Why Reforming the NHS Doesn't Work: the importance of understanding how good people offer bad care

Valerie Iles

Chapter One: A history of NHS reform in England – through different lenses

For over two decades governments in many countries have been concerned about increasing costs of health care. This chapter starts with a light hearted history of some of the major governmental attempts to contain costs and improve productivity within the NHS in England in that time period. It then suggests that all of these policy initiatives, whatever the colour of government, have been strongly influenced by a particular way of looking at the world and that using alternative paradigms could lead to very different approaches to policy.

In 1983 Roy Griffiths, a business man with considerable experience of a service industry, commented, about the NHS, that 'If Florence Nightingale were to be seen today she would be using her famous lamp to try to find out who is in charge'. He advocated replacing the three person District Management Team (of District Administrator, District Medical Officer and District Nursing Officer) with a single General Manager. He explained this as removing 'management by veto', which was how he described the requirement for consensus among DMT members if decisions were to be taken. In a short while administrators and their profession disappeared and a new one was born. Retired Rear Admirals and Wing Commanders competed with business people and those (soon-to-be-ex) administrators for the new general management roles. Now that the problematic 'veto' was no more and there was a single person in charge, the blocks to imaginative provision of services were removed, with improvements in quality and reductions in costs naturally taking place.

Except that they didn't.

Flirting briefly with the idea of dismantling the NHS, Margaret Thatcher's policy advisors decided the problem was lack of incentive to improve organisational performance, and that this could be generated by the creation of an 'internal market'. The 'purchaser / provider split' in which identification of health needs and purchasing of services to address them was separated from service provision, was followed by provider units becoming Trusts, no longer managed by a District Health Authority but selling their services to them, and to GP fund holders, as 'money followed the patient'. Naturally, now that not only had the veto been removed but managers and their organisations were energised by having to compete in a market, services were very quickly and imaginatively redesigned to increase quality and reduce costs.

Except that they weren't.

When changes took place they were at the margins (faster, more reliable discharge letters, shorter waiting times for a few patients) as a result of specific demands from fund holding GPs. There was considerable change, as there always had been, in clinical practice as a result

of new technologies and also as a result of a newfound emphasis on 'evidence based medicine', but the design of services as a whole remained resolutely familiar.

With GP Fund Holding unacceptable to the incoming Labour government, Primary Care Groups and then Primary Care Trusts were formed, in which GPs and other primary care professionals would influence commissioning decisions (which replaced purchasing decisions) through membership of the Professional Executive Committee which was 'the engine room' of every PCT. At the same time the government invested very considerable additional funding and, to ensure it would not be wasted, imposed access targets for a range of services (that were so far from the practice of the time that most providers found them highly challenging) and a requirement that all parts of the system live within their financial means. A culture of 'personal accountability' was encouraged, in which individual managers were held accountable for the performance of large complex interdependent systems, which was another way of energising managers to focus on organisational performance (this time against the targets). This combination of money and reforms led inevitably to the thoughtful redesign that provided better care, shorter waiting times, and lower costs.

Except that they didn't. Even when expertise in service redesign was fostered in a central Modernisation Agency, which seconded excellent health care professionals from specific specialties to generate best practice service templates, local clinicians often resisted implementing them. Targets were, largely, met through additional expenditure and, as there were other calls on the new money (commitments to additional services, new technologies, pay increases, new buildings and plant…) most organisations found it increasingly difficult to stay within budget.

So, if this wasn't the answer what would be? If removing management by veto, giving managers the power and the energy to implement change, informing commissioning decisions with clinical opinion, and ensuring sufficient redesign expertise within the system, does not lead to change on the scale that is needed, what would? Suppose all hospitals were autonomous Foundation Trusts which entered into binding contracts with powerful, well-informed commissioners and they were allowed to succeed or fail according to their ability to offer services of high quality and low costs. Suppose too that patients chose for themselves the service provider they preferred, and that there were a national tariff for payments so that efficient providers were rewarded and inefficient ones penalised, then it would be in the interests of managers and clinicians alike to redesign their services and cut out waste and focus on quality.[1]

---

[1] This is the system described by Monitor (the organisation monitoring the capability of Foundation Trusts) in English Healthcare 2008-9, An interpretation of the government's reform vision. Monitor. April 2005. There actual words were: *'Providers, purchasers and transactions are the heart of the day to day running of the [health care] system'.*

And of course that worked well.

