

Localism and Big System Change in the NHS

A Healthcare Infrastructure Forum debate

Can the new localism in the National Health Service deliver the innovation needed to avert a forthcoming crisis?

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The founding members of the Healthcare Infrastructure Forum are from leading UK and European university research groups and others with decades of experience, working with companies and organisations in healthcare and related infrastructure. From this multi-disciplinary knowledge base we view the issues from a range of perspectives.

We are indebted to those who took part in a special Forum debate on 22 May 2013, where many of these ideas were discussed.

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Introduction

Is localism really fit for the purpose of transforming the NHS?

The shift towards localism in the NHS, with the creation of Clinical Commissioning Groups and devolution to Foundation Trusts, has occurred at a moment which some observers regard as a 'tipping point' for the health service. A perfect storm of an expanding older population (many with long-term conditions), combined with constrained public spending, is gathering momentum. All this raises the question whether the post-2013, more locally-determined NHS has the leadership and governance to adapt and change in time.

We invited three key thinkers – respectively from government, NHS management and healthcare academia – to tackle this issue. They set out their arguments on localism and the NHS crisis at a forum involving senior figures from the NHS, universities and industry.

Lord Norman Warner, former Health Minister and one-time director of the country's largest social services department, comes from an interesting background. He helped to engineer one of the biggest and most successful shifts of resources from acute into community-based care – 'Care in the Community' – during the Ken Clarke era. He was also a health minister in the boom years, when the NHS enjoyed its most generous funding. He warns now of an impending NHS 'train crash', whose avoidance requires a rapid shift to strong, central leadership.


Dr Mike Burrows, NHS England's Director for Greater Manchester, sets out the often tortuous process by which he is achieving change through building alliances and consensus at a local level. His prescription for the future – a rationalisation of acute care plus tackling variation in NHS practice and performance – is rooted in long experience. He, too, worries that time for action is short and that the system retains many and various means to frustrate urgent, much-needed change.

From Universities UK, John de Pury explores the growing development of Britain's 'healthcare innovation infrastructure', designed to deliver transformation. Including academia, healthcare institutions and industry, it should, on paper at least, be the envy of the world in its capacity to articulate and implement change. There are, however, weaknesses, he says, as innovation is too often directed unsuccessfully from above, rather than demanded and 'pulled' from below.

These insights have created a vibrant discussion from colleagues wondering why the NHS is so slow to adapt, compared with other industries, and why the power to frustrate change seems so much greater than the energy to innovate in the face of such danger to the NHS.

With the launch of this paper, the first of the new Healthcare Infrastructure Forum's debates, we hope that you will be inspired by the discussion and contribute your views via our website:

www.healthcare-infrastructure.net



Professor James Barlow

Professor of Technology and Innovation Management, Imperial College Business School, and Co-Director, Healthcare Infrastructure Forum

1. Localism will not fix the bust NHS business model



The NHS is living on borrowed time and needs system-wide, rapid change. We cannot rely on localism to deliver what is needed to avert a serious crisis, argues **Lord Norman Warner**, a former Health Minister.

I don't doubt that the NHS and social care need local innovation, particularly around integration of care for the millions of people with chronic long-term conditions. I could agreeably discuss integration, competition and new providers, building up services in the community instead of hospitals, consolidation of specialist services on fewer sites, more use of technology and patient self-care, 'total place' projects for better use of public expenditure. And many other worthy and worthwhile topics that need to happen.

However, we have talked about these topics for years and, in some cases, for decades. What we never do is go for major change at scale and pace. We failed to do it in the years of plenty in the 'Noughties' and now we are in a decade of austerity. So, at the risk of depressing you, I want to explain why we now need system-wide change across the NHS – and rapidly – and I seek to question the deliverability of this change purely through localism.

The NHS wasted the Labour years of plenty and, as a government, we didn't ask enough of the NHS for the extra taxpayers' money we pumped in.

My starting point is that the NHS is living on borrowed time. Its business model is bust. It is like IBM and ICL several decades ago – pre-occupied with mainframes while the world was moving to PCs. It wasted the Labour years of plenty and, as a government, we didn't ask enough of the NHS for the extra taxpayers' money we pumped in.

Now we have a political class that knows we cannot go on like this but is reluctant to engage with the public on what needs to be done. Contrast this with Enoch Powell: 50 years ago, he told the health professionals and the public that we should 'tear down' the Victorian asylums.

There are five issues I will briefly mention that make radical change inevitable – whatever the political obstacles. These are finance and the economy; NHS productivity; demography and disease profile; the wrong business model; and our bankrupt social care system.

First, finance and the economy. The UK's deficit reduction timetable has been extended to 2017 and is likely to be extended further. Given the cuts already made in other public expenditure – especially local government – the NHS cannot sensibly be ring-fenced in future public expenditure rounds including the current one.

A recent report from the Nuffield Trust suggests that the NHS faces a decade of austerity. Its findings are a £44-54 billion funding gap by 2021/22 for the NHS unless it delivers unprecedented productivity gains or the public finances improve sufficiently to allow NHS funding to increase significantly faster than inflation. Whoever governs after 2015 will have to face up to this economic and fiscal reality.

Let's look at NHS productivity. The NHS is supposed to be in the middle of meeting the so-called 'Nicholson' challenge of saving £20bn in real terms over four years. This means making at least four per cent efficiency gains for four years on the trot and maintaining those gains in perpetuity.

The NHS has never made a four per cent real terms efficiency gain in any one year, let alone four years in succession. Such evidence as is in the public arena suggests that most of the savings made so far have been made through pay restraint, one-off items and top-slicing rather than significant lasting system change. The NHS productivity record in the years of Labour plenty hardly encourages reliance on the NHS driving productivity. According to the Office of National Statistics, between 1997 and 2007, NHS inputs went up by nearly 60 per cent and outputs went down by four per cent. Even allowing for quality improvements, this is poor.

