Chapter Eight: How we look determines what we see: loosening the grip of the economists, reforming the NHS and improving the delivery of care.

Unless we understand and accept the causes of poor performance in the NHS and the dynamics that allow these to remain unchallenged we will never be able to reform it. This book has suggested that the fundamental causes are our responses to the five winds and the vicious circle created as a result and that the more limited diagnoses of economists do not help us either to identify this or address it. In this chapter we will look at how we must expand our ways of diagnosing the NHS, at the special responsibilities of the most powerful professionals and at how the current reforms could be used by these professionals to work in ways that take us closer to its original aims.

In the preceding chapters I hope to have convinced you that we have all, unintentionally and unwittingly, contributed to an impoverishment of the kind of care offered within the NHS. We have done this in our responses to the five 'winds' blowing around us. We could not of course have changed the direction of the winds or protected ourselves from them, but we could have responded to them differently.

For example, we haven't realised that concepts such as *audit* and *transparency* that sound so neutral or beneficial can change so radically the systems we think we are merely observing. (And of course we are never merely observing, we are also labelling, judging, and rewarding or punishing. Perhaps if we could find a way of merely observing we could use these concepts without the insidiously devastating consequences that we have described).

We have run from the simple hard to the complicated easy as our able intellects jump from half understood problems to solutions. Solutions that require only the agreeable engagement of our minds rather that the more challenging use of other senses: our observations, our experience, our intuition, our empathy and our courage.

We have lost our ability (or our preparedness) to include subjective judgement in our decision making, choosing to take the pronouncements of expert advisors of all sorts[1] as the decision itself and not merely factors to be taken into account in making the decision.

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[1] Including those who devise guidance and protocols.

We have failed to take our places in stewarding our organisations, services or teams: not being prepared to engage others in difficult dialogue about decisions that affect us and our patients, and the outcomes achieved by the organisation as a whole.[2]

We have implemented diktats imposed from above, knowing as we did so of their negative consequences but failing to protest or suggest alternatives. We have not kept in mind the ends and used those to challenge the means that have been presented to us. When we have objected we have done so on ideological grounds (anti privatisation for example) rather than insisted that the means are tested in real life against the ends they purport to achieve.

We have lost touch with the value of our emotions, blaming ourselves and others for our anxiety and pushing it as far as possible out of sight, where it influences our decisions and behaviours in damaging ways, that in turn increase our overall levels of anxiety in a vicious circle.

Taken together across the NHS as a whole, from front line to policy makers, by behaving in these kinds of ways we have introduced armies of people undertaking complicated easy[3] tasks which do not need doing. Collectively, responding to the five 'winds', we have squandered the greatest new investment the NHS has ever had.

Not all is lost. We can try to realise the potential of what we have gained (some new buildings, new kit, new insights, experience) but to do that we have to **look at the NHS world with new eyes**. Otherwise we will simply repeat our mistakes. We need to realise that it is not particular solutions or policies that have been wrong, it is the LENS through which decision makers have been looking when they devised those solutions and policies.

At the macro level we have let economics dominate all other kinds of thinking, so that politicians and managers become merely its technicians. Along the way we've almost swallowed the economic fiction of the rational, self interested human. The 'human' who uses only reason (no emotion) to make well informed consumer decisions, comparing goods of like value.

In moving away from a view of patients as people who should be grateful for whatever health care they get, we have chosen to treat them as demanding consumers when we could instead have treated them as welcome guests. In parallel with this we have treated our professionals as impersonal units of production. And in doing this we have corrupted

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[2] And although we say, and mean, 'we', we suggest that the highest status professions should bear the greatest responsibility here. Without their involvement in this kind of stewardship any decisions that are critical are either avoided or imposed – neither being at all satisfactory and both exacerbating the problem.

[3] I.e. distinct from the simple hard

both our ideas *about* people and us *as* people. We need to remember that we are so much more that economic units operating in an economy, and that to understand us and the dynamics between us we need to consult so many more schools of thinking.

We can describe our nation of 55 million people, including the one million or so working in the NHS, as an economy and consult economists to understand us better. Or as a society and consult the sociologists. Or as people and consult psychologists and anthropologists; people with a history and consult historians, with a sense of fairness (moral philosophers) and power distribution and a need to reconcile different interests (political philosophers and political scientists). And if we really want to understand us then we have to consult all of them and more.

These are all rich subjects with deep knowledge, to which the imperialistic efforts of economists, as they attempt to colonise them under the heading of behavioural economics, cannot possibly do justice. So we need to see economists and their technicians (managers and politicians) as valuable contributors (but only contributors) to a richly multifaceted debate. We somehow have to find ways of loosening their grip.

When we do so, one of the profoundly important things we realise is that humans are so much more than our intellects. We know that ALL decisions have an emotional component to them, and that we involve our emotions as much as our reason all through every day. We also know that in decisions we take at times of disease, distress or impending death the emotional element is especially strong.

We therefore have to include in our decision making processes people with heart felt experience of life events – the events that link us to the emotions of human kind: loss, pain, sorrow, grief, hope, joy, contentment, anger, frustration, peace.

We must not have our NHS run by impatient intellects, we must have our health care services designed for people who are in need of them by people who fully and genuinely understand those needs. Otherwise we will continue to have systems that rely on fictions and simply cannot work in the real world.

We must never again say (or even think) that *‘Providers, purchasers and transactions are the heart of the day to day running of the [health care] system.’*

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But if those are conclusions for all of us, there are special messages in this work for doctors.

The nature of their expertise gives this group the highest status and thus the power to set the tone for their practice, their services and their organisations. This group could be the key to a human approach to health care. The fact that they so often do not behave this way makes it tempting for policy makers to try and reduce the power they have to block changes to the system. And over the last 20 years they have attempted to do so in a number of ways that we have described in Chapter Four.

However I hope we have shown that it is in part because doctors are not being cared about and encouraged to flourish (in their ability to serve others) that they are not able to do this for others.

