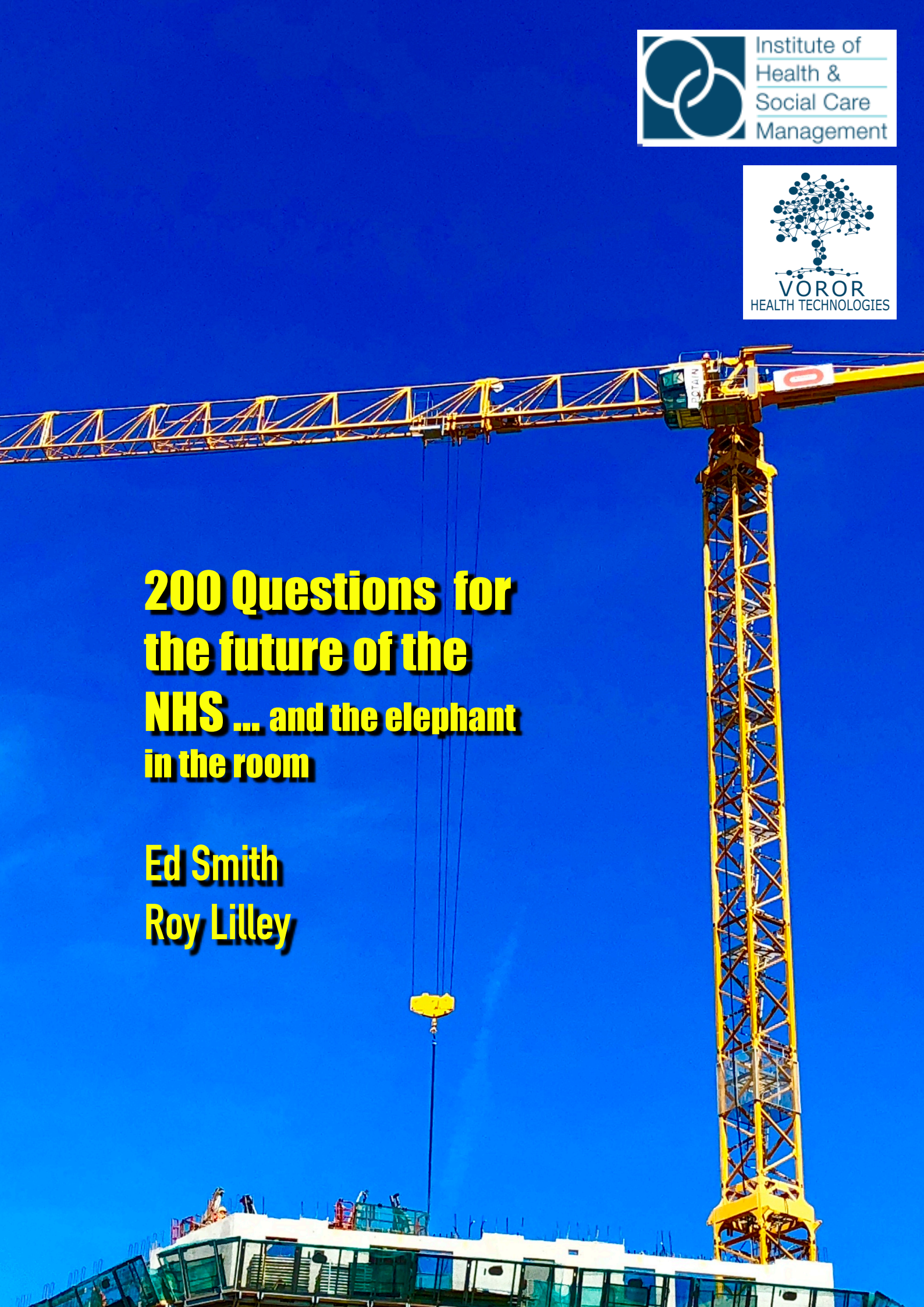
Institute of Health & Social Care Management

VOROR HEALTH TECHNOLOGIES



200 Questions for the future of the NHS ... and the elephant in the room

Ed Smith
Roy Lilley

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Thank you for your support and interest.

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Dedication

This book is dedicated to the fabulous NHS people who, time and again, deliver more, for less…

It has been written with the help and guidance of professionals in the Service and the members of the Institute of Health and Social Care Management.

Our thanks to them.

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The Institute of Health and Social Care Management is the leading independent membership organisation for managers and leaders who plan, deliver and support health and care in the UK and across the world.

To be part of the Institute, find out more about membership, here.

Following the publication of this book the Institute plans to create special interest groups, around the six key topics,

- Technology
- Workforce
- Structure
- Delivery
- Funding
- Leadership

… you can join a group and be part of the discussion. Click here and join the group (s) that most interest you and we will add you to the list and let you know when the series of virtual meetings will take place.

Once the meetings have deliberated we plan to produce another book, featuring your thoughts and an actual real, face-to-face get together to share your findings and observations.

Please join in and be a part of our policy thinking.

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Notes: There are live hyper-links in the text of this book. They were all tested and correct at the time of publication but there are no guarantees or assurances that they will remain current, neither that the websites and other materials they link to are virus free.

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200 questions for the future of the NHS

In January 2023, Prime Minister Rishi Sunak hosted a crisis meeting in Downing Street to discuss the situation facing the NHS; recovery from Covid, strikes and waiting lists.

> The fact the PM was involved serves to underline the concerns there are surrounding the performance of the Service and its ability to deliver ever greater volumes of treatments and diagnostics, as it tries to recover from the impact of Covid and from the ten years of near flat-line funding.
>
> Following the world banking crisis, limits to funding led to a shortfall in investment, the legacy of which is a £9bn plus, backlog in buildings' maintenance and a workforce crippled with vacancies.
>
> **Both events have left their mark.**
>
> Before Covid the prestigious Commonwealth Fund think-tank, in their international comparisons of healthcare systems, rated the NHS as the top performer.
>
> Today the English NHS dropped to fourth and occupies a place at the bottom or in the bottom quartile, of most international comparisons for numbers of beds, medics, clinicians and diagnostic equipment per 1,000 head of population.

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Even more salutary, the fact that the Downing Street meeting, involving leading clinicians and managers from the NHS, the Secretary of State for Health, the Prime Minister and the Number 10 policy advisors ended with nothing in the way of fresh thinking and a statement that can only be summed up as…

… more of the same.

The focus of discussion was on discharge arrangements to free-up NHS beds, in an attempt to reinstate the flow through the system and avoid backlogs. A sensible move but it does not solve the underlying issues of NHS' declining performance.

It is clear the NHS is struggling.

At the heart of the difficulties are the problems faced by social care. Local government funding fell by an estimated 49.1% in real terms from 2010-11 to 2017-18. The combination of rising demand, increases in the elderly population and costs, in the face of reductions in funding, has placed the social care system under very great and unsustainable strain.

In its present state, the system is not fit to respond to the demographic trends of the future.

In 2022-23, councils' core spending power increased by 7.4% in cash-terms. When the government set out its plans in December 2021, this was expected to be worth £2.3 billion in 2021-22 prices, a 4.6% real-terms increase year-on-year.

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However, higher-than-expected inflation has meant the actual real-terms increase was a much more modest £1.2 billion (2.4%).

High quality social care support can often stop people going to hospital in the first place as well as helping to prevent readmission.

Crucially, the NHS depends on the care provided by social services to move vulnerable people, medically ready to leave hospital, home safely and supported.

In many parts of the country cuts to services and low wages in the care sector has meant the flow through hospitals has ground to a halt as local care services have struggled to provide care packages.

The care staff vacancy rate is the highest since records began, rising sharply from 7.0% to 10.7%. The number of vacancies risen from 110,000 to 165,000.

Social care struggles to compete with supermarkets on pay.

NHS and care services are doing what they can with the resources available but it is mostly firefighting. New initiatives are really only creating new points of access, to diffuse demand or creating virtual services to support patients at home, which can be resource heavy. As novel as these attempts might be, they are in no way a step change in how the health and care does its business.

The NHS is full of local innovations, ideas and changes to working practices. People do their best to deal with their problems. Some are better at it than others.

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But it is remarkable how slow the NHS is, to share and diffuse novel approaches or to cascade ideas and solutions.

The preoccupations of the day-to-day weigh heavily.

Sharing ideas, or in management speak Diffusion is never easy. Particularly in the NHS. It is a national system but actually is made up of hospitals that are legally independent organisations and are free to go their own way.

Similarly, information cascade is difficult and is often inconsistent and unreliable.

The Academy of Fabulous Stuff remains the only free-to-access repository of ideas, innovations and best practice. Shared and submitted by people working at the sharp-end of care.

Delivering the right message, to the right people, at the right time is difficult, as there is no real mechanism to ensure ideas are shared, for example, from the front line of one hospital, to the front line of another.

Primary care and secondary care have very separate structures, funding and oversight are inextricably and mutually dependent.

The way large global organisations '*bubble and spread*' innovation, best practices and improvements does not seem to be in the DNA of our NHS and begs the question;

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Why?

Primary care has its own unique problems. Founded on a patchwork of small businesses,, entitled to deliver services in the way which suits them best, within a complex framework

The primary care model designed over 70 years ago may have run its course but what comes next?

Certainly, it is likely to be part of a wider system change…

… leveraging technology, service integration and workforce change. Alongside these drivers is alignment of funding to population health, rather than supply side components.

It is against this background we are seeking to provide a platform of thinking around what we consider are six key issues, which if addressed locally, regionally and nationally, might create the climate of improvement the NHS will need to see it into an uncertain future.

There are cautious warnings about further reorganisation.

The NHS is undergoing changes which the service broadly welcomes, but it is important to shape these changes to best advantage.