So what about demand? Bad news as well. A century ago there were 60,000 people in the UK aged over 85. There are now 1.5m and this number will double by 2030. Not only are we living longer – a cause for celebration – but very often we are living with a greater combination of diseases. Many of these conditions we have inflicted on ourselves through smoking, alcohol, bad diet and lack of exercise. There are now about 17m people with long-term chronic conditions that cannot be 'cured' but which have to be managed. This rising demand and complexity might be manageable if the NHS had adapted its business model to the changes in its core business since 1948. But it hasn't.

Almost without people noticing, the NHS core business has become managing chronic conditions in an ageing population but with an acute medicine add-on set of services. However we have retained for the most part an expensive, hospital-dominated, service delivery model with insufficient competent community-based services for managing the core business.

Study after study reveals that 25-30 per cent of the people in acute hospitals should not be there. Yet our reward systems incentivise hospital care and people working in hospitals. We seem politically, professionally and managerially incapable of changing this failing business model at the pace now required. Nevertheless, change it must because, as a recent report by the Public Accounts Committee – under a Labour Chair – concluded, every NHS organisation will have to make significant changes to patient services to become financially sustainable. When she's finished with Google, Apple and Starbucks, I hope Margaret Hodge will return to the NHS.

With an ageing population, more chronic conditions and the need for a more community-based approach, the NHS needs to integrate its services with a financially-robust, means-tested, adult social care system. Unfortunately the social care system is neither financially robust nor well-integrated with the NHS – other than in a few places. Publicly-funded social care has never been as well-funded as the NHS.

We need leadership to force consolidation of 24/7 acute services on fewer specialist sites; redeployment of resources - staff and money - to better community-based services, integrated with social care; and rebuilding the funding of social care at the expense of the NHS.

The latest survey of Directors of Adult Social Services shows that, by next April, local councils will have stripped out £2.7bn from their budgets since 2010. This is the equivalent of 20 per cent of their budget. In nearly 90 per cent of councils, you are eligible for services only if your condition is 'critical' or 'substantial'.

Localism will not fix the bust NHS business model

Demography will worsen matters, year on year, by 3 per cent or, in financial terms, by some £500m a year. The consequence of not funding social care properly is plain to see in increased NHS emergency admissions of elderly people to hospitals and their longer stays in expensive and inappropriate medical wards of acute hospitals.

This will not change with the new Care Bill or implementation of the Dilnot Commission proposals unless we plug the gap in social care funding and stop the gap opening up again. This means, in my view, a transfer of resources from the NHS of a sum in the order of £2 billion plus full funding of the Care Bill's implementation.

The *Economist* summed up the state of the NHS in its edition of 6 October 2012: 'The NHS is a strained system struggling to keep its costs in check and producing patchy and sometimes dreadful outcomes for patients where management falls short.'

The NHS is not well placed to cope with the years of austerity ahead. There is an urgent need for the kind of leadership that can force a consolidation of 24/7 acute services on fewer specialist sites; redeployment of resources - staff and money - to better community-based services, integrated with social care; and rebuilding the funding of social care at the expense of the NHS. And I haven't had time to talk about beefing up public health, conspicuously absent in the new Care Bill.

I do not see how local initiatives alone can drive the change required in what is a national, risk-pooled, health service funded centrally from taxation with all the Parliamentary accountability that involves.

Local initiatives can make a contribution but it must be very doubtful whether they can drive the necessary consolidation of specialist services on fewer sites and the extraction of resources from hospitals to fund better integrated community services without central political and professional leadership. I cannot see this leadership emerging before the 2015 Election. However, unless there is urgent action, I can see a financial train crash after the 2015 election. Afterwards I fear it will be panic stations as the money runs out, the Treasury takes charge and radical NHS funding changes are considered.

It is worth bearing in mind that in the British Social Attitudes survey of 2012, 44 per cent of people thought that in 10 years' time the NHS would not be paid for by taxes and free for all. The 1940s' consensus on funding and running the NHS is breaking down. This is the context within which localism now has to operate.

I can see a financial 'train crash' after the 2015 election. I fear it will be panic stations as the money runs out, the Treasury takes charge and radical NHS funding changes are considered.

The Rt Hon Lord Warner of Brockley was Minister of State for Health, responsible for NHS reform in the last Labour government. He is one of the three members of the Dilnot Commission on Funding of Care and Support and a former Director of Social Services for Kent County Council.

2. Harnessing localism for major service change in Manchester



The creation of CCGs and other new NHS bodies has multiplied stakeholders and created challenges of leadership and governance just as acute services require major reconfiguration, explains **Dr Mike Burrows**, Director, Greater Manchester, NHS England.

As we plan big and vital service change in Greater Manchester, the issues raised by, on the one hand, localism and, on the other, more centralised decision-making present many challenges.

The first challenge for change, following the Health and Social Care Act, is that there are now more players involved in any process of change. Complexity has increased considerably - it is more difficult now to establish both mechanisms for change and leadership for change. Power and decision-making has moved, in some respects becoming more localised, in others closer to the centre.

Prior to 2013, under the old arrangements, a unified allocation went directly to Primary Care Trusts. This system was quite hierarchical, but relatively straightforward to understand. However, the desire to place resources more locally with GPs means that a series of further arrangements have had to be put in place. These are to make sure that all those functions that once sat in Primary Care Trusts and Strategic Health Authorities are appropriately picked up. So, for example, Public Health England's resources have shifted upwards in the hierarchy. NHS England Commissioning Board resources for specialised services and primary care have actually moved away from where patients currently are. These different movements show how the system has become more locally determined in ways - and more centralised in others.