This lack of being cared about applies just as much to other healthcare professions and they too are finding it difficult to care about their patients[4] and many may be irritated at the focus on doctors. All are important and we do need to find ways of caring about all our staff, but we have to have the courage to address the doctor issue directly or nothing else will ever change.

Unfortunately the professional pride that rightly accompanies the assumption of professional responsibilities (and the weight of those responsibilities) has, in an environment in which professional status is under attack, all too often led to a stronger sense of entitlement and grievance that even those who are friends of the medical profession can support. Indeed the greatest of supporters (and this includes the members of the learning set) see this spirit of resentment towards change, towards anything that challenges practice in any way, as self righteous, self indulgent and complacent. And that it damages the profession and its members as much as it does society.

How could we find a way of helping all the professions to see their professional autonomy as 'a value to live by'? Suppose we were explicitly, deliberately and purposefully, to choose to value our professions and professionals and, as we do so, *expect* them to behave as professionals using their expertise, their experience, and their judgement with good will towards individual patients, towards the services offered to patients, towards the overall performance of the organisation in which they work, and towards the communities whose health needs they are meeting. Suppose we expected them to want to help society to flourish.

We would need to stop seeing them as units of production, instead expecting them, as part of their role working towards a healthy society, to accept the need for systematisation and standardisation of many aspects of care.

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[4] See if you can read the Patients Association report 'Patients ..not numbers, People … not statistics' without a sense of distress

We would move from expecting them to behave badly to expecting them to behave well. And if any failed to do so we would act.[5]

Of course we must not be naïve and we will need managers (most of whom will be clinicians themselves) who understand emotions and our psychological defences against perceived threats, so that they can help professionals deal with anxiety, with envy and with sabotage, without being disabled by them.

So we should envisage, too, a different task for managers: caring about their professionals, in robust relationships in which they are supportive and challenging, and make their high expectations confidently clear; helping professionals care about patients and about each other, encouraging all to work together to realise the potential of ALL the assets of the organisation in the best interests of society. And these assets are fantastic – some of the most able people in the whole of society, as well as more kit than the health systems of many other countries put together. But at the moment the whole is so much less than the sum of its parts – and the fact that we do not see that as a failure on the part of management suggests that we are conceiving of the management role in a very odd way.

If we conceived of the management task differently who knows what might happen? Perhaps we would find that we do not need a market and that we can afford all the care the country needs.

So where does this leave us, and at a time when a major reform of the English NHS is us? In five years time will clinical commissioning be describable in the terms used in Chapter One? As yet another rationally sound attempt that fails to change any of the dynamics that matter? Or could it transform the system and take us into a new covenant of care?

That will depend on whether these new commissioners adopt the viewpoint and assumptions of their predecessors or look at their task through a different lens.

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The two tales that follow are just that, tales, fairy tales written to illustrate the these different lenses.

While the details of structures, systems and policy will undoubtedly not reflect the real world of 2014 and onwards, the attitudes and perceptions of those in positions of influence

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[5] Currently we rarely act effectively when they fail to perform to acceptable standards

are the real focus. Critically the tale that most closely prefigures the NHS of the future will depend on whether the highest status health care professions prove the economists right by behaving as self interested units of production or whether they choose to adopt a sense of professionalism that leads them to use their status and their professional judgement to serve the interests of society.

Conclusion: Life after Liberation – Two tales of Clinical Commissioning

Fairy Tale One[6]

Choice, competition and the market

The Boards of Hospital Trusts entered the financial year 2013-4 with mixed emotions. Negotiations with PCTs over QIPP had been troublesome from the beginning and ludicrous towards the end. After all everyone knew neither the PCTs nor SHAs had any teeth anymore and the new commissioning consortia had not yet grown any so the overspend that year had been massive and most care economies went into the new arrangements burdened with large debts and even bigger arguments about where these would land.

However their clinicians and managers *did* feel energised. They had ambitious plans for improving services and were optimistic that their good relationships with clinically led commissioners would ensure a more sympathetic hearing for these than they had received from PCTs.

They were prepared for skirmishes with GPs as these attempted to move care from secondary to primary care settings, seeking the commissioning of a number of new multipurpose community care centres offering a range of services ‘closer to home’, although surprised at just how ambitious there expansion plans were.

Using their status and their credibility with the public, and thus their leverage with MPs, the acute trusts made a number of arguments:

- that in times of financial hardship it was ridiculous to spend money on new buildings when existing ones were adequate,
- that the tariff was merely a fictional cost that was distorting decisions, and that when real costs were examined it was clearly more efficient to offer care in one place (the hospital) rather than in many,
- and that GPs had a vested interest in offering services that increased their income,

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[6] These are just that –fairy tales; nothing within either tale should be taken as referring to real people or organisations

and were thus able to see off what they saw as predatory action on the part of primary care.

In the years that followed ambitious young clinicians in provider trusts started to take MBAs (and many medical students the increasingly common MD.MBA dual qualification) and moved into positions of influence, first at specialty, then divisional and organisational levels.

The Trusts (and/or parts of them) became Social Enterprises, as did several teams of enterprising health care professionals keen to shake off bureaucratic constraints and develop new services and pathways. In the heady rhetoric of social enterprises, about shared ownership and the way that this was bound to prompt entrepreneurialism and innovation among the 'owners', the underlying sociological dynamics were ignored. Behaviours continued to be shaped by them however – just as they had through all the previous reorganisations.[7] So, while the formalities changed the behaviours did not and services and service levels changed disappointingly little.[8]

At the same time a new breed of organisation entered the market in which entrepreneurial doctors partnered bright financiers, sought and accessed city money and built glitzy new facilities. These doctors were each given an explicit business target to reach (bring in £X of new business each year), while over in the acute Trusts clinicians worked with management colleagues to develop enthusiastic plans for increasing trust income by improving and expanding services. In both cases they believed they were doing the best for their patients, although outsiders observed that these plans and ambitions were at least as much in the interests of the clinicians who devised them. This eliding of professional and patient interests had been observed by sociologists for many decades so, as far as they were concerned, this kind of behaviour was not unexpected.

