Good Governance Institute

The Goldberg Report:
Strategy and the New NHS

David Goldberg

December 2012

www.good-governance.org.uk

Document name: The Goldberg Report: Strategy and the New NHS
Date: December 2012
Author: David Goldberg

This report is part of a growing series of reports developed by the Good Governance Institute that consider issues contributing to the better governance of healthcare organisations.

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Published by the Good Governance Institute
Old Horsmans
Sedlescombe, near Battle
East Sussex TN33 0RL

December 2012

ISBN 978-1-907610-17-2

Designed by www.mercerdesign.com

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Preface

The mission of the Good Governance Institute is to push governance thinking forwards. We do this through our work with both individual boards and organisations, and through wider national studies and programmes. We have now worked with multiple NHS and other boards, and have been able to complete some important programmes of work around patient safety, quality, healthcare futures, risk, accountability, clinical networks and systems reform.

During this time, we have promoted a consistent credo that healthcare boards should spend more time discussing healthcare. Also, and whilst recognising the environment for healthcare boards is turbulent, we have encouraged boards to place greater emphasis on strategy and move on from solely obsessing about assurance and performance management. The world of the NHS is often described as circular, with the same themes, the same structures and the same individuals returning again and again. We have termed this the 'Flying Dutchman school of management': stay still for seven years and you will see the same issues (and approaches to dealing with them) come past again, again and again.

We believe that this cycle is unsustainable, and with the issues facing the world in the coming decades, a health system that simply serves up more of the same will break. Local healthcare organisations need to think their way out of the current model, and focus their effort on creating a healthcare system that caters for tomorrow's society, economy and illnesses.

Yet, our day-to-day experience of working with boards leads us to conclude that many boards are merely playing at strategy. When we review prospective NHS Foundation Trust's Integrated Business Plans, we still usually find noble but nebulous mission statements, and strategic aims that smack of motherhood and apple pie. We could usually predict there will be strategic aims such as 'to provide the highest-level of healthcare for the people of X' or 'to be first at innovation'. Commendable though these are as strategic aims, they are meaningless unless they create actual change. And so, when we examine board papers and assurance frameworks, we still find that most boards are doing little to lead their organisations onwards to reliably achieve their goals.

In 2008, while I was working at the American healthcare insurer Humana at their European headquarters in London, I worked with David Goldberg who had been brought over from Oregon to set up and lead the Humana Commissioning Institute, a joint initiative with the NHS Alliance. David wasn't a Humana company man, but had worked for several decades independently in the USA, UK and New Zealand at senior level, with boards and groups of clinicians. He has, over the years, been associated with many of the best healthcare organisations in the world and has counselled clinicians and healthcare leaders through some extraordinary changes. His thinking isn't stuck in the NHS, but neither is it moulded in any one New World system. He has worked with many Primary Care Trusts (PCTs) through the World Class Commissioning odyssey and then has been away from the UK. This autumn, GGI felt it seemed timely to ask him back and to get his view on the strategic context for healthcare in England, and his thoughts about what conversations ought to be happening around and between the boardrooms of the NHS.

This report from David Goldberg is another step on GGI's own journey to help healthcare organisations implant good governance practice, and thereby better succeed in their own purpose. We want the boards we work with to be certain of the added value they intend to bring to their organisations over the coming year, decade and beyond. Our thinking has been strongly influenced by Professor Mervyn King from South Africa, who reminds us that boards preside over immortal juristic persons, and should be thinking more about their holistic impact on the world we live in. Through his work on integrated reporting, Professor King encourages boards to reflect on what is material and report on their environmental and social impact as well as their economic success. Such strictures are especially apposite around the board tables of the NHS, where decisions are being taken that will affect individuals, families and whole communities for decades to come.

Although David's work for this report has focused on the NHS in England, there are lessons here for Wales, Scotland, Northern Ireland and beyond. GGI have been promoting the cross-fertilisation of learning between the different nations of the UK, and also more broadly, by our work in both Europe and the New World.

The NHS is now starting to be seen for what it is: a unique national asset. It has served our country well for more than 60 years. The challenges of the future, however, are significant as the opportunities for patients multiply through new technologies and therapeutic possibilities, as the population grows and greys, as the diseases of plenty replace the diseases of want, as resources become scarce and the economy needs to become greener, and as the world we live in changes ever-more rapidly, thanks to the ITC revolution we are all living through. The NHS of the next few decades needs to be lead by strong boards who know what needs to be done to do more with less, and have a clear idea about the difference they will be making as they chart their way through the interesting times ahead. We hope that David Goldberg's strategy report will help us, with the NHS boards and others we work with, find the right way of encouraging better strategic grip and real results. In the conclusion, our Chairman, Dr John Bullivant, draws out some themes that we wish to test with you as part of a continuing debate on the roles and place of the board.

