Essay collection October 2018

Doomed to repeat?

Lessons from the history of NHS reform

nuffieldtrust

About the report

Since 2000 the NHS in England has seen at least six major national plans, accompanied by at least ten reorganisations at various levels. From Tony Blair's NHS Plan to the recent Five Year Forward View, they all aimed to create tangible, widespread changes in the health service that would give patients and taxpayers a fundamentally better deal.

Now the NHS is once more being asked to draw up a master plan for its future – one which will last for 10 years, and will be backed by £20 billion a year in extra funding on top of the largest budget of any public service. NHS leaders and politicians from all parties have one important advantage over their predecessors: the ability to learn from the past about what works and what does not.

This essay collection brings together our research and analysis of the key questions that should inform the new plan. What factors always seem to be forgotten, and tend to trip up even the best thought out visions for the future? What is the track record of lining up staff and money to support changes, and how could this be better? How do you choose priorities that can actually happen? We hope the essays will start a debate about the lessons the long history of NHS reform can teach us today.

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Key points

- The sheer number of plans and reforms in the English NHS comes at a price. It causes disengagement at the front line, takes up money and staff time, and makes it hard to tell what has worked.

- Major changes in the past have repeatedly foundered as a result of not having enough of the right staff. Policymakers need to ensure first that the workers needed will be available before determining what they should do.

- If anything, policymakers should err on the side of training too many staff. The problems of an oversupply are not as bad as the shortages, excess costs and delays in reform caused by an undersupply.

- Plans in the past have been undermined by poor or misleading public engagement. A successful plan needs to engage with the public and be very careful not to pretend to do so if it is not going to.

- Policymakers should use big, ambitious pledges carefully. In clear-cut cases an ambitious goal can spur people into action, but national pronouncements are much less suited to the question of how to get there because the best answer often varies locally.

- Where progress is needed but we don't know exactly how much is possible, or how to do it, an ambitious national target plucked from the air can do more harm than good. The highly political nature of the NHS has often driven leaders to promise goals that are simply not possible.

- Funding needs to move to services or areas that are expected to do more – something that has often not happened in the past.

- Policymakers can expect financial incentive schemes to have a broad effect, but they are not necessarily a precision tool. The service often responds more or less than expected, and there is a particularly patchy record of delivering multiple goals at once.

- Even very controversial or high-profile reorganisations seem to have had less actual impact on front-line services than people expected. Policymakers need to weigh the disruption of reorganisation against the benefits and consider that other factors like staffing and culture are more important than what sort of bodies make up the NHS.

- Reform relies on staff behaving differently. This means plans need to be written in a language that those who work in the NHS understand, and have goals that appeal to the values that motivate them. Policymakers need to plan for staff to have adequate time to change what they do and think differently.

Timeline of NHS policy from 1980s to the present

1983

The Griffiths report

General management function introduced into the NHS, replacing consensus management by committee

1989

Caring for People

Local authorities given lead responsibilities for community care – as enablers and purchasers (followed Community Care: An Agenda for Action, 1988, and Audit Commission report, Making a Reality of Community Care)

Working for Patients

Purchaser/provider split and introduction of self-governing hospital trusts and GP fundholding (1990 Act)

1992

Health of the Nation

Set targets for improving health in five key areas: coronary heart disease and stroke, cancer, accidents, mental illness and HIV/AIDS and sexual health

1995

Health Authorities Act

Abolished RHAs – replaced by NHS Executive offices; DHAs and FHSAs merged

1997

The New NHS: Modern, Dependable

Population focus and separate planning role from provision. Clincal governance introduced. Comprehensive spending review linked money to reform

1998

Health Action Zones

Locally agreed strategies to improve the health of the population, implemented in around 10 areas, including early attempts at health and social care integration

A First Class Service

Addressed concern over clinical standards and led to establishment of NICE and CHI (predecessor to Healthcare Commission and CQC), and later to NPSA

1999

Health Act (effective April 2000)

Enabled joint working between health and social care

The NHS Plan

Investment in NHS alongside reform to improve services, including introduction of many specific targets across a wide range of areas

1999

Primary care groups introduced

New bodies took over paying for most care locally, as well as directly managing community services like health visiting

2001

Shifting the Balance of Power

Structural change to support implementation of NHS Plan – established PCTs and strategic health authorities. NHS Executive became part of Department of Health

Health and Social Care Act

Optimised performance of the NHS; changes to regulating practitioners; modernised pharmacy and prescribing services; extended direct payments for social services users; changes to funding for long-term care; legislation to abolish CHCs (implemented 2003)

Delivering the NHS Plan

Introduced foundation trusts and policy of developing greater plurality of provision (expansion of ISTCs). With NHS Plan, marked shift to intention for regulated rather than hierarchical managed health system

2002

Care trusts

Introduced commissioner and provider based care trusts, to promote health and social care integration