Well it would have done. All it needed was for:

1. Clinicians to behave like professions in many other industries, recognise a management hierarchy and do as they are told

2. The press to lose their habit of reducing complex situations to simple fights between 'goodie-baddie' caricatures in which they almost inevitably cast doctors as goodies and managers and politicians as baddies

3. MPs not to mind negative coverage in the media

4. The unremitting emphasis on organisational performance not to impede the thinking across organisational boundaries that was necessary for service redesign to yield highest quality lowest cost care

5. Health care organisations in England to behave in a completely different way from those everywhere else. When similar incentives have been introduced elsewhere (e.g. the US) they typically trigger an initial reduction in costs through greater efficiencies which is then followed by a larger and more sustained increase in costs as hospitals try to gain competitive advantage either by adding 'kit' (e.g. the latest scanner, DVDs in private rooms) and/or by securing a regional monopoly which allows them to increase prices and/or 'game' successfully with funders.

This is uncannily reminiscent of the joke:

A physicist, a chemist, and an economist are shipwrecked on a desert island with only a can of beans to eat and with no tin opener or any other tools. The physicist suggests using a stone and calculates the correct angle, mass, and velocity that would split open the can. The economist vetoes this suggestion on the basis that it will spill the beans. The chemist then offers to use some local plants to make an acidic juice that will corrode the metal and open the can. The economist vetoes this too on the basis that it would contaminate the beans. Finally the other two ask for a suggestions from the economist. 'Oh this is very straightforward' he says, 'first, assume we have a can opener.'

So another change was needed and this time it was agreed that commissioning was the problem, that it needed to be tougher. So PCTs were merged into fewer, larger (hence stronger) units and a major management consultancy advised on how to make NHS commissioning 'world class'. Their detailed lists of competences, descriptors and examples of evidence that commissioners could provide to demonstrate their competence were deemed helpful by the new PCT leaders who invested considerable amounts of time, energy and money in enhancing (and demonstrating) the competence of their organisations. In this they were very ably assisted (if they chose) by the same management consultancy.

So now that tough negotiators from the high status acute care organisations met their match in world class negotiators from the PCTs and both sets were informed by better and better information and were meeting regularly as required within the competences, health care naturally became sensibly planned, with local needs well researched and converted into a credible list of local priorities , and care was delivered in seamless packages across primary, secondary and tertiary care boundaries, with clinical quality and patient experience a focus for all involved.

Well it should have done.

Instead recorded admission rates to hospital rose steadily and inexorably, to the consternation of PCTs and their bosses, the Strategic Health Authorities, and to the financial advantage of hospital trusts.

In the absence of credible studies of the causes, accusations flew. GPs were too lazy and greedy to make appropriate referral decisions. Patients were ever more demanding and were insisting on unnecessary prescriptions and referrals. Hospitals were admitting too readily, indeed were using admission as a means of meeting the 4 hour A and E target. Salaried GPs were over-referring. Out of Hours GPs were over-referring. Doctors in acute trusts were actively encouraged to offer procedures they might have rationed before. There was no increase in admissions only in coding[2].

Whatever the cause, the hugely generous growth monies that could have been used to develop 'world class' services across primary, secondary and tertiary care, based on thoughtful, sensitive redesign that incorporated the experience and enthusiasm of all the clinicians involved, made its way to acute trusts, whose managers now had no incentive to rethink ways of working, or indeed to do anything other than congratulate themselves on 'running successful organisations'[3] .

PCTs could do little but grind their teeth and make cuts in the services they directly managed: community services. Indeed these became, once again, the subject of vacancy freezes, skill mix reviews, and general asset stripping and budget reduction, just as they always had done – from the days of the old District Health Authority onwards.

In the midst of this two enquiries into 'excess deaths' at a hospital in Mid Staffordshire reported shocking lack of care on some 'care of the elderly' wards – which seemed to stem

---

[2] When every GP in Plymouth agreed to make referrals through a single referral centre, enabling accurate data to be collected, it became clear that there was no increase at all in referral rates.

[3] This was the answer given by a Foundation Trust CEO when asked how they accounted to members of their community who were deprived of other services as a result of their capture of this money 'I make no apology for running a successful organisation '.

from inadequate staffing levels[4]. At the same time the Patients Association published a number of similar case studies from a number of different hospitals. It appeared that at a time of unprecedented financial support, care in at least some parts of the NHS was not just poor but scandalously so.

Is there another way of looking at this?

