THIS TIME IT'S

The NHS has repeatedly talked about revolutionary change but the roundtable panel on improvement agreed: this time it really has to happen. Alison Moore reports on experts' views of how the health service can deliver much more for much less

No one doubts that the NHS will need to improve to meet the myriad challenges of the next few years. But how that can be done is much more contentious.

An *HSJ* roundtable – sponsored by the NHS Institute for Innovation and Improvement – pulled together some of the leading figures in improvement to talk about the challenges the NHS faces, the drivers for change and the barriers preventing improvement being as fast as they would like.

The session started with a lighthearted warning from panel chair and *HSJ* editor Alastair McLellan, who joked about the dangers of levitation in discussions such as this. The focus needed to remain on the reality of delivering healthcare over the next few years and dealing with the world as it was, he said, not as they would like it to be. "Can you do this in Bolton should be the test," he urged.

Looking forward, he asked what was the most significant change the NHS needed to achieve over the next two or three years.

Helen Bevan, chief of service transformation at the NHS Institute, said that many people would highlight technical changes but she thought a change in mindset was more important. "It seems to me that change is not the goal. The goal is the goal," she said. There was a need to build a massive sense of shared purpose across the whole system which would make it easier.

David Fillingham, chief executive at the Advancing Quality Alliance, said: "I think the NHS is stuck in the industrial age, it is back in the middle of the twentieth century. It needs to move from the industrial age of medicine

towards the information age of healthcare." This would involve shared decision making and a move from professional knows best. While much of this was happening, it needed to accelerate over the next three years.

But the NHS needed to mobilise all its assets, suggested Maxine Power, director of NHS Quest. It still communicated badly with some communities and there was a need to build partnerships. But the big change would be moving from healthcare to health, and prevention rather than cure.

Dr Junaid Bajwa came with a different perspective, as a GP in Greenwich involved with his local clinical commissioning group. "The challenge is going to be how we change how we commission... for health outcomes." He said commissioners were expected to improve quality outcomes for the population but did not really have any contractual levers to enable GPs to do this. And providers needed to change behaviour so that integration was supported and patients did not get duplicated services.

Open culture

Heart of England Foundation Trust chief executive Dr Mark Newbold said: "We need to move to an open leadership culture where we engage in dialogue regularly with the public and others around the challenges we face." The challenges the NHS faced were not politically or managerially imposed: they were inherent in a developing healthcare system, he said.

Mandy Hollis, who works in service improvement at Oxford Radcliffe Hospitals Trust, highlighted the gap between people on the frontline and those in management – and a quality agenda on one side and a financial one on the other. People became stuck on burning platforms which inhibited innovation.

For Beverley Matthews, director of NHS Kidney Care and NHS Liver Care, the challenge would be to move people from good to great. She would like to see the role of the carer change in the next three years. Carers needed to believe that they had the same access to NHS resources as the patient.

And she added that there was a need to connect all the bits of the NHS that worked well and to share learning, to avoid reinventing the wheel.

Julian Hartley, who is interim managing director of the new NHS improvement body, called for a practical approach to deepening employee engagement within the NHS. Alignment between employees' efforts and the aims of the organisations was important.

"People come into the NHS because it is a vocation but somehow there is an opportunity that is missed to translate that into great outcomes," he said.

NHS Commissioning Board director Steve Fairman agreed on the importance of mindset. "The workforce is really critical in this. There are too many people currently working in the NHS who don't believe we can increase quality without increasing costs and that needs

ROUNDTABLE PARTICIPANTS

Alastair McLellan *HSJ* editor and roundtable chair
Helen Bevan chief of service transformation, NHS Institute for Innovation and Improvement
David Fillingham chief executive, Advancing Quality Alliance,
Dr Junaid Bajwa GP and clinical commissioning group board member, NHS Greenwich
Maxine Power director, NHS Quest
Dr Mark Newbold chief executive, Heart of England Foundation Trust
Mandy Hollis electronic patient record manager, service improvement and business support to the chief nurse, Oxford Radcliffe Hospitals Trust
Beverley Matthews director, NHS Kidney Care and NHS Liver Care
Steve Fairman director in the medical directorate, NHS Commissioning Board
Julian Hartley interim managing director, NHS improvement body
Dr Robert Varnam GP, clinical lead for commissioning, NHS Institute and co-chair for integration, NHS Future Forum