The escalating competition led to provider organisations starting to merge, and services being 'rationalised'. Many mergers were 'horizontal' but more and more involved care along the pathway on the basis that this would allow efficient, effective, seamless care. Historians noted that this was an argument at least 40 years old and constantly found not to be borne out in practice: low tech / hi touch community care always eventually financially bailing out the hi tech specialist care.

With fewer, bigger centres as a result of these mergers a 'Russell Group' soon emerged, of 'centres of excellence' with new buildings and comprehensive kit. 'Local' hospitals (some as far away as 100 miles and in cities as large as Bradford) became feeders, becoming smaller and more generalist (i.e. lower status) in the process. As the NHS was still a major employer

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[7] See Chapters 1, 3, 4 and 6.

[8] It is the preparedness to engage personally and with others in thoughtful reflection and redesign that brings about difference and there is nothing about social enterprise structures that (on its own) makes this inevitable or even likely.

these changes in the numbers, skill levels, and attractiveness to the highest status staff, had a direct effect on the economic health of areas, with some centres gaining and others losing, thus exacerbating socio-demographic inequalities.

Soon there were a few giant chains of providers with whom local commissioning consortia negotiated in vain, so the consortia, too, merged. Negotiations now resembled the clash of the Titans, with the services available to millions of people depending on ‘who blinked first’[9] when provider and commissioner negotiators met. Those small social enterprises, already having difficulty being commissioned (despite developing new services and radically improved pathways, with good evidence bases to support them), now found it impossible. They were first put into administratively tidy but clinically nonsensical ‘provider consortia’ (ragbags of various small providers clumped together to reach a scale that warranted the attention of the commissioners’ contract negotiators), and then ‘merged’ or acquired by bigger providers.

The negotiating teams were of course armed with mountains of data collected by armies of data collectors in every organisation. As commissioning contracts became more sophisticated increasing sums made their way to lawyers and contract compliance teams. The costs of running the system rose inexorably and the percentage of the NHS budget spent on front line care fell from approximately 40% in 2010 to 27% in 2017.

Competition between organisations also led to the emergence of ‘star managers’ whose reputations and salaries hit the stratosphere.[10] Star consultants too realised that they could choose where to work and became self employed, successfully negotiating for admission rights to a number of different hospitals.

Discussion in the media of what was happening was led by those who could stand up to the increasing number of interviewers with simplistic superficial understanding and an aggressively disrespectful manner. So ideologies (‘choice’, ‘competition, ‘transparency’, accountability’,) were peddled and statistics traded (‘I don’t recognise your figures, what I can tell you is…’). The debate was structured by those with complete faith in markets. No-one mentioned tranquillity.

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[9] This preparedness not to blink first was the pre-requisite defined by at least one SHA Chief Executive for chief executives of PCTs – in the days when there were PCTs.

[10] Systems and game theorists who had researched Napoleon’s wish to appoint lucky generals and found that luck has nothing to do with it (these are just what you would expect from the dynamics of the system), would have predicted this emergence and noted that it was unlikely to have anything to do with ability

Care

There was of course[11] an overall cap on NHS expenditure. Costs however were continuing to rise. There was the cost of increasing longevity, and the ever higher costs of new technology and drugs. In addition the providers of acute care had such a strong incentive to fuel demand for their services that they were unable to resist doing so, and consortia found it impossible to contain demand for admissions. So once the mergers had squeezed all the rationalisation savings (see chapter 6) out of the system (and people were dealing with call centres at the other end of the country to book their care) government ministers were forced to have a 'grown up conversation'[12] with the public, in which it was explained that not all care could be afforded. The prospect of rationing was introduced in a White Paper entitled Your Health, Your Choice, Your Responsibility, which was quickly followed by a national decommissioning initiative called Making the Most of Our Money (MMM for short). Along the way NICE guidelines became the ceiling for care instead of the floor.

As services decreased and service levels sank further, those who could took out private health insurance.

As competition intensified, as prescribed by the think tanks, organisations innovated, and stripped out cost after cost, becoming ever more efficient. Wherever possible staff were replaced by IT. A visit to the GP or consultant involved touch pad reception, on screen questionnaires with menus allowing patients to say why they were there, and piped music (to reassure and calm those waiting). This allowed the consultation to be as brief and efficient as possible. Every aspect of nursing was covered by a protocol so nurses were largely replaced by Health Care Assistants. In these ways health care was made demonstrably more efficient, a point that was highlighted in the media by managers and ministers.

Other observers noted a large increase in overall health costs and an even larger increase in health inequalities.

Consultation with patients about organisational changes (required by a government that took patients voice seriously) took place through representation on commissioning boards. These single representatives naturally became colonised almost instantly – not least because no-one became a patient representative unless they were reasonable, aware of

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[11] Rightly

[12] A grown up conversation always being at the behest of someone in parent mode telling you you are not allowed to have or do something you previously could.

financial realities, conscious of the need for prioritisation and understood just how hard everyone was trying to make the system work fairly, efficiently and effectively.[13]

The quality of patient experience (again of genuine concern to the government) was measured by patient surveys. This ensured that survey after survey reported over 97% of patients were so enthusiastic about their care they would recommend the service to others.[14] The fact that the questionnaires never included questions that real people cared about answering seemed to go unnoticed.

It was only the elderly and the mentally ill who did not report such satisfaction and no-one cared about what they thought since it was only the votes of Middle England that mattered and somehow there are few vulnerable people in Middle England. Indeed the *most* vulnerable of these groups, whose care costs were considerably higher than average, found it increasingly difficult to persuade commissioning consortia to include them in their membership, and for the first time in the UK since the inception of the NHS a health underclass developed – of people with no access to health care other than at a few charitable centres.