Andrew Corbett-Nolan
Chief Executive
Good Governance Institute

Introduction

In October 2012, I had the opportunity to visit the UK to meet with a variety of NHS leaders, managers, GPs, Trust Board members, executives and chairs, and strategy experts. This report has been synthesised from these interviews and informed by many reports and commentaries on the recent health reforms and strategy in England. My report is also flavoured by my personal experience working with PCTs through the World Class Commissioning (WCC) process. In 2008 and 2009, my then team and I spent many hours working with GPs, executives and boards facing the challenge of the WCC assessments.

This report is not meant to be an exhaustive academic analysis of strategy in the NHS, nor an assessment of the nascent Clinical Commissioning Groups (CCGs) and the new provider landscape. Rather, it is offered as a set of informed opinions and perspective on strategy and, more specifically, on the strategic current state of affairs facing the NHS. My purpose is to shine some light on the importance of strategy and on the trends, challenges and opportunities facing commissioners, providers and the NHS generally in the years ahead. I also hope to provide food for thought for boards throughout the NHS, to frame strategy that can be implemented to improve the quality of care, the efficiency of care and the quality of the patient experience.

I would like to thank the Good Governance Institute for the opportunity of undertaking this review and also the many individuals who met with me and offered their candour and insights. I believe many of you will see that your ideas and perspectives influenced this paper.

Disclaimers and biases

Before beginning my analysis, it is important to disclose some of my biases. First, based on years of professional experience working with GPs in the UK and New Zealand, and with Family Physicians in the US, I believe strongly that placing leadership and control of local priorities and budgets in the hands of organised groups of GPs is wise and sound policy. In working with the NHS, I have been struck by the resilience of GPs as they watch government after government change the NHS. New agencies and organisations are created with new acronyms and schemes. While all of this is occurring, GPs continue to be dedicated to the patients and residents of their patch. They are the true backbone of the NHS. They are the beginning of most of the journeys patients take within the NHS. They care for the largest number of people who require reassurance, guidance, treatment and direction through a complex health care system. I believe GPs want the best for their patients in terms of quality care and convenient services. This initial report focuses mainly on the new CCGs from where local health strategies need to be generated, although I do make observations and recommendations for the secondary care sector too.

Second, the NHS, as a system, is, in my view, disintegrated and houses a collection of perversely contradictory incentives to various components of that system. For example, due to the dire financial constraints facing the NHS, GPs and CCGs, as well as Acute Care Trusts, are all being asked to look for efficiencies and to root out waste and duplication. Yet, Acute Care Trusts are rewarded based on volume and, given the serious financial condition of many District General Hospitals, the last thing they seek is a reduction in revenue, particularly at a time when they aspire to become NHS Foundation Trusts.

Third, I believe the focus of the NHS has not been on the patient and the patient experience. The NHS has many organisational boundaries that patients must cross in order to get care. Patients are often lost, forgotten and are commonly inconvenienced by the bureaucracy and in finding their way through the system of care. Data systems have not been integrated and a patient's primary care, secondary care, mental health, pharmacy records etc. reside in separate, often unlinked databases. The need for greater "integration" is a major theme of this paper. Interestingly, I heard much talk of integration – common data systems, bringing mental health and community care closer to GPs, CCGs working with Acute Care Trusts in shifting secondary care closer to patients' homes and communities. This comes at a time when there is growing impasse in the negotiation for a new GP contract and where the last negotiation brought a significant disintegrating strategy, where after-hours care was separated from GP primary care.

Finally, I am concerned that changes to the NHS coming from each successive governments are always transitory. The current regime has created and invested in the creation of CCGs as the fundamental organisational foundation for designing and commissioning care. Yet, the next election is less than three years away and I believe that if policy changes again, away from GPs, the effect will be to disenfranchise GP leaders and GPs in England for many years to come. Indeed, the Shadow Secretary of State has committed to repealing the Health Act if returned to power in 2015.

So what is strategy and why is it so important?

"Would you tell me, please, which way I ought to go from here?"

"That depends a good deal on where you want to get to," said the Cat.

"I don't much care where--" said Alice.

"Then it doesn't matter which way you go," said the Cat.

"--so long as I get SOMEWHERE," Alice added as an explanation.

"Oh, you're sure to do that," said the Cat, *"if you only walk long enough."*

So goes the exchange between Alice and the Cheshire Cat in Chapter 6 of Lewis Carroll's Alice in Wonderland. It has often been summarised as, *"If you don't know where you are going, any road will get you there."*

I define the word "strategy" as **how an organisation plans to fulfil its mission, achieve its vision and goals while keeping to its values.** Strategy is not, however, lofty aspiration. Rather, **it must include ordered response to a specific challenge with an identified set of coherent actions and committed resources.**

Organisations within and outside of the NHS rarely have a coherent and reality-based strategy and strategic plan. In a July 2011 study by the Institute of Chartered Secretaries and Administrators, *"Minding the Gap, Highlighting the Disconnect between Governance Best Practice and Reality in the NHS,"* the authors came to the following conclusions about strategy n NHS boardrooms:

- There was little discussion relating to a board's vision for staff and stakeholders.
- Boards believed holding the executive team to account was a higher priority than strategy setting.
- On average, 10% of agenda items were dedicated to strategic issues in contrast to best practice recommendations of 60%.

