# Health Care Systems' relationships with the public are an essential factor if they are to survive financial pressures on the NHS in England

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**Abstract** A redesign across the National Health Service (NHS) in England aims to transform services and make them sustainable, in response to significant financial pressure. We argue that the scale of economies and changes required will inevitably have impacts on patient care and on staff, and that ways of managing these impacts may not be transparent or may involve unwanted consequences. Important ways of mitigating these risks are to involve people and communities, and to adopt a style of leadership that makes openness more possible. We describe frameworks and approaches that can be used for these. They are not simple propositions, in the NHS's context of some continuing

centralised command and control, pressure for very rapid change and likely gaps in capability. A review of using other policy levers to improve services suggests that they would not be sufficient on their own to achieve the change sought without priority to both engaging people and communities and developing leadership approaches.

KEYWORDS: NHS, England, transformation, involvement, leadership

## INTRODUCTION

Along with the likes of Minis, afternoon tea and the BBC, the National Health Service (NHS) in England is one of the institutions that help define national identity. Following the financial crisis it is part-way through an unprecedented decade of minimal growth in expenditure on health care, which began in 2010. As demand continues to rise, but income does not, increasing numbers of hospitals are posting huge deficits — reported at £2.45bn/US$3.2bn by the end of financial year 2015/2016, but with some estimates that the underlying deficit could be even greater.[1] The most recent policy response to this situation has been to promote radical local system redesign — based on collaborative integration of services across areas, in contrast to previous policies, which encouraged competition — including a requirement for multi-year, multi-agency 'sustainability and transformation plans' (STPs).[2,3]

All areas of England are formulating STPs, with aims likely to be familiar to health systems around the world of better health, better quality care and better value for money. A number of 'vanguards', mostly integrating certain services rather than whole local systems, have already been established. At a policy level, public involvement and accountability are emphasised as important in this process. Debate is now under way on how in practical terms that emphasis should translate into actions.

The King's Fund, an independent think tank, is helping to shape the debate. Through its leadership and organisational development programmes, it also supports NHS organisations to manage change.

In this paper, assuming that financial pressures are addressed through existing plans rather than by provided that additional funding, we describe how challenges facing the English NHS will involve certain risks that can probably only be properly mitigated if the public is meaningfully engaged as part of the approach to redesigning health care systems. This in turn will create requirements for the leadership of STPs and the services within them. We describe two frameworks that together can help with taking this forward in practice: one for engaging people and communities, the other for collaborative leadership. We explain why involving people and communities, and not relying on the other available policy levers on their own, is essential — although also noting some reasons why it is neither easy nor quick.

## WHY ARE WE INTERESTED IN THE ROLE OF THE PUBLIC?

There are two sets of issues arising from the current situation in England, which we believe particularly highlight the need for engaging the public.

The first issue is the NHS deficit, and its implications for sustainability of the overall current system. The deficit is prompting a number of assertive management interventions.[4] It is not only a managerial issue: change at this systemic level also has an ethical dimension.

- The sheer size of the deficit makes it inevitable that patients will be impacted either in relation to the treatment and care that they need as individuals, or

the availability of services to them as a community of citizens.
- The NHS is valued as an institution not only because of its longevity but because of the regard placed by society on its constitution.[5] The constitution includes principles that determine how patients will be treated equally, and sets out people's rights and entitlements to access free health care. Changes to this constitution, or systemic breaches of its values and principles, can be expected to provoke a public reaction.
- The NHS is one of the largest employers in the world, and its culture is such that staff are similarly invested in its ethos and values (evidenced, not least, by the staff role in defining principles and values of the NHS constitution). There are examples of staff choosing to engage with patients' interests rather than managerial or policy priorities, where these are felt to be out of alignment (eg, see Timmins, 2016, quoted in Box 1[6]). With this in mind, it is also worth noting the significant strength of evidence from the English NHS of correlations between staff engagement and clinical outcomes, patient experience and organisational performance (West et al 2014a).

