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Do NHS services have to be provided by the NHS?

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After 18 months of political trench warfare over the health bill, the Westminster bandwagon is moving on. However, for the NHS, this is the beginning not the end. Leaders in the NHS need to make sense of the hand they have been dealt and start turning the Health and Social Care Act 2012 into a workable system that delivers better care for patients.

At times like these, it is useful to look back on the past decade or so of policy-making in healthcare – in the NHS and further afield. A constant issue that governments have faced has been finding a balance between centralisation and localism. Advocates of centralism stress and place value on 'the need to standardise' and emphasise 'equitable access'. Meanwhile, advocates of localism prize the importance of 'clinical freedom' and 'encouraging innovation'. Behind such ideas lies a recurrent, fundamental and often unhelpfully polemical debate about the best way to ensure that equitable, high-quality healthcare is available to all of a country's citizens rather than an elite few, with no wide gulf in citizens' quality of care. It is therefore well worth reflecting on the way policy makers and senior leaders in the UK have responded to the question over the past 15 years to see what that tells us about the future.

To begin, one should recognise the ideological factors in play; for example, people in the UK fundamentally believe that access to healthcare is a universal right and have strongly supported this principle since the inception of the NHS. However, in recent years, the policy development of using choice and competition to move from a universally available, average system to a higher quality, more-personalised and individually tailored system has begun to challenge these fundamental assumptions. In light of this, the issue of centralism versus localism has often and misleadingly equated the centralist view with a predominant desire for equity, while the non-centralist view has been equated to a less-managed, deregulated world in which a market philosophy sits more comfortably. This has led to decentralisation policy becoming a political question and, unhelpfully, has turned what should have been an evidence-based debate about policy into a hotly contested political debate. In 1997, the incoming Labour government did not hesitate to declare its preference on the spectrum, moving immediately to centralise and standardise the offer for patients. It abolished the previous Conservative government's flagship GP fundholding programme, which was perceived to be highly partial and, after eight rounds of applications, had only just managed to cover more than 50% of the nation. The Labour government put in place primary care trusts to commission services with universal coverage, the National Institute for Health and Clinical Excellence (NICE) to standardise decision making on treatment, and performance-managed national targets.

Interestingly, there was an opportunity to decentralise in 2000 when the Labour government set out the NHS plan – a 'national framework within which they could have encouraged local freedom' – and backed this with a huge increase in resources. However, the desire of ministers to account for the use of these resources to improve waiting times led to centralised performance management – not empowerment of frontline organisations. In their defence, policy makers of that time might point to the creation of foundation trusts, arguing that the decentralisation of power was focused on provider side policy rather than commissioning. However, many – including some former ministers – would say that the aspirations to liberate foundation trusts to act as real local agents were frustrated – first by political concessions and then by an overzealous regulatory regime. To this day, many foundation trusts question the notion of having thousands of members as part of their governance arrangements.

A second big opportunity for decentralisation came three or four years later. The NHS was performing well against central targets, with dramatic reductions in waiting times across the country, new money was coming on stream and understanding of how patients moved through the healthcare system had improved. The modernisation agency helped managers to drive change at the local level, but the NHS then overspent its vastly improved resources by more than half a billion pounds – a hugely disappointing performance. Cue a change in regime to tighten, rather than loosen, central grip. The 28 strategic health authorities became 10, and the new regime had to recover the financial position and deliver further improvements against nationally defined standards. Although the centralist culture of this regime was felt strongly across the NHS, a new rhetoric of decentralisation emerged. Professor the Lord Darzi of Denham's desire to promote quality as a priority in the NHS was accompanied by encouragement of local flexibility to approach and define the standards locally, but this happened just at the stage when all of the evidence worldwide pointed to standardising and codifying best practice in a series of mandated care bundles or standard interventions. Ironically, even when ministers were committed to decentralisation, they may have got the balance wrong.

And so on to more recent times. It may well have been the last phase of 'NHS-experienced centralism' and misplaced localism that shaped the previous secretary of state Andrew Lansley's desire to trigger major change and facilitate local decision making. The coalition government's policy in 2010 was a major

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surprise to the NHS, which did not see such a move coming because it was widely thought to be performing well, with high levels of NHS satisfaction. And there lies the rub. Given the context of time, it is indisputable that the centralising measures, alongside huge financial growth, proved their worth and clearly had a major impact in terms of driving down waiting times and infection rates, but it is not clear that these measures are the right approach for the future. Clear downsides to the predominant centralist approach have created a legacy problem for the future. For some in the NHS, the past decade disempowered local managers and clinicians and suppressed local innovation. Hence the question: will this come back to haunt us? My view would be yes. The big issues we now face, such as chronic disease and the need for better lifestyle management, make it essential for the NHS to engage differently with the public and patients to better connect with the communities it serves. This requires much more local sensitivity in policy and decision-making than we have previously seen. This time localism needs to be real if we are to succeed, and securing a paradigm shift in the balance between centralist and localist policy is, therefore, essential. Standardisation has a part to play if we are to reduce local variations in quality and experience, but only when the evidence shows that this is the best thing for our patients. It must not get in the way of genuine local engagement and leadership. However, history shows us that the popular rhetoric of decentralisation has rarely been delivered.