How does all this effect capacity for change? Under the old arrangements, we achieved substantial big service change in Greater Manchester. We closed four maternity units. We centralised acute stroke services. We put major trauma centres in place. This work was not very dissimilar to what has happened in London. The process was reasonably straightforward. We established a joint committee of the 10 PCTs across Greater Manchester. There was, of course, plenty of heat generated in public consultations, but, relatively speaking, the noise was fairly quiet.

Politicians challenged plans as we went through that change process but, by and large, it was managed on a reasonable basis. It worked well as a mechanism for engineering major change. The Strategic Health Authority had responsibility for providing assurance up towards the Department of Health in terms of the processes that we put in place and it was all relatively straightforward. The processes for change are now more complex.

But we really do need change – some issues were not confronted properly in the recent times. We have a population, including the inflow of patients into Greater Manchester, of approximately 2.8m people. There are 10 local authority areas within the conurbation, in each of which, rather like London boroughs, typically resides a huge amount of civic pride. So places like Bolton, Salford and Oldham have this great sense of pride in themselves and in their own NHS institutions. That can create challenges for us because Greater Manchester has an oversupply of acute services. Some parts of the country would be stunned if they saw some of the infrastructure we have here.

Too much of the new money that went into the NHS in Greater Manchester supported a configuration of services that should have been addressed, but which we were not, perhaps, brave enough to tackle.

Harnessing localism for major service change in Manchester

We have four Type 1 hospitals with accident and emergency departments, relatively close to one another. Over the past 20 years, we knew this was an issue that we had to address. However, for a variety of reasons – lack of political courage and probably because the platform was not burning sufficiently hotly – we tolerated this set-up. In reality, too much of the new money that went into the NHS in Greater Manchester supported a configuration of services that should have been addressed, but which we were not, perhaps, brave enough to tackle.

When MPs challenge me across the table and say: 'What are you going to do to my local accident and emergency services?' I say that I am actually trying to save them.

So we have overdue questions to face up to in terms of service reconfiguration – at a time when we have just introduced a new system of decision-making. We did anticipate this problem, to some extent. Two years ago, as the precursor to the changes that have recently come into place, Primary Care Trusts were clustered into groups. In Greater Manchester, we gathered 10 PCTs into a single cluster so that for the first time we had decision-making at a Greater Manchester level. We took that opportunity, with single leadership, to start asking increasingly pressing questions. We started to debate healthcare infrastructure across Greater Manchester and whether it was appropriate for the future.

To address what Lord Warner has been referred to as the impending NHS 'train crash', we spelt out for politicians and Acute Trust leaders the economics of what the future looked like. We came up with some fairly scary figures. Even with an annual cycle of cost improvement and cost reduction taking place within institutions, we could tell that, within a fairly short period, we faced some major challenges to avoid a potentially catastrophic meltdown of services.

We had a debate amongst ourselves. Do we let the market rationalise our services for Greater Manchester or do we go through a process of managed change? We have met regularly with a group of MPs in Westminster. We explain that they might not like what we are doing, but it is the lesser of the evils. When MPs challenge me across the table and say: 'What are you going to do to my local accident and emergency services?' I say that I am actually trying to save them.

The services, I explain, may end up looking different and may not provide the same kind of service as is currently on offer. But, if we don't do this piece of work now, then, in three or four years' time, they probably won't have an A&E department. I tell them: 'These are the choices you face. We've read the runes and here is the time frame to tackle the melt down.'

The process is already under way. We already have an Acute Trust in Greater Manchester with what would, in the past, have been considered an unimaginable cost reduction programme. They have really grasped this process with us now as part of this shared leadership arrangement.

Nevertheless, leadership has been a big challenge for us. We have gone from 10 PCTs to 12 Clinical Commissioning Groups. We have worked for two years to make sure that we bring together at least some of the clinical leaders from those new organisations. Many of these clinical leaders have come from small GP practices that probably did not give too much thought previously to the macro-economics of the NHS in Greater Manchester. We recognised that, as PCTs were abolished and CCGs took over leadership, we had to prepare them for the leadership responsibility to stand up and begin advocating at a Greater Manchester level for the series of changes that we think need to be put in place.

That process has gone well but it has taken time. It took two years to get that leadership in place. Time is now a major issue for us. It was a luxury that we had two years and now we must go to public consultation for the changes that are needed.

The constructive dialogue we have had with them promises to hold us in good stead and we won't get hammered. We will be faced with a more qualified, better informed critique.

Governance has also been difficult for us. The scope of the work we are doing on service reconfiguration incorporates commissioning groups and area teams, looking at the areas of overlap that sit between CCGs and the ambit of local government. We are also doing work that has direct implications about how Primary Care is configured in Greater Manchester. So there are plenty of difficulties. For example, the Health and Social Care Act 2012 does not set down in express terms how CCGs can be formed in a joint committee to undertake, at scale, a piece of work like this. In the past, it was more straightforward – you would create a joint committee of PCTs and it could consult on service changes. There will need to be secondary legislation to re-establish this piece of governance for CCGs.

Politics have been a challenge. We are working closely with political leaders in Greater Manchester. Everyone knows that the integrated care model which underpins much of the redesign of hospitals in Greater Manchester aims, by taking services out of hospitals, to provide the critical solution to ensure the survival of social services in the future.

I am not naïve enough to think that, when the rubber hits the tarmac in the heat of the battle, all the politicians will stand shoulder to shoulder with us. That will be challenging for them, particularly as opposition parties start to position themselves. But the constructive dialogue we have had with them promises to hold us in good stead and we won't get hammered. We will be faced with a more qualified, better informed critique.

I am glad to say that NHS England has made clear that it intends to press ahead with the reconfiguration of services and not be delayed by electoral timetables. That is music to my ears because we cannot afford to waste any time, for all of our sakes.

Dr Mike Burrows is Director, Greater Manchester, NHS England and Chief Executive, Greater Manchester PCT Cluster



3. Driving innovation in local and regional health economies



The new Academic Health Science Networks have a mission to create broad partnerships to spread innovation for the better health and greater wealth of regional populations. **John de Pury**, of Universities UK, assesses the opportunities and challenges.

