), through eight months of 2013 (April – November) 32 of the 62 NHS Acute Trusts were in deficit with the forecast of £314 million for the 2013/14 fiscal year versus a budgeted £171 million deficit.[7] According to Monitor, *The acute sector is the most financially challenged, with the highest proportion of financially troubled trusts. It has been in a net deficit position (before impairments and transfers) throughout this financial year. Small and medium sized acute trusts are the worst performing with EBITDA margins of 3.5% and 4.3%, respectively.*[8] The change in commissioning to CCGs occurred at the same time as the Francis Report[9] was finalised. Acute Care Trusts have been besieged by Monitor (for NHS Foundation Trusts), TDA (for NHS Trusts), the Care Quality commission (CQC), the new Inspector of Hospitals etc. etc. etc. So whilst Acute Care Trusts are dealing with year-over-year Cost Improvement Programmes (CIPs) of 4%, they are being squeezed by CCGs in an effort to reduce hospitalisations and A&E utilisation (impacting revenue), and pressured by regulators to improve staffing (particularly nursing) to address quality and safety concerns (cost impact). It is not surprising that Trusts are in deficit. There must be a more rational allocation of secondary and specialist services, because year-over-year CIPs are not sustainable. NHS England is presently studying how the more than 30 hospital-based specialty services can be significantly reduced (to under 10). This would have a dramatic impact on service configuration. I am sceptical of whether it will be possible to follow through on their recommendations as they are due to be presented in the autumn of 2014, a mere six to nine months prior to the next general election. Politicians have a difficult time supporting the closing of services in their local Trusts.

  During the last year, Acute Care Trusts have been under added scrutiny regarding public disclosure of their Hospital Standard Mortality Ratios (HSMRs). This comes following the Mid Staffs disaster and the Francis[10] and Keogh[11] reports, and it works. The public is understandably confused and frankly so am I. HSMR ratings are just one of many measurements of quality.

[7] Trust Development Authority, *Board meeting, 23 January 2014: Paper E: Service and Financial Performance of the NHS Trust sector for the period ending 30 November 2013,* 2014, p.18

[8] Monitor, *Performance of the NHS foundation trust sector: Nine months ended 31 December 2013,* 2014, p.17

[9] Robert Francis QC, *Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry*

[10] Ibid

[11] Professor Sir Bruce Keogh KBE, *Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report,* 2013

- **Academic Health Science Networks** (AHSNs) – In London and around other major metropolitan areas and although not initially conceived with this aim, these are now providing some interesting approaches to dealing with the acute care crisis. One bold approach could be to capitate AHSNs to provide all acute care (secondary and tertiary) for a defined geography, so that Acute Care Trusts would have to contract or merge with a AHSNs. This could realign financial incentives and could rationalise care in a more efficient, coordinated way. Effectively, it could enable AHSNs to have a steady supply of patients for their education, service and research needs, and potentially strip duplicative non-clinical functions out of Acute Care Trusts. It could also create a more uniform flow of patients from primary and secondary care to tertiary treatment centres of excellence. One fear is that AHSNs provide more expensive care, so there is likely to be upward tariff drift for the services presently being provided at secondary Trusts, and further that the lead tertiary care hospitals have not yet demonstrated that they provide more efficient care.
- **Other healthcare providers:** I have had only limited experience with other providers of care (mental health trusts, community care trusts, third sector organisations and social care). During the past year, my exposure to providers has mostly been with a few Acute Care Trusts that have been in trouble and are involved in significant cultural change regarding patient quality and safety concerns.
- **Data, data, data:** Every conversation I have had over the past 18 months has identified lack of data connectivity as the largest weakness. The Government's partial answer is in Care.data. Care.data is an NHS England initiative to combine data from GP records with the national Health and Social Care Information Centre (HSCIC) databases. The approach is geared to have combined data available for research, and to aid in designing prevention and care schemes. However, it comes with much baggage and the roll-out to date has been seriously flawed, with many patients already opting out. In listening to the testimony before the Health Select Committee in February 2014,[12] one is astonished at the approach being taken. Big consolidated stored data is a flawed approach and will fail. The recent debacle where more than £10 billion of public money was spent and the project was ultimately abandoned in 2008 did not demonstrate that. One only has to look across other industries to see that low cost, distributed data, that stays within its protected source and is temporarily linked for specific authorised purposes, is the future. Rather than moving data from its home database to a third huge mega data base that is very expensive to create and maintain and requires additional physical security and cyber security, it is now much simpler, timelier, and more cost-effective to be able to access and look at data from various data bases about a patient at the time of care or need. Hence, what is needed is a practical way for an A&E consultant to see a summary patient record from a local GP's electronic medical record in a way that gives the consultant temporary access, in real time, to information such as; what medicines the patient is presently taking; drug allergies; and the reason for recent visits to the GP. In other countries (France and New Zealand) patients now have access to this information and can grant access where appropriate, either by swiping a card (France) or by actually displaying the needed information on their smart phones (New Zealand). Patients should ultimately control access to their medical information. Further, Care.data is not intended to provide clinicians with patient data from other parts of the NHS when it is most needed – at the point of providing care.
- **Clinical variation:** As a follow-on to having better real-time data, addressing clinical variation at all levels can be the low-hanging fruit to improve quality and costs. When clinicians are asked to participate in assessments of clinical variation – actually looking at their clinical decisions as compared to those of their colleagues – there is often a run for the door. Comparisons in the past were often approached as a vehicle for finding the poor performers and punishing them. This approach will always fail. Why alienate the 98% of the dedicated clinicians to find the 2% who are problematic?