Importantly, we all should learn from the mistakes of the past where superstructures were created without aligning incentives, which inevitably impacts on patient outcomes and productivity.

As with all change, a crucial factor will be clarity of responsibility and accountability. These are

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two essential components which are the drivers of success, finance, workforce and technology.

This book is not presented as a series of solutions.

It is a framework to encourage thinking about issues. It is looking for solutions, practical thoughts and exploring pathways to implementation through conversation and dialogue with colleagues.

Think national, act local.

Looking and thinking about issues is important. As a prompt there are two hundred questions 'to get the juices flowing'.

You will certainly have your own questions and based on your experience, practical suggestions for improvement.

What's next?

Through the membership of the Institute of Health and Social Care Management (IHSCM), and their active special interest group network, we expect to create a forum for discussion, capture the outcomes and publish them in a later volume. Sharing the best ideas and thoughts.

So, it's a practical book and a stepping stone. Use it to promote discussion, debate and challenge…

… and the pursuit of excellence.

Ed Smith
Roy Lilley

Spring 2023

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Fifty NHS facts and figures*

for background, to help your thinking, make you look good at the next meeting and for the pub-quiz!

1. Two pounds in every hundred is spent administering the NHS
2. Managers make up 2% of the workforce
3. Outside the NHS, managers, directors and senior officials in the UK as a whole, make up 9% of the workforce
4. About a third of managers are also clinicians
5. The NHS spends about half the OECD average on admin and planning; 1.5% of its budgets. Compared to 4.1% in France and 7.9% in the US.
6. One in seven hospitals are still using paper based records
7. The NHS spends over £350,000 a minute and cares for 7,000 people every 60 seconds
8. NHS hospitals carry out more than 10,000,000 operations every year
9. GPs are seeing nearly 30,000,000 people *every month*

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10. The number of vacancies across the NHS in England is about 10% of the workforce
11. The NHS has (per equivalent population) a third of the beds of Germany, half the beds of France
12. The NHS has less than half the number of scanners than the OECD average, 15% fewer doctors, 25% fewer nurses
13. The NHS has a 92-94% bed occupancy rate, *in the summer*
14. Social care has 160,000 vacancies
15. In 2022, forty thousand nurses left the NHS ahead of retirement
16. Health accounts for two pounds in every ten, spent by HMG…
17. … and four pounds in every ten spent on public services
18. Health and social care are the single most expensive thing HMG does
19. In 2019/20 the budget was £140bn
20. In 21/22, because of Covid, the budget rose to £190bn
21. NHS funding dropped, dramatically, in the austerity years following the world banking crisis with almost ten years of an under 2% uplift

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22. It is generally accepted, to keep pace with inflation, growth in demand and an ageing population, just to get-by, the NHS needs an annual up-lift of around 4%

23. The NHS financial settlement was originally agreed with government in the 2021 Spending Review and covered the period up to 2024/25. Funding for the NHS has since been confirmed in the 2022 Autumn Statement. This provides an additional £3.3 billion for 2023/24 and 2024/25 which is required to fund forecast higher inflation.

24. Covid funding reduces from £5.1 billion in 2022/23 to £2.4 billion in 2023/24, with a further £2 billion reduction in 2024/25.

25. Taken together, the NHS budget is estimated to have reduced in real terms by 3.4% in 2022/23 and will increase by 1.8% in 2023/24 and 2.0% in 2024/25.

26. The total NHS pay bill accounts for £70bn, around 65% of a provider's expenditure

27. Pay remains the largest component of the total NHS operating costs

28. The NHS budget has been set until 2024/25 and includes ‘stretching efficiency’ targets

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29. The 2023 funding settlement requires the NHS to deliver annual efficiency savings of at least 2.2% each year, which is significantly higher than the c1% per year the NHS has historically delivered.

30. Each additional 1% uplift in nurse pay, taken together with associated employment costs, adds £1bn to the wage bill

31. NHS Staff Survey results show that – save for a limited number of measures – staff experience has declined over recent years. Sickness absence rates increased during the pandemic and remain significantly higher than before the pandemic

32. Around 40% of the NHS workforce is over age 50.

33. In July 2022, the largest annual leaver rate increase was identified in the staff group ‘support to healthcare scientists’ up by 5.5%

34. The only staff groups to show a reduction in the annual leaver rate were support to nurses and support to allied health professionals (AHPs), down -0.1% and -0.7% respectively

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35. Across all staff groups, fewer people left the NHS throughout the COVID-19 pandemic, but since September 2021 rates have been increasing month on month and are now higher than pre-pandemic levels

36. Although the number of nurses leaving the NHS is lower than during the pandemic, since September 2021 the annual NHS leaver rate has increased and is now higher than pre-pandemic levels, at 7.6% in August 2022 compared to 6.8% in August 2019

37. Between October 2019 and October 2022 substantive midwifery vacancies increased by 1,975 to 2,852 FTE, a vacancy rate increase from 3.8% to 10.9%.

38. Increasing demand and vacancies are driving the increased use of temporary staffing, both agency and bank. The spend was £2.9bn at the end of 2021/22

39. The NHS pension scheme has over 1.7 million members, who pay on average 9.8% in employee contributions; the employer contribution rate is 20.6%

40. Pension tax rules have recently changed allowing relief on pension growth of up to £60,000 in any one tax year. The lifetime

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earnings cap removed. Will it be enough to encourage more high earners to do more sessions in the NHS?

41. Over the next 15 years, England's population is projected to increase by 4.2%, and…

42. The number of people over 85yrs is estimated to grow by 55%

43. There is a 10% productivity difference between the average of the ten most and ten least engaged Trusts

44. For those with a combination of high productivity/effectiveness and high engagement, their working practices and workforce models can be quite distinctive. For example; specialist nurses working on surgical wards

45. The NHS has a Culture and Leadership Programme. A structured approach that helps organisations understand their own culture, identify the root causes they need to change and then to address them

46. There is also a Health and Wellbeing Framework, which defines what organisations and systems need to do to create a wellbeing culture

47. The Model Health System is a data-driven improvement tool that enables NHS health

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systems and trusts to benchmark quality and productivity. By identifying opportunities for improvement, the Model Health System empowers NHS teams to continuously improve care for patients. The Model Health System incorporates the Model Hospital, which provides hospital provider-level benchmarking.

48. In June 2022 NHSE published the Flexible working toolkit for individuals and line managers

49. As a minimum, 25% of permanent roles in the NHS, should be advertised with clear flexible working options

50. Digital staff passports enable people to hold a verified portfolio of their qualifications, professional registration, employment history, competence and assessed experience so that they can move between different NHS employing organisations easily and quickly, without the need for repeat form filling, checks and duplicate training.

*Facts and figures compiled from official sources, think-tank reports, news, gossip and the back of an envelope and are all correct at the time of publication but may change or vary over time.

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The Hewitt Review

As work on this book was coming to close the Hewitt Review of integrated care systems was published.

In November 2022 the Rt Hon Patricia Hewitt a former Labour politician and secretary of state for health, was appointed, by Chancellor of the Exchequer, Jeremy Hunt as an advisor to the government.

She was tasked to review the progress and future of the 'new-kids-on-the-block', the Integrated Care Systems.

Her report runs to over eighty pages with thirty six recommendations. They are wide ranging. Broadly the report has been welcomed but the complexity of the recommendations and their far reaching consequences, in the opinion of most observers… it's destined for the long-grass.

The DHSC said; 'ministers will study it'.

The report covers much of the ground that is the subject of our 200 questions. Rather than inflict another 100 questions on you, we decided to include a link to the report for you to judge for yourself its relevance and the practical likelihood of much of it being incorporated into policy. Click on the image.

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Just to get the juices flowing…

Before you start…

There are six sections to this book, under the headings;

- Technology
- Workforce
- Structure
- Delivery options
- Funding
- Leadership

For any one thinking about the future of the NHS, these topics are probably self defining. They are important, often the key drivers of success and failure of the system. They are the obvious levers, probably the most changed and fiddled about with!

But, there is more.

There are structural issues that for all kinds of complicated political and financial reasons do not get addressed.

The purpose of this book is to get a conversation going. To get people talking about change in a non-threatening way. To understand the implications of change and what is practical and what isn't. Many of the questions are workplace related and reflect what is actually going on in the NHS. Life at the sharp end.

More?

By 'more' we mean the underlying issues that makes change so difficult. It is true the NHS has

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been the victim of endless ‘reforms’ but nothing has really changed. We still have primary care, secondary care and all the important bits in between. We have reorganised how they are managed and often rebadged them but fundamentally, they are still in the same place, doing the same job.

Perhaps technology has made parts of the job easier, or quicker, or more accurate. Perhaps spurts of investment have made access faster but we still came back to the fact that the NHS looks very like the NHS of 1948.

Is it the fact that this configuration has endured because it ‘works’? Perhaps it is because the forces of professional organisations make it impossible to really ‘shake up’ health care delivery.

Maybe, we are just not smart enough to figure out what really good healthcare looks like and make it happen. That leads to the question; what is really good healthcare.

The World Health Organisation tells us it is;

“A state of complete physical, mental and social. well-being and not merely the absence of disease or infirmity”

Note, there is no mention of systems, policies, structures of hierarchy.

For us a more reachable answer to the question might be:

- Preventing people getting sick in the first place

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- Easy access to care, regardless of wealth, age or location
- Continuity of care, seamlessly delivered in accessible locations
- Constant evaluation and review to assure safety and improve quality
- A commitment to the use of technology and data where it is appropriate to improve care in all its aspects
- A commitment to sharing, learning and training

… easier said than done.

Before you and hopefully your colleagues and friends embark on your journey through this book, here are some things to think about.