Similar findings regarding the paucity of "Clinical Content" of Trust Board agendas were reported in the 2006 University of Plymouth study commissioned by the Burdett Trust for Nursing. Their analysis suggested that an average of only 14% of Trust Board agenda items addressed clinical issues. So, if Trust Boards are not addressing strategy nor clinical issues, what are they considering? Presumably operations and the day-to-day "administrivia" of their Trusts. My experience working with PCT Boards with World Class Commissioning was reinforced as remaining a contemporary picture during my recent interviews. Here are a few insights:

- Strategy is often imposed on NHS organisations from above.
- NHS organisations are often held responsible for strategy that they cannot impact – for example the NHS cannot single-handedly eliminate the results of deprivation and poverty.
- Effective strategic planning often requires more time than annual redrafting, even longer than the length of time a government is in power. NHS organisations rarely have had the luxury of sufficient time to make strategy work.
- Strategy and strategic planning is often commissioned to outside consultants. Whilst the plans are well conceived and written, they are neither "owned" by the boards nor the executive teams of the organisation, nor indeed clinicians working within these organisations. Boards need to know how to utilise strategic plans and how to gain assurance they are being advanced.
- Once strategic plans are written, they often are filed on a shelf. The box is ticked and the plans are ignored until they are required to be revised in the next cycle.
- Boards do not use strategic plans to evaluate the effectiveness of executive teams and the success/failure of their organisations.
- Boards do not evaluate nor align policy initiatives from elsewhere (even within the UK).
- Boards that do not have strong and clear strategy are often sidetracked by central directives and initiatives.
- Boards are often overwhelmed with lofty aspirations that have little chance of being accomplished.
- Board members (particularly non-executive directors) do not know what questions to ask in order to gain assurance that progress is being made on the strategic goals of their organisation. The Good Governance Institute has developed a focused approach to assisting Boards in this regard. Through their focus on creating board assurance prompts. Alas, few Trust Boards use these tools.

Population trends and demographic issues

As a strategist and planner, one must be aware of the environment in which one is planning. There are several significant demographic trends that will determine much of the patient demand on the NHS and how the NHS will need to be staffed to handle the increased demand.

Demographics of the population – In the United Kingdom the population is both increasing and ageing. According to the Office for National Statistics (ONS), the overall population of the UK will increase from 62.3 million in 2010 to 71.4 million in 2030. The population gain will mostly affect urban centres with London facing a 12% projected increase. More children will live in the UK. Further, people over the age of 65 constituted 16% of the UK population in 2010 and will increase to 23% of the population by 2035 and individuals over the age of 85 will double from 2.5% of the UK population in 2010 to 5% in 2035. I cite these statistics only to show that demand for GP services will steadily grow. As patients age they tend to develop long-term conditions and their demand for GP services (as well as secondary, tertiary, mental health etc.) increases accordingly.

Another interesting aspect of the demographic changes affecting the UK, and the rest of the Western world for that matter, is the curious bi-modal nature of the wealth of the growing elderly segment of the population. Many baby-boomers have accumulated financial resources and are quite well off, whilst many others face an end of life in poverty. The NHS and other western health systems must grapple with the differing expectations of care and service from these two distinct sub-populations of the elderly. No doubt, western governments will be considering how citizens of means can financially shore-up strained health systems with co-pays etc.

Demographics of GPs – As the UK population grows and ages, so too GPs are ageing. According to the NHS Information Service, the proportion of GPs aged 55 and over rose from 17.5% in 2000 to 22.2% in 2010. As many as 10,000 GPs have expressed the intention of retiring in the next five years. This loss of GPs due to retirement is not being made up by new trainees, nor by immigration. The NHS was founded on a deal made with GPs to allow GP practices to remain independent enterprises with guaranteed contracts with the NHS. The day of solo practice surgeries is thankfully almost gone, occasioned by demands for scale (electronic data systems for example), profitability of partners taking on employee GP associates and a real change in the expectations of young GPs, many of whom are young women attempting to create a balanced work and family life and many seek only part-time employment. Clinical Commissioning Groups (CCGs) are new entities, requiring GP participation. However, many GPs have ducked their heads for the nth time, expecting CCGs to go the way of Fund-Holding, Primary Care Trusts, World Class Commissioning etc

The financial environment and resource scarcity

One of the main drivers of the reforms of recent years has been the serious financial condition of the NHS, the United Kingdom and much of the western world. The reasons for the present financial condition have been studied by many experts. In addition to the overall financial recession, the NHS faces additional financial burdens. There is clearly overcapacity among NHS Acute Care Trusts at the district general hospital level. Further, there are inefficiencies in many care pathways where patients are being inappropriately and expensively placed in acute care hospitals when, if better planned and supported, they would be better off at home, or in community care settings. The policies of the present national government have, to date, delivered some savings, mostly due to redundancies, wage freezes and tariff controls. According to published reports during the past two years more than 42,000 jobs have been eliminated in the NHS. Unfortunately, it has been reported that the cost of achieving savings has equalled the savings itself. Therefore, to date, there has been little net savings, though presumably the reductions in staff will deliver savings into the future.