Staff

Professionals in provider organisations were divided in their response to the changes. Some thrived in the Evidence Based, protocol driven environment, keeping up with all the new evidence, and the guidelines and competences that flowed from it. (For example, when neuroscience demonstrated the beneficial impact of relationships on clinical outcomes they welcomed the Randomised Controlled Trials that elicited the exact width and frequency of smile required to give an 18 % improvement in outcome, the degree of eye contact, the number of relational words to use when, and the resulting competency framework and assessment driven training programmes).

A few were sufficiently expert (‘House’ – like) to stand above protocols and generated a following of their own.

Others, now fearful for their NHS jobs as resources at the front line were squeezed to pay for the ever more necessary staff who negotiated and monitored the contracts, felt forced to comply with protocols even when their judgement suggested alternative courses of action were better advised.

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[13] After all this was exactly the way the people selecting them saw the world.

[14] Especially when guided to that rating by the friendly nurse giving out the questionnaire, as happens in car service departments and mobile phone shops– you really think health care will be different?

Individual HCPs looked in vain for havens in which they could offer the kind of care they wished to (and knew was needed), but all the small organisations in which they might have had voice and influenced the approach and culture, had been deemed too small to be financially viable (i.e. .too small to deal with all the contracting) and had merged and disappeared. So those HCPs who cared about care and about people rather than only processes, and who wanted to make a mark as an individual relating to other individuals, failed to thrive in the large thrusting organisations left in the market, where they were treated as merely units of production.

GPs segmented. Some became fluent in economic concepts. More acquired, like most of the chattering classes, a smattering of economic language, which they deployed to overcome the anxiety associated with not being able to meet the needs they saw in their patients. Some acquired tough negotiation skills and started to use them as much with their GP colleagues as with secondary and tertiary care negotiators. So general practice also became increasingly specified and controlled, with money following high status conditions (cancer, coronary heart disease...) and their speedy diagnoses, and away from long term conditions, the elderly and the mentally ill. This led to the increasing specialisation of primary care so the generalist, family doctor role became a thing of the past.

The largest health care profession became that of audit: those setting the framework for different kinds of audit, those mining and manipulating the data, those presenting and putting a spin on the results, those responding to the results with counter arguments and additional data. All of which was necessary, naturally, because money followed patients and patient outcomes and quality indicators.

In their zeal to make the most of their commissioning budgets clinical commissioners (like their social service counterparts before them) were oblivious to how provider organisations met their contract obligations. As a result the terms and conditions of people employed in services they outsourced (patient transport for instance) fell drastically, to the minimum wage, with no pension rights. This group of workers grew steadily in number, soon encompassing, for example, most of the Health Care Assistants on hospital wards. (At the same time the people owning or managing the companies providing these outsourced services paid themselves really rather well, as they did their lawyers and their negotiators).

So the NHS (the government still called it that) was no longer a service in which (as in the late C20) the salaries were broadly level between members offering the same level of expertise within the same profession and where the ratio between the highest and lowest paid seemed fair or at least justifiable to most. It became as ruthless a market for services as any, with particular medical specialties attracting higher pay than others (surgery out paying psychiatry by 3 to 1), with every large hospital including in the people working within their walls some of the highest and lowest paid in society.

As a result members of staff used every spare moment to upgrade their knowledge to the next skill level to increase their salary and their (material) life chances. Thus those at the front line, meeting the most intimate needs of patients, were not only the lowest paid but those paying the greatest attention to working hard to move to the next step on the ladder, where they would earn more and then be too expensive for those front line roles.

This wasn't because they stopped caring about patients, but is what happens inevitably when markets are insisted upon and market failure (at every level) is demanded by some and feared by others.

Observers of language noted that no-one spoke of tranquillity, of wellbeing, of community, of a flourishing society or the civilised relations between individuals and groups that together comprise it, of health as a foundation for achieving potential, of health equity and equalities, of fairness, of justice. Not many talked of patients, not with any concern for them as people, of compassion, of care. (Care was now almost always part of a composite term: care pathway, care package, care process, care professional. It had ceased to be a verb and become a rather meaningless label). If they did the words had been purloined and attached to meanings so different that the concepts they had originally labelled had no means of expression.

Instead the language was of choice, of competition, liberty, freedom to choose, efficiency, productivity, cases and case mix, acuity, length of stay, innovation, and many of these words came to mean something altogether more sinister than when they were originally moved from their factory and financial origins into the world of health care.

People talked about health care at school gates and at dinner parties, they also twittered and tweeted. They talked about it in ways that Europeans had not done for 60 years. Interestingly, those using the internet rarely commented adversely anymore on individual practitioners or even organisations, so fearful were they of reprisals in the form of withdrawal of services. Thus souveillance (Chapter Two) had been a short lived 'noughties' phenomenon.

All, except the wealthy, talked fearfully of how they would afford the supplements being charged or the insurance premiums they felt they needed. The *choices* they had to make were between the different packages of care they opted for when taking out insurance or cover with their commissioning consortium. The *competition* they experienced was that between people with different clinical conditions as they lobbied NICE for guidelines that affected their lives.

Across the increasingly widening social divides the language was different of course. And the tone. The wealthy still relished the choices they had and the way the large insurers, commissioners and providers competed for their custom. Indeed the combination of innovation and financial self interest with the asymmetry of knowledge that is a feature of professional services allowed the pharmaceutical industry and entrepreneurial clinicians to develop products for all sorts of life style illnesses, for which the wealthy became obedient and grateful consumers. The poor (who now included many of those working in health care) felt ever more acutely the importance of choice (which hospital, which school) but had no means of taking more than the lowest cost option. Social strata further separated and solidified.

In parliament though, and in the media, it could be demonstrated that choice and competition in the NHS had delivered the more efficient care that contributed, if not to wellbeing or flourishing, then to the ease of the money markets, that appeared now to dictate national policy.