Discussion

1. It is often said the NHS does not spend sufficient of its GDP on health care. As GDP is linked to the overall performance of the economy, world events and fluctuations in demand and currency values, it is possible to envision a country with a low GDP, spending a higher percentage of it on healthcare, but still not reaching an average of comparator nations. Is GDP the right measure for an international yardstick?
2. An alternative measure is the amount spent on healthcare per head of population. In approximate terms, expressed in US$ the UK spends $4,000

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per head of population. France spends $5274, Germany $6518, Netherlands $5739. It is fair to say, richer countries would spend more per head… so is this a fair international comparison?

3. Do international comparisons matter? What do we gain from knowing one country spends more than another?
4. Is the principal measure, health outcomes? Issues such as: smoking, the biggest cause of preventable deaths; obesity, we are fast becoming the most obese country in Europe. Vaccinations for children - we lag behind Belgium, Greece, Japan and Portugal in coverage of diphtheria, tetanus and pertussis. Low birth weight; the UK is in the middle range for live birthweight in babies. Cancer screening, antibiotic prescribing, the UK has consistently had one of the lowest rates of inpatient suicide. What should we measure?
5. It is often said it is the Treasury that blocks investment in healthcare. Part of their missions statement is; '…*spending taxpayers' money responsibly and ensuring value for money… creating a simpler, fairer tax system – alongside a well-functioning welfare system…'* They don't define 'well-functioning'. How would you define a well functioning welfare system?

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6. Is there a bigger role for the Treasury in the delivery of health and welfare, beyond their role of being a control on spending?
7. The NHS does not have an investment strategy. Should it? What would it look like?
8. The Parliamentary cycle, five years, means that longterm commitments to health and care services are rarely made. Even if they are, they seem to be rarely followed through . Nowhere is this more obvious than in the problems facing social care, where an absence of a longterm commitment has left it, bluntly, close to bankrupt with a dysfunctional supply side. What would it take to get policy makers to commit to thinking long-term?
9. A high turnover of ministers anxious to 'make a mark', 'make a difference', 'put something back', means the NHS is vulnerable to 'the next big idea'. Is it good that the NHS can be subject to political whim, does it keep it current and nimble, or are these interventions really an interference and a distraction? How can we benefit from innovation and change but at the same time keep the fundamentals of service delivery stable?
10. Some ministers are very capable and bring to their Office experiences in other industries, others are barely better than middle management who are suddenly faced with running a multi-billion business, employing thousands of people,

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and have no real idea how to behave. Should NHS England be the principal source of policy change, with ministers' only role, holding them to account?

11. What is the relationship between the DHSC and NHSE? Do we need two organisations, overlapping and in many instances, fundamentally doing the same thing?
12. Civil servants are generalists and few have specific knowledge of the practicalities of working say, in the digital sphere, education or certainly health and care. Should civil servants be generalists or specialists?
13. How should we measure the work of civil servants'?
14. Ministers have special advisors, often known as SPADs. Have they acquired too much influence over service delivery?
15. Ministers are very close to service delivery. Is that good or bad?
16. The Secretary of State for Health has overall responsibility and control over health and care. However, they report to the Cabinet, where other ministers will have their say across each others' portfolio which can have merit as there are interactions between health, education, and other Departments. It also means health policy could be influenced in ways that we will never know the mechanism for, or their instigation, or motives. Cabinet minutes are published

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at 20 year intervals. Should Cabinet minutes be published as soon after the meeting as practical?

17. Does the centralist nature of policy making in the NHS make for faster quicker, better policies? Or, would decentralised policy making be more responsive. Perhaps on a regional basis, giving Mayors more say… even though it might run the risk of emphasising 'post-code' entitlement.
18. Thinking about the safety of healthcare; the present system is highly regulated. There are professional bodies, national regulators, inspectorates and law. Does this combine to protect the public or to stagnate advances in health outcomes?
19. When a mistake occurs, history tells us, the first reaction can often be to cover it up. Does regulation play a part in that? If it does, how could it be changed to encourage people to speak up and share their errors so we can try to put things in place to ensure they don't happen again?
20. Thinking about choice; is it important that patients have choice in their care and treatment or is it more important that the care they receive is high quality at the expense of choice?
21. They say the NHS is embedded in the British culture and the same is also said of the Dutch healthcare system. What part does culture play in the delivery of care? Does it help or hinder change?

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22. We talk a lot about integration of care. What does it mean to you?
23. Is it realistic to move elements of care from secondary, to primary/out of hospital care? Is it practical and does primary care have the bandwidth?
24. Can these changes take place without a major rethink about the tariff system? Should the tariff be changed, replaced? If so, with what?
25. Quality standards are important in healthcare. There are various approaches. Royal Colleges publish standards and guidance. The Get It Right First Time programme has its own agenda. There are also NICE guidance and World Health Organisation recommendations. Is this confusing? Should there be a single source of quality advice? If so, from whom?

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Technology

It was over twenty years ago that the NHS first attempted to manage its workflows by the use of technology and computing power.

Today, after hundreds of millions have been spent and a succession of high-level management appointments, 19% of our hospitals have no electronic patient record system and the ambition that 90% will have an EPR by 2023, is, astonishingly, regarded as acceptable! Even though it is unlikely to be achieved.

This is not a shining example of enabling a healthcare system

This poor and expensive progress is attributable to a number of factors but principally the lack of central ambition to achieve it and no sense that various governments nor NHS leaders regard themselves accountable for squandering millions.

It is probably true that the failure of a number of central initiatives has cautioned policy makers against trying again.

In 2023 the Queen's Nursing Institute published a survey about the IT arrangements for community and district nurses.

They compared today with a previous survey in 2018, just about five years ago. Here's a taster:

5yrs ago; 32.7% reported problems with lack of compatibility between different computer systems… in 2022 the figure had risen to 43.1%.

5yrs ago; around 85% of respondents reported issues with mobile connectivity… in 2022 this figure was around 87%.

5yrs ago; 29.5% reported problems with device battery life… in 2022 the figure was almost 53%.

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But try again they must.

The future success of the NHS will depend on the extent to which it successfully embraces the management of its workflows by the use of technology.

The independence of Trust hospitals and Foundation Trusts, which allows management to make its own decisions on the choice and performance of IT partners, and procurement rules, which place more emphasis on the fairness and openness of the tendering process, than uniformity of speed of implementation, has led to a patch-work system that has provided little in the way of learning or warning.

Add to that the mismatch of Primary Care technology and a system awash with data which for years the NHS has been scarcely able to analyse or turn to practical advantage… and it becomes understandable that a fresh start and a coherent, deliverable IT strategy is long overdue.

The cornerstone of any enterprise management system has to be the relationship the organisation has with its customers. Their profile, references, history, needs, and demands. In the wider world it's called customer relationship management.

Does the NHS have 'customers?

Whilst healthcare does not require a transaction at the time of service, it is taxpayers who fund the service and as the end user, yes, they or their families are the 'customer'.

Despite the importance that 'customer' relationship management might have in the

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sensitive and intimate sector of health and care, patient records are not comprehensive, centrally collected, nor accessible to professionals across the care system.

Paper records still dominate too many clinics, and health professionals rightly complain about accessing painfully slow systems, with unforgivably long log-in delays.

Since 2015, the NHS has been trying to move away from paper records.

A fundamental tenet of modern healthcare must be that an individual's health data should be wholly accessible to them, alongside the ability, with safeguards, for health and care professionals to access that record, at the citizen's point of care wherever that might be.

Taking that principle further is the concept of permissive access…

… where, subject to an over-riding system for emergency access, the patient, via a pin-number type process, akin to bank-cards, grants the clinician access to records… either on a one time basis or permanently. The important point is, the patient is in charge and makes the choice.

This has been achieved in Australia and it is not without irony that the executive who, successfully, established the system in Australia, once tried to do the same thing in the NHS but, in the end, gave up. Defeated by attitudes and lack of investment.

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Discussion

26. Why has the NHS been so slow to adopt technologies, what are the barriers?
27. What technologies have been a adopted that have worked and why?
28. What can we learn from successful adoptions?
29. What aspects of healthcare would most benefit from technologies?
30. Cloud technology makes it easier to store big-data and creates easy access points. Should all health records be held in the Cloud?
31. Are there risks or disadvantages with Cloud storage? Can they be overcome?
32. Thinking about patients; what are the benefits for patients, granting permissive access to their health record?
33. The present balance is tilted towards the NHS controlling and having 'ownership' of the patient record. Is that right?
34. What might the benefits be in tilting the balance towards the patient? Having

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them control access to their records as, for instance, patients do, in Australia

35. What are the risks for patients and clinical professionals, to giving patients control of their records?

36. Turning to the question of procuring systems. Should there be a national specification against which all procurement should be made? How rigid should it be?

37. Should IT procurement be local, by Trusts, ICB, social and community care and others, drawing on central funding? Or should all procurement be run and organised centrally?

38. What are the advantages/ disadvantages of procurement as a capital item versus procurement on a lease, or pay-to-use revenue basis?

39. To what extent are you confident that the NHS has a well thought through and effective digital strategy?

40. It is said there is an ‘incumbent’s curse’ meaning established, older-generation organisations find it difficult to reinvent themselves in a technology driven generation. How can the NHS reinvent itself to take advantage of these technologies?

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41. Most incumbents who have accomplished successful transition have had a period of double running cost, because they have effectively run two organisations, old and new at the same time, to ensure safe and smooth transition. Is this possible in the NHS and if so how might it be achieved?

42. What is there to learn from other health systems who have made better use of technologies, overcome interoperability challenges and healthcare analytics ?

43. What role could data analytics play in workforce and rota planning?

44. Much is made of the role of artificial intelligence in healthcare. What role could it play in practical, everyday healthcare?