DIFFERENT

In association with
NHS Institute for Innovation and Improvement

The panel: (opposite page) Alastair McLellan (left) and Mark Newbold; (clockwise from top left) David Fillingham, Maxine Power, Helen Bevan, Beverley Matthews, Steve Fairman (right) and Julian Hartley, Robert Varnam, Mandy Hollis, and Junaid Bajwa

to change," he said. "I don't think there are enough people working in the NHS who genuinely believe patients have a role to play in improving services. Transparency of information and outcomes will be critical in that.

"People need to think that it is completely unacceptable that the NHS is a series of islands of excellence in a sea of mediocrity."

GP Robert Varnam said there was a need for clarity about the purpose of care. "The big shift needs to be around patients and their communities not around ourselves," he said. There was a need for reorientation around a different purpose which lay outside ourselves. What was needed was a focus on achieving things rather than "being busy".

"The purpose too often now is just about being busy, rewarding ourselves for being busy, moaning about being busy, judging ourselves by how busy we are."

But, asked Mr McLellan, what were the barriers to making change and innovation – and what made it so difficult in the NHS? He said there were things the NHS was good at changing and others that it was not.

Barriers to change

He turned to Mr Fillingham whom he described as the "most optimistic man in the NHS." Mr Fillingham said there were three sets of barriers. The capacity and capability to support change in the NHS was far better than in the past but still nowhere near enough, he said. This was important for boards. Second, the culture of the NHS was based around quality assurance and compliance rather than improvement. He warned that there was a real danger that the Francis report might make this worse – increasing focus on compliance. That would not lead to the sort of transformation needed.

The third barrier, he suggested, was that pretty much every incentive was pointing in the wrong direction. Payment by results, for example, built big hospitals. Measurement was often not around whole systems.

But do healthcare professionals value the right things? Ms Power suggested that they "valued the rescue". "We somehow have to switch that off so we value the mundane as much as we value the rescue."

And she highlighted that data collection alone did not help. "Drowning in data but very little intelligence... we are in danger of building more and more capture systems without building the skill set in the workforce to skilfully interpret that."

Mr McLellan asked why the NHS was bad at capturing good practice. Ms Power said there was a sea of change happening with nuggets of gold in the NHS but it was really bad at sifting and capturing those nuggets.

Dr Bajwa highlighted the fragmentation of the NHS as a factor which creates challenges – but Mr McLellan pointed out

WILDE FRY

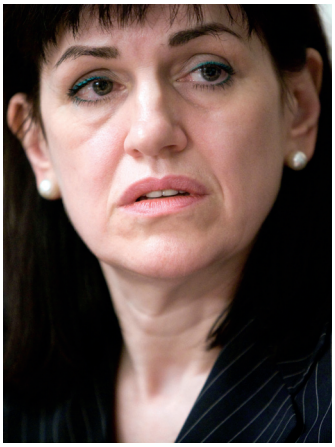
Do you love innovation? Panel members questioned whether trust boards, individual health professionals and the public were fans of radical changes to the NHS

that other sectors, such as car production or retail, were considerably more fragmented yet innovations could sweep through them within months.

Dr Bajwa added that there were cultural issues and there often adversarial relationships between commissioners and providers. "When I was a senior house officer everything was the GP's fault. Now I'm a GP everything is the hospital's fault," he said.

As might be expected from an acute trust chief executive, Dr Newbold could see many barriers. One was the PbR and tariff system which were not made for urgent care and block innovation and integration. The regulatory regime was both stifling and short term in its approach, and staff engagement was not good enough. "We do not yet have the relationship with our staff we would need to innovate as fast as we would like," he said.