Present system givens

The NHS has a number of system requirements and policy objectives that are creating a pressure cooker within the system:

- A stated desire to reduce costs and increase efficiency.
- Set tariffs for secondary and tertiary care that are by and large non-negotiable.
- The 18-week maximum waiting period for consultation now forged in the NHS constitution.
- Many acute care hospitals that are still in deficit with little hope of becoming Foundation Trusts.

With these givens on top of the demographic pressures, something has to give. It is unclear what the consequences will be if deficits continue to accumulate throughout the NHS. As one looks at these givens it is not far fetched to see one probable beneficiary – the growth of private care. As the population grows and ages there will be increased demand for services on the NHS. With expectations raised and codified in the NHS Constitution – patients will "…start consultant led treatment within a maximum of 18 weeks from referral…" However with budget constraints, actual non-emergent procedures may not be able to be funded. The growing population of wealthy elderly, with high expectations of service will increasingly opt to leave the waiting queues and receive their care outside of the NHS. This bodes well for a growth in private health insurance and in the provision of care privately. In a curious way this will serve much like a means test for the well-to-do to pay for their own care.

A strategic examination of the components of the NHS care system

The care system in the NHS is complex with multiple elements:

GP practices

GP practices are the backbone of the NHS. They are first line of care, as they exist within the communities where their patients live. Yet, they are fragile organisations. GPs are themselves ageing. With demand for GP services increasing due to population growth and ageing, there will likely be shortages. These will often first be seen in rural areas but without investment in training of new GPs and/or an easing on immigration of GPs to the UK, shortages will spread as GP retirements increase over the coming decade. During my interviews, I heard that in some rural areas, recruitment of replacement GPs is already becoming more difficult. Dr. Sarah Wollaston, Conservative MP for Totnes, recently wrote, "We have known that there is a workforce issue coming for some time now. In the southwest, there is a 12% vacancy rate, which was unheard of in the past. In five years, we will have a retirement bulge. We have increasing numbers of female GPs, which is great, but we all know leads to more part-time working. For years now we have trained too many hospital specialists, for which there are no jobs."

GPs are independent professionals, (technically in contracts with the NHS). GPs have worked for 60 years in independent practice. GP practices have increased in size from the traditional solo practice surgery (often attached to the GPs home) to more complex group practices with professional management. Many GP practice owners (partners) have employed non-owner GPs as associates. GPs have embraced electronic medical record systems (EMR), but in a given patch, there may be multiple EMR systems that do not communicate with one another. GPs have been participants in

strategic planning as past governments challenged them with various policies such as “Fund Holding” and “World Class Commissioning.” GPs often served as the senior medical officer for Primary Care Trusts and were active members of local Professional Executive Committees (PEC). Now, they are being asked to serve as the strategy and policymaking bodies for commissioning much of health care. While they have the local experience and many keen insights into how to make the NHS better, they lack the time, training and experience to be effective in so short a timeframe.

Some strategic questions for GPs:

- Given the predicted shortage of GPs, how can we continue to attract GPs to our area and practices?
- How can we improve continuity of care? (The ability of a patient to see the same GP, or at least a GP with ready access to a patient’s medical record. This has been shown to have a significant effect on reduction of A&E visits and elective admissions.)
- Is there value in GP leadership and participation in CCGs or are they a passing political fancy?
- How can GP practice organisations grow?
- How can GPs within their practice organisations reduce variations in care and the use of secondary care services among their members?

Clinical Commissioning Groups (CCGs)

CCGs are relatively new organisations proposed to be composed mostly of local GPs. They were created by national policy to be the fundamental commissioning unit of the NHS. The idea is that local GPs have a well-grounded understanding of the health needs of their population and, consequently, they should take the leadership in deciding how and where care should be commissioned and delivered. CCGs also offer the possibility of aligning the responsibility for care choices through referral with accountability for resources. During the past two years, CCGs have been formed as new organisations and have focused much of their attention on becoming authorised. The reality, however, is quite different. In July 2012, ‘Pulse’ reported that following their investigation, less than half of the board members on CCGs were in fact GPs. They found that CCG Boards were composed on a mixture of managers and finance professionals, nurses, public health professionals, representatives from local councils and GP practice managers. Further, only one-third of the CCG accountable officers are GPs. Most GPs appear to be keeping their heads down and anticipating the passing of these latest reforms.