A different history of the same events

The lens through which the health care system has been viewed in all these initiatives is a managerialist (or perhaps MANAGERIALIST[5]) one, strongly influenced by the economists' view of the world. This is so much part of the zeitgeist that many of us have forgotten there are others. If instead we consulted a historian, or anthropologist, a sociologist, a complexity theorist, a political scientist, a psychologist, or theologian, we would find some very different explanations.

A sociologist, for example, or a political scientist, may not have observed 'management by veto' in the old District Management Team (DMT), but a process that reflected the difficulty of reconciling a number of different interests, where some of the stakeholders hold a status that makes them ill prepared to accept challenge and leads others to find it difficult to make that challenge. In such a situation they would have predicted that any general manager would find it just as hard as the DMT to address any issues other than a few hotel services. They would have predicted too that increasing the organisational incentives (and penalties) by introducing a market would lead to a dash for cash in which acute units sought to develop new facilities and attract more patients, with the higher status centres being more successful in this than others, so that organisational energy would not be vested in redesign of existing services but in adding to them. This would also result, they may have suggested, in tertiary centres either receiving more than their 'fair share' of resources or feeling aggrieved that they hadn't.

Their forward gaze might also have indicated that the higher status secondary and tertiary care clinicians and their management colleagues would perceive PCTs, and especially their managers, as 'low calibre' – whether they were or not. This would be exacerbated, our crystal ball gazers might have speculated, by the fact that because posts in PCTS would always hold a lower status than those in the acute sector, they would not attract people

[4] Interestingly the original cause for concern and the reason why the first enquiry was conducted was a poor set of Standardised Mortality Ratio figures. These figures may have been triggered by excess deaths but it is also possible that they reflected poor coding. In which case the attention of the investigating bodies was serendipitous and we really do not have any idea just how many hospitals are offering the kind of care described in these reports.

[5] In Managing the Myths of Health Care, Feb 2006, Henry Mintzberg distinguishes between managerialism and MANAGERIALISM. We will explore this further in Chapter Two.

determined on a fast track to the top, however rapidly salaries in PCTs were escalated. PCTs would struggle, they may have predicted, to make an impact. Would they have gone as far as suggesting that acute and foundation trusts would see PCTs off – persuading the department of Health that they had 'failed'? Perhaps.

They would certainly have foreseen that all but the most self confident of SHAs would continue the age old practice of supporting acute sector managers in any dispute with primary care or community care colleagues. As a result they would have foreseen that while PCT folk would be able to see that financial pressures on their health economies were leading to short term fixes and fudges they would be unable to do anything about it. They may also have foreseen that PCTs, unable to prompt change in the design of services in the acute sector, would try and keep patients in (cheaper) primary care settings, thus using new resources to duplicate facilities already available in acute centres. These combined with the cult of personal accountability and the resulting inability to convey any bad news upwards, would lead, they may have suggested, to serious financial problems once those short term fixes and fudges could deliver no more 'savings' and the additional costs of duplicate provision and of meeting and monitoring targets kicked in.

How might they have viewed the suggestion in 2006 that increasing the 'power' of 'strategic commissioners' was what is needed? Perhaps they would have suggested that any increase in pressure on acute sector managers would mean they now found themselves between a rock ('powerful' and intransigent commissioners) and a hard place (clinicians who see no reason to change), and that the increasing pressure would lead to an ever more rapid turnover of those managers and their teams – or to a strong desire to increase admission figures.

And their view of the 2010 policy of 'liberating the NHS' from the bureaucracy of the PCTs, transferring commissioning responsibilities to clinicians? Probably as yet another attempt to bring high status autonomous professionals 'inside the tent', doomed to fail for the same reasons as all previous ones.

What is it we have been trying to achieve?

Philosopher / development economist Amartya Sen[6] encourages us to focus on what it is we are trying to achieve rather than on economic processes that are supposed to take us there. So perhaps it is worth being clear just what it is we are trying to achieve.

If the problem is that we have professionals, of sufficiently high status to be able to skew local decisions in their favour, paying insufficient attention to the needs of the tax payer and the population as a whole in their concern to be able to offer ever better services for their

[6] See Development as Freedom Amartya Sen, Oxford University Press 1999

own patients, then what we want to achieve is good quality decision making informed by clinical perspectives but not inappropriately influenced by issues of status. The solution is likely to involve high status professionals reflecting proactively on their own practices and the design of services in which they are involved[7], and taking a collective responsibility for the stewardship of the organisations of which they are a part[8], and if that is what we are trying to achieve we should give it the explicit attention it deserves.