Mandy Hollis highlighted the chasm between people running organisations and the frontline. People running organisations were often tied up with fire-fighting, while ward staff often had a very different set of priorities. "Some nurses feel very aggrieved to be pushed down a quality improvement agenda and feel people at the top don't understand what it is like to be on the frontline," she said. "It all feels rather messy and I don't feel like we have a real hold on



'Local political agitation is important. It makes it difficult for local leaders to enact change'

what we want to achieve."

Mr McLellan questioned whether some groups were getting off lightly in the discussion so far. He said one problem might be the institutional resistance of healthcare professionals to change that challenged their status and role.

Ms Hollis agreed that some changes – especially around pathways and "no health without mental health" – would affect the roles of health professionals. "I don't know that the professions have quite thought that through and grasped those changes that are ahead," she said.

Ms Matthews said there were some real practical needs if innovation was to spread in the NHS. Part of this was that NHS staff needed support back at base; enabling leadership would make a real difference.

Mr Hartley took a broader view. "Part of the barrier to change is how hard it is to make changes in local communities that affect hospitals... in terms of reducing beds, closing wards, changing institutions. Local political agitation is important: by-elections depend on it. It makes it difficult for local leaders to enact the change they need to do.

"We have a challenge to overcome that barrier with making the case strong enough and getting local politicians to play their role in that."

Mr Fairman suggested that innovation was not valued in the NHS. "I recently visited a big car company which has plants all over the world," he said. "That company grades plants by the number of ideas that come out of it. The one individual who comes up with the idea gets promoted. It was really energising to go there and see how they value innovation."

Dr Varnam said the NHS persisted in incentivising the wrong thing – "busyness" rather than success. He said that one of the reasons for the slow spread of innovation was that there was no fear of the consequences of not innovating. In other industries people needed to innovate. And he highlighted a lack of courage as a barrier: there was a need for courageous medical leaders (nursing was more advanced) willing to say that we could be better.

"There is still too much expectation that medical leaders will be representatives, and reinforce the status quo," he said. Courageous politicians who would put the needs of the population above an old narrative of schools and health were also needed.

Intrinsic motivation

Helen Bevan said she felt compelled to use the NHS change model framework. She said this meant linking to people's intrinsic motivations for change. Extrinsic aspects were eating up or killing off the intrinsic motivation: the two needed to be aligned so that incentives connected with values.

And there was a need as never before to connect two types of people – those concentrating on hard performance and the "fluffy" organisational development people. Mr McLellan said he had recently talked to someone in the NHS Commissioning Board who had also said it was important to win

over the "hard performance" managers who occupied other senior positions.

Ms Bevan added: "History tells us that the big performance people won't change the world."

Mr McLellan asked if some groups were still escaping this analysis. "Are we being much much too nice about the public and patients? Their expectations and their views about the NHS and healthcare – are they one of the most significant barriers to delivering change?"

Dr Varnam said that patients sometimes had very low expectations, including around their ability to bring about change. "I think we need to help patients and the public get to a different level and operate as collaborators... then they could be drivers of significant improvements." He urged patients should not just be seen as consumers.

Mr McLellan said there was a reservoir of desire to be involved. It could be the usual suspects who stepped up to be involved and he asked whether the desire to be actively involved was more general than this.

Ms Matthews said there might be a generational element to this. She said there was a question over whether the NHS was ready to cope with her generation of working women who would be more challenging and demanding than those who went before.

Mr Hartley said there was some way to go in utilising foundation members and governors, though some areas had done well at engaging them and changing as a result of feedback from members. "It is an important resource that we should not forget as a driver for improvement in foundation trusts."

Mr Fillingham pointed to evidence that, when fully informed, patients often wanted less invasive treatments and it was health professionals who tilted towards more invasive ones.

Is this time different?

Mr McLellan then raised the issue of why change would happen now when it had been talked about so many times before yet little had actually materialised. Why was this time different? He pointed out that we were now in an era of little money to spare after a period of plenty – how did that affect it?

Ms Power said one factor was the ability to connect with people in a way that had not been possible before. A lot of this could be done for free through self-organising networks. And also much could be done without travelling or being face-to-face. Dr Bajwa pointed to the impact of technology even among the panel: several people had iPads in front of them.