[12] Health Select Committee, 2014

An approach I have seen work repeatedly and very effectively is one that trusts the clinicians. Physicians are smart individuals who are dedicated to the wellbeing of their patients. Further, they are competitive learners as evidenced by their training regimes. If clinicians are assured that the information to be gathered is solely for their use, that they will be involved in selecting the topics to be compared, and that the data is recent and accurate, then they not only agree to participate but when they see the data they actually change their clinical behaviours (if they see themselves as outliers). Enabling clinicians to look at their day-to-day clinical behaviour without external judgment always, in my experience, produced a reduction in clinical variation. Having clinical leadership, a guarantee of safety, and accurate real-time data are critical elements for success.

- **Workforce:** There is a perfect storm heading our way. On the demand side we have a growing ageing population. Managing long-term conditions now consumes a majority of the nation's health spend. On the clinical supply side, we expect the baby boomer GP population to retire over the next few years, and many GPs recruited from abroad in the 1960s are coming up to retirement age too. The pressure this will place on patient access to primary care will be extraordinary. Every health worker, from medical assistant to practice nurse to neurosurgeon, must work to the top of their capacity. We must add productivity by automating as much of the non-clinical work as possible, and be open to embracing care that can be supported by modern technology.

  The workforce crunch will not only be felt at primary care. Community care trusts have had great difficulties filling vacant positions. Acute Care Trusts and Mental Health Trusts also have struggled to maintain safe staffing levels by utilising bank and agency staff, as well as recruiting staff from overseas. Other countries cannot be relied on to pay to train clinicians and care workers whom the NHS then gobbles up, and immigration caps may well confound efforts to maintain the staffing levels in the NHS. Given the trends of an aging population, many with multiple complex long-term conditions, hospitals will increasingly be for very sick patients occupying a bed for short periods of time. This will place great stress on the bedside staff at a time when quality concerns are under great scrutiny.

  One must also look to technology for ways to improve care. Telehealth and telecare offer technical resources that enable patients to be better managed at home. But here too there must be data links so that appropriate clinical expertise is integrated into the care pathway.

- **The patient voice, and co-production.** Given the universally shared view that the behaviour of individuals is a key component of their health and wellbeing status, self-management must be better understood and valued in commissioning. There is a growing science and literature about prevention, co-production of care, and real inclusion of the individual to address critical lifestyle choices that are determinants of illness and disease, and consequently utilisation of healthcare services. Across the world social scientists and clinicians have been working on how to engage with patients and motivate them to better control their health. One such approach, with which I am familiar, called the *Patient Activation Measure (PAM)* developed by Dr. Judith Hibbard at the University of Oregon (USA)[13], reflects a developmental model of activation and measures the extent to which:

  – patients know how to manage their condition

  – have the skills and behavioural repertoire to manage their condition

  – have the confidence that they can collaborate with their health providers, maintain functioning, and access appropriate and high quality care

  Better understanding and actually commissioning for self-management must be considered and included if we are to have impact on the most difficult healthcare challenges.