If we do so, if we think about individuals with sufficiently high status to be able to recruit the media and the public to their cause, we can see they will be able to resist any pressure from managers or politicians to change. We can imagine too that exposing them to a centrally generated specification of best practice will influence some but is likely to antagonise just as many. And we can imagine that increasing either kind of pressure will severely reduce any enthusiasm they may have had for sharing a responsibility for the organisation as a whole.

So, if pressure from managers or from centrally recruited peers will not work what are the influences that will prompt high status individuals to design or accept change? There are several (our sociology or political science observers may suggest) and they all involve allowing[9] individuals to see for themselves that change is both necessary and possible.

1. Information

Information about how their practice and their service compares with that of others, or with their own practice/service over time, allows practitioners to reflect on what aspects of their practice and their service they could valuably change. The information needs to be credible (based on robust and relevant data) and presented in a way that is meaningful to those concerned (analysed in terms of activity clusters at the right level of detail/aggregation, for example).[10]

---

[7] Making good use of resources will always involve a consideration of whether savings can be made in some areas to allow investments in others. When savings have to be made there are four major means of doing so: cuts, rationalisation of services, redesign of services, and reflection by practitioners on individual practice. In a healthy system all four are used, starting with the last – reflection by individual practitioners. In organisations with a connected hierarchy in which the front line broadly accept the authority of their managers, in which there are organisationally sanctioned incentives for individuals and teams to reflect and redesign, this is what happens. However where the hierarchy is disconnected and especially where high status groups can operate with considerable autonomy, there is a tendency instead to focus only on cuts and rationalisation and not on redesign and reflection. *See Chapter Six for more about this.*

[8] There is some evidence in the States of clinicians being actively involved in the stewardship of some of what are regarded as the best hospitals and hospital systems (e.g. Kaiser Permanente, Mayo Clinics, Massachusetts General among others).

[9] 'Encouraging' may be as useful a word here as allowing, but only if it does not stray into 'requiring'.

[10] Interestingly, one centrally driven initiative in the late '80s did focus on information. Work undertaken at six Resource Management Initiative pilot sites brought clinicians and managers together as they devised means of implementing clinical information systems from which information could be drawn for clinical (delivery and audit) and managerial (resource

2. Peer example.
While *pressure* from peers can be resisted, opportunities to discover that the practice of peers and the design of their services is different, and exploring the implications of those differences, can lead to very constructive reflections on both of these. Engaging in this process of discovery is likely, however, to be resisted unless one of the two following features is present:

3. Managers who genuinely care about the care that is being offered and who want to help clinicians improve that care.[11]
When managers care first about care and only then about their organisations (as the best means of offering good care), and demonstrate that commitment by taking an active interest and by responding creatively and quickly to clinical suggestions about service improvements, then their credibility will allow them to draw attention to some of the opportunities described above.

This enthusiasm for care cannot deter them from stating clearly financial and other realities, and they must demonstrate their competence at dealing with managerial processes, but they must be driven first by concern for effective care, and definitely not by a primary concern for balancing books which allows care to suffer in order to achieve it.

4. Thought leaders who are from a high status group who don't impose their own prescriptions for action but who hold high expectations of the performance of others.
Similarly the credibility of these individuals allows them to provide the challenges and support that encourage mature reflection rather than defensive resistance.

5. Organisational stewardship.
Where high status clinicians are allowed and encouraged to form some kind of 'clinical senate' whose brief is to shape the organisation's strategy, to ensure the consultant body understands the internal and external pressures that make it the best way forward, and to

---

deployment and organisational performance monitoring) purposes. Unfortunately it was overtaken by the advent of the internal market, and the formal evaluation, using the dominant economic lens again, found it had not improved clinical or financial outcomes, despite the major impact it had had on clinical-managerial relationships. A sociology lens might have indicated that these just hadn't had time to yield tangible results, but that they were well on the way to doing so.

Now that an interest in information has re-surfaced, this time energised from a patient perspective (what do patients want to know about outcomes) and by the needs of boards of foundation trusts to take responsibility for the fortunes of their organisation, some useful work has been done identifying the kind of information needed for effective decisions about deploying resources and monitoring sub-organisational performance. If this is to yield genuine improvements in efficiency and effectiveness it will need to reinvent or build on the approaches of some of the RMI sites. This will mean taking a totally different approach from the national IT project now called Connecting for health which has chosen to focus entirely on lowest common denominator data for clinical delivery, ignoring the opportunity to help clinicians (and managers) understand and control costs, as well as incur and monitor them.