I have been asked to discuss the new Academic Health Science Networks (AHSNs) and how they might improve health and create wealth in 15 regions across England. How will they operate to innovate? Do they offer something different from the traditional top down processes of change in the NHS?

We recently celebrated International Clinical Trials Day which commemorates the work of a Scottish naval surgeon, James Lind. In the 18th century, scurvy was still the curse of the Royal Navy, killing more men than the French and Spanish fleets combined. Caused by Vitamin C deficiency, the disease affects connective tissue leading to loss of teeth, sunken eyes and hair falling out, a picture reminiscent of junior doctors in the 1980s or NHS chief executives today!

Famously, in 1747, Lind took 12 sailors with scurvy and divided them into six groups of two. Group one was given a quart of cider each day - they remained ill but happy. Group two was less lucky: they were given 25 drops of sulphuric acid daily. The third group was given six spoons of vinegar and the fourth half a pint of sea water. Group five was given oranges and lemons and started to get better. Group six had a spicy paste which didn't do the sailors any good. So James Lind was able to confirm that oranges and lemons were a cure for scurvy, the first systematic clinical trial.

There is of course a bigger story. Lind was not the first to understand the connection between citrus fruits and scurvy.

For example, in 1617, John Woodall, first surgeon-general to the East India Company, was detailing in the 'Surgeon's Mate' that, as a cure, 'the Lemmons, Limes, Tamarinds, Oranges, and other choice of good helps in the Indies... do farre exceed any that can be carried tither from England'. Many others had observed the connection, but Lind was the first to offer systematic proof. He had bridged T1, the translational gap between discovery and effective first use.

Yet, despite this proof, nothing much changed for another half century. It's this next chapter of the story that is particularly relevant to the mission of the AHSNs, ensuring that healthcare innovation influences practice and policy, quickly and effectively. This is the 'second translational gap'.

Not until 1794, 47 years later, did Rear Admiral Alan Gardner make widespread the practice of supplying citrus fruit juice to sailors as well as ensuring establishment of plantations around ports the Royal Navy was likely to visit.

Two features of this story are particularly interesting. First is exposure of the so-called 'valley of death', the often lengthy period between healthcare discovery and actually delivering practice at scale, a period now said to average 17 years.

Second, and possibly more important, Rear Admiral Alan Gardner took his action in response to rising demand from ships' surgeons and sailors. So the Gardner intervention was an innovation pulled by service users – by mutinous demand - rather than simply being pushed from above.

Even simple interventions for simple healthcare problems often require a range of individuals, groups, disciplines, institutions and sectors to be brought to bear.

The broader point in this well-known story is that even simple interventions for simple healthcare problems often require a range of individuals, groups, disciplines, institutions and sectors to be brought to bear. The challenge to those of us involved in innovation is engineering ways to make that process happen more quickly and more easily.

This brings me to the licensing this summer of Academic Health Science Networks. These new bodies – 15 of them so far – have been designated by NHS England to lead the innovation agenda, as first set out in the *Strategy for UK Life Sciences and Innovation, Health & Wealth*. They are new infrastructure tasked with accelerating the spread of innovation in regional health economies in England.

The idea of AHSNs owes much to the global development of academic health science. Academic health science centres (AHSCs) started in the US as a simple response to competition: they join a university with a hospital, thereby linking research and service delivery. The centres are varied in structure and quality, hence the phrase: ‘if you’ve seen one academic medical centre, you’ve seen one academic medical centre’.

Over the last 15 years, we have seen an extension and expansion of this model, summed up in a critical paper from Dr Victor Dzau, Chief Executive of Duke University Medical Center in the US. Dzau’s paper spoke about a recalibration of academic health science centres, redirecting the tripartite mission of those centres around research, education and delivery so they are aligned and focused specifically on delivery of better health for a particular population.

It is encouraging to see how in Britain today, we have, at least on paper, the infrastructure to achieve this goal. We have world-class universities and medical schools, and a comprehensive translational research infrastructure including AHSCs, Biomedical Research Centres and Biomedical Research Units. CLAHRCs (Collaborations for Leadership in Applied Health Research and Care) deliver key functions around applied research and implementation. Now, with the creation of the new AHSNs, we have a systematic infrastructure for delivering innovations across England.

The AHSNs’ mission is to bring together commissioners, providers, academia and industry to spread innovation at pace across the NHS. They have a dual purpose. One is to improve health and the second is to create wealth by delivering step changes in the way the NHS identifies, adopts and spreads new innovations. More recently, they have also been charged with implementing key local commitments within innovation, health and wealth as decided by NHS England, raising questions about whether the centre is reeling in their autonomy.

AHSNs are, in the simplest terms, provider-led networks, inclusive of all NHS organisations within their geographical footprint but also inclusive across sectors, so they include all major higher education institutions, universities and also any industry in those regions.

Five of them have academic research science centres nesting within the networks and seven have CLAHRCs. All of those AHSNs that had such existing infrastructure within them put forward very convincing applications for licenses.

Lower-than-expected funding might turn out to be good fortune. It may allow them to resist the ‘push’ on various agenda from the centre and focus more on the ‘pull’ from below that history suggests must be harnessed to make innovation happen.

Driving innovation in local and regional health economies

Can AHSNs prioritise, generate and maintain political will to deliver with these small budgets?

However, in the current public sector battle for resources, the AHSNs' system-integrating network for change in the regions has ended up squeezed. Initial promises of around £10m a year per network have been degraded to a maximum of £5m, with some of the networks getting close to £1m per year. So there are, for example, networks that are smaller than the CLAHRCs in their regions.

