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Competing priorities for NHS leadership

Last week the government announced £6.6bn in extra funding for the NHS over the next six months to support its continuing response to COVID-19. That brings the total of extra government funding for health services in 2020/21 to more than £50bn.

But for the decade that followed the 2008 financial crash, the NHS faced what the King's Fund called 'the most prolonged spending squeeze in its history'. Despite a relatively generous five-year settlement in 2018, the service still faces a significant funding problem.

In January this year, nearly five million people were waiting for NHS treatment to begin. More than 300,000 had been waiting over a year to start hospital treatment – the highest number since 2008. And A&E attendances have also been much lower than usual. These numbers are going to get worse before they start to improve.

The impact of COVID-19 on the care of people with long-term conditions has also been huge. Between March 2020 and the end of the year, there were just under four million fewer referrals for hospital care than there were in the previous year.

The effect of the pandemic on the mental health and wellbeing of NHS staff has yet to be fully assessed but early research suggests a high prevalence of depression, anxiety and PTSD among frontline workers. This will have an impact on absenteeism and staff retention – which were already challenges for the health and social care sectors before the pandemic began.

This all adds up to a massive operational challenge that must somehow be balanced with the cultural, political and practical challenges of embracing the new integrated care model – the biggest shake-up in the way health and social care has been run in this country for a decade.

The focus of integrated care is on adopting a more holistic, place-based approach to health and social care by working with partners across the public, private and third sectors to address the causes of ill-health. This will require unprecedented levels of collaboration

But make no mistake, as we have said in a previous illumination, the main focus for ICS boards for the foreseeable future will have to be on addressing the NHS's financial and performance issues.

Partnership with purpose

These challenges should not be seen as mutually exclusive. Developing the right collaborative strategies will drive performance improvements. In fact, we would argue that the improvements we need cannot be achieved without innovative partnership working. ICSs and provider collaboratives in particular have huge potential to tackle many of the challenges we have highlighted – but they must be approached with clear objectives in mind.

Partnership with purpose in the immediate term means improved efficiency and effectiveness in reducing waiting times through collective waiting list management. It means finding workforce innovations through clinical networks to develop staff and share resources. And it means collectively managing the agency market to drive down staffing costs.

All of this requires lean, pragmatic governance that's focused on delivering collective strategy and objectives, not convoluted processes that add nothing but complexity. This requires an unrelenting focus on finding the simplest possible solution. The watchwords for good governance in a partnership context should be agility, proportionality and responsiveness.

Simple outcomes from complex systems

Professor Marcel Levi, the outgoing CEO of University College London Hospital Foundation Trust, said in an interview with the HSJ: "I think we have actually demonstrated how effective integrated care could be and how well organisations can work together. [The concern is] this very agile, flexible, fantastic, result-oriented system will actually now come to a grinding halt because everybody's now talking about boards, and about terms of reference, and about meetings and meeting frequencies, and who should be on the subcommittees of the provider alliance. And these are all very boring discussions that really distract from what you want to achieve and that is better care for patients and… better care for the population."

Professor Levi was correct to stress the importance of starting with outcomes in mind. He said: "We just need to take a step back before we start with these discussions about whether we should have one or three or five boards, [and] actually think, 'what do we want to achieve and what's the easiest way of achieving it, and how can we keep bureaucracy as far [away] as possible from all this?'"

Today, on the anniversary of the UK's first national lockdown, health leaders find themselves at a crucial moment in the history of the NHS. They would do well to remember Professor Levi's words. But they must also remember that the priority for the UK right now and for the next two years is to recover from the pandemic, fix waiting times, and ensure funding models are sustainable.

Beyond this immediate focus is an integrated service that might look complex from a system point of view but is beautifully simple for the user in its focus on their health outcomes, from cradle to grave.

Illuminations

- Cost control and operational improvement are not incompatible with collaborative working – in fact, we would argue they are impossible without it.
- Lean and flexible governance that is focused on outcomes rather than structures and bureaucracy must be at the core of collaboration.
- Leadership is about keeping now and the future in equal focus. The immediate priorities must be recovery, funding, and bringing down waiting times. But we must not lose sight of our long-term goals of providing people with all the care they need in a local system, in which they only have to tell their story once.

If you have any questions or comments about this briefing, please call us on 07732 681120 or email **advice@good-governance.org.uk**