In a tax-funded, state-controlled system, the pressure will always be on ministers and managers to account for the NHS on the basis of the lowest and poorest performance. Centralisation typically reduces variability, keeps ministers better informed and allows them to seem more accountable to their constituents. In the NHS, perhaps more so than in other healthcare system around the world, taxpayers and service users value fairness and equity above all else. Decentralisation in this environment will always be challenging. What does this all mean for current policy? Once again, we have a political commitment to decentralise, empower the frontline and allow local setting of priorities. However, I worry that this attempt at decentralisation will face the same problems as previous attempts.

At the NHS Confederation, we are in no doubt that implementing the Health and Social Care Act 2012 is going to be one of the toughest projects the NHS has ever taken on. Actions will be required across the system if the NHS is to implement these reforms successfully and improve care for patients. A few of the most important issues are discussed below.

Freedom to act

Given the arguments above, we have to get the correct balance between central control and local determination. Clinical commissioning groups must be allowed the freedom to act and, where necessary, should be encouraged to be bold in their redesign of services. They have huge potential, operating under clinical stewardship and in partnership with health and wellbeing boards, to win local support for often quite radical service change.

At the local level, ministers, members of parliament and the NHS Commissioning Board must back leaders who make a case for the redesign of services, even when it heralds reductions in hospital-based services or changes the shape of community, primary and social care.

The regulatory system also has to help. The NHS Confederation has already put its members on high alert for excessive burdens in the new regime. When it comes to changing services, we believe that Monitor, which will soon take over as an economic regulator, must avoid implementing a regime that is overly cumbersome and that creating inflexibility and inertia as people struggle to understand its bureaucracy.

Finally, payment and pricing structures need to give providers incentives to change the shape and size of services to improve safety or productivity. Providers must not be forced to pursue growth-only solutions that keep them filling hospital order books rather than pursuing innovative services.

Healing the rifts

We need to heal the rifts that have opened as many NHS staff members have debated the merits of the Health and Social Care Act. Successful reforms require staff to buy into them. The government needs to provide a compelling narrative to support implementation of these reforms.

Running the system

Leaders from clinical commissioning groups, providers, and health and wellbeing boards need to get together regularly and resolve strategic issues across health economies. Just because no part of the system is tasked with this does not mean that leaders should not fill the space.

The alternatives are unacceptable. We cannot rely on regulators to fulfil this role because they will only be able to step in once services fail. An NHS that changes only on the back of catastrophic service failure will never win public support.

Health and social care integration

Commissioners from different parts of the healthcare and social care systems must work together. It will be almost impossible to integrate provision if commissioning becomes disintegrated. The NHS Commissioning Board, with its primary and specialised service budgets, must work closely with clinical commissioning groups, holding their community and secondary care budgets. The clinical commissioning groups, in turn, must work closely with local government, which will now hold budgets for health improvement alongside social care.

This cannot be about hierarchy or power, which are issues that have been major impediments to successful integration in the past. It is about joining up intentions, incentives and rewards so that patients receive seamless care. A family with a disabled child whose condition goes through chronic and acute phases will despair when they realise that six budgets are in play when it

comes to arranging care. Coordination will be critical to their child's quality of life.

Coherent messages

National bodies must ensure that NHS organisations and suppliers receive consistent and coherent messages. Otherwise, we risk chaos. National bodies must share business plans and any service requests they make, including outcome frameworks, and must consider their impact on an NHS that has far less management capacity to implement their requirements than before.

Leadership

One of the saddest aspects of the whole passage of the act was the needless denigration of managers and leaders in the NHS as bureaucrats. As we move to implement the act, the fact is that the right type of leadership is going to be make or break in terms of whether these reforms work.

I believe that NHS leaders will be up for the challenge of making the reforms work for patients. Failure cannot be an option, and it has to be game on for us. It is not just services that will need to be offered in different ways; the NHS needs a new model of leadership and a new culture of engagement and empowerment. As new clinical and administrative leaders emerge in the coming months and years, there is a real opportunity here. The NHS Confederation is determined to provide practical help and has set up a new policy forum to give NHS leaders a more powerful, more assertive voice, so that we can shape our own destiny and control policy.

In much the same way as 'localism' and 'centralisation' have unhelpfully moved from a question of policy to a question of politics, discrimination between 'bureaucrats' and 'clinicians' is unhelpful.

As the story of these reforms unfolds, we have to remind people that good care is provided by skilled clinicians and managers working together as leaders of the NHS acting in the interests of patients. Now more than ever we need strong leaders to make sure that high-quality care remains while we implement the bill. The politicians may well have moved on, but it is down to us to make the new system work. There is no one else to do it.

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