"There are some truths in what people have said. You can't have a trust in deficit for many years without people taking action. There is a lot of waste in the system that you could argue has been removed. PCTs have had to make a cull, local authorities have had to make a cull, our authorisation visit questioned us about innovation."

Dr Newbold felt that money was the distinguishing feature. People could see that an organisation losing money was not sustainable – although Mr McLellan questioned whether there was still an assumption that the government could not let the NHS fall. At the *HSJ* summit a senior government official had said no government would go into an election saying the NHS was to be reduced, he added. But Dr Newbold said the view that there would be a bailout was diminishing.

And he also pinpointed that the medical profession was on the cusp of change. This reflected a wider intake into the profession over the last few years and a cohort several hundred strong of junior doctors who were interested in leadership.

"I think more broadly the culture is changing. I think the social era is here. There is an awful lot of networking and accepting of ideas," he said.

The change in how we are communicating was picked up by Mandy Hollis, who spoke of how social media was making sharing much more engaging. "Some of the nursing Twitter chats have had patients joining in."

Ms Matthews highlighted how patients were coming in with an idea of what they wanted. But austerity had also had an impact. "I'm sure

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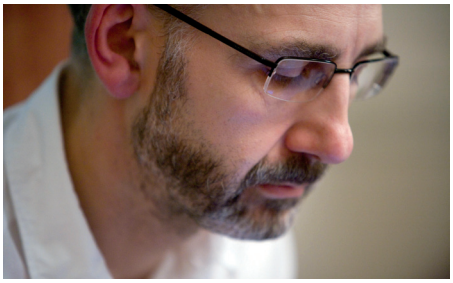
Panel members debated whether the NHS had the expertise needed to drive radical improvement – and how it might acquire them if not



without the financial pinch people would still be travelling to a meeting across England," she said.

But is the rise of the quality agenda important in driving change? Mr Hartley said that the need to address both finance and quality was creating a situation where organisations can't just turn the wheel faster to get out. He believed boards were now spending more time talking about quality than money – although other panellists were unsure about this.

And he added that things such as Dr Foster reports "just sharpens up the perspective with the public wanting to know what goes on inside hospitals".

Mr McLellan asked what impact the Francis report would have on improvement. Ms Hollis pointed out that change was often implemented without all the consequences being thought through.

"We say something must be done and we bang the drum but never give it the chance to settle down," she said.

Mr Fairman highlighted competition as a new driver for change. "A lot of trusts, even community trusts, have not had a challenge to how they provide services to patients. This is proving a challenge," he said.

Dr Varnam said: "We are putting commissioning in the hands of people who are closer to where people live and are less bothered about the traditional

'Share advances in real time rather than waiting 18 months for a report by which time the landscape has changed'

NHS way of doing things." CCG leaders were more prepared to think outside the box and well-advanced CCGs were helping general practice be part of the solution, he said.

"The people who are now responsible for making that happen will be accountable for making it successful," he said. This offered a genuine opportunity for clinicians to drive change.

Helen Bevan pointed to the enthusiasm for change and the progress which was being made in some areas already. Dementia was an example of this with involvement from outside the NHS in Dementia Action Alliances and the development of dementia friendly hospitals. This wider involvement in change was bringing on board a whole set of resources which had not been available before. "It feels very different and it makes me very hopeful," she said.

David Fillingham said what was different this time was that the NHS was facing a perfect storm and appeared ripe for restructuring. It had a new set of commissioning organisations with a lot of energy. "I think there will be big change but will it be change for the better or for the worse?" he asked. He was not quite seeing a compelling vision of a better NHS.

Ms Power suggested there was a compelling vision and this could be seen in the NHS Constitution. Mr Fillingham countered that this needed to be sense checked to bring it back to earth. Dr Newbold said the sentiment of the constitution was often discussed at board level but it was not often quoted directly.

Ms Power also stressed the chaos the NHS was in was a driver for change. "If we had a very stable NHS structure we would not have as much opportunity as we have now," she said.

Finally Mr McLellan turned to the biggest question of all – how would those round the table bring about change, promote innovation and make it stick and spread?

Dr Bajwa said: "It's a culture thing. From the person cleaning the wards to the senior manager it is a culture thing.