The second area of concern is the ways in which financial pressures can impact on patient care. The King's Fund has developed a framework of six ways to identify these impacts in England (see Box 2).[7] It is currently carrying out research (due to publish in 2017) to explore whether and how these ways of restricting care are manifesting themselves in the current financial pressures, and if so what the impact is on the NHS and on patients.[8] It is already clear that waiting times for treatment have increased,[9] there is significant concern about quality of care,[10] and NHS leaders are encouraging debate about what public and providers' expectations should be for care quality.[11] The six types of impact are often insidious, for example if arising from short-term decision making focused on meeting immediate financial priorities rather than a full assessment of consequences, which may only become apparent at a later date.

In summary, the important risks that concern us are:

**Box 1:** NHS staff values and loyalties

The King's Fund carried out interviews in 2016 with a number of recently departed chief executive officers of NHS hospital trusts in England, reflecting on their experience of the NHS throughout their careers, how it had changed and what was important to them about it.

> To whom did I feel accountable? Well, the board first and foremost because they appointed me, and I suppose ultimately to the secretary of state. . . . But emotionally I was accountable to the patients.

The quote above, from Sir Jonathan Michael, illustrates espoused and underlying loyalties that the interviews indicated to be commonly held.

**Box 2:** Six ways in which NHS financial pressures can impact on patient care

- Deflection: Individuals are bounced from one funder to another (eg between the health care and social care systems) or between organisations (eg between general practitioners and hospital services).
- Delay: People have to wait longer for treatment.
- Deterrence: People do not access services because the NHS (either intentionally or unintentionally) makes it difficult for them to find out about services or book an appointment.
- Denial: People are not routinely provided with certain treatments.
- Selection: Individuals with particular characteristics (like being obese or smokers) are not eligible for certain treatments.
- Dilution: Patients receive a lower-quality service as resources are spread more thinly.

- How decisions in response to financial pressure will be managed, in relation to the values and expectations of patients, staff and the public, which help maintain public and political confidence in the NHS.
- Whether that process will be transparent, especially in relation to the risk that decisions that may be rushed, rationalised or even unconscious or covert in order to achieve short-term financial imperatives, may turn out later to have had unforeseen negative effects on care quality.

We believe that the most powerful levers available to mitigate these risks are actively involving the public in decisions and, more generally, being accountable to them through openness and transparency.

## WHAT DOES THIS RELATIONSHIP WITH THE PUBLIC INVOLVE?

Health care services' relationships with the public are complex. They may engage with them, for example, as service recipients, customers, partners in shared care and service design, targets for education and influence on behaviours, sources of income and, in the NHS, as the ultimate owners. The relationship can range from passive to assertive engagement, and from considering providers' interests (eg for income or to comply with requirements for consultation) to public accountability. The complexity is graphically illustrated by Alison Cameron,[12] from the perspective of an individual engaging with the system as a patient.

We believe that managing this, in practical terms, will require two particular things.

1. A clear, shared understanding of what is involved for health and care services to *engage people and communities* in how they work.
2. *Leadership*, which promotes cultures, values and open relationships that embed the engagement of people and communities, not just to 'tick the box' but as part of an organisation's *modus operandi*.

Frameworks and approaches have started to be established at a national level for both of these, which we describe below. Health care providers can use them to identify how best to make progress locally.

### Engaging people and communities

The current strategy for the NHS in England, known as the *Five Year Forward View*,[13] places a significant emphasis on engaging people and has established a national board to develop a single, clear articulation of what this will involve. Hosted and chaired by National Voices, a leading coalition of health and social care charities, the board has defined public engagement as entailing 'involvement and co-production'. It has set out a model with six principles for engagement, each supplemented with suggested essential interventions, measures of success, indicators and evidence (both existing and for development).[14] These are summarised in Figure 1.