45. If machines are relied upon for diagnostics, who is liable if a machine makes a mistake?

46. How will machines and technology impact the doctor patient relationship?

47. As technologies, including wearables and Apps become more common, is the current regulatory environment adequate?

48. In the wider application of these technologies, what policies and laws will be required?

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49. Does the medical curriculum pay sufficient attention to telemedicine and associated technologies?

50. Who is going to make the major change in health care technologies. The likes of Amazon and Google, or small start-ups? Will it influence how the NHS manages the transition?

51. What is the role of digital providers in primary care? Video consultations and the like?

52. What is the role of video consultations in secondary care. In particular, outpatients?

53. If you were to found a health technology start up today, what area would you focus on and why?

54. At the Oral and Maxillofacial Surgery Department of Radboud University Medical Centre Nijmegen in the Netherlands, the head of the department, Prof. Stefaan Bergé redesigned his whole department based on a book, The Guide to the Future of Medicine and designed the rooms based on patients' suggestions. What can we learn from this?

55. Today's healthcare is place-based. The right patient in the right place, at the right time. In the future, digital technologies will make it possible for

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large parts of healthcare to move from its place to the patient's place. Patients become the point of care. What impact could that have on the healthcare estate and running costs?

56. What impact will the Internet of Things have on healthcare?

57. 3D printing has already been used by one Hospital (United Lincolnshire Hospitals Trust). Their clinical engineering department made a handheld scanner to help in the care of a patient with learning disabilities and made a hard to source component for a medical device. What are the wider applications for 3D printing?

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Workforce

The lack of central workforce planning has undoubtedly contributed to the problems the NHS presently faces.

Proper workforce planning is a continuum. It must take into account the nature of work, the future of work, the impact of technology on work; demand and user profiles; the availability of people with the right qualifications to be attracted onto the workforce; renumeration and retention.

Training and opportunity.

These are challenging professions, particularly nursing, the single largest in the NHS. Around 17% quit in the first year and in 2022, 40,000 nurses left the profession.

Another factor is the debt that students incur. Confusion over nurse bursaries hasn't helped.

An insistence on graduate entry narrows the field and may exclude many who have an aptitude and desire to work in the caring professions.

However, these roles have become more complex as they are rightly, more involved in the clinical management of patients. Now part of a widening skill-set in the function of care and caring.

The new data set, published February 2023, by the Universities and Colleges Admissions Service (UCAS), shows a decline in nursing applicants across all age groups and within each UK nation for 2023-24, as of the January deadline.

Nurse leaders have described the figures as "damning" and urged the government to consider measures to "turn this situation around" immediately.

Some 33,570 individuals have applied to study nursing from this autumn – more than 7,600 less than the same time in 2022 (-18.5%).

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The assumption is, nursing particularly, will get more complex as technologies become more accessible at the point of care. Planning needs to reflect this, looking at core capabilities and competencies.

Medical training is long and complex and based on the assumption the candidate will complete a training pathway to eventually emerge as a consultant.

Is there a case for a review? Modernising historic curricula and in-hospital training?

In nursing, allied professions and in medicine, training is likely to become longer and more complex.

This impacts the nature of the candidates who can be accepted for such arduous demands and the expectation is courses will get longer and more expensive.

Government has imposed a cap on medical training places clearly, under pressure from the Treasury. This will bring politicians into conflict with workforce planners who will want to see an expansion of the workforce.

Discussion

59. Recruit, reward, retain, retire are four of the key stages of workforce planning, what are the key aspects of each of them?
60. Which of them could be improved and how?

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61. Should staffing and demand forecasting be in the hands of an independent body? Call it an Independent Workforce Review Body reporting to Parliament on a regular basis? This is an idea turned down by Parliament. Are MPs wrong?

62. Considering, first, recruitment; planning must include the nature of the work, the skills and qualifications for carrying it out, the timescale of training and funding… how should the NHS respond to these aspects, in particular, do we have sufficient insight into what the future of healthcare looks like?

63. We know workforce planning has been neglected in the NHS. Inevitably it is a long-range project. What can be done to solve some of the NHS immediate problems? Are there three key immediate steps? What are they?

64. The NHS has an increasing dependence on overseas recruitment. How is our need balanced against being a responsible global citizen?

65. Training defines careers. Is the shape of training and careers fit for the future? Is there a case for more porous boundaries in training, for example a multi-skilled health and social care qualification, or a social care qualification encompassing benefits and rights advice?

66. What part do Royal Colleges play in the definition of skills and qualifications. To

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what extent are they enablers of change or impediments? Is there a case for change? If so, what is it?

67. Thinking of training. Nursing, for example, is a graduate profession. Is this necessary, desirable, essential, are there alternatives?

68. Pay Review Bodies emerged in the 1960s, do they remain fit for purpose? Are they sufficiently transparent? Do they work quickly enough? To what extent can they claim to be independent?

69. Agenda for Change is the contractural framework for pay for most of the people working in the NHS. The framework is designed to reflect length of service and qualifications. It is nearly twenty years old. One outcome of the nurses' industrial action may be to change some AfC structures or replace it with a version just for nurses Does it need refreshing? If so what aspects would you change? Is it a good idea to break up AfC?

70. The NHS has a final salary pension scheme. Some staff, particularly lower paid nurses, are starting to opt-out of the scheme. They take the view they'd rather have the value of their contributions available to them now. The scheme is contributed to by the individual and the employer. Is it

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sustainable or indeed relevant, compared to current pay levels?

71. What are the alternatives: lower employee contributions and a smaller pension but higher salary and or benefits; a defined contribution pension scheme; a choice of self invested pension plans?

72. There are over 300 apprenticeship schemes available in the NHS, including a way into a nursing career. Take-up of the scheme has been slow, around 20 a week since 2017. The Health Select Committee described them as being 'in poor health'. Funding for places is https://www.bma.org.uk/advice-and-support/nhs-delivery-and-workforce/pressures/an-nhs-under-pressure. What role could apprenticeship training play in the workforce of the future? What can be done to improve take up and allow students to *earn and learn?*

73. Can careers in medicine be offered without the assumption all doctors will become consultants or GPs?

74. More people with comorbidities will mean we will need more clinicians able to provide care in broad specialties in a range of settings. Does current training address this issue? How does it need to be changed?

75. Thinking about GPs. Is it likely that the partnership model is sustainable and a career in primary care, viable?

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76. How could the NHS incentivise GPs and others to work in hard to doctor areas?
77. To ease the pressures on workforce for doctors, The Greenaway Report suggested full registration move to the point of graduation from medical school, provided there were safeguards in place. Is this a sensible change?
78. There is evidence that some doctors drop out of training because of financial pressures. Are there ways to help?

Retiring and returning to work in the NHS.

On reaching retirement employees must end their NHS employment in accordance with their contract. However, such are the arcane rules, they may be able to return to the NHS after a break of 24 hours! After that, there is no restriction on the number of hours a returnee can work.

The scheme is called 'retire and return'.

Unfortunately, only a handful of people actually return… around 20 a week, despite there being a well funded and supported NHS programme.

Discussion

79. To what extent are the national guidance and associated processes and 'support' arrangements easy and welcoming?
80. How could the 'Return to Nursing' and similar schemes be improved?
81. How could the 'Return to HCPC register' requirements be improved?

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82. Midwives have their own return to practice scheme. Could it be improved?
83. The Career Refresh for Medicine programme (CaReForMe) was developed to help support doctors who have had a break in practice, including those new to the NHS, return more easily and safely. Are you aware of it? Does it work?
84. Can you identify unnecessary bureaucratic steps and activities in the various Return to Practice policies, processes and regulations which should be removed?
85. Is a centralised approach really necessary and helpful?
86. A less centralist approach might be to give Trusts the responsibility of managing the return to NHS in their catchment area. Prospective returnees directed to their nearest Hospital HR department. Allow Trusts to asses the capability and training needs of the individual and perhaps, speed up the process?
87. Do Trusts and practices have the skills to assess the returnee and the bandwidth to provide the training needed?
88. What are the disadvantages of Trusts taking on returning to work programmes?
89. Could the returnees be employed to work on the wards or in other aspects of healthcare, in some capacity, whilst they are undergoing refresher training?

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Retention

Last year (2022), saw a 25% increase in the number of NHS nurses leaving their role, with an additional 7,000 leaving compared to the previous year. The largest increase in numbers leaving was seen among the younger nurses, two thirds of leavers were under 45 years of age.

The Nuffield think-tank analysis, for the BBC revealed more than 40,000 left the NHS in 2022. The report does not identify reasons for leaving but strikes for better pay and complaints about working conditions must play a big part.

There are around 140,000 staff vacancies in the NHS, meaning roughly 11% left the active employment in the NHS in one year.

The General Medical Council estimates around 4% (which equated to approximately 4,950 doctors) permanently leave the NHS every year. The European average is 3.2%.

Furthermore, many others will seek new opportunities abroad and many countries are delighted to make the move as easy as possible.

NHS Absence rates in October 2022, the most up-to-date number NHS Digital has shown the overall sickness absence rate for England was 5.6%. This is slightly higher than September (5.0%) and much higher than the public sector average.

Covid will have taken its toll as will understaffing at the front line of care. Many staff find the pressures unbearable and look for employment elsewhere, often better paid.

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Why staff leave is not clear. Whilst NHSE provide guidance on exit interviews they are not mandated and employers miss an opportunity do find why people leave and what they might do to stop it.

Assessing staff attitudes

Each year the NHS embarks on a national, staff survey. About 600,000 people take part. It is mandated that Trusts take part, but there is no obligation on primary care, neither in other parts of the NHS.

It is a huge undertaking and the biggest of its kind in any healthcare system in the world.

The survey considers the following headings;

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are always learning
- We work flexibly
- We are a team
- Staff morale
- Staff engagement

The 2022 Staff Survey provides some interesting insights.

The overall picture is very similar to the results in 2021 with the exception of those relating to job satisfaction, morale and pay.