2003

New consultant contract

Increase in earnings and pensions, recognition of non-clinical and on-call duties, and more flexible working patterns. Formalised provision of services over an extended day, to promote better use of resources through new ways of working and greater clarity over private practice

New GP contract

Introduced new GMS contract: QOF to promote quality improvements and incentivise preventative care; alternative contracts to promote alternative providers; practices permitted not to provide out-of-hours care

Payment by Results

Implemented in 2003/4 to promote choice and incentivise greater activity. Provided commissioners with levers to manage activity and influence provider behaviour

2004

NHS Improvement Plan

Further development of NHS Plan approach. Introduced 18-week target (planned to meet this by 2008), and 48-hour GP access target

Agenda for Change
Streamlined pay system across NHS

2005 **Commissioning a Patient-Led NHS**
PCT and SHA reconfiguration. PCTs would no longer have provider responsibilities, although implementation of this was delayed until 2009

2006 **Our Health, Our Care, Our Say**
Promotion of quality improvements and choice in primary and community care, including more support for LTCs

2008 **High Quality Care for All (Next stage review)**
Improving quality and safety through engaging staff in quality improvement. Identified new priorities to improve access to primary care. Introduced integrated care pilots

2009 **Personal Health Budgets: First Steps**
Set out policy to pilot personal health budgets.

2010 **Francis report (Mid Staffordshire)**
Inquiry report into Mid Staffs failings established case that quality and safety responsibilities of hospital leaders should not be secondary to finance responsibilities

Equity and Excellence: Liberating the NHS
Set out reforms which eventually resulted in Health and Social Care Act 2012, implemented in 2013

Quality, Innovation, Productivity and Prevention/Nicholson challenge
Identified £20bn savings target for NHS and mechanism to achieve this – features in 2011/12 and subsequent operating frameworks

2011 **Commissioning clusters**
Transitional arrangement between PCTs and clinical commissioning groups (CCGs) – established to oversee closedown of previous system and establish new system

2012 **Health and Social Care Act**
Created CCGs and NHS England (formally National Commissioning Board), along with other new national bodies. Regulation of providers and commissioning only joined at national level. Shifted public health to local government

2013 **Prime Minister's Challenge Fund**
Develop models to deliver improved access in general practice through additional funding for innovations in participating areas

Better Care Fund (Integration transformation fund)
Promote integration and shift funding to local authorities to provide social care services to reduce admissions/ support discharges

Every Day Counts
Standards for seven-day hospital services (Sir Bruce Keogh standards)

2014 **Five Year Forward View**
Shift to place-based planning and delivery, integration of care, and renewed focus on prevention, to deliver 'triple aim'. Vanguards and new models of care established, and STPs introduced to support place-based planning

Parity of Esteem
Ensure parity of esteem between mental and physical health. Evidence for this required in 2014/15 planning guidance, and specific target to achieve funding parity by 2020 included in 2015/16 planning guidance.

2015 **New Deal for General Practice**
Addressed workforce and infrastructure challenges, and plans for seven-day working. Became 2016 GP Forward View

NHS Improvement established
Simplify regulatory landscape by bringing together Monitor and the NHS Trust Development Authority

Sustainability and Transformation Fund
Additional spending (from 2015 spending review) linked to delivering system goals and supporting Five Year Forward View transformation

2016 **Sustainability and Transformation Partnerships**
STPs bring together NHS trusts, commissioners and councils to plan health and social care jointly for local populations

See a glossary of abbreviations and acronyms used in this timeline on page 55

Foreword

In the last 20 years the NHS in England has seen at least six national strategic plans. The spaces in between have been filled with several further reorganisations, and a healthy haul of reforms to contracts, regulation and relations with local government.

NHS leaders are now hard at work on a seventh. Why again? Why now? There is in fact a respectable answer. As so often, the plan comes linked with major new funding. That is a legitimate reason to reassess what the health service can promise to the public in return for billions in additional funding taken from their pockets. The regular rhythm of elections and spending reviews all but guarantees that the English system of government will create such a need every four years or so.

This creates a powerful dynamic of national plans and policies recurring and changing at regular intervals. One upside should be that having been here so many times before, we can learn a lot about the problems that tend to emerge and what can be done to deal with them.

The first and deepest of these problems is the sheer rate of reform, revolution and directional change. There are probably too many plans happening too often, rewriting too completely what has come before. This causes disengagement at the front line, costs money and staff time, and makes it hard to tell what has worked.

The political timescales which drive planning also often mean that the time for discussing and refining plans is extremely limited. I sometimes work alongside the World Health Organization with small, middle-income countries formulating health policies. Despite having much smaller budgets and bureaucracies than we have in the UK, I can think of three that have far longer and more sophisticated planning processes than we do.

Perversely, there is often also a striking lack of investment in people, expertise and data to get plans right: the repeated failures in planning the NHS workforce have all too often reflected this.