Fairy Tale Two

Some clinicians recognised the financial dangers as PCTs and SHAs lost influence and recognising that this would make their commissioning role more difficult shrugged off their habit of sitting back and blaming the government and decided to do something about it themselves. They talked with clinical colleagues across the primary, secondary and tertiary care divides early in the transition years, and fostered a sense of clinical stewardship across the care economy. Not everyone played ball of course, but enough to ensure that overspends were manageable and the culprit departments clearly identified.

What fuelled these relationships? Information. The real time information of the GP referral collaborative was so much more accurate and credible than that produced by the provider trusts that it drove down primary care referrals and literally kept the Trusts honest (up-coding became a thing of the past), and led to sensible discussions about pathways, about the nature of the relationship between GPs and consultants, and about effective liaison services. With the improved clinical relationships length–of-stay came down dramatically, admission and readmission rates rose slightly but were not seen as inappropriate, and indeed readmissions were not seen as failures (unless they really were) but as a sensible taking of risk.

With such effective collaboration, early plans among GPs to move care out of secondary and into primary care, and, on the part of hospitals to develop outreach services, lost their partisan support and instead a web of services was developed, without the label of either primary or secondary.

Since the tariff got in the way of some of these decisions the clinical stewards (as we can call them, i.e. the GP commissioners and their secondary and tertiary colleagues) started thinking instead in terms of real costs. They thought about cost structures and how costs behaved with changes in volume, and negotiated sensible arrangements about which cases would be charged at average cost and which at marginal. Monitor (the regulator of Trusts) huffed and puffed but faced with a hostile media scrutiny of their argument merely issued dire warnings about the lack of any financial bailout.

In all of these discussions the people involved drew directly on their experience and on credible data generated for clinical purposes. There wasn't space for MANAGERIALISM, merely for good management.

Serendipitously something else happened that proved to be transformative. With so many other organisations (including other commissioning consortia) ticking the patient and public participation box by putting a tame patient on the board, the clinicians here exhibited a not unheard of rebelliousness, self righteousness and elitism (as well as a good measure of ethics and common sense!) and decided they would commission some in depth research into patient experiences and expectations. They got the local university interested and put together a steering group which included a sociologist, an anthropologist, a psychologist and a historian. To their surprise they discovered when they read even the preliminary findings that their patients, far from being the hostile, demanding, unsatisfiable consumers they had seen them as, were actually very concerned about the welfare of their local health professionals, wanted arrangements that suited *all* concerned[15], and called upon the services far less often than they might. Their experiences of the services (across the care spectrum) surprised and sometimes shocked the clinicians reading the research. The anxiety before making first contact with a doctor (about whether this was serious enough to trouble him or her), the difficulty in making an appointment, the time spent trying, the feeling of being passed from pillar to post and never seeing the same person twice, the hours and hours waiting in A& E, or waiting for domiciliary services to arrive, the interminable boredom and wretchedness of being an inpatient, the impact on family, friends and neighbours who were needed to provide babysitting , shopping or other support while all this was going on, on jobs even, this was all a revelation. Not in all cases, but far more often than they had realised.

It was clear that this was a very different level of service from that which people experienced in every other area of their lives. Far from being demanding consumers the

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[15] See Otto Scharmer's description of work with patients and clinicians to revitalise part of a German health care system: Kaeufer K, Scharmer C.O., Versteegen U [2003*] Breathing Life into a Dying System*

public (on the whole) routinely accommodated lousy service and were surprisingly forgiving, and supportive of their professionals and understanding of the pressures they were under.

Too understanding the professionals thought. Not always of course, some patients were naturally demanding, and some had found that the only way to deal with the increasing withdrawal of access and attention by health care professionals was to become more demanding. An unhealthy vicious circle had developed, that the professionals now recognised and sought to reverse. With a different attitude, and insight into the impact of their arrangements, and a genuine desire to live up to the reasonable expectations of their patients, they decided they must co-design processes and pathways that genuinely met their patients' needs.

By publishing the research and their response they prompted a dialogue (with the local media actively involved) between themselves, the public, service users, and all sorts of service providers (existing, new, large, small). A number of new service options emerged from these, and wherever possible the commissioners involved the public in decisions about what to commission. Some decisions they put to a local vote. Others to a citizens jury. They made sure that patient representatives made meaningful contributions to service design, actively encouraged web based patient feedback,[16] set up means of independent enquirers contacting every patient two weeks after an inpatient visit to ask about their experience, and fed the results back to the provider services immediately. It cost money but the information was so valuable it was seen as money well spent.[17]

Health promotion programmes were commissioned for specific groups, targeting their needs, availability, and preferences. The take up was huge, the health impact too.

Enlightened by these results the commissioners expressed an interest in the experiences of staff across the care economy. The asked the same researchers to have a look. Initially warned off by the provider managements who made the case that the role of commissioners is to commission and that it is up to the providers to provide in whatever way they choose as long as the service meets contract specifications, the clinical stewards persisted. It helped of course that some of these stewards were providers.[18] This

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[16] Valuing the independence of these avenues and resisting pressures from providers (including from other clinicians) to try and control them

[17] And it did mean they could save on many of the tick box exercises like the patient satisfaction survey. There was a ruckus of course but once they showed conclusively that the latter gave results that bore no relation to real experiences it died down and they were left to their own devices.

[18] They even persuaded the Research and Ethics committee to give the go ahead in three months rather than the usual 12 (well this is a fairly tale after all).

information was of interest to all, they said, would be shared and used to inform discussion about the nature of the care represented by those contracts.

The levels of anxiety, stress, emotional distress, even exhaustion, shocked them. The different terms and conditions surprised them too. There was, they realised, all too little support for staff at the front line. Too little induction and clarification of what was expected of them, too many practical obstacles to providing good care (stuff not available when needed: linen, IVs, the right forms…; hostile relations between staff groups or individuals, bullying or harassment…), support systems that didn't work, no stable relationships that could reduce anxiety – because shift patterns meant teams came together for no more than one shift. For the same reason no credible, useful feedback was being given on performance.