Practical guidance from National Voices[15] is helping health care organisations to translate these principles to their local situation and services. It includes diagnostic questions for services to ask of themselves and prompts, case studies and examples, and signposting to resources, guidance and research. This is a essential resource for going beyond the 'why' to consider the 'how' of engaging people and communities.

The King's Fund has also produced a practical online toolkit,[16] supported by videos, case studies and a LinkedIn group for practitioners, on experience-based co-design. This offers a radical and evidence-based[17] approach to involving patients in service development. The Point of Care Foundation is now taking this forward in the UK; its website includes further practical resources, events and support for health care providers


**Figure 1:** Six principles for engaging people and communities

wishing to engage people in service improvement and development.

## Leadership

West et al[18] found that organisations that deliver high-quality, continually improving and compassionate care have cultures characterised by:

- an unwavering commitment to provided that safe, high-quality care
- a commitment to effective, efficient, high-quality performance
- behaviours characterised by support, compassion and inclusion for all patients and staff
- ways of working that focus on continuous learning, quality improvement and innovation
- enthusiastic cooperation, teamworking and support within and across boundaries

Yet although the NHS in England has a constitution with espoused principles, values, rights, entitlements and responsibilities, many institutions have developed their

own cultures-in-practice, which do not always fit with the officially described one. Dissonance is indicated, for example, by the NHS's persistently poor staff survey findings on levels of bullying and harassment (experienced by 18 per cent of staff in 2015[19]), which is likely in at least some cases to be associated with top-down or 'command and control' leadership; and by patient survey findings, which show significant variation in how empowered people feel in their own care (eg, national survey results compared in National Voices[20] range from 3.3 per cent of GP patients with long-term conditions who have a written care plan, to 90 per cent of inpatients who feel involved in their care).

The King's Fund, together with the Faculty of Medical Leadership, the Centre for Creative Leadership and NHS Improvement,[21,22] has set out an evidence-based view of 'collective leadership'. It describes how collective leadership offers a means to move organisations closer to the culture described by West et al. as summarised above. Collective leadership entails distributing and allocating leadership power to wherever expertise, capability and motivation sit, both within organisational structures and across boundaries. This view of collective leadership includes a number of themes such as:

- ensuring that patients' voices and patient representative voices are consistently heard and taken into account in all areas of work and at all levels of the organisation (patients can include those current, past or potential);
- relentless focus on patients' experiences and outcomes, and on improving these;
- including patients and their representatives within the distribution of leadership roles and responsibilities, according to where the best expertise and motivation sits.

As such, it is a framework for understanding how leaders across health care systems can promote the cultures that drive the behaviours that engage people and communities, in order to enable high-quality compassionate care.

## SOME CONSIDERATIONS

Developing greater public accountability is not an idealised proposition: we believe it is entirely feasible. It is likely to involve a number of challenges and here we reflect on three of particular note.

First, it is clear that — as a general statement, but with some notable exceptions — the NHS in England is some way away from where we aspire to be. We have already noted that the cultures of many institutions may continue to have top-down or 'command and control' leadership. What we wish to highlight here, is that this style is also seen at system leadership level, which may in turn encourage these approaches within individual organisations. As part of current efforts to manage the NHS deficit, external direction to providers from their regulator in 2016 included, for example, detailed stipulations including how any carry-over of staff annual leave from one year to the next should be managed;[23] allowance of eight working days to agree reorganisations of back office functions and pathology services;[24] warning of non-negotiable removal of funding streams if quarterly financial targets are not met[25] and the list goes on. This climate of external scrutiny and intervention is perhaps understandable in relation to the financial crisis facing the NHS in England. It also creates a potential risk that the culture of compliance that it engenders could encourage providers to 'tick the box' and focus disproportionately on short-term achievements.