Interestingly, some AHSN leaders have suggested that this lower-than-expected funding might turn out to be good fortune. It may allow them to resist the 'push' on various agenda from the centre and focus more on the 'pull' from below that evidence suggests must be harnessed to make innovation happen. We'll see.

So what is possible with these networks? First, these are cross-sectoral, hybrid organisations, very much NHS-led but, in the Government's terms, sitting outside the NHS, joining industry, the NHS and academia to improve health outcomes for populations and patients and to create wealth in their regions. From my university perspective, I see big opportunities. Health and wealth is core business for UK universities. There are about 50,000 researchers involved in health-related research. We get about £2.2bn worth of funding out of health related research. But we also give back in the sense that we create wealth. Indeed, non-academic impact is increasingly at the core of our mission.

The first opportunity and goal for AHSNs is engagement of their health sector members and across all other relevant sectors. It will be important to identify quickly a few areas of population health requirement. So, for example, Chris Streather, Managing Director at the South London AHSN, recently described how south London will have a focus on dementia and will use that focus and success in that area to engage its members in future work programmes. His goal is to use the momentum from initial successes to deliver further change.

In other countries, one can see examples of success that should encourage AHSNs. I recently visited the Welfare Technology Network in Odense, southern Denmark. It's a really interesting alignment - a possible future for AHSNs - drawing together local government and a great deal of political will, along with health and social care, universities in the region and industry.

The network is aligned for delivering excellence to an emblematic citizen - never a patient, always a citizen, in this case a frail, elderly citizen. So they are able to focus industry, healthcare innovation and also some structural innovation around that.

Secondly, I have been encouraged by an organic local partnership in Leeds. It is nothing to do with AHSNs. In Leeds, the Chief Executive of Asda - which is headquartered in the city - is leading an engagement involving business plus local health and social care, built around the critical civic identity that, as Mike Burrows explains of Manchester, is an important regional asset. It will be interesting to see what this prioritisation, plus business and political will, can deliver in Leeds.

There is much to take heart from in the development of local and regional health and social care innovation infrastructures in Britain. The big question for AHSNs is: can they prioritise, generate and maintain political will to deliver with these small budgets as the NHS faces so many big decisions and there is so much instability around them?

John de Pury is Senior Policy Adviser at Universities UK, which represents more than 130 universities.

4. Localism and Big System Change: Discussion

Q: How do we assess evidence for shifting from acute care into more community-based services?

Lord Norman Warner, former Health Minister:

It is vital to look at what actually happened when it worked well. Consider the development of community care in Kent, for example - where I was director of social services - but also in the other southern counties, away from the urban centres, places such as Essex, Sussex, Kent, Hampshire and Hertfordshire. They closed beds in care homes and nursing homes and replaced them pretty successfully with a totally different care management model.

The care manager simply brokered – in NHS speech – services, so they were the forerunner of personal budgets. In Kent, everyone said that we would have to use social workers. But we didn't. We recruited a totally new breed of people, mainly women returners to work and trained them to be care managers. They were practical with no professional baggage, so they didn't come with a view about what services had been provided in the past. They aimed to listen to people and work with them within a budget to do what they most wanted, which was to stay in their homes well-supported and not have to live in residential care.

In this process, we changed the model of care. It only went wrong when the budgets were not maintained by central government, which established the programme with a big injection of cash, based on savings from social security spending that had gone into building a network of private nursing homes.

That money was redistributed to local authorities following a blazing row between Mrs Thatcher and her Health Secretary, Ken Clarke. Her hatred of local government was far greater than her hatred of the NHS, so she preferred the NHS to get the cash, but Ken Clarke prevailed.

That is a good change programme to look at. Unfortunately, the NHS often spurns looking at change programmes in local government for delivery of local services. But you have to be prepared to do low level stuff – not all professional-driven stuff – in the care sector if the NHS is actually to survive. And you are going to have to place some big bets, because if the people running the services don't place the bets, I'll tell you who will place the bets. It will be the Treasury after 2105. They will place the bets for you. They will turn the NHS into an insurance system.

If you look at prisons, at psychiatric hospitals and, I think, at acute hospitals, you find again and again that, if you have beds, then they will be filled.

Lord Warner, former Health Minister

You will find that if the professionals can't run it now properly as a tax-funded system, the Treasury will narrow the range of services, move to a pooled risk system that prevents catastrophic decimation of people's resources. Beyond that, people could be left to fend for themselves with a mixture of tax-funded care and their own resources. That's where all this is heading unless enough people wake up quickly enough to change the way things are done.

John de Pury, Senior Policy Adviser (Health Research & Innovation), Universities UK:

We have to come back to the question of evidence, particularly evidence about what really works to reduce emergency admissions. At the moment, 'magic bullet' solutions, such as telecare, are simply not working for the kind of prices that we are willing to pay. That does not mean that the key challenge of reducing emergency admissions goes away. We still have to tackle that challenge, but we have to bring in evidence to answer the question. If we just go from one policy to another without really looking at the evidence, we will end up with chaos.

Localism and Big System Change: Discussion

Lord Norman Warner:

In a perfect world, you are right. But we have got three years to sort out the problem. So if there is some evidence, we've three years to produce it. For myself, the striking evidence is that, if you look at prisons, at psychiatric hospitals and, I think, at acute hospitals, you find again and again that, if you have beds, then they will be filled. That is an eternal truth of public sector services over this country and other places.

Dr Mike Burrows, Director, Greater Manchester, NHS England:

I have been involved in a recent piece of work in which we looked at reducing emergency admissions. When I looked at the evidence base for some areas of care provision, I found that, for every bit of supportive evidence about putting community services in place, you could find another piece of evidence suggesting that it did not work.

However, we do know that there is a huge amount of unexplained variation occurring in our healthcare system and we cannot ignore that. It is not explained by social economic status and it is not explained by demographics. If you look at two GP practices half a mile apart with similar populations, there is, for example, enormous variation across a range of indicators in terms of how their patients access hospital. There has to be something in that.