However, some other key indicators are taking a nose dive.

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- Staff prepared to recommend the NHS as a place to work, falling from 59.4% to 57.4%.

- In the perception of staff, quality of care has fallen and the willingness to recommend the NHS as a place to be cared for has dropped from 67.8% to 62.9%.

- Satisfaction with pay plummeted from 32.6% in 2021 to 25.6% in 2022

And, worryingly high levels of staff attending work when unwell along with staff considering leaving, both contribute to the fall in the morale indicator.

NHS Employers sum-up the results:

> *'The fact that some scores held up despite the current context is a positive reflection of the work by employers in these areas and especially action on leadership and culture, health and wellbeing, flexible working and staff engagement.*
>
> *The scores on these measures do though remain lower than pre-pandemic and the falls in staff confidence on reporting concerns, willingness to recommend and rising pressures on staff are a cause for concern.'*

There are wider issues in-play here. The NHS may quietly congratulate itself that some scores have 'held up' but the fact is, few serious employers outside the NHS, could be content that 30% of staff cannot

agree that their employer acts on complaints and concerns raised by patients (customers).

Getting on for 10% of staff have experienced some form of workplace discrimination and almost 60% do not feel their organisation values their work.

It would be fair to say the NHS has gone through a unique period of workplace pressure and disruption but that should not be allowed to camouflage the fact the NHS does not come out of the survey looking like a good place to work.

The survey took place last Autumn and the situation may have improved, or got worse. We won't know until next year. Which begs the question, what is the value of an annual survey?

It is costly, takes months to collect and analyse the data and it is hard to see where the NHS acts on the outcomes to make improvements or how actions are measured.

Is there a better way to assess staff attitudes? Should we consider pulse-surveys ? They are quicker and would appear to enjoy a higher response rate .

Brevity, frequency and sharply focussed they create a continuous feed-back loop. Creating an opportunity for the employer to make changes and most importantly, for the employee to see changes taking place.

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Finally, the key indicators in the NHS staff survey, around pay and workload, that impact morale, are beyond the NHS employer to change.

The size of the workforce is determined by the government, as are pay-scales.

We might wonder, what is the point…

Discussion

90. What steps could organisations take to improve staff retention?
91. Does your organisation conduct exit interviews? What learning is there, from the results?
92. If your organisation doesn't conduct them, why? If you agree they should, who could make that change?
93. The drop-out rate from medical school and nurse training is high. What could be done to improve it?
94. Does the high drop-out rate point to selecting the wrong students or to lack of care for the students, under pressure whilst training? How could these factors be improved?
95. Leaving the NHS shortly after training points to what?
96. The staff survey is a huge undertaking which produces interesting data but months after it is collected. What is its value?

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97. Would pulse-surveys, giving a less in-depth but more timely result be a better alternative?
98. What role does a staff survey play in a well run organisation where management is on top of staff attitudes? Does an annual survey become a redundant and easily out-of-date management tool?

Workforce Planning

The NHS is a 'people heavy' organisation. Meaning; much of what it does depends on face-to-face contact with people providing the service.

Some sectors have been able to replace people with robots and machines. Motor manufacturing is a good example. To build a modern car takes somewhere between 18-35 man hours. Down from about 60 around 30 years ago. All thanks to robotics. And, the work is cleaner and safer.

Health care is nothing like making a car!

However, there are opportunities to look at health and care to consider how innovation may make work easier. If work is easier, it is usually done more productively. For example, there is a high expectation that artificial intelligence and machine learning will play a part in diagnostic support… but at the end of the day, many aspects of health and care are a people business.

How many people we will need is part of workforce planning. This is a key ingredient

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in planning for the future. The NHS has been promising a workforce plan since the publication of The Long Term Plan. The document actually says;

'…[we must] ensure we have enough people, with the right skills and experience, so that staff have the time they need to care for patients, well.'

At the time of writing the rumour is that the long awaited NHS Workforce Plan may not be far off but apparently delayed by the Treasury, who are concerned at the financial implications of training costs and a burgeoning salary and pensions bill in the years to come.

However, back in the real world we should look at the role of workforce planning and ask some questions.

There are four principle reasons a workforce plan is important;

Anticipation; future workforce needs will change as technology improves, as populations age and demand shifts. For example, to a digital first service which will change the training needs of clinicians. In the nearer term predicting the numbers of clinicians that embark on training helps to avoids 'reactive-hiring', from agencies with the associated costs.

Optimising; understanding where shortages are likely to occur creates the opportunity for managers to optimise the staff they have, increasing skills and focussing investment in

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innovations and training. Perhaps changing the nature of work.

Reducing risk; the risk created by filling workforce gaps with temporary staff often unfamiliar with the workplace and practice and the potential damage to safe services by insufficient staff able to work effectively. Also, the financial risk of having to foot agency bills for unplanned and unexpected gaps in rota.

Alignment; the workforce plan should align with the HR strategy, with a particular focus on retention and recruitment, which should align with the 'business' strategy. In the NHS we call it The Long Term Plan.

In brief; making sure we have the right people in the right place to do the right job at the right time.

Workforce planning is not just a national imperative. All organisations need to have reasonable assurance of their workforce, training and supply especially when they are dependent, as many NHS organisations are, on funding and supply decisions that are outside of their control.

Recruitment may be difficult in some areas. Geography and connections may make travel to work difficult. An ageing population or a particular demographic may determine a need for a particular kind of care professional. Development of new services will need skills and people.

The emergence of a new employer in the locality may attract people away from the

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caring professions. All these factors will be an important component of a local workforce plan, for the organisation to achieve its goals.

Discussion

99. What is the importance of a workforce plan where you work?
100. Do you see the need for a workforce plan?
101. What are the key considerations of your workforce plan?
102. How often should an organisation update its workforce plan?
103. Who should be involved in developing a workforce plan?
104. What data should be used to inform a workforce plan? And do you have it? Is it collected?
105. How can a workforce plan help your organisation reduce costs?
106. Is there a way a workforce plan can add to the organisation's productivity?
107. In what ways can a workforce plan help your organisation manage risk?
108. The NHS has been forced to delay the publication of its workforce plan on the grounds of training costs. What are some other challenges that you might face when implementing a workforce plan?
109. Aligning the workforce plan with an organisation's overall strategic plan is a

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fundamental. How would you ensure the two documents are aligned?

110. To what extent should technology and innovation be factored into a workforce plan?
111. What success measures should be included in a workforce plan?
112. Where would you look for best practice to develop a workforce plan?
113. Planning is based on assumptions and they may change, how can you ensure a plan is flexible enough to adapt to changing circumstances?
114. How does a workforce plan differ from an HR plan?
115. What are the benefits of a workforce plan for employees?
116. What would you do to ensure a workforce plan is equitable and inclusive?
117. There is a huge amount of employment law. How would you make sure a plan complies with relevant laws and regulations?
118. What are the pitfalls organisations can fall into when developing a workforce plan?

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Structure, delivery and reform

Whenever the NHS faces difficulties there are commentators, politicians and others who say the NHS needs reform.

Is reform the answer?

During the career of many working in the NHS, there have been half a dozen major reforms and goodness knows how much fiddling and fine tuning.

Since the Beveridge Report in 1940, and the birth of the NHS on 5th July 1948, no decade has passed without a major policy or structural change taking place in health care.

After the formation of the NHS in 1948, it took the Griffiths Report of the early Thatcher years to give us the first major shake-up.

Griffiths introduced a management structure to the NHS and commented;

'... if Florence Nightingale were to walk the corridors of the NHS, with her lamp, she would be forgiven for being unable to search out who is in charge.'

General management was the first major shake-up, focussing on objectives, budgets and strategies.

That was followed by the reforms, overseen by Tory secretary of state for health Ken Clarke, who 'reformed' district general hospitals, into Trust hospitals, giving them a measure of autonomy and operational independence.

John Major tentatively introduced an internal market. Although healthcare services are an EU derogated policy area, left to the determination of

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individual member States, the UK, nevertheless incorporated an EU style competition and tendering process for health services. This created an internal market and an awkward interface between NHS providers and the private sector.

It was left to Labour's Alan Milburn to let the internal market rip. Any service valued above EU limits (which culminated in a value of £150,000), was tendered… creating a crippling bureaucracy and no evidence that it either improved quality or cut costs.

Indeed, many of the commercial companies who won contracts for the provision of healthcare services have long since gone. Unable to make it pay or stymied by bureaucracy. Virgin, Serco, Babylon come to mind. Circle healthcare took on a whole hospital and within three years paid a £5m penalty, to exit the deal early.

Conservative Andrew Lansley introduced a controversial set of reforms that were intended to break-up central control, distance ministers from day-to-day involvement and turn many of the existing departments into arms-length-bodies.

Lansley's reforms were hotly disputed and as many professional bodies and others predicted at the time, ended in dysfunctional chaos.

The latest changes were put in place to repair the Lansley damage and bring closer together, health and social care.

Many would argue… overdue.

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However, it is not without difficulties as often working relationships are poor, the root of the tension, as ever… money.

Local government has been through a fallow period of funding as they struggle to contract with service providers at viable rates and in consequence there are huge vacancies across the care sector.

Working together is often framed as cost-shifting in the face of competing priorities.

Nevertheless, there is a detectable willingness and realisation that closer working relationships are in the best interest of citizens, patients and clients.

As ICBs settle in, there are those with long memories, who say we have come full circle… to the District Health Authorities of the Griffiths era.

It is difficult to find any evidence that any of the 'reforms' or changes brought significant improvements to outcomes for patients. Indeed, the constant reinvention of structures has led to an internal focus, an explosion in bureaucracy and little sense of direction.

That said; for every £100 spent by the NHS, only £2 are spent on administering and managing the service. There are about 43,000 managers in the NHS out of a total workforce of 1.2 million

However, that is still a big number in cash terms because of the sheer size of the NHS.