Our second consideration is that meaningfully engaging the public is not a short-term proposition, and in particular should not be seen as such when health and care organisations are themselves often only starting to develop the quality of

relationships that will enable partnership, rather than being competitive, working. Central planning guidance[26] for STPs set what are in our view extremely short timescales for organisations to agree partnerships (within one month); develop relationships and agree on collective plans for the coming year (within a matter of weeks); and submit agreed plans for approval covering the next five years (within five months) — and at the same time, engage people and communities in each of these. The guidance does not mean that engagement of people and communities will be 'done' as if completed in this timescale, but in our experience the initial time needed just to develop relationships and build up shared commitment should not be underestimated. By way of contrast, the Southcentral Foundation provides a notable example of involving people and communities in the Nuka health care system in Alaska. Collins[27] found that its quality and depth of engagement with people and communities were significant, but at the time of his study this progress had been built over 17 years and was with a smaller, less diverse community population than any of the NHS's areas for STPs in England.

Our-third consideration is that while health care providers are often — in different ways, and to different extents — familiar with involving individual patients in redesigning care processes, community engagement may be less familiar both to provider organisations and to communities themselves. Millom, a small town in North West England, is an example where the local community became actively engaged after local services were placed at risk by financial pressures (see millomalliance.nhs.uk). It appears to have required this significant event to catalyse the engagement of community groups and volunteers, who were previously not especially well known in this regard. Now the local health care system is learning from Millom in order to engage other communities across its large, mainly rural catchment area. It is likely that other services will similarly be on a learning curve in relation to community engagement, but without the head start that experience in Millom has given this particular area.

## HOW DOES ENGAGING THE PUBLIC RELATE TO OTHER POLICY LEVERS FOR HIGH-QUALITY CARE?

England has tried out a number of policy approaches over the last 20 years for ensuring high-quality health care that is responsive to people's needs.[28] For example:

- National benchmarks and assessments of cost-effectiveness
- Performance management of providers
- Inspection, performance assessment and regulation
- Promotion of competition in procurement processes and by offering patients a choice of hospital provider
- Earned autonomy for higher performing providers
- Direct intervention in providers deemed to be failing.

All of these external drivers of high-quality care can add value and contribute to sustainable high-quality care. None of them has proved to be a silver bullet: by itself, the sheer number of approaches that have come in and out of fashion over a 20-year period indicates that each has only ever managed to get us part of the way there.

Reviewing the various approaches that have been tried and the evidence of their impact, Ham[29] concluded that engaging doctors, nurses and other staff in improvement programmes locally should be seen as more important than national policies and nationally designed interventions (or, as he put it, 'bold strokes and big gestures by politicians'). He argued for investment

in quality improvement methods to drive a culture of commitment rather than compliance. And he highlighted the importance of leadership, including sufficient stability (or at least lack of rapidly changing political priorities) for leaders to develop and engage staff and patients in strategies for improving services and cultures (see Figure 2).

Ham's model illustrates the factors needed for mobilising high-quality compassionate care from the capability that exists close to the front line, rather than from pressures from external drivers. It positions patient engagement as a central component of quality improvement. We understand his description of patient engagement to include current, past and potential patients, their informal carers and groups representing them or their communities. He notes the fundamental importance of improving patient engagement as part of quality improvement, seeing it as 'one of the innovations needed to make a reality of new approaches to the delivery of care' (page 41).