And if the frustration and emotional labour and vulnerability of clinical staff shocked them, no less surprising were the experiences of people they classed as managers. Without defined shifts the working hours of many of these were long in the extreme. Long and unboundaried with emails being dealt with at all hours of day and night. Here too stress levels were very high with individuals feeling overwhelmed by their responsibilities, given objectives that required changes across a whole system with no authority over many of the people involved in it. When they tried to obtain advice or guidance from their own managers they were told not to bring problems only solutions. Their macho exteriors, the researchers found, hid doubts, vulnerabilities, fear, shame, relief. Feeling that they had to perform in ways that justified their salaries, while aware of how limited their effectiveness was, they often passed their anxiety and insecurity down the management hierarchy. No wonder they focused on the transactional, they had few means of enacting the covenantal - clinicians wouldn't play their part in the covenant. Daunted by those clinicians who wore their status in the form of high handed behaviours, in their refusal to think about systems and processes, and in their arrogant denigration of approaches from other fields ('this ludicrous *lean* language'), managers chose to delay or avoid consulting senior clinicians about issues they foresaw would provoke anger. Thus clinicians felt (and were) consulted only when things had been all but decided.

And yet these managers often held the information needed if care was to be radically improved. They were often the ones who understood things like Statistical Process Control and how it was 'the voice of the system', how using it would enable clinical teams to assess the reliability of their processes and improve them in ways that few other approaches would.

Looking at these results the Commissioners felt for everyone involved. Across the care economy[19] they insisted on a training programme for first line managers, proper supervision, and a task force to look at shift patterns. To their credit the Trust Boards took this on with a will, they had had no idea. Chastened they responded with less hostility when the clinical stewards asked how they *would* know in future, and drew up and invested in a Trust-wide system of supportive supervision.[20] GPs too responded with shocked concern at the findings in their own sector and started to think seriously and differently about the responsibilities and accountabilities of the partners, and about the support, challenge and infrastructure they needed to be truly effective.

Another outcome of this research was the identification of several more proactive and committed clinicians from other professions – therapists, pharmacists, nurses- who jumped at the opportunity to come on board with the clinical stewards to work on care pathways and processes across the care economy.

These inter-organisational conversations also led to the start of a new relationship with provider managers. These made available robust clinical information from their clinical dashboards and, armed with this and the richness of the patient and staff experiences, the clinical stewards and Trust managers worked together to tackle some of the entrenched unproductive clinical practices that had resisted change for years. They did so gracefully but firmly. With support from psychologists they understood that, where behaviours were a problem, it was their colleagues' anxiety that so often lay behind the mask of the complacent arrogance that had defeated many previous attempts to challenge them. The desire to maintain a private income, or the fear of loss of status, or the uncertainty about new ways of doing things, all of these and more had contributed over the years (all the more because they had been unchallenged over that time) to some of them using their status in their own interests at least as much as their patients'.

Steeled by their knowledge of the impact these out dated practices had on individuals across the system (both patients and other staff) the clinical stewards combined empathy with persistence. Gently, lightly and humorously where possible, they raised contentious issues in the course of face to face conversations about credible data and real patient experiences. They prepared well for these conversations and debriefed afterwards, becoming more skilful, more empathetic and more determined, and at the same time less nervous and more satisfied with the results.

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[19] For these patterns of under- supported, mismanaged staff occurred as much in primary care as in acute settings

[20] See Chapter Four

Thus information played a critical role. Not in the form of crude and misleading league tables or bare statistics, but rich information from credible sources. And not used as arbitrary judgements on performance, but as the basis for highly productive conversations in which all parties were able to reach nuanced judgements on a range of relevant factors.

Early on in the transition the clinical stewards realised that the measures of clinical *outcomes* suffered from the same limitations as the process targets they replaced. They measured only the measurable.[21]

Instead they developed their own ways of understanding and monitoring the overall impact local health services were having. They developed rich ways of knowing/understanding what was happening,[22] ways that in themselves contributed to dignified relations across the community, to confidence and to tranquillity. Out of these they were able (often) to tick the boxes of the check lists required of them, so avoiding the need for separate box tickers.

On the occasions when they saw that the situation on the ground locally was being made more difficult by central policy they did two things. They logged constantly exactly what was happening in reality, and reflected these facts and experiences back, constructively, to policy makers. And they developed alternative ways forward- in the *spirit* of the policy although not necessarily the letter of it – and implemented these, explaining and discussing their actions with the local media, patient representatives, staff and politicians. These were genuinely ‘grown up’ conversations.

Their careful noting of what was actually happening gradually increased in its gaze. They started asking how much of their commissioning budget was spent on front line care. They then looked wider and asked where the commissioning budget came from, and how large a proportion this was of the total NHS spend. They asked a research team to track NHS finances more generally. They looked at just how much of the overall sum leaving the Treasury had a trackable beneficial impact on care and flourishing at the front line and into the community. They looked at how much ended up in the hands of lawyers, or owners and managers of companies providing outsourced services such as agency staff, facilities

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[21] And so the outcome targets focused on a few lead indicators (for example the outcome about avoidable deaths translated eventually into a target about specific forms of CHD). So it would, the stewards realised, prove almost irresistible for everyone in the system to concentrate on a few, perhaps at the expense of the many, just as schools had delivered their targets of x % of pupils achieving 5 or more GCSE passes, by putting extra resource into the few who could be pushed from 4 to 5

[22] They were inspired by the notion that in Bhutan the government monitored Gross National Happiness rather than Gross National Production, and that they assessed the level of this by interviewing a sample of people for about half a day each. They commissioned in depth interviews of individuals and groups by people who knew how to conduct these – so not opinion pollsters and statisticians but anthropologists and psychologists.

management, patient transport. ‘Interesting’ they thought when they found out,[23] and they made the figures publicly available. ‘NHS millionaires’ ran the press headlines.