Some strengths of CCGs are:

- They are composed of local GPs and other local health professionals with years of patient care experience.
- There are experienced GP leaders who worked with PCTs and who understand the commissioning landscape.
- The mere formation of CCGs encourages the trend to grow the size of GP practice units and to encourage mergers.
- One premise for success is that CCGs and therefore GPs will work more closely with other care providers (secondary and tertiary care consultants, mental health providers, community and social care professionals) to improve on the coordinated and integrated care needs of their patients. The goal is to provide quality care in the least expensive place supported by a coordinated team of care-givers.

Some weaknesses of CCGs are:

- They are new and fragile organisations that GPs have been forced to join. Most GPs are nominally members but pay little attention to CCGs.

- GP leadership is very demanding and requires organisational skills that they are not necessarily trained for. Further, if successful, there needs to be thought and planning given to the succession of leadership over time.
- With more demands being placed on GPs, taking talented GP leaders out of clinical practice will further strain the care system.
- CCGs have focused on becoming authorised. By the time many CCGs are authorised there will be a new election, and with it possible government change and probable health policy change.
- CCGs are on a steep learning curve on the art and science of commissioning. Their success will be heavily dependant on how well they work with the Commissioning Support Units and how well the CCGs will hold them to account.
- What is the glue that holds CCGs together? There is little financial reward and I believe that over time GPs will withdraw back into their day-to-day patient care and practice management.
- Member GP practices often have different electronic medical record systems, making an area-wide integrated electronic record difficult. This will make improving continuity of care difficult.
- If CCGs fail or if government policy changes, the NHS will lose a generation of GP leadership jaded by the experience.
- The £25/population limit on management costs may be inadequate to effectively set up and manage CCGs. One indication of this is that GP membership on CCG Boards is being thwarted due to the back-fill costs of compensating GP practices for the loss of a GP.

Some srategic questions for CCG Boards:

- In the time we have, how can we make significant impacts on care pathways that might survive national commissioning policy changes?
- How can we lead and advance a strategic agenda of improving care quality, efficiency and patient satisfaction that crosses organisational boundaries (GP practices, Acute Care Trusts, Mental Health Trusts, community care, social care, Ambulance Trusts, third sector organisations and other related stakeholders?
- How do we effectively work with the commissioning support units to embed into contracts with Acute Care Trusts incentives to improve the efficiency of hospital stays, reduce A&E admissions, incorporate aggressive utilisation management, and discharge planning strategies into every admission and work with community care organisations to move patients out of acute care settings?
- How do we embed the need for active and frequent patient feedback into commissioning cycles so that patient input can effectively improve commissioning for care?
- Which **few** strategic initiatives will produce the greatest impact on quality of care, care efficiency and improved patient experience?

Commissioning Support Units (CSUs)

Commissioning Support Units are basically the remnants of the abandoned PCTs. Many believe that just as the PCTs were maturing into effective commissioning units, government policy changed. Now following hundreds of redundancies, we are left with CSUs the remaining staff of which have been told will not be part of the NHS in 2014. Morale is reported to be poor across the country. Further, since CSUs are new entities, their relationship to the NHS Commissioning Board is still being developed.

Some strengths of the CSUs:

- They have expertise in commissioning and contracting.
- They have existing personal relationships with secondary care and with mental health care.
- They hold the historical data and organisational history.

Some weaknesses of CSUs:

- Morale is presently low.
- Staff are challenged with the need to plan for being independent non-NHS organisations in 2014.
- They now have multiple client CCGs each of which may require unique contract requirements.
- Many talented staff have left with the demise of PCTs.
- We have yet to see if they will be as effective or more effective commissioners/contractors of care than their PCT predecessors.
- The role is presently confused with the National Commissioning Board.

Some strategic questions for CSUs:

- How do we both effectively work with CCGs and contracting Trusts to improve commissioning and at the same time prepare for independence in two years?
- How can we demonstrate our expertise and effectiveness as the business and technical arms of the commissioning process?
- How can we serve as the bridge between organisations to have real impact in improving efficiency and quality?

NHS Commissioning Board (NHSCB)

In October 2012, the NHS Commissioning Board was formally established to oversee more than 200 local CCGs, as well as to directly commission more than £20 billion of specialised and tertiary care. It is really too early to tell how effective the NHSCB will be in regulating CCGs and in commissioning care. One of the points of the latest reform was to avoid confusion and to clarify commissioning roles. How will the NCB be held to account as commissioners?