Commentators and others focus on inefficiency and the sheer number of roles which seem peripheral to delivering better health outcomes.

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About 4% of the total workforce are managers, whilst outside the NHS, in business and commerce, managers, directors and senior officials make up 9.5% of the 'civilian' workforce.

The NHS spends 1.5% of its budget on administration and planning, compared to the OECD comparator health system's average of twice that. France spends 4.1% and it's a whopping 7.9% in the US.

The evidence suggests that the NHS is under-managed. Would the NHS be more efficient if more was spent on management? The cost of administering systems can distort non-clinical comparisons. The NHS employs a low level of technology in the management of its systems.

Discussion

118. To what extent do NHS structures improve or inhibit performance?
119. Can you construct a tight connection between the performance of the organisation and its structures?
120. Strategy begets structure. Management guru Micheal Porter talks of three strategies; differentiation, where the product or service meets an identifiable set of needs; low-cost strategy where the market is dominated by price sensitivity and focus strategy oriented on a narrow market. The NHS is all three; focussed on patient need, resource constrained

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and highly specialised. What does this combination imply for structure?

121. To what extent do NHS structures impact communication?
122. How does service delivery change when there are workforce shortages?
123. NHSE guidance says ‘providers **must** deploy sufficiently qualified, competent and skilled staff’. Given the gaps in the workforce, this is not possible. What should front-line staff do about this?
124. If for reasons of staffing, service delivery is not safe, are there sufficient safeguards in place for the patients and the staff?
125. Organisations should have clear lines of accountability. Is it currently true of the NHS? If not, what needs to be changed?
126. Thinking of change more generally; the NHS calls it reform, which is code for upheaval and distraction. Is there a case for evolution, or does change have to be a revolution?
127. Is there a case for reforming the NHS? What is it? From what, to what?
128. Is the goal of reforming the system to get more healthcare for less money, or is it better patient outcomes?
129. Are these two goals incompatible?
130. If there was a ‘golden era’ of the NHS, when was it and why?
131. ICBs are the latest iteration of change. If they are to be successful, how would we know and by when?

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132. If you were going to restructure the NHS, what would you do?
133. Thinking of primary care; it faces challenges of workforce, investment and demand. Based on the present partnership model, can it survive?
134. Is the future of primary care to be found in the vertical integration of primary care with Trusts?
135. Is the future of primary care in a horizontal consolidation, with larger organisations forming companies and cooperatives, very like the Hubs which are occupying a good deal of management time at the moment?
136. Is there an alternative integration model involving social care and some domiciliary and out of hospital care?
137. Turning to the question of managing change. Is the NHS well prepared for change management?
138. If your organisation is undergoing change, does everyone understand the reason for the change? How is the 'vision' shared? Should it be shared? How?
139. Is change 'on top of the day job' or is there a dedicated team, managing change and transition. If not, what would be the benefits?
140. Change can have a devastating effect on employees, particularly if they think their jobs are at risk. How could you reassure colleagues at a time of change?

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141. It is important to understand the forces and pressures driving change. Is something being changed to make it cheaper, quicker, simpler, better… better for whom? Does everyone understand the real reason?

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Delivery Options

The design of NHS structures is an important part of identifying responsibility and accountability, as well as for the flow of revenues and capital and crucially for integrating services.

However, for the public, it probably doesn't matter that much. Providing people can easily access NHS services and care when they need it and providing it is, in all material respects, free at the point of use.

Private healthcare is expanding.

The proportion of healthcare spending from people paying for private hospital care, fertility treatment, health screening, private GP appointments and other sorts of care has risen from 0.46% in 1980 to 1.77% in 2020 – the biggest rise in the G7.

In recent months, much has been made of the role of the private sector and the extent to which it may be helpful to the NHS in resolving some capacity problems.

The private sector has only 8,000 beds (the NHS has about 150,000) and many private hospitals have no ITU. The absence of intensive care is important because if a procedure undertaken in a private hospital runs into a problem or there is a complication, for example during an operation, they will be dependent on a 999 ambulance response, taking the patient to a nearby hospital.

Hence with some notable exceptions, they often undertake the less complicated treatments.

The private sector is centred 60% around London and the home counties, mainly reliant on NHS trained staff for their workforce. Many surgeons

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and anaesthetists work privately in the evenings and weekends. Outside their NHS contracted hours.

The NHS has many contracts with private companies for the provision of care. Indeed, there are more contracts now than in 2019, before Covid.

According to NHS accounts, the purchase of healthcare from independent sector providers rose from £9.69bn in 2019/20 to £12.17bn in 2020/21, although the percentage of NHS spending with the private sector was 7%, roughly the same as in recent years.

Private companies generally contract for diagnostics and treatments at NHS tariff rates… the same price the NHS pays itself.

As patients are marooned on NHS waiting lists for so long, there has been a resurgence of 'self-pay' in the private healthcare market.

These treatments are generally undertaken at premium rates, which exceed the amounts specified in NHS contracts. Hence it is not entirely clear what the appetite is, for the private sector to get into lockstep partnerships with the NHS.

There is no doubt, some individuals, or families clubbing together to pay for procedures, are trying to avoid the delays facing patients on NHS waiting lists. Poor funding, the pandemic, a collapse in social care, and workforce pressures have taken their toll on the NHS' ability to respond to overwhelming demand.

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It is likely we will see a resurgence of the self-pay market and because of profitability issues, the private sector providers may become less enthusiastic about some NHS contracts.

Out of hospital care

Recent improvements in technologies, reliability, access and affordability are set to change where and how patients are treated.

In the present NHS crisis outpatient appointments have been made more accessible, people kept out of hospitals and discharged from care earlier, all with the help of technologies.

Virtual clinics and virtual wards are becoming commonplace. They bring with them their own needs for governance, regulation and training.

Maximising the potential of fairly simple technologies can have a profound effect on the patient experience and calls on health services.

Amongst others, these include technologies such as digital outpatients and virtual wards; remote monitoring and assessment technologies; digitally enabled polyclinic hubs and self care at home.

These are far from theoretical, or trials. They exist, they are working, they are popular and look well on their way to fulfilling their potential.

The questions to ask are; can these technologies be adopted faster, can the value and experience be diffused across the Service better?

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The Academy of Fabulous Stuff exists to share ideas and innovations. There is a huge appetite to share best practice. In the 8 years since its inception the Academy has had 7.5million page views and ideas shared on a global basis.

It is often said the NHS has more pilots than Easyjet. Out of an abundance of caution and more often lack of pump-priming funds the NHS can only be described as a 'slow adopter' and struggles to make the most of innovations.

In so many walks of life we take for granted remote services rather than physical service delivery. Banking, shopping, insurance, holidays, scarcely no aspect of day-to-day living is untouched by a virtual presence.

In the US Amazon, Google, Apple, Microsoft and others, along with existing health providers have introduced on-line health services, which range from simple monitoring to diagnostic, assessment and even to intervention.

Closer to home, in an effort to speed the discharge of hospital patients medically fit to go home, the NHS is using virtual wards.

Based on simple technologies patients are monitored, and cared for in their homes. If troubling signs are detected a phone-call or a visit can easily be arranged.

Preventing admission, particularly for the elderly, increasingly depends on technologies flagging up risks such as domestic falls.

Apps to remind patients to take their medication, video consultations and vital sign monitoring are all part of the modern repertoire of healthcare.

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We are seeing apps for home diagnostics for kidney disease, blood pressure monitoring, sleep pattern and neural degeneration.

Almost certainly there are many more scattered across health economies in the developed world. We are really in the foothills of a very different relationship between citizens and healthcare services.

Given the value of these technologies, not only to the patient but healthcare economies, how do we accelerate their adoption and as we design the healthcare of the future, how do we encourage their adoption?

Is slow uptake the result of patient reluctance or the unwillingness of the NHS to adopt new ways of working?

Managing health inequalities will be a big part of future health planning. Adopting technologies across a system assumes equitable and equal access. This is not the case and it matters.

At it simplest, technologies can help us reinvent health care, both prevention and intervention.

The NHS is the sum total of many components; primary care, community care, diagnostics, pharmacies, mental health, social prescribing and the physical hospital.

In what appears to be a preamble to the next election Labour is already signalling the return of the Darzi style polyclinic. Perhaps more digitally enabled and integrated than the first time around, with many of the facilities, diagnostics for

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example, generally only available in secondary care, available locally, in primary care.

Technology now enables near patient blood testing, ultra-scans and imaging in primary care. Miniaturisation has endoscopy equipment, once the size of a wardrobe, in a hand-held device no bigger than a hair dryer, complete with store and forward imaging capacity. The latest from the US

This means nurse endoscopists could work in primary care. More convenient for patients, undoubtedly cheaper and faster.

Expect developments in attachments to iPhones to come thick and fast.

The creation of multipurpose hubs close to populations, with shared premises and shared middle and back office systems and resources, looked like a good idea back in 2008 and looks an even better idea now.

Perhaps we should ask why they didn't happen 20 years ago?

Discussion

142. What are the obstacles which need to be tackled to deliver more digital activity?
143. How would you evaluate the benefits to patients, communities and health care staff in implementing digital outpatient activity?

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144. What opportunities exist in your organisation for advancing the virtual hospital environment?
145. Does your practice offer virtual consultations? What is the uptake? Could it be more?
146. What are some of the obstacles which need to be tackled to deliver a virtual environment?
147. Are there opportunities in your organisation for embracing more remote monitoring of patients using existing technologies or those adapted from other walks of life? What are they?
148. What is preventing a move to more remote diagnostics and monitoring of patients in their home? How might these be overcome and what would it take?
149. To what extent is your organisation open to learning from others both in the UK and overseas about what remote monitoring and assessment is working well?
150. Which organisations in your geography should be driving the various components of out of hospital care and to what extent is this prioritised?
151. Is it time to stop the rush into ‘virtual’ step back and carefully evaluate systems to make sure we are not storing up problems for the future?
152. What are the enablers of more out of hospital care?Are those enablers dependent on system redesign;

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technology; workforce capacity or capability, attitude or other factors?