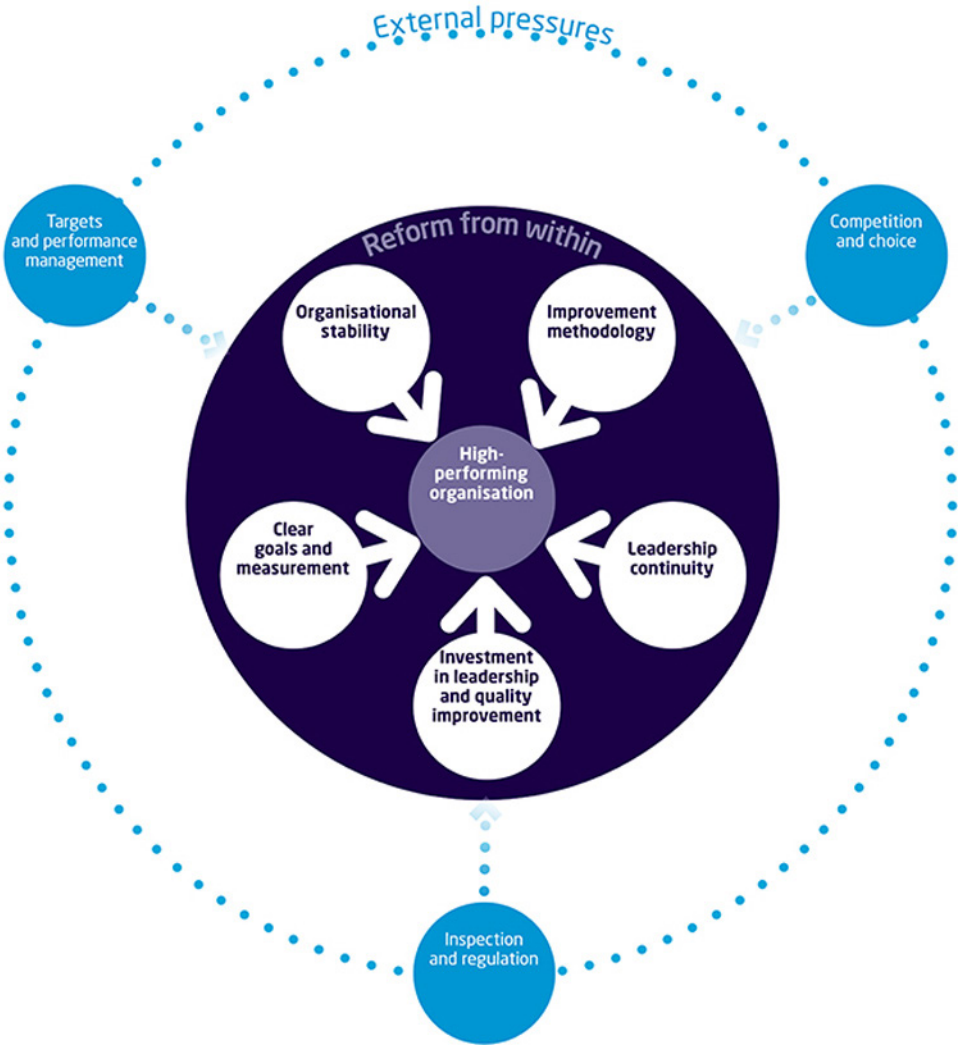


**Figure 2:** External drivers of quality compared to reform from within

## CONCLUSIONS

The current authors believe that the current unprecedented challenges facing the NHS in England can probably only be properly managed by involving the public in decisions and by being open and accountable to them. Trusting in the NHS to solve its existential crisis on its own will not address the risk of (intentionally or unintentionally) placing short-term financial pressures over patients' and the public's long-term interests.

There are frameworks and approaches now in place that can help. Important as it is to have frameworks that can ensure a shared understanding, they are only frameworks. Part of the leadership challenge, and the expertise required, is that health care providers will need to assess how to turn them into practical actions in their own unique circumstances.

This is not offloading responsibility onto providers, so much as inviting them to take the driving seat. Even if some in national organisations — and even some frontline staff — may hope that clever government bodies will be able to design the solution and to set a timetable that is heroic in the sense of enabling heroes to shine, rather than setting them up to fail, history suggests strongly that this will not happen. Leaders of local health care organisations need to engage their staff and nurture and promote meaningful, resilient partnerships with other services and above all patients and the local community; with these partners, they need to develop structured sustainability and transformation plans underpinned by quality improvement methodologies; and, together identify a timetable and measures of success that will work for them all.

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