Acute Care Trusts

Acute Care Trusts have been challenged with either becoming NHS Foundation Trusts or risk being incorporated into existing NHS Foundation Trusts. Much time and effort is being spent by Acute Care Trusts (and others) to meet Monitor's tough NHS FT qualifications. Interestingly, to date in November 2012, only one new Acute Care Foundation Trust has been approved in the current year. At this rate, it will be years before all of the aspirant NHS FT applications are considered. Further, the stated consequences of not achieving NHS FT status are rather hollow in many parts of the country. There are many rural areas with failing DGHs and, in many cases, multiple DGHs in deficit with no NHS FT in the area. There does not appear to be the local political will to radically transform or eliminate financially failing DGHs.

As the next national election approaches, there is little likelihood of forcing closure or restructure of local acute care services. Whilst there could be a real alignment of strategy between local Acute Care Trusts and CCGs around such important populations as frail elderly, A&E utilisers, patients with long-term conditions and patients facing the end of life, financial incentives and realities do not favour collaboration.

There is a whole further report to develop around secondary care providers. GGI is finding that there are issues with both the NHS FT pipeline of current NHS Trusts, and indeed the boards of many existing NHS FTs are struggling with developing a sound strategic future and at the same time maintaining a grip on both funding and service quality. The coming years will be marked by the manifestations of these struggles, as service sense and political pressure clash.

Some strategic questions for Acute Care Trust Boards:

- How can our Acute Care Trust **take the lead** in working with CCGs and community and social care to focus on moving patients (frail elderly, end of life care etc.) out of a hospital setting into less expensive, safer and more patient friendly home and community settings?
- How can we work with CCGs to gain financial incentives to improve efficiency?
- How can we improve listening to patients to improve care quality and the quality of the patient experience?
- How is the performance and viability of adjacent provider services going to impact on our own strategic opportunities?

Mental Health Trusts

We have seen progress away from the block contracts between commissioners and Mental Health Trusts for the care of the mentally ill. Patients with mental illness do not fit well into the demands of GP practice. These patients tend to require more time that GPs do not have in their daily diaries. There is great need to better integrate primary care mental health resources around the GP surgery, to better integrate the patient medical records and to better coordinate community and social care around the needs of the mentally ill. Further, mental health patients often have co-morbidities that demand improved continuity of care. This is a huge challenge. Mental Health Trusts are also applying for NHS FT status that is taking much of their management energy and focus.

Community care

Community care services now reside in many organisational entities – Acute Care Trusts, local councils, independent third sector organisations etc. If CCGs are to be successful in reengineering the primary and secondary care system, there will need to be much collaboration with community care. Every smart idea around community care points to the need to better integrate it with primary care and with GPs. This involves bringing together multiple cultures, work styles and histories, and will not be easy.

However, if a goal is to care for patients closer to home in the least expensive place where quality care can be provided, then community services and community health professionals are a critical component. Many report that the provision of community care is being provided much the same as it was fifty years ago, with multiple independent care-givers delivering services in patients homes and in other community settings. Notes about the care offered are not typically integrated into the patient's GP medical record.

Local Authorities

Social care is the responsibility of county, city and town councils. In addition, with the demise of PCTs, public health now resides within the local authority too. This should strategically require CCGs to work closely with social care and public health to address the larger and more difficult aspects of population health, such as deprivation, childhood obesity, addictions etc. Here again, a broad team approach to caring for a local population is required. Scotland is looking to integrate health and social care. Northern Ireland already has done so.

Academic Health Science Centres and Academic Health Science Networks

Academic health science centres are typically strong organisations with talented management. These are complex tertiary centres of excellence in care delivery, research and education. Most are NHS FTs (but not all) and they have grown in size and influence. Many of the individuals with whom I met believe that this is where the real innovation and hope for care pathway reengineering will occur. They are, however, quite distant from CCGs and it is unclear whether there will be any significant influence by CCGs on Academic Health Centres.

In June, the idea of Academic Health Science Networks was formally introduced. Further, academic organisations must work more closely with organisations such as the Nuffield Trust and the Kings Fund to promote, pilot and broadcast the results of innovation in quality, efficiency and the patient experience.

Others

Other third sector organisations and Ambulance Trusts also must be coordinated into coherent plans.

Strategic implications and challenges

Looking at the societal megatrends, the identified system givens, care organisation strategic strengths, weaknesses and strategic questions, one is struck by the challenges facing the NHS. In light of a growing and ageing population and the financial constraints placed on the NHS, one sees drastic conflicts ahead. The health care demands of the public cannot be met without radical reconfiguration and/or the willingness to bear unplanned financial impact. Further, the need to fundamentally realign systems of care to be able to provide safe and quality care in patients' homes and close by in their local communities will organisationally challenge every component of the care system.