I recently came back from a trip to India. They are building some really low-cost models for primary care. I came across one organisation that is providing a GP consultation, prescription and laboratory services for one pound.

Loy Lobo, BT Health

I would also say is that there is now extremely good evidence that we should re-arrange hospital services. But, whatever we try to do, we often find that professionals will battle each other, tooth and nail, to maintain services that are patently not in the interests of patients. So, we have a lot of work to do there too in terms of winning hearts and minds.

Loy Lobo, Director of Strategy and Innovation, BT Health:

We see variation and we can't explain it because we don't have enough data and we don't have consistent processes. In every other industry where they want to take variation out systemically, they have consistent processes and then it is easier to see how to take the variation out. We are not there yet in healthcare. We need to get there.

So where do we get the evidence? I just came back from a trip to India. A revolution in healthcare is taking place. People pay for their own health care and are finding that hospital care is becoming unaffordable. So they are desperately trying to engineer a revolution in primary care in the hope that it will reduce hospital admissions.

We might as well get our evidence from there. They are building some really low-cost models for primary care. I came across one organisation that is providing a GP consultation, prescription and laboratory services for one pound. There are some really radical approaches being taken. They are saying: 'Never mind what we learned through medical education. Let's find a solution that works for the customer.' It comes back to what John de Pury was saying about the lessons of history and the introduction of lemons for sailors. Where is the crucial 'pull' going to come for innovations? When we talk about the AHSNs, I am concerned that we still trying to 'push' innovations out there. We really need to create mechanism for the 'pull'.

We know what the problems are. We also know the solutions. If we could just put in place what we know works, we would deliver a huge amount of improvement in quality and productivity.

Professor James Barlow

Richard Darch, Healthcare Partnering Ltd:

In terms of evidence, sometimes we look too much for a panacea and for a solution that looks perfect. There is a lot of data that we can use now. If you look at a simple, high level, analysis of hospital admissions over a year or two year period, you find similar trends everywhere. They show that, of emergency admissions, about 50 -60 per cent will be related to maybe five major conditions such as strokes and COPD. A similar picture emerges for long stay patients. You will find 20 per cent taking up 80 per cent of the bed days and capacity. Of elective patients, you will see that most of admissions are between zero days or a one day stay. So a very clear pattern emerges. It is easy to see and similar across any hospital institution. And yet everything is going on in the same building.

It's inefficient, with emergency admissions clogging up the hospital. A lot could be done simply by re-engineering these flows, using simple data. Instead of looking at new builds, let's look at what we have got and how we can reorganise within what we have got.

We also know that, given that 20 per cent of the patients take up 80 per cent of the capacity, there is a lot of capacity there that could be used more appropriately and for the patients to be cared for in an environment focused more directly on their needs and dependency. Over time, that could allow us to reduce capacity and release some value which could then be used to invest in some new types of infrastructure – either on the site or elsewhere.

There is also an element of mind set in all this. I would encourage people to try to improve things for next Tuesday rather for five years' time. Take the NHS budget for a city - probably £1bn or more. There is a mind-set worrying about how do we shave £150m from that. Instead, we would be asking: 'How do we spend £850 million? How can we use what we have available and do things better because I think we can do things better and quickly?' The evidence and supportive data clearly show that we can.

Lord Warner:

That's exactly what we need to do. But it does come down to the point that Mike Burrows made. There don't seem to be sufficient burning platforms to stop people holding onto their territory and their services as it is run now.

The real problem is that we need someone to drive the solutions. Someone has to say: 'We are not going to do these services in these places.' In London, when stroke care was overhauled, someone made a decision to limit the number of hospitals that would receive stroke patients. And that was the key lever. Taking that decision produced the change. In the same way, specialist commissioners at NHS England may start saying that they will commission services only from certain places and that's it. Unless they do, we will continue with this melange of different arrangements. It is simply unrealistic to be asking CCGs to take all of these decisions.

Dr Mike Burrows:

The key thing is getting the incentives in place. The NHS is working on the 'Year of Care for Long-Term Conditions'. I think that will be a game changer, changing incentives and disincentives. We are looking at the accountable care model within Greater Manchester, the concept of pooling budgets for care.

There is also a question as to how managers and local organisations can start to get better at winning public debate over changing services and over hospital closures.

Helen Crisp, Health Foundation

Localism and Big System Change: Discussion

Lord Warner:

Accountable care is essentially a resources allocation for a weighted population. I have heard a number of very impressive presentations. But, where this is taking place, in the US, they are pretty generous per capita allocations.

So I should think that anyone could run an accountable care system in this country with some of the allocations that are currently being used over there.

I can see that the Treasury would look at accountable care. They would look at it and say: 'Here's a chunk of money, we will distribute on the basis of capitation. And that's it.' But then you start to take the 'N' out of NHS and you actually create a much more local set of arrangements as to how money is spent.

Professor James Barlow, Principal Investigator, HaCIRIC:

HaCIRIC is conducting a study currently of the new emerging public private partnerships models in Europe around healthcare. In these case studies, providers bundle together not only the physical infrastructure and associated services, but also the clinical care. A number of models are beginning to spring up. The point is that risk and reward is being shared across the different organisations in a new way, potentially allowing incentives to deliver improvements. That work is continuing and should be finished by the autumn. It's a model that has not really been looked at in UK, but which I could see government exploring.

Q: Should we focus on short-term or longer-term problems?

Professor James Barlow:

I am hearing that, in reality, we know what the problems are. We also know the solutions. If we could just put in place what we know works, we would deliver a huge amount of improvement in

quality and productivity. But it is difficult to do - Mike Burrows spoke about how much work has to go into building leadership and consensus.