[13] Verna Burden, MS, RD; Laura Blue, MPH; Susan Butterworth, PhD, MS; Ariel Linden, DrPH, T*aking Charge, What is the Relationship Between Patient Activation and Motivational Interviewing,* 2010

Further, getting the voice of the patient heard in a way that can better inform improved care is critical. There is considerable public engagement, patient representatives are members of CCG Boards/governing bodies and HWBs, for instance. In my view, the patient voice in these settings is not heard.

The market is becoming flooded with opinion-collecting devices and apps that healthcare providers can use to get feedback from patients about their experience. One sees in hospital reception areas kiosks asking for feedback. How this data and feedback is actually used to change the way care is delivered seems ephemeral.

The most effective way I have seen to get meaningful patient (and carer) feedback that can have real impact on the way care is delivered in future, is to focus the feedback. I have seen focus groups and larger gatherings of, for example, all of the hip replacements done by a musculoskeletal service over a three-month period. These patients and their carers were asked about the entire journey from diagnosis to rehabilitation – what they heard and expected, where they were surprised, and how the journey could be improved. The summarised (and in some cases videotaped) feedback was then shown to the senior musculoskeletal clinical staff, who were then asked how they could improve their communication and service to embrace the patient/carer feedback.

One aspect of the patient voice not being heard is the increasing dislocations patients are experiencing as a result of the changes in commissioning. One hears about patients receiving letters in the mail from NHS England telling them that the provider of specialised care they have gone to in the past is no longer available to them and they will be required to switch to a new clinical provider due to contracting changes. Further, the creation of CCGs has led to additional jurisdictional challenges for patients and clinicians alike. Here is an example of such a case from the viewpoint of a clinician who works in a hospital in one of the UK's major cities (not London):

"The case I mentioned to you related to the lovely new extra-care in our city. The GP practice that some people living here have registered to is also physically in the same city, but has allied itself to a CCG that principally commissions from another hospital to ours – one also in the city, but not like us in the city centre itself.

Person unable to access the beds with the local community trust, though they have facilities, as GP 'not from our city'. By this they mean city centre.

Unable to access the social services reablement unit as GP 'not from our city' – same logic. Unable to access rehabilitation beds within the area of the CCG concerned as 'lives in the city centre'. Dealt with this by getting special agreement at Board level from the community trust that we could refer to the community beds as a 'special arrangement.'

I also recently had a very similar situation with a lady from a care home in our city but had a GP from a nearby town (but within the city limits). Unfortunately unable to negotiate an exception, and she would have had to go to the county town for rehabilitation (15 miles from her home) rather than the community hospital one mile from where she lived."

Finally, one of the expensive challenges facing the NHS is end of life care. Living in two countries, the differences between the United States and Great Britain can get highlighted. End of life care is one such area. The challenge and costs of end of life care are very similar in both the USA and in the UK. In the USA, however, every hospital and every legal advisor promotes planning for the possible scenarios at the end of one's life. So, my wife and I personally each have a written ten-page document outlining our preferences for care or no-care as we consider the medical choices that might confront us at the end of our lives. In addition, we have carefully drawn up medical powers of attorney signed and available if we are incapable of making choices. I have seen very little of this in the UK. One piece of evidence supporting my perception is that death rates in UK hospitals are 45% higher than those of US hospitals.[14] Many Americans choose to die outside of hospital – at home or in a hospice situation.

[14] NHS, *Death rate 'much higher' in English than US hospitals,* 2013

My conclusions

"GPs are doing all they can but we are being seriously crippled by a toxic mix of increasing workloads and ever-dwindling budgets, which is leaving patients waiting too long for an appointment and not receiving the time or attention they need and that GPs want to give them." Dr Maureen Baker, Royal College of General Practitioners

The tone of this report is considerably more optimistic than that of my first report in 2012.[15] This is due to the exceptional work and spirit I have seen by GP and management leaders at CCGs. The actual strategies and strategic plans have improved dramatically. Many CCG plans are now focused on achieving measurable short and long-term population health outcomes, and are attempting to get away from simply measuring targets and processes.