With their greater understanding of the lives of patients and the local population generally, the clinical commissioners began to see their own salaries in a different light. Finding that a Legal Aid lawyer, working longer hours than theirs on complex cases with life changing impact for clients, earned less than half a GP partner’s income amazed them. Realising just how few local people earned anything like their salary they stopped comparing themselves with bankers and the relatively few high paid public servants in the area and instead thought of the many private sector owner managers working long hours with responsibility for the livelihoods of hundreds, who earned modest sums in comparison.

This realisation liberated them from a victim mentality and a self righteous greediness (neither of which they had recognised while in the grip of them, and which they eventually realised had been a disastrous outcome of the 2004 New Contracts).

It also led to their taking an interest in the salaries of senior managers of organisations offering services within or to the NHS. So when the Boards of these organisations argued that they needed to pay large sums (e.g. 8 times the average wage locally) to attract the best people[24] since the role was so complex, they countered with a suggestion that four posts at twice the average wage be created instead! They had, of course, no right to insist or intervene but their interest prompted conversations that resulted in much more moderate salaries and much more doable roles. The emperor’s clothes of the star managers were at last being questioned.

This had a ripple effect over the whole of the local economy. The public now began to challenge the super salaries of any newly appointed council Chief Executive, Chief Commissioner of Police, or Education supremo. They stopped believing in magic and accepted that people in these roles would be fallible. The local press changed from being hostile to those in power and now they were no longer paid such vast sums took an interest instead in the natural, inevitable, structural obstacles to their success.[25]

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[23] Indeed they found this so interesting they turns their attention to risk (what risk was being held where) and power. Although crude at first these enquiries became more sophisticated over time. One thing they highlighted early on was that in almost any deal between public and private sector the risk, although nominally taken by the latter in practical terms fell to the former. Power was interesting too. Frustrated when decisions that made good sense locally fell foul of a ruling elsewhere, they investigated some of these. They speculated in jest that there were half a dozen key clusters of people who, by asking questions of lawyers in ways that gave them the answers they wanted they were able to influence the structure of decisions across the NHS. Not with Machiavllian intent, merely a narrowly Hayekian one. This was more tricky to discern so they left a small research team working on it as and when they could and we await their results with interest.

[24] Naturally to sceptical doctors they never seemed like the ‘best’ people, just ordinarily good people

[25] Do remember this is a fairy tale – but just imagine if it were possible

One unanticipated but healthy consequence was that the spirit of stewardship enlarged and a cadre of those taking strategic decisions in organisations right across the community (health, education, housing, police, industrialists...) developed a habit of consulting others about their plans, and this led eventually to shared community goals. A sense of community stewardship evolved.

Of course this meant that the market in health care became less of a market, as aims for community flourishing replaced those that were more easy to specify and include in a contract.[26] Where providers were able to offer responsive care from properly motivated staff[27] commissioners were happy to commit to cover the majority of fixed costs of provider organisations, allowing care to be offered much more responsively and flexibly because the decisions about care resulted in only marginal changes in costs and hence charges. They kept an eye on all the information about patient experience and kept close to possible other providers to see if commissioning changes would be beneficial and when they were they engaged in constructive discussions about managing any transition. To encourage further a healthy rivalry the stewards instituted local ‘Nobel’ type prizes for different clinical categories with significant awards for the services that won. In these ways they fostered a healthy competition that could be replicated at every level of the system without damage.

Naturally market fundamentalists were horrified – although these arrangements met at least two of Michael Porter’s three criteria for effective competition much better than the wholesale quasi market ever did[28] - and made persuasive arguments about the importance of allowing market failure, that appeared logical and reasonable. However, rooted in their own experiences, their intuition and their research results the community stewards (by now a pretty large group) were *not* persuaded. They could demonstrate (not speculate) that care was so clearly better, both in quality and quantity. The libertarians huffed and puffed and talked of European competition laws, but they couldn’t blow this house down.[29]

Indeed it was possible to demonstrate not only good care and clinical outcomes but a genuine commitment to tranquillity, to dignified relations in society and to flourishing. The commissioners counter argument to that of the ‘choice and competition’ brigade observed that the choice agenda had been exposed to serious scrutiny and had been out-competed in local opinion by equity and tranquillity.

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[26] This could have been dangerous if those involved were MANAGERIALIST technocrats, but constantly challenged by the research findings and the, by now much more informed public, the practical humanists were able to carry the day. See Chapter Two.

[27] I.e. offering acts of work and courage in the service of others, because their managers engaged in acts of work and courage to keep them motivated to do so

[28] The competition was between services not organisations and whole pathways not parts of them.

[29] This **is** a fairy tale remember

Reflections

Although the commissioning role and spirit was now held much more widely, the original GP commissioners[30] still met as a group and reflected on their progress. On one such occasion, on their way home from a national conference about ‘prioritisation’, they reflected on the metaphorical journey they had taken. Their observations included the following:

When we started:

- we thought that information would give us answers, that it would tell us what we wanted to know. Now we know that information is only ever the starting point for the conversations that eventually lead us to understand what we want to know.
- we thought that health was all about longevity, now we know it is about flourishing and that flourishing is something we can and should be involved with. Not only us, our colleagues in education and housing and local employer too, but we have an important part to play. We also know that our own flourishing is important – not salary, not hours, although those contribute, but flourishing.
- we thought that patients were demanding and that we were being prevented by government from offering care that was covenantal by their focus on the transactional. Now we know that the care we were offering wasn’t either: not transactionally sound nor a meaningful covenant. Now we can offer both, and our own working lives have become more enjoyable and satisfying as a result. We also know that we can’t commission care that is covenantal unless we commission it in a way that is itself a covenant. In other words our commissioning processes need to be sound transactionally and also embody good robust relationships.
- we were using simply our brains now we actively draw on so much more, we are much more attuned to our emotions and intuitions and how these are translated into sensations in the body, and we take notice of these rather than ignoring them. As a result our decision making has improved in ways we would have thought ridiculous before we started.
- we took an interest in our own patients, now we still care about them but we also take an interest in the needs of the wider population. We foster a shared sense of responsibility.
- we thought being ‘tough’ commissioners meant negotiating hard on contracts –but the contracts don’t give power over the things that really matter. These are affected (and only affected) by a spirit of collective stewardship and real concern for patients and these are badly jeopardised by an adversarial stance. It was important not to be suckers but we’ve succeeded by building relationships, being firm and keeping the door open.