My concern really is longer term –the next 10 years, not the next two years. We have a rising elderly population and associated conditions. There are said to be eight million people currently alive in the UK at the moment who will live to be 100 years of age. So we really do need to seriously look at these radical healthcare innovations in countries such as India that Loy Lobo has mentioned. However, translating that to here is another matter, given the physical landscape and the institutional framework.

Q: How should those leading change create public support for their plans?

Rob Smith, Visiting Professor, University of Salford and former Director of Estates and Facilities at the Department of Health:

When I worked in the NHS, I remember the uproar at trying to close a small maternity hospital out in rural Gloucestershire that had nine midwives attached to it and which, in its last year of operation, saw five births and only two of the midwives delivered any babies. There was huge opposition to closing it. All of the evidence about safety, for mothers and babies, counted for nought.

I went on to work on a large acute teaching hospital that was being built on a new site and found an unholy alliance of Friends of the Earth, the Socialist Workers' Party and a Conservative ward all working together in opposition to the relocation of the hospital. It was terrifying really and demonstrated the scale of the challenge. Meaningful engagement with the people served by the hospital and the presentation of factual information was essential to counter miss-information being spread.

I am under no illusion that the NHS is a single homogenous employer organisation. ...We don't have a single corporate structure. So how is change to be achieved in that disparate set-up that we have?

Rob Berry, Kent, Surrey and Sussex AHSN

Helen Crisp, Assistant Director of Research and Evaluation, Health Foundation:

What would be the key factors in getting change at the coal face? It is an enormous ask for people who are trained professionals, who have been taught to work in certain ways and have an identity very much built around what they are delivering. They feel as though they are being asked to undertake an enormous change. They don't feel confident about it.

There is also a question as to how managers and local organisations can start to get better at winning public debate over changing services and over hospital closures. You hear of these unholy alliances of people working together, making terrific use of social media and the local community. The NHS and local authorities all seem to be on the back foot. They don't really get their message out in a compelling way using the same tactics. How might that be better managed?

Lord Warner:

We would do well to look at how Obama got re-elected. He used social media. The people who have a built-in incentive to do something about the health service are the people who are my children's generation. They use social media. They are the next working generation who will be paying for the NHS. If we don't actually change it, it is going to be a bigger bit of their tax take. They have a built in incentive to change.

Professor Derek Bell, Chair in Acute Medicine, Imperial College London :

Fundamentally, we don't invest in change and innovation. It is left to chance 90 per cent of the time and then we wonder why it fails. We don't invest in ideas of reorganisation and then fundamentally the changes struggle because there is so much to do. Working with frontline staff is key.

We know some of the background to this. We do have the data and we do have some of the solutions and, for some of our overstretched organisations, we know where they are and we have known for some time that they are

Transformational change, even in a 'basket case' industry, is possible. Automotives have done it. Petrochemicals have done it. Why are we not using those lessons?

Professor Colin Gray

overstretched. If we do nothing now, we will be further behind than we were 10 years ago. We have the solutions and the data to support those solutions, but we need the support of frontline staff. If we don't have that, then we will fail.

Rob Berry, Head of Innovation & Research, Kent, Surrey and Sussex AHSN:

One of the problems is that we can't see what Lord Warner calls the 'train crash' coming. So, whilst we can't see the 'train crash', we get on with what is in front of us and miss the opportunity for directing energy to avoid the train crash. There is an issue of visibility as to what that 'train crash' looks like.

We don't seem to know how to plan. If you were to look at the £20 billion cost saving plan, the NHS produced a plan which was good at getting the numbers right and kept people happy but it wasn't a plan that solved the problem. If the figure was £40bn, I am sure a list of things could be created that, if they were implemented, would add up to £40bn. But it will never happen because we are not going to put the resources in place to make it happen.

Localism and Big System Change: Discussion

We need to invite different people into the ‘train crash’ discussion, from academia and industry and help create that drive for change and not that nice political picture that suits individuals at a national level.

Professor James Barlow:

I completely agree with Helen Crisp’s comments about selling change better at a local level. We have spent seven years in our HaCIRIC research centre gathering evidence about what works, being rational about what needs to happen. But we all know that doing it in the real world is immensely difficult. This country lacks leadership to take those difficult decisions - we have seen that with issues such as another London airport, High Speed 2 and housing on the green belt. These decisions are immensely difficult for any government to take and, no matter how much consultation takes place with local communities, somebody has to say: ‘We are going to close these hospitals and reconfigure services.’ I can’t see it happening in either the old structure or the new one of CCGs and fragmented governance.

Q: Could part of the solution be a hypothecated health tax?

Lord Warner:

I have some sympathy with this suggestion because people don’t know how much this system is costing them. But a hypothecated health tax is a double edged sword. There is good evidence that the British public values a pound spent on health more than it values a pound spent on anything else. So there is a risk that, if people were asked to vote for increasing a hypothecated NHS budget, we might end up with no police force, very little else. Certainly a lot less of other public services.

It’s happening already. The status of the NHS is already changing dramatically compared with other public services. It will be even starker by General Election, because the levels of funding in most public services - including even the once

sacrosanct police force – are falling rapidly. Yet, we still have lots of politicians competing with each other to protect NHS spending. Don’t be surprised if, in the coming two years, Lloyds is repatriated to the private sector, money is found to pay down the debt and, by some amazing process, we still continue to give a nominal increase in funding to the NHS up to the next General Election.

Loy Lobo:

For real systematic change to take root in an organisation, there needs to be clear view of the change process all the way through and that it needs to be vivid. Everyone needs to understand the implications for them. That’s vital.

Secondly, there must be a cascade of leadership throughout the organisation. So there need to be leaders at every level of the NHS and social care for real change to happen. I have seen this in organisations of 50,000 people. The whole organisation has changed in two years by ensuring that the leadership message went down level by level so that each coach was mentoring no more than eight people through change. It was not hierarchical. It was relationship based.