The "integration" of health and social care has had a demanding year. There are substantive barriers to integrating health and social care. There are significant cultural and procedural differences between health and social care governance and leadership. There are different budgetary silos and rules. Yet, brave and dedicated councillors, directors of social care, directors of public health, and CCG leaders have dedicated themselves to improving the way citizens receive coordinated health and social care. Leaders have shown keen interest in whole system thinking and working. New ways to integrate care data must now be embraced. In a data rich environment (health and social care), it is critical that those at the point of delivering care be connected to the most up-to-date appropriate information about the patient while respecting the patient's right to privacy.

Market forces must also be considered. There has been, and I believe there will continue to be, consolidation as Trusts face financial challenges. Failing hospital Trusts are being absorbed by neighbouring Trusts; Acute Care Trusts are venturing into community care and even primary care. In urban areas, AHSNs are significant actors that will impact how the care system is organised. The private sector also has a role, and I believe their presence in the market increases the pressure on the NHS to improve access and service to patients.

[15] David Goldberg, *The Goldberg Report: Strategy and the New NHS,* 2012

My recommendations

"My greatest fear is that if a new government reorganizes the NHS yet again, a whole generation of GP leadership will be alienated and lost." David Goldberg

Based on my recent work in the UK, I offer the following recommendations to support the sustainability of the NHS, an idea and an organisation for which I have consummate respect. The NHS provides many more opportunities for maintaining and indeed improving population health than other configurations of healthcare services, or indeed other national healthcare funding mechanisms.

I have organised my recommendations for different key players in the key, as well as for my colleagues at GGI:

To politicians: First, it is important to understand the political context we are now in. Over the next sixteen months there will be considerable political uncertainty with a Scottish referendum, a possible European referendum, European elections, and a General Election in the UK. With all this in mind:

- It is critical that the next British Government not undo the latest reorganisation of the NHS. Doing so would dampen the fire of commitment and enthusiasm that GP leaders of CCGs have shown across the country.
- There should be a clear continuance of a policy that encourages and rewards integrating social and health care without transferring health funding to the control of local politicians.
- Government needs to promote a campaign to raise the consciousness of the populace around planning for end of life care.
- Individual politicians should show some selflessness and leadership when faced with local service reconfigurations, and indeed hospital closures. Political parties should reign in any tendencies for nimbyism by both Members of Parliament and Local Authority Councillors

To NHS England: I have a great deal of respect for the way in which NHS England is shaping up for the many challenges ahead. There is much to do, and political as well as managerial skills will be considerably tested over the coming few years. It is important that NHS England:

- Enable and encourage the merger or federation of both CCGs and CSUs.
- Re-focus efforts to enable the integration of patient care data where it matters the most – with the clinician who is at the time caring for a patient. Further, support the principle that patients own and control their medical information.
- Support the idea that the GP practice where a patient is listed should become the patient's "medical home," a single place where his/her medical data is securely housed. Patients should have easy **read only** access to their GP medical record.
- Encourage the growth in GP services within increasingly complex organisations. Newly trained GPs should expect to work in or become partners in larger integrated primary care organisations.
- Explore capitation as a means of purchasing services. In my experience, capitation (with appropriate and rigorous controls) offers a way to align financial incentives to provide the most efficient care. Capitation must come with real downside risk. Government or commercial reinsurance can be utilised to address outlier risks such as an influenza pandemic, or a run of poor neonatal outcomes.

- Put some thought into how care homes can be better brought into the mainstream as potential local centres for the vulnerable elderly, some of whom will no doubt remain living in the community.

To the regulators (Monitor, CQC and the TDA): In a future report I might have the opportunity to look in more detail at the role of regulators. Without doubt, they are a crucial element to maintaining and improving population health. In the meantime, it seems very important that regulators:

- Encourage and enable the merger of Trusts where the goal is the improvement in the quality and safety of clinical services.
- Prepare now for what I believe will be growing financial challenges to Acute Care Trusts at a time when the patient quality and safety agendas are so important.

To CCGs: I have been impressed with the progress CCGs have made in their first year, building on often good work by the former PCTs and at the same time bringing in new enthusiasms and skills from their GP memberships. There is much to do though over the coming years and the environment is going to get much tougher. From the many recommendations I would like to make for CCGs I offer these as the most pressing to work on:

- Continue to focus on delivering outcomes.
- Provide data to track progress (real-time data where available and appropriate, retrospective data to assess trends).
- Seek ways to deliver benefits to member practices whilst recognising that adding administrative burdens to GP practices is not sustainable.
- Develop strategies to address clinical variation.
- Improve data connectivity at the point of care.
- Develop the next generation of GP leaders.

