They should do something about it…

Your editor is often struck by the number of individuals whom he encounters in various healthcare-related settings who, through their keenness to improve services to the patients they serve identify a perceived or real deficiency in care and assert 'they should do something about it'. He often muses as to whom 'they' actually are? Sometimes this is self-evident. Individuals encountering the day-to-day frustrations associated with providing a clinical service either should be able to overcome these through their own initiative, or turn to line managers or systems of governance for assistance. Indeed, annual appraisal is supposed to bring together the lessons learnt in clinical practice to develop ourselves and improve our performance. However, sometimes 'they' are less easy to identify. Do we mean others within the provider arm of the NHS, who may be employed by the public or (increasingly) the private sectors? Do we mean commissioners, who may be difficult to identify or to interact with directly for those working at the coal face, but who seem to place increasing demands upon those that supply services, thereby applying the principles of Outcomes Based Incentivised Commissioning (sic)? Or do we mean 'the government'? Since the Health and Social Care Act of 2013 arrived to brighten our professional lives, your editor perceives an increasing distance being created between elected politicians taking responsibility for deficiencies (but rather less so for any successes) in healthcare provision and those tasked with overseeing its provision. In an effort to address this question, I have in this column selected three pieces of evidence that have emerged since last I wrote, each of which cast some light upon this issue.

The first is the *NHS Five Year Forward View* ('5YFV') published in October 2014 by NHS England, which sets a positive spin on the future, based around seven models of care.[1] These include multi-speciality community providers, primary and acute care systems, urgent and emergency care networks, the viable smaller hospital, specialised care, modern maternity services and enhanced health in care homes. The plan is compelling, calling for change and action regardless of the funding crisis in which the NHS is currently embroiled. In some respects the report was more about the chief executive officer of the NHS and the report's author, Simon Stevens, than its content. In challenging politicians to provide the funding needed to deliver his vision, Stevens was praised for apparently rising above narrow partisan debates, and thereby shifting the soubriquet 'them' from politicians towards the NHS leadership. The chief executive's position has not been associated with glory in the past, but the mix of national and international, public and private healthcare experience that Stevens brings to his role suggests that he may be better qualified than many to shoulder the burden now resting on his shoulders. The plan itself in many respects follows hares that have already been set running, and in avoiding yet more radical change it is both novel and welcome. Moreover, its emphasis upon variable and individual solutions for service delivery according to demographic and geographical variations accords very well with the Future Hospital Commission's stance that local ownership and needs should define the precise model of care used in specific communities. Furthermore, 5YFV reinforces the message that changes to the NHS need to occur from within organisations rather than being driven from the centre, representing a move away from the command and control structure upon which the NHS has relied to date. Readers may be kind enough to recall your editor's piece on regulation and the tendency of national bodies to descend upon provider organisations and impart their views on precisely how, what and where care should be provided. Taking the NHS out of politics completely may not be either desirable or possible, but letting the Service become 'they' rather than politicians seems to your author to be a step in the right direction, and to accord very much with the principles upon which the Future Hospital Programme was based.

The Dalton Review[2] published in December 2014 was to a certain extent overshadowed by Simon Stevens' vision which emerged two months before. Dalton was asked to explore ways to address the challenges faced by providers of the NHS in the particular context of variations in standards and access to healthcare delivery. Stevens' report expressed the view that it is not how or where healthcare should be provided that should preoccupy us, but rather that it is delivered with equal and open access to all and to a common standard. Any unacceptable variation in quality needs to be recognised and addressed. Dalton acknowledged that the district general hospital established by the 1962 Plan can nowadays struggle in isolation to meet the needs of any given population. This probably comes as no great surprise to readers of this

publication, but the idea that institutions should be preserved partly because they exist and are seen to be 'owned' (however erroneously) by local populations needs to be challenged. Dalton's contention is that there is no right or wrong organisational form; what matters is what works. He suggests that collaborative solutions should be encouraged, involving shared services working across organisational boundaries seven days a week to meet relevant and defined standards, or using integrated governance arrangements covering primary, secondary and social care designed to bring coherence to a locality. Contractual and consolidated models should allow opportunities for successful organisations (at least in theory) to bring proven leadership processes and expertise into those unable to demonstrate clinical and financial viability.