It is the only way I have seen to bring about change successfully within a short period of time. The view of the ‘train crash’ needs to be consistent. Everyone must see it coming. And there must be leaders at every part of the organisation sharing the vision.

Rob Berry:

I am under no illusion that the NHS is a single homogenous employer organisation. We have GPs who are independent practitioners, who have got their own drivers and they have a fantastic contract at the moment. We have got Foundation Trust hospitals, NHS trust hospitals, we have independent sector providers. We don’t have a single corporate structure. So how is change to be achieved in that disparate set-up that we have?

Summing up

Professor Colin Gray, Co-Director, HaCIRIC:

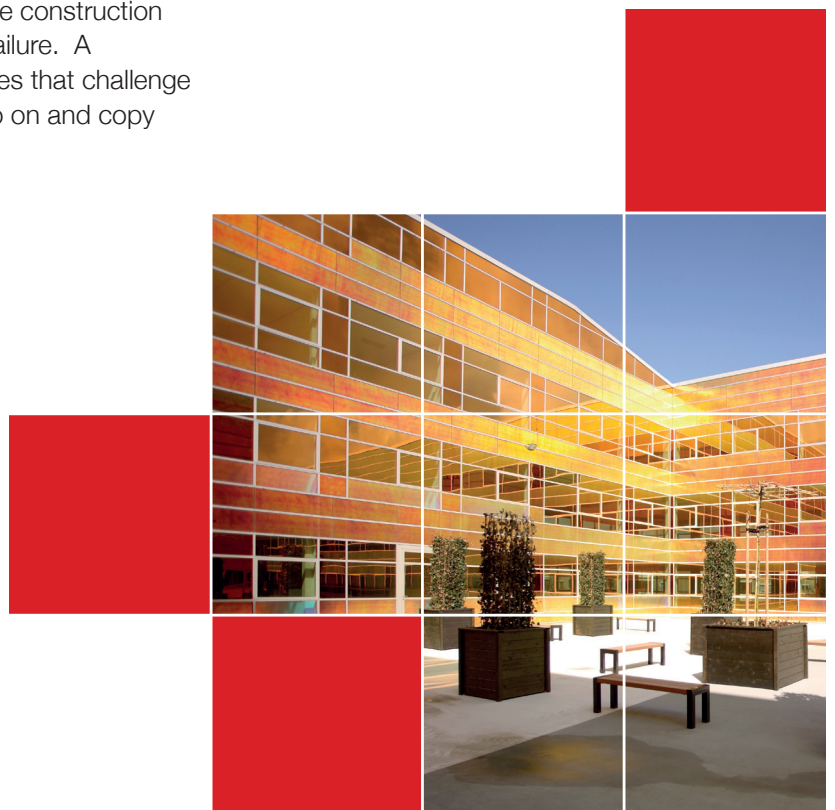
I have been involved in HaCIRIC since its inception, eight or nine years ago. My background was in construction. If you think health is an industry in trouble, then the construction industry, when I started, was a really sick case.

In that time though, we have transformed the construction industry in the UK to being probably one of the most efficient services. On major projects, in the city of London, we can build much more complicated buildings than the US can, much faster, to a much higher standard. And the US is regarded as a bench mark.

So transformational change, even in a 'basket case' industry, is possible. Automotives have done it. Petrochemicals have done it. Why are we not using those lessons? We should learn from these industries. For me, the key learning is to set a very simple objective such as, in the construction industry, zero accidents and zero failure. A leadership or organisation then takes that challenge and creates a model that others go on and copy again and again.

The level of education required to do that in an organisation is phenomenal. It is a huge investment but the actual cost is paid back time and time again. With the construction industry, you have to do it for every project. You have to go back to square one and start again. Retaining the memory is impossible. You have to keep doing it because the people keep changing.

The rate at which people change over in the health service has the same characteristics. Typically, at least two or three teams per ward per day change around. Each team each time has to be educated into the day's change agenda. We are talking about a very serious level of commitment, if you really want to change a system like the NHS.



Our online library

The HIF website provides access to all publications developed as a result of HaCIRIC and HIF's research work, as well as links to material developed by others in the field. These include the following:



Complex Healthcare Made Simpler

HaCIRIC September 2012: Advances and opportunities in improving healthcare delivery using modelling and simulation.



Controlling Healthcare Acquired Infection

HaCIRIC September 2012: New learning on how performance management and design can reduce HCAI.



Adaptability and innovation in healthcare facilities: lessons from the past for future developments

James Barlow, Martina Köberle-Gaiser, Ray Moss, Ann Noble, Peter Scher, Derek Stow: HaCIRIC, The Howard Goodman Fellowship. September 2009 Reviews capacity for innovation in PFI hospital building programme, contrasts it with earlier NHS hospital building programmes and suggests lessons for the future.



How should we create 21st century healthcare infrastructure to deliver best value?

The HaCIRIC Insights document, published in September 2011, sets out key findings and expertise developed during Phase 1 of the HaCIRIC programme. The document details how HaCIRIC has expanded the evidence base linking infrastructure and health outcomes, improving decision-making and helping to future-proof healthcare infrastructure.



Better Health Through Better Infrastructure

The report reviews HaCIRIC's projects and sets the vision of the organisation.



The bridge to 21st Century Infrastructure for Healthcare

HIF's new brochure sets out the four critical factors for infrastructural success that HIF brings together: knowledge, disciplines, stakeholders and strategy.

HIF Partners

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The HIF Team

The Healthcare Infrastructure Forum is unique. We are the only international centre dedicated to improving healthcare delivery by focussing on infrastructure. We provide vigorous, independent and informed debate, as well as access to high level research and policy review.

We open the way to radical change in healthcare delivery by understanding and connecting the diverse but critical factors leading to successful infrastructural solutions.

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- Design effective procurement to ensure innovative thinking from all parties
- Develop implementation approaches to embed the delivery of innovative practices and healthcare.



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