[11] For a discussion of what we mean by care see Chapter Five

challenge behaviours and practices that are not consistent with that direction, then results can be impressive.

*6. **First** hand stories from patients and from other HCPs.*
While second or third hand stories and written complaints can be dismissed and the motives of their authors impugned, first hand stories are a different matter. These can reflect the experiences of patients or those of other HCPs. It is often one of the most valuable outcomes of discussions about care pathways – as long as the highest status people are in the room to hear the stories, and often they are not; and as long as the discussions are well facilitated so they consist of personal narratives (this is what I experienced) rather than accusation and blame (this is what you did).

7. And especially when these become embedded into the culture of the organisation.
We can imagine that while one or two of these methods are helpful, if they became embedded in 'the way we do things round here' their impact would be very much greater. So we can suggest, and quite strongly, that it is a shift in the culture of this kind that is what is needed.

Could world class commissioning from foundation trusts have taken us there?

Looking through the economic, or MANAGERIALIST lens 'strategic commissioners' were encouraged to:

- draft legally binding contracts skilfully, using knowledge gained from poachers turned gamekeepers (people with a good knowledge of acute sector provision),
- build in penalty clauses for underperformance on a number of dimensions,
- monitor that performance carefully and exercise their power to enforce the contract provisions

on the basis that organisations would then '***have***' to deliver quality, efficiency, effectiveness …etc

Using instead a sociology or political science lens we might have said, 'yes, but ***how*** will the organisations do this?' 'How will tough contracts lead to the kind of behaviours just described?' A historian would have observed that similar pressures have not had this effect in the past. An anthropologist would have noted that when people resist change they do so for a reason: ' For anthropologists resistance to reforms is not to do with complacency, backwardness, laziness, inefficiency etc. Opposition is encapsulated in a whole symbolic complex through which people can feel their realities traduced.' [12] They would have encouraged us to ask ourselves how 'tough commissioning' overcomes those feelings that realities are being traduced.

[12] McDonald. M, Chapter 4, Audit Cultures Ed Strathern M [2000]

If, as we approach clinical commissioning, we keep in mind that what we want is clinicians in all care settings reflecting on their own practice and on the design of the services in which they are involved then, instead of emphasizing the toughness of the contract, we will encourage commissioners to focus explicitly on this dialogue between all those concerned with the provision of care.

To do this though we need to understand much more about the dynamics at play. We need to understand what it is that stops clinicians reflecting on their own practice, and on the design of services in which they are involved, in ways that draw on their creativity and good will. We need to see the health care system as very, very, much more than a set of transactions between purchasers and providers. Just as importantly we need to understand how it is possible that health care has ever been described in that way.

This is vitally important, not only because the NHS does not currently meet the legitimate expectations of its patients, nor because of the country's current financial problems, but also because of the very great impact that sociodemographic shifts (rapidly increasing longevity and equally significant decrease in birth rates) will have on demand for health services and our ability to pay for it. Increasingly policy makers and commentators are making the case for a paradigm shift, a shift in which services are radically reformed and attitudes seismically refashioned.

The shift being pursued at the moment, as described above, is one devised largely by economists who believe that the public services have been captured by the vested interests of producers and whose remedy is choice, competition and regulation leading to innovation and hence increasing efficiency and productivity.

This view of providers as self interested units of production contrasts with others that see professionals as society's way of dealing with uncertainty (its only way in some cases) and the need for professionals not to abandon their concern for society and its members and become self interested, depersonalised units of production. These other views have not been sufficiently heard or understood, and the following chapters in this book explore them and look at what happens to care when they are not.

In other words, even if is 'true'[13] that public services have been captured by the vested interests of the producers, that is a very high level abstraction, so distant from the level at which real people act and interact as to be, on its own, useless. The important question that should always accompany it is '***how*** have the vested interests of producers captured the public services?' If we understand ***that*** we can begin to devise means of releasing services from that capture. When we understand that we can find means that allow all those involved (patients, tax payers, professionals and policy makers) to flourish.

---

[13] By which I mean that this phrase is one way among many of describing in a short hand manner the complex reality which is too big to be described in full and so can only be discussed in ways that do not represent it fully

So in this book I am not suggesting that the analysis of economists is wrong merely that on its own it is unhelpful and that other fields of knowledge must contribute to our ways of thinking about this. Without these contributions the reforms demanded by economists and policymakers are dangerous.