That was when we started, now we also find:

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[30] Those who had been involved from the beginning

- we don't get seduced by arguments that focus on means rather than ends. If people can't show us a convincing link to a flourishing society with dignified relations between the people and groups that make it up and individuals realising their potential, then we don't buy their argument.
- our relationship with the public has been even more important. We didn't know just how much credibility we had and how much they trusted us – or wanted to trust us. Knowing that has given us an obligation and a real desire not to squander it. We've actively tried to act in their interests at all times and to challenge any behaviours or processes or attitudes that put provider interests first. Knowing that this is recognised and valued is hugely rewarding in itself.
- knowing so much more about our patients, our population, and our colleagues of all kinds, has made us impatient with simplistic management models and management speak. When we discuss processes and pathways we always try to tell the whole story (what the existing service is really like for people, real people) and simply won't listen to any explanations from providers unless they empathise with the people involved. Our discussions involve analysis but always relate back to people.
- our contract with patients, public and colleagues has put us back in touch with what we came into medicine for. We now realise we've been developing our own careers and the expectations of our younger colleagues in ways that diminish their (and our) humanity. We have to find ways of putting them back in touch with their concern to help others and related well with others instead of fostering a strong sense of self interest. Somehow we have to get away from the narrow undergraduate medical training and offer instead a real education.

There was much more, this had been such an exciting and, yes, liberating time. Government policy had played a role in that, but more important was the GPs' different responses to the five 'winds' and their understanding (based on excellent multifaceted research) of the dynamics at play in the system. They were behaving like humane professionals who recognised the obligation conferred on them by the trust of the public to earn their autonomy by working in the service of society. They sustained this by engaging directly with the public, asking for their help when it was needed, and accounting to them in rich and meaningful ways that further informed and educated all concerned. The NHS once again became a secure foundation for health, this time an enterprise in which the whole of society was engaged.

So where are we now?

We have a government that intends to transform public services, making them more responsive to users and better able to meet the rapidly growing needs associated with our increasing longevity and reducing birth rate. Empowered by the current economic crisis to make decisions the public would be wary of at other times it seeks to use choice and competition to rescue services which they see as having been captured by the vested interests of producers and invigorate them by unleashing an entrepreneurial (social entrepreneurial) spirit. For all the reasons explored in this book this will not work.

In other words the government has the best of intentions and is proposing the most limited of methods.

The danger of this is great. Healthcare services have resisted for decades change which makes them more responsive to the changing needs and preferences of their users, largely because of the soft power wielded by the medical establishment.[31] This is not a power that arises through economic forces but sociological ones. So unless we look at health care through multiple lenses and not merely the economic one we will have war between a determined government and an entrenched service, in which the losers will be patients and the public. Instead of a focus on using limited resources excellently we will have poor quality, inefficient services being rationed.

We ***have*** to ***look*** at this differently, before we develop policy about what we are going to ***do*** differently.

And when I say ‘we’ that is what I mean. The charge of the economists is that the vested interests of producers have captured the public services. But ALL of us are complicit in this. Not just the producers but also the people making that charge *and* those believing it - because we are all subject to a number of forces (we have identified five, there will be others) that influence our thinking and behaviours in ways we are not noticing. If we understood those forces we could respond to them differently and participate in a renewal of the NHS fundamentally different from the kind of reform that is being introduced now.

We must resist the temptation to blame the government (or the doctors or the unions or any of the usual suspects). Much more constructively we can help them understand how they have arrived at their diagnosis, how their prescription is not a solution but a further turn of the wheel, and that if they thought deeply and openly (using other fields of knowledge) about how to respond healthily and awarely to the five winds they would propose something different. And to do that all the rest of us must do so too.

To support us in this there is a special responsibility on the part of those teachers and researchers in the humanities to make their insights known to the rest of us. If they were to enthuse us with the value of examining the world using their particular approaches and skills we would see that the methods and assumptions of economists are valid but limited,

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[31] In what they perceive to be the best interests of patients but often coincides with their own.

that their field of vision omits much of what we value and deem important. If they were to make their insights available to the public in accessible, compelling prose we would have other vocabularies with which we could examine and discuss the issues that that affect us. If they ran commentaries on decisions made by those in positions of power and influence, then our media would have richer material on which to draw and would be able to move away from simplistic labels of left and right, neoliberal, socially conservative etc. In the process we could develop a more multifaceted understanding of what may be gained and lost in the wake of the decisions of the powerful. This would in itself be valuable, but we may also reawaken some other instincts, our awareness of some deeply human needs and cares that we have lost sight of in our obedient response to the injunction to pursue only our economic interests.

This will not be easy since the country, or rather its governing processes, its media and increasingly its chattering classes, have been captured by the vested interests of economists, to such an extent that they now structure the debate and dictate its language. This results in the people who use different language and concepts appearing naïve and irrelevant. We need to liberate ourselves from the economists' dismal grip and restore belief in a richness and humanity that they have forced underground. To do so we need to invite the active participation in policy making and policy commentary of sociologists, anthropologists, historians, political philosophers, moral philosophers, theologians, and more, and escape from the current intellectual straitjacket. And perhaps we in the NHS could lead the way.