Boards of care organisations are increasingly being required to look past the needs and interests of their particular organisation to the needs and interests of improving the health of a population. Better, more integrated care will result in improvements to the quality of care, the efficiency of care and the patient experience. This has been well researched and documented by the Nuffield Trust and the Kings Fund in their excellent recent report, *"A Report to the Department of Health and the NHS Future's Forum, Integrating Care for Patients and Populations, Improving Outcomes by Working Together."*

The need to integrate information and staff and leadership has never been greater and boards must work together with the boards of other organisations to coordinate efforts, to reduce needless duplication and to see the system of care through the eyes of the patient. David Nicholson, CEO of the National Commissioning Board echoed this opportunity in the Operating Framework for 2010/11, when he stated: *"The quality and productivity gains we need to make lie not within individual NHS organisations but at the interfaces between primary and secondary care, between health and social care, and between empowered patients and the NHS"*

GGI have championed the need for good governance between organisations (GBO) and, with increasing need for joint and delegated decision-making, we can expect new models and demands on collaboration, decision tracking and audit. (HFMA/GGI GBO BAP 2012)

For new organisations, such as CCGs who are in the process of becoming authorised, and for established organisations such as DGHs that have struggled financially and are in the process of applying for NHS Foundation Trust status, this will be very difficult indeed. Further, all of this is taking place within a political system that will soon be focused on the next national election.

CCGs offer hope that could catalyse GPs to work closely with community and social care to effectively restructure how preventive and primary care are delivered. Further, I see the real potential for the development and implementation new models of community based care for the frail elderly, patients with long-term conditions, the mentally ill and patients facing end of life choices. The challenges will often require overcoming traditional ways of providing care and bridging the organisational boundaries that, I believe, plague the NHS.

For me, it always gets back to focusing boards and organised groups of clinicians and care providers around fundamental strategic questions:

- If this were my money, would I spend in the way proposed for the intended outcome?
- If this were a member of my family, would I want her to get care and treatment in the way planned?

Analytically, I expand these simple questions to four:

- Is what is planned safe?
- Is it efficient?
- Is it based on an evidence-based understanding of quality care?
- Does it provide for a positive patient experience (as perceived by the individual patient)?

The boards of each organisation must be able to frame their strategic questions that address my fundamental strategic questions **across** organisational boundaries. Perhaps Health and Wellness Boards can provide the impetus. Here are some strategic challenges:

- CCGs:
  - Integration of their electronic medical records and further integrate this electronic system first with other loci of primary care – urgent care, after hours care, A & E, community and social care. Then data integration can expand to secondary care.
  - Address variations of care and referrals to secondary care within their GP membership.
  - Write into contracts with Acute Care Trusts the need for real-time utilisation review and aggressive discharge planning so that when a patient enters a hospital for a planned or unplanned service, there are staff in the hospital whose sole role is to coordinate the care, eliminate inefficiencies, remove delays and coordinate with community care and primary care, to enable a safe and efficient post-hospitalisation transition.
- DGHs need help and incentives to restructure and in many cases close services. This will require a political will and political cover that is presently lacking. Acute Care Trusts must work with CCGs to assist in the shared need to shift care to community settings supported by a better integrated primary, acute, community and social care service, focused on the needs of these community based patient. Together they can begin to eliminate unnecessary days in hospital.
- Mental Health Trusts must strategically focus on better integrating with primary care to push primary mental health services into GP surgeries and community settings.
- Academic Health Science Centres and Academic Health Science Networks must reach out to failing Acute Care Trusts to assist in the strategic realignment of care to the least costly settings.

In every case, feedback from the actual users – the patients – must be elevated to the strategic level so that improvements can be made that reflect the experience, needs and desires of the user population.

The strategic questions across the NHS have become complex. In the past, strategic discussions and planning within organisations has been weak and, in my view, ineffective.

Now, however, the important strategic questions are **across** organisations:

- From one GP surgery to another to better coordinate patient records and to reduce variation in care among GPs.
- Between CCGs, Acute Care Trusts and community care organisations to seriously address how to get groups of patients (the frail elderly, those with long term conditions, those facing the end of life) out of hospital beds and back home or into safe caring community settings. There is now a growing body of evidence in the United States that strongly supports the efficacy of advanced planning for end-of-life care having the dual impact of (a) insuring care is provided consistent with a patient's wishes and (b) reducing the overall cost of end-of-life care to the health system. In my state, Oregon, pioneering work in end-of-life planning began the early 1990s. Now through a voluntary program virtually all hospices and skilled nursing homes actively encourage the completion of advanced directives and living wills. These have been strengthened by the addition of medical orders, signed by a doctor – know as Physician Orders for Life Sustaining Treatment (POLST).
- Between CCGs, Mental Health Trusts and Community Care to better serve mental health patients (many who have other health problems) and prevent expensive hospitalisations.
- Between Acute Care Trusts and Academic Health Centres to improve the coordinated care of patients with very complicated secondary and tertiary care needs.
- Between local politicians and their populace to honestly address the need to reconfigure and close some hospital services in local communities.