"Can we give more autonomy to people? The GP practice where I work wanted to try to give each of the receptionists a day out of being a receptionist to do something else in the NHS."

But he warned that it was not necessary to review targets all the time. There was a danger of "paralysis by analysis".

Dr Newbold said existing leaders needed to step up collectively and make change happen. "The quickest way for change to happen was for those with hands on the levers to make it happen.

"But it will be risky. We have to acknowledge that. It feels a very dangerous place to be but I think we have done enough talking."

Social media

Ms Hollis stressed the importance of using the right language to get people engaged and the need to capitalise on social media to reach the public and patients. "We need to be enabling society to be more responsible for its own healthcare."

Ms Matthews said there was an opportunity to rebase and bring in consistency and

stability, but an eye needed to be kept on the next generation.

Mr Hartley said that life for many people in healthcare felt like a constant treadmill of demands: "It's surviving and working through the unpredictable demands that people face.

"How do we get from that to a better place? Organisations need to invest in some extra capacity to allow people to do it."

People needed to be able to step back, he said – but Mr McLellan asked where the money to pay for this would come from. In the current financial climate, investment needed to be matched by disinvestment.

Mr Hartley said that, for many organisations, there was a cost to not doing this work – that they would not achieve what they needed to.

"Sometimes that takes the form of looking at taking out bed capacity... assuming that length of stay will reduce because of assumptions about how they will work differently with primary care colleagues."

Mr Fairman said: "I think we are going to have to invest time and energy in creating partnerships that work." These could be between clinicians and managers or between the NHS and other bodies.

But he also pointed out how asking people for their views brought beneficial change, citing Manchester City Council asking 10- to 14-year-olds who they wanted to perform at the Christmas lights switch on, listening to them – and getting their biggest ever crowd as a result.

Dr Varnam said: "I feel we should spend less energy telling people what to do and more time giving them the skills." He found that people were more likely to ask how to do things than what needed to be done. "There's a lot of what, we need to focus on the how."

Ms Bevan pointed to worldwide evidence that high performing systems invested heavily in people and capability. People were not expected to pick up skills in other areas along the way – so why was there an expectation that those with other jobs should just pick up improvement skills?

"How can we take the opportunity to do this right first time rather than doing catch up?" she said. The answer was to build improvement into the system in the first place – for example, when defining the skills that CCGs needed.

Mr McLellan asked what skills a team director from the National Commissioning Board would need to help drive improvement: Ms Bevan said they would be around system leadership. The NHS was coming out of an age of compliance.

"The era that we are moving into is much more about commitment. How do we build a massive sense of shared purpose?"

Accountability would be different from the old system – where it was done through performance management – and would need to be created in relationships.

Pioneers needed

Mr Fillingham said the NHS needed some pioneers. "Inequality is the engine which drives excellence," he said, pointing to the role of pioneer organisations in the US. The NHS needed to hothouse development, learn from it and then spread it.

But Mr McLellan, playing devil's advocate, questioned the idea of deliberately allowing inequality and whether this would be acceptable.

Ms Matthews said it was important to share advances in real time rather than waiting 18 months for a report by which time the whole landscape had changed.

Ms Bevan pointed out that some of the early sites adopting productive ward were not official but were some of the quickest. The NHS Institute team had dubbed them the "renegades".

Ms Power questioned whether they had danced around naming the problem. Talking about harm and waste led to a lot of discomfort, she said.

But she added that the problem was that the NHS was essentially designed for the 1960s rather than for the modern day. There was a danger that it could become unaffordable.

"I wonder how many decades the NHS could stumble on or muddle through?" asked Mr McLellan. "Do we really think that if we don't deliver the required level of change then the NHS is going to be looking down the wrong end of a barrel in the near future?"

Ms Hollis suggested no government was going to make radical changes because it was an election loser. Employees might not want to make radical changes because they had an interest in it. And radical change was overwhelming.

Concluding, Mr McLellan said: "I think if we had thought about this a few years ago we would have said 'we should do it' because there is lots of money and that it is about the Modernisation Agency. Now we are talking about the culture." ●

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