153. To what extent is the concept of more integrated out of hospital hubs (Polyclinics) a way forward to improving patient access and patient treatment in your area?
154. Do the skills exist in primary care for a step change?
155. What are the obstacles to creating integrated out of hospital hubs in your geography and how might these be overcome in practice?
156. What are the critical areas for investment to establish integrated out of hospital hubs-technology, workforce, equipment, estates?

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Funding

Perhaps the real issue for the NHS is not how the NHS is paid for, but how much we pay for the NHS and moreover, do we really know.

Fallow periods of funding after the flu outbreak in 1999, and in the austerity years following the world banking crisis, have left the NHS with a depleted workforce, a depleted capital programme and long waiting lists for treatment.

In the Blair years, following an horrendous flu epidemic in 1999, the Labour administration committed to matching European levels of spending on health. NHS funding reached 9% of Gross Domestic Product by 2008 , comparable to other EU nations.

In the years following the banking crisis, the NHS had pretty much flatline funding of under 2%.

Matching spending per head to France or Germany would have led to an additional £40bn and £73bn a 21% to 39% increase respectively of total health spending each year in the UK

The Health Foundation Analysis examined how health care spending in the UK compared with EU countries in the decade preceding the pandemic.

If UK spending per person had matched the EU14 average, then the UK would have spent an average of £227bn a year on health between 2010 and 2019 – £40bn higher than actual average annual spending during this period (£187bn).

Over the past decade, the UK had a lower level of capital investment in health care compared with the EU14.

Between 2010 and 2019, average health capital investment in the UK was £5.8bn a year.

If the UK had matched other EU14 countries' average investment in health capital (as a share of GDP), the UK would have invested £33bn more between 2010 and 2019 (around 55% higher than actual investment during that period).

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We know the NHS needs around 4% uplift per annum to keep going and keep pace with an ageing population, demand and developments.

The magnitude of the yearly differences in spending and investment between the UK and these other countries point to sustained, suboptimal spending per head on our health care.

The knock-on impact of this underinvestment affects access (longer waiting lists), quality, overstretched staff and lack of investment in technology, in turn leading to a less resilient and efficient system.

How and how much to fund the NHS is a political choice and the choices are made against the competing priorities of the nation, its education, wellbeing and security.

There is no obvious reason for the UK economy to not support EU average healthcare spending. However, the measure of spending as a percentage of GDP is dependent on the performance of the UK economy, the rate of national growth and comes with a health warning; if GDP falls, so does funding.

It is a good yardstick for governments to be measured by and good for NHS planning, however any fluctuation in economic performance, in some years, could reduce health funding.

A better comparison might be health spending per head of population.

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Measured in US$, by the OECD, in 2019, the last stable year before pandemic funding distorts comparisons, the UK spent $4500 per-head, Germany $6518 and Switzerland $7138.

Nevertheless, there are those that would seek more radical funding options and this may evolve into a central theme at the next election.

Is there any room for reform ?

Yes there is; particularly in the relationship the NHS has with the providers of adult social care, including domiciliary care.

These services are provided, mainly by the private sector, via a patchwork of mainly small companies, many trading on the brink of solvency. There are only able to afford basic, low wages, little in the way of training and no career structure. The sector finds it hard to recruit and retain workers.

A new approach to funding social care is long overdue and despite political promises, seems unable to get itself to the top of the 'to-do' list.

Other funding reform suggestions include co-payments, social-insurance and various contributory payments for specific services.

Lessons from health systems around the world would seem to tell us, whilst social insurance systems make room for greater competition on the provider side, unless they are funded adequately, the health outcomes can be poor.

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The debate about the future of the NHS is regarded by some as essential. If true, there is probably no consensus about what the future would look like.

There are a range of options. Co-payment and insurance systems are expensive to collect, and exemptions, if they follow the present payment exemptions for prescriptions where over 80% are dispensed free, would appear to yield little fresh revenue.

Of course, exemptions could be reviewed and be less generous.

For example; prescriptions are free for the over 60s, the age determined at a time when people in their 60s were expected to be in poor health and near retirement… recognising, poorer health often accompanies ageing.

Today healthier lives and lifestyles may signal a change in the age related exemptions.

Whilst collecting money for the NHS is cheapest and quicker through taxation straight to the Treasury, money collected in this way is not hypothecated to health care. Meaning that is deposited in the general fund and can be moved to other government cost centres, as the Treasury might determine.

There have been instances, in the past, where National Insurance Contributions have been hypothecated to specific health care needs. Gordon Brown, Labour's Chancellor in 2002 announced a 1% hike in national insurance to

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help finance an £6.1bn increase in health spending.

A more recent attempt by the Conservative government to raise National Insurance contributions to pay for social care, was parked.

It's argued that citizens have no real feel for the amount of their taxes actually spent on health and healthcare. Might this be important? It might be better to let them know the actual price of an episode of care.

Just how much it costs to send an ambulance and how much their hip-replacement cost.

Charging to accelerate access to healthcare and jump the queue, with top-ups and co-payments, perhaps for diagnostics, like speedy boarding on an Easy-Jet plane, only gets you to the same plane, and the same journey.

On the other hand, it might get some people off NHS waiting lists. A paid-for diagnostic may well indicate no further treatment is required. It could mean peace of mind for the individual and one less patient for the NHS to worry about.

In the end, unless you are insured or able to afford private care, most citizens will depend on the NHS for operations or treatments.

Other countries? What can we learn from elsewhere? Australia, Canada, New Zealand and the Nordic countries just are some of the other countries that rely mainly on general

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taxation to fund health care. However, no country relies on general taxation alone.

Methods of levying tax vary considerably between different countries, particularly whether they are raised by central or local government.

In Sweden, for example, public funding for health care comes from both central and local taxation. Local taxes accounted for around 70% of county councils' revenues.

Discussion

158. The current funding model is based on central collection and redistribution. Are there viable alternatives?
159. Should we consider; social insurance, co-payment and hypothecation? What are the benefits and dis-benefits of each?
160. There are two types of hypothecation; strong, where a dedicated tax funds a service and; weak, where a tax is imposed to meet a particular need in time. Both are transparent, people can see where there taxes are being spent. What are the advantages of both?
161. Taxation is generally regarded as equitable, the whole population joining together regardless of wealth, education or employment. Is this a sustainable

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method or should the rich pay demonstrably more?

162. In some countries, for example Portugal, Spain and to some extent, the UK, private health insurance is used to allow faster access to care with a choice of providers from the private sector. This insurance does not exempt people from paying taxes into national health systems. Should these people be offered tax breaks, in recognition they are paying twice for their care?

163. The Australian government gave a 30% tax rebate for people paying private care premiums and, at the same time, tax-surcharged people with higher incomes who could have afforded to pay private premiums, but did not! What are the benefits, or not, of that?

164. In Germany wealthy citizens may opt out of the government's health care system provided they have full insurance cover. If significant numbers opt-out the viability and equity of nations schemes might be undermined. However, are there benefits of such schemes?

165. Does private healthcare reduce the pressure on the NHS?

166. Social insurance systems are normally arranged by employers and members contribute according to their income. In Germany such schemes take around 15% of gross income. The schemes are

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run by sickness funds. A defined package of care may vary from provider to provider. What benefits do such schemes have?

167. France has social insurance schemes but they do not cover the total French health budget, so additional funds come from taxation and co-payments. This gives rise to a bureaucratic system of claims and rebates. Are there any parts of the French system that might be worth introducing here?

168. Funding healthcare through taxation, creates a risk pool. Can insurance systems ever achieve this, on a population basis?

169. Many overseas health care systems are admired because they appear not to have the waiting that blights the NHS. Capacity is the issue and of course, workforce. Is there any substitute for consistent adequate funding and proper planning? You know the answer to this!

170. Top-up charges are co-payments where the user pays for elements of service, as in India and some 29 countries across the OECD. Charges are made for visits to the GP, pharmaceuticals and some tests. In many EU countries exemptions apply to ensure low income families get the care they need. Some people pay medical savings accounts that they can use to pay for their care. Do co-

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payments have a place in the NHS system?

171. Do user charges discourage people from seeking initiating care?

172. It is sometimes suggest there should be a small charge to visit the GP, say £10. Based on 2016 visits to the GP, the King's Fund economist John Appleby estimates such a charge could raise around £4.5bn. Since then the number of GP appointments have ballooned. If exemptions were put in place, along the lines that prescription charges are exempted, with protections for low income groups, taking into account the cost of collection, what are the benefits and disadvantages of such a policy?

173. There are strong political pressures to control spending, even if it means the services are underfunded. Would it be better to legislate for a permanent funding threshold, below which health and care funding could never fall?

174. Is there any real political accountability in the system. If voters want more health spending, their voice is not really heard until a general election and even then, there is no guarantee promises will be kept. How could greater accountability be built into the system?

175. As social care works ever more closely with the NHS what is the case to merge funding streams and what are the benefits, or is it just cost shifting?

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176. NHS funding is a political choice, what would be the benefit of having funding decisions arrived at independently, rather as decisions on interest rates are arrived at, independently, by the Bank of England?
177. Is there a case to make citizens more aware of the cost of their treatments and interventions, to help understand what modern healthcare costs. Perhaps issuing them with a statement of cost at the end of their treatment?
178. Is the NHS able to do this? Would the costs outweigh the benefits?
179. Could a statement of cost be paid for by advertising on the paperwork?
180. Most real change requires a period of dual funding, keeping the existing services going whilst introducing the new. This often defeats NHS finances. Are there alternatives, such as an NHS Improvement Bank, or NHS Bond, to fund changes in the short term?