To HWBs: As I have described, I am perplexed by the role of HWBs. Where they have worked well they have certainly provided a vibrant forum for whole system thinking and this is to be encouraged. I would encourage HWBs to:

- Seek ways to pool social and health budgets.
- Eliminate the silos that compromise good service to residents.
- Develop better understanding between health and social care.
- Build an understanding of healthcare services and the many issues the NHS faces with local politicians.
- Work at mobilising the resources and powers of the Local Authority to make meaningful contributions to population health.

To GGI: This report was commissioned by GGI, who are my colleagues and friends. Through GGI I have had access to NHS boardroom discussions and have been enabled to meet those who day-to-day are accountable for local healthcare services. GGI's work often means we see local healthcare leaders at stressful and difficult times, and GGI has considerable power to support those running local NHS organisations as they face difficult decisions and situations. The GGI team have worked hard over the last five years to create an organisation with considerable power now to do good. This small organisation has a lot to do over the next five years as a consequence of their success. GGI should:

- Build on the work GGI is doing with NHS England on standards for improving CCG leadership and governance.
- Focus attention and resources on the critical governance and leadership challenges of integrating health and social care across multiple organisations.

- Seek ways to enable Boards and governing bodies to have real assurance that their strategies are achieving desired outcomes.
- Find and partner with colleagues who can demonstrate effective and appropriate data integration to improve the quality, safety and efficiency of care to patients and the population.
- Develop and refine expertise related to supporting and improving governance and leadership of merging organisations.

David Goldberg
Portland, Oregon
April 2014

Concluding remarks and next steps

"The NHS in its current form is unsustainable." Without transforming how it cares for patients the NHS will face "managed decline." Sir David Nicholson

GGI are very grateful to David Goldberg for his research and reflections. It is very helpful to have an informed but external viewpoint on the way our domestic health world is evolving. David's worldwide and helicopter view compliments our day to day activity working with Boards and their support teams throughout the UK. Everywhere, we see well-meaning boards dealing with immediate clinical and financial problems, responding to central reporting but struggling to find time for the strategic issues only they are equipped to address. We find that Boards need to agree new forms of communication with their stakeholders and commissioners/providers; be prepared to intervene more with struggling partners or suppliers who otherwise can compromise their viability or reputations and that this will need news ways of working to cope with a very changing landscape.

Our work on risk appetite, with NHS England on governance, and the quality programme we are running with South London CSU and their local CCGs has helped to define a new simple to understand governance language. It is helping create a way of working which is both much more intimate in the need for commissioners/providers and partners to work closely together sharing problems and assurances. There is often an increasingly adversarial atmosphere within commissioning, as intractable financial and clinical problems run up against political diffidence and too many central and regional agencies trying to undermine boards sovereign status.

This is set against some real pressures to act. David has outlined many of these but I would add:

- The need to learn lessons from the devolved nations on how they are tackling the integration agenda, not least the tricky governance issues of risk sharing and spending monies for which others are accountable.
- A realistic sustainable approach for small DGHs who do not have geographically viable or politically acceptable partners for merger or takeover.
- The need to reopen the co-payments debate. It is obvious that some patients will not be treated unless they pay themselves and this issue has been fudged for too long.
- Clear exit/renegotiation strategies for failed PFIs.
- Guidance for FTs and aspirant FTs on establishing limited companies to run, for example, care-homes, diagnostic services and wound management with clarity on how to manage company failure, buyouts etc.
- Support to Boards to set out workforce strategies that do not treat flexible workers/locums as unwarranted costs but as a component of a mature approach to managing variations in demand and skills availability.
- Clarity on the status of social enterprises; now embraced within the Monitor regime but treated as non NHS providers.
- Acceptance of cross border flows with Wales and Scotland as a reality and the need for sustainable and quality assured patient pathways to meet patient needs rather than barriers at the borders. Luxembourg provides a creative model of cross border working.

Once again though we thank David Goldberg for his stimulating report, and we will be working to ensure that the recommendations he makes are properly tested and then, ideally, implemented.

Dr John Bullivant, Chairman
Good Governance Institute
Cardiff, April 2014

Goldberg II: Delivering on strategy in the NHS

David Goldberg – April 2014

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