Your editor feels that Dalton's excellent work has not necessarily achieved the prominence it might. The way in which organisational change occurs is extremely important, and in many ways will under pin any success that the FHC might achieve. Dalton's conclusions that one size does not fit all, that quicker transformational and transactional changes are required, and that ambitious organisations with a proven track record should be encouraged to expand their region of influence may seem self-evident, but is the first time to your editor's knowledge that these principles have been stated so boldly and clearly. However, two weaknesses in the report are apparent. First, what motivation strong organisations might have to collaborate with or even take over less successful providers is unclear. Short termism is rife within the NHS, partly because of year-on-year variations in tariff, and also because of the very rapid turnover of leaders, at least at the trust chief executive level. The penalties of failure are also manifest in Mid-Staffs and other recently well-publicised cases. In the healthcare environment in which your editor practises there is no evidence that successful trusts are queuing up to take over or even assist the less successful brethren. Second, the composition of the Dalton review panel was almost entirely non-clinical. It is inconceivable to your correspondent that a review body looking at reorganising the armed forces could be composed entirely of civil servants rather than generals, admirals or air vice marshals, but I suggest this message comes across loud and clear from Dalton. Even if clinicians are not able to contribute to the extent that senior managers can to this kind of debate – a contestable view – the perception of engagement and ownership is crucial. Partisanship and tribalism between managers is just as rife in the NHS as that seen between clinicians and specialities. Anything that can be done to overcome this would seem to be highly desirable.

Lastly, the King's Fund Report on the reconfiguration of clinical services *What is the evidence?* published in November 2014[3] presents a brilliant synopsis of how the National Clinical Advisory Team (NCAT) conducted reviews between 2007–2012. NCAT was set up to provide an independent clinical assessment of local reconfiguration proposals, requests for its advice coming predominantly from project teams attempting to lead reorganisation. Sometimes the strategic health authorities or Gateway (providing independent assurances to the Cabinet Office on significant programmes and chance) suggested NCAT become involved. Candace Imison writes in more detail about this report (which she led) elsewhere in this edition of the *Future Hospital Journal* and I do not wish to steal her thunder. Nevertheless, the overview of which services were subject to reconfiguration, what the key drivers were in each case, what evidence was available and used to guide service change and the processes through which this was achieved makes fascinating reading. However, it again smacks of organisations trying to use 'them' (in this case NCAT) to justify, plan and carry out changes that they could not achieve alone.

The common theme in all three reports is a drive towards more integrated healthcare, which segues us neatly into the special theme of this issue of the journal. The report of Simon Stevens starts the ball rolling in this direction, and empowers the providers of healthcare to assume an increasingly central role in identifying what the populations they serve need in the way of healthcare provision, and how it can best be supplied. The Dalton Review extends this in making specific suggestions concerning processes that may facilitate change. The King's Fund report shows how this was done in the past, often in a fairly piecemeal and not always successful manner.

What can we conclude? In future, 'them' is moving towards being 'us'. We have to assume responsibility at the grass roots level for making changes that will improve healthcare. The reports cited here provide valuable insight as to how that might be achieved and within what framework. It is now for us to get on and do it. ■

Timothy W Evans

References

1 NHS England. *Five year forward view.* London: NHS England, 2014. Available online at www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf [Accessed 15 April 2015].

2 Dalton D (chair). *Examining new options and opportunities for providers of NHS care. The Dalton Review.* London: Department of Health, 2014. Available online at www.gov.uk/government/uploads/system/uploads/attachment_data/file/384126/Dalton_Review.pdf [Accessed 15 April 2015].

3 Imison C, Sonala L, Honeyman M, Ross S. *The reconfiguration of clinical services.* London: King's Fund, 2014. Available online at www.kingsfund.org.uk/publications/reconfiguration-clinical-services [Accessed 15 April 2015].