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Leadership

The NHS has some spectacularly good leaders. Stepping back and looking at the complex environment where they work, there is no doubt, managing to extract more safe care from resources that are uncertain and more often than not reducing in value, is little more than management by magic.

It is also worth pointing out that many of the bigger Trusts are at least as big as some companies on the FTSE, either in terms of numbers employed or turnover but unlike commercial companies, Trust bosses have no share plans, company cars, executive travel nor any of the other perks we associate with commercial boardrooms.

We will leave the question, why do they do it, unanswered!

That said, the NHS is a unique environment and there are five key issues that make it especially difficult to lead.

Funding:

The NHS consistently faces issues with money. Leaders have no control over decisions made by the Treasury nor the Department of Health and Social Care in the allocation or access to revenues or capital.

A combination of an ageing population, inflation and the cost of technologies combined with financial constraints makes it increasingly difficult to manage within unpredictable financial constraints.

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Capital allocations are uncertain, from year to year, making long-term planning and essential investment next to impossible.

Fragmentation:

The NHS is perceived by the public as a single whole. In reality it is a complex system involving multiple organisations and agencies each providing their piece in the jigsaw of care.

This fragmentation results in managing and leading across boundaries, sometimes with explicit powers and more often than not just influence. This can create challenges and inefficiencies in the delivery of care.

Performance targets:

The NHS is sometimes criticised for being overly focused on hitting performance targets. Following the disruptions of Covid and its aftermath there is some evidence that some targets are likely to be reviewed.

Nevertheless, a target driven organisation can sometimes find itself in conflict with hitting a target and missing the point. Targets lead to gaming, such as the manipulation of numbers which we have seen in A&E.

Performance targets are often based on a political imperative, sometimes responding to adverse press comment. They are often imposed with little real consultation and no real clinical or scientific base. Pressure to

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deliver them can result in bullying which, sad to say, is all too common in the NHS

It takes experienced leadership to stop bullying becoming rife in a organisation managed on targets as opposed to goals.

Workforce shortages:

It is well known the NHS faces significant shortages across the whole of the workforce. No NHS leader has any real say in the numbers recruited to join the Service, nor any say in pay and conditions.

Workforce training is funded by the DHSC and at the time of writing the promised workforce plan is, yet again, delayed.

Leading an organisation where there is no say over the workforce, nor how much they are paid, redefines the words, ‘in charge’.

Nevertheless this doesn’t stop regulators regularly criticising leaders for not having enough people on the ground. Management by Kafka…

Governance:

The NHS works in a complex governance structure, which at the time of writing, is undergoing yet more changes.

Defining who does what and how decisions are made adds to the challenges. Decision-making and accountability slows decision-taking and makes the job of NHS leaders more complex.

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Adapting to this ever changing environment means leaders have to change their style to fit the needs of their team.

This is true of big organisations where the leader is responsible for thousands of staff and for the smaller teams that play such an important role in the delivery of safe, efficient care, whose working practices and approaches may be upended by mergers, joint-working or budget sharing.

The latest structural changes to the NHS Integrated Care Boards plan to bring together a range of service providers, including the private sector, social care and the charity and voluntary sectors.

The NHS leaders of the future must be aware of the nuance and difference between these organisations and develop a new style of leadership. Something we might call ‘negotiated leadership’.

Each organisation around the table of an ICB will have a different starting point, different timelines and variable objectives.

Leaders in this situation have to be ‘active listeners’ to really understand where others are coming from. This requires patience, particularly where there are tight timelines.

Keeping promises becomes very important. Particularly where there are deadlines.

The art of persuasion takes centre stage, finding alternatives and looking for consensus are part of the repertoire of the

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new leader's style. Negotiation and leadership hand in hand… and most important for a negotiation to be successful, all parties have to sense a gain and to see the outcome of the negotiation beneficial for the whole, over the long term.

Here are some examples of typical leadership styles. Do you recognise them?

Transformational Leader…

… are leaders who inspire their teams to achieve a shared vision or goal. Motivates them and celebrates success. They are often seen as charismatic and can create a strong sense of unity among team members.

This type of leader is often found in organisations where they have had a long tenure and success is built on relationships and trust.

They are also likely to be invested in the relationships in their ecosystem and able to create partnerships and be good at managing external boundaries.

Transactional Leader…

… focuses on rewards and punishments to motivate their team. '*You do this and you'll get that*'. More commonly found in industry and particularly in a sales environment.

The lack of a 'reward structure' in the NHS makes it difficult for this type of leadership

to flourish. However, they will set clear goals and provide feedback based on performance.

'Feedback' has to be handled carefully at the pace the employee can cope with and in a style, that even if they have done badly, does not crush their morale.

Servant Leader…

…this type of leader says, 'what do you need to succeed?' Ideally suited to the NHS environment where highly skilled people need the freedom to develop and flourish and managers and leaders have the power to deploy resources.

Make things happen.

They focus on serving the needs of their team members. Helping them achieve their goals. Empathy, listening and collaboration are the hallmarks of this type of leader. The question sometimes arises, if the management of change is important does this style drive change or does it just let it emerge

Autocratic Leader…

… this style of leadership was popular in the 60's… captains of industry. It is also a type of leadership that the armed services are trying to leave behind.

They will make decisions independently and without input from team members. The days of 'grip' and 'just-get-it-done', went out with the ark but we all know they

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still exist, mainly in leaders who lack confidence.

Democratic Leader…

… this is a leader who involves their team in decision-making and values their input.

They create a collaborative environment and prioritise consensus-building. In their deliberations they can slow down decision making processes. In circumstances where time is of the essence, that may not be a good thing.

Laissez-Faire Leader…

… this is a delegating leader. Passes decision making to the team. Trusts their judgement and encourages them to work independently.

They just let people 'get on with it' and provide little in the way of help, guidance or support. This works well if the team are all on-the-ball.

Defining leadership style is difficult because everyone is different, Life experiences, education, training and family background all combine to create the person who becomes the person we call the leader.

So, the list is not definitive but is serves as a guide to watching leaders at work and more important, how to work with them.

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Managing Complexity

In the unique environment of the NHS, managing complexity is becoming a key skill. The operating model, that sits behind Integrated Care Boards, brings together organisations who have, traditionally, not worked well together. This is new and underdeveloped and it will be easy for leaders to become swamped or even trapped.

Three things to watch out for. If you see them, you're probably looking at a real leader:

1. Leaders are visible, have a vision and share it often… you can't be a leader sitting behind a desk.

2. Always hire people who are better than them… do that, step back and take the credit. Do the opposite, step forward and take the blame.

3. Create the time and space for good people to do great things.

There are a lot of moving parts in ICBs and the gravitational pull is to the centre. Will leaders be able to break free of the burgeoning bureaucracy, and focus on 'doing the right thing'?

There is an old management aphorism;

How do you eat an elephant? Answer; elephant stew, elephant steaks, elephant kebabs…

… in other words, break it down into manageable chunks. So it is with complexity. Break down the problems into smaller ones.

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That helps to identify what is most important. From there you can go on to prioritise.

Abstraction, simplifying concepts helps to understand complexity, identifying the components.

Borrowing again for the lexicon of good old management ideas; ask 'Why' five times and you will be more than likely to cut through the complexity and be on the road to a root-cause.

Staying organised with minutes, records, keeping track of progress is essential.

Working with others to help see the problem from different angles helps to manage complexity.

More importantly, aim to break free of the gravitational pull that complexity creates.

Create the space to focus on doing things right, by doing the right thing.

Discussion

181. Does the NHS spend enough time and effort cultivating and supporting its leaders. What else could be done?
182. Most of our leaders are homegrown. Would it be worthwhile for NHS leaders to spend some time working in the private sector?

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183. Are the six styles of leadership in our list comprehensive or are there other styles?
184. What do you think are the most important qualities for a leader to possess?
185. How do you keep your team (or if you are not the leader how is the team kept) motivated?
186. Prioritising your time as a leader is difficult. How do you do it?How do you balance empathy with accountability as a leader?
187. What do you think is the biggest challenge facing NHS leaders today?
188. Innovation and finding new and better ways for providing care will be an essential part of the future of health and care services. How do you foster a culture of innovation in your part of the NHS?
189. How would you equip NHS leaders to deal with the challenges of complexity?
190. From time to time all teams have to face conflict. How do you manage it?
191. How do you build trust with team members?
192. Some team members can be demanding, even needy. How do you balance the needs of the individual with the needs of the team as a whole?
193. Some times decisions will have to be made, involving risk. What is your approach to risk-taking?

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194. Training is often the first budget to be cut. How do you create a culture of learning where you work?
195. How do you approach decision-making?
196. How do you handle difficult conversations with colleagues?
197. How do you stay up-to-date?
198. As a leader, what are your long term goals, how do you measure success?
199. Things won't always go right. How do you handle setbacks and failures as a leader?
200. What advice do you have for aspiring leaders?

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Conclusions, thoughts and it's a wrap…

We hope you have enjoyed your journey though this book and it has added to your knowledge and thinking about the biggest, most complex and most vital organisation in England.

We are left asking;

Will the NHS survive and what will it look like?

We can answer that question…

All the time there are people like you, with an open mind, a focus and a willingness to learn, share the best and commit time and expertise, the answer is YES - so let's get cracking!

Thank you.

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…and finally the elephant!

The biggest question of them all - the elephant in the room. The question everyone avoids because the answer involves just about every department of government. Central government, regional government, devolved government and local government…as well as ourselves as citizens!

⚠️ How do we stop people getting sick in the first place?

That's probably the most important question of all. Look out for the next book!

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