Each of these and other strategic challenges require focused work at a time when CCGs and Trusts are busy applying for authorisation and NHS Foundation Trust status. Time is an enemy. As new governments come into power and new reforms are proposed and implemented, the amount of time needed to qualify and assure the capability of new organisations pushes up against the next political cycle. Reforms are not given the time necessary to bear fruit. It seems that much of the strategic energy within NHS organisations is focused on the next certification, authorisation and qualification.

In the past several years alone I have witnessed strategy resources devoted more on the World Cass Commissioning Assessment, the CCG authorisation and NHS Foundation Trust qualification than on any strategy that actually impacts quality and efficiency of care or improving the patient experience. The opportunity, indeed the pressing responsibility, is for boards to now focus on strategy that will be sustainable and make a difference.

David Goldberg
Oregon
December 2012

What next?

We are extremely grateful to David for reviewing the current landscape and for observations and advice. David is a knowledgeable commentator on the UK scene but his absence over the last 18 months allows him to more clearly assess whether the reforms are living up to their promise or are we still bogged down in transition.

David is also more keenly aware that lessons can be found in different systems than the one we are tinkering with and sensibly draws on experiences both close at hand in the devolved NHS systems of the UK and further afield. I would add to this the work supporting GPs moving into Rhondda Cynon Taf in Wales and the whole system commissioning prevalent in Scotland.

I detect a number of areas in this half-term report where we should be doing better but where the pressure of compliance with authorisations as CCGs, Foundation Trusts and new regulatory expectations has been distracting. Francis may not have reported but the ether is buzzing.

There are four areas that I draw from David's report that GGI would like you to comment on in terms of our future focus and direction.

a) **Strategy:** It is clear that strategy is the business of the Board but the question is how to avoid falling into the trap of acting like the branch factory merely complying rather than doing the right thing. Professor Mervyn King has offered guidance on this but his ideas on the incapacitated entity, risk appetite and integrated reporting need a wider airing in the UK with Boards choosing to adopt such ideas rather than being told to do so.

b) **Balance & Reporting:** What is the right balance between strategy and grip on day to day events. The debacle at the BBC has highlighted the risks of losing grip, but commentators have also warned at the backlash of micromanaging that often follows operational failures. David also raises the question of how much time is spent on clinical issues, the real business of healthcare.

   We have seen a renewed appreciation of clinical issues in board agendas with GPs taking the lead in Commissioning and reflecting their very different risk appetite from PCTs. This needs nurturing with more focus on boards clarifying what they and stakeholders find material, defining the quality outcomes they expect from their investments and reporting honestly on what they have achieved and plan to achieve with others from their stewardship of public funds.

c) **Rationalisation:** The system needs rationalising but there is suddenly a gap in the strategic planning landscape with imbalances between the mega providers planned, for example, north and south of the Thames in London and the capacity of CCGs and their support organisations. In London, this looks like a vacuum for the Mayor to step into, but across the country there will need to be strengthening of resolve to take difficult decisions on closures and mergers in a way that the population and politicians can feel involved and comfortable that they are signing off on the optimum healthcare they need and we can afford.

   We believe this needs a new model of governance between organisations, reflecting the imperatives of joint and devolved decision taking without abdicating accountability. A start could be made by Boards putting best value reviews back on their agendas. If we are not good at a service and have no appetite to improve, it is unacceptable to hang on heroically to providing that service. We need to encourage alternative and new providers to engage.

d) **People:** We need to rethink who will do the work of planning and delivering better outcomes. We have a dearth of analysts compared with data processers; in many cases we have not valued, understood or used our information systems to inform our strategic decision taking, nor have Boards demonstrated that their strategy informs their prioritisation of agendas and risk-taking. It is clear that succession planning for NEDs, Doctors, Nurses and Managers is a muddle that needs greater clarity and commitment.

   The heath service is not only the largest business we run, but also one of the richest in impact, personal opportunity and fulfilment and the ability to drive economic benefits… potentially. The saddest feedback we get in our work is from the workforce saying 'this may be a learning organisation, but here we are not empowered to make the changes we recognise need to be made. Try that here and you get punished' We must have faith in our staff to deliver, but they need to be trained and valued as, for example, in Tayside where over 1000 clinical staff have been trained in quality improvement techniques. Clinicians also need to be held to account for what they do and do not do, e.g. how quickly they innovate.

Perhaps an odd choice to end with, but often the best advice come from those who have experienced failure. So, to quote from Lord Patten, but applied to our clinical staff:

"So we do have to devolve decision making as much as possible, but with devolved decision making comes people's preparedness to take responsibility. And one of the things, which I note, is that those who have responsible positions (in journalism, in editorial) are very reluctant to accept that they're therefore part of management, but they are."

(from the Andrew Marr Show, BBC, 11 November 2012)

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The Goldberg Report:

Strategy and the New NHS

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