The role that strategic plans have in holding the NHS to deliver to voters and politicians also tends to lead to an emphasis on big, specific, tangible commitments. Some of the greatest achievements of the NHS in recent years, such as the strides taken against MRSA, have come when it was ordered to aim high and rose to the challenge. The problem is that the way of achieving this type of change has been applied more generally to issues for which it is not applicable.

Specific, national, tangible commitments may work to define goals, but they misfire when they try to specify the processes used to get there – because the best way forward will vary from place to place. Grand ambitions from the centre also tend to do more harm than good where the goal itself is uncertain. This is the case, for instance, in the current drive to shift care out of hospital. The extent to which this is actually possible varies, and we do not yet really know what the best or most efficient way of achieving it is. We need to encourage, incentivise and enable staff and organisations to feel their way towards the right answers, using trial and error and local knowledge. Dropping detailed targets on them to deliver on what may turn out to be semi-irrelevant measures will not help.

The political visibility of the moment and the tradition of the grand commitment also exert a powerful temptation to promise the impossible. This latest long-term plan in particular will be launched into a system with chronic, damaging shortages of staff, and will be backed by a level of funding that only just keeps pace with demand.

Lack of realism can manifest itself not just in goals being set too high, but also in ignoring what is lost elsewhere when money, staff and leadership are diverted to deal with them. Trade-offs are inevitable, but confronting them in health care is always painful and uncomfortable. Making, say, cancer more of a priority is meaningless unless something else is made less of a priority.

There are powerful reasons for all these recurring structural flaws in NHS strategic plans. But they may not be inevitable: they can be avoided with careful work and clever politics.

One dynamic that needs to be recognised is the way in which each reorganisation carries the seeds of its own replacements. Because of the scale and complexity of the health service, each new structure always turns out to be poorly suited to some places or types of care. There is then always a temptation to replace it. Sometimes this is justified – but the number of reorganisations should serve as a signal that the puzzle has no perfect solution.

And there are many much more specific points we can learn from the successes and failures of the past as well. What have we tended to get wrong on staffing? What have we tended to get right about the use of funding?

The six essays in this collection look at major areas the plan will have to deal with to consider what we can learn from the past about managing these tensions and getting the specifics right. In all our discussions of the recent and distant past, we are keenly aware that there is no single historical truth.

These are our judgements, based on our combined experience and reading – but we aim to start a debate about what went wrong and what went right, not end it. If the English NHS is to remain world-leading in its output of grand plans, we have a duty to try to become world-leading in getting them right.

Nigel Edwards
Chief Executive, Nuffield Trust

Lesson 1
Avoid the temptations of the grand plan

Nigel Edwards

Over the last two decades a vast amount of effort in the NHS has been expended on writing plans outlining how health services need to change. But the track record of putting these plans into practice has been far less impressive, and new proposals are often developed a short way through the lifespan of their predecessors.

This constant cycle of planning and revision has much to do with the way national plans have been constructed in the first place. Both the environment that health care is provided in and the organisations that provide it are highly complex and heterogeneous. A look at the historical evidence suggests that planning approaches designed with insufficient realism and understanding of this are likely to fail.

Make sure your solution is based on evidence, not groupthink

Many instances of a problem being identified and an appropriate solution being put forward do exist, but an organisation as large and complex as the NHS remains susceptible to groupthink. At times it has misread the various forces at play within a system or misinterpreted the available evidence – both of which can lead to a misdiagnosis of the problem.

The presumption that moving care out of hospitals and into the community would save the overall system (rather than merely the bodies buying care) money is a case in point. The goal of delivering health care closer to people's

homes is not a new one and has been an aspiration of numerous policy initiatives within the NHS for many years. But once faced with a £22 billion gap in health service finances, a widely held hope took hold that moving care out of hospital would deliver on a 'triple aim' of improving population health and the quality of care for patients while reducing overall costs.

However, an in-depth review of this policy by the Nuffield Trust found that while out-of-hospital care may be better for patients, initiatives for achieving this are unlikely to be cheaper for the NHS in the short to medium term. Many of the learning points from the research pointed strongly towards a need for greater understanding before a policy is implemented and more detailed research to support change as it takes place (Imison and others, 2017).

There needs to be a clear and evidence-based link between the problem and the proposed solution. The use of techniques such as logic models by national and local organisations has improved this (Department of Health and others, 2015), but they only help up to a point. Complex problems are not very amenable to simple solutions or one-size-fits-all policies. In the same way, focusing too much on improvements relating to specific types of care or a particular disease area such as cancer carries a risk of neglecting more systemic improvement and of crowding out improvements in less high-profile areas (Atun and others, 2008).

Unfortunately, the process of introducing policy has often lacked some key mechanisms which would help gather evidence and expertise. Sheard (2018) looked back as a historian on almost 70 years of NHS policy on waiting times, finding that initiatives from the 1970s to the 2000s were marked by a lack of clear evaluation phases and a failure to consult communities of experts who had been working on these issues.

Don't ignore the importance of local context

Across the country, health care is delivered from different starting points. The cultural context differs hugely, and variations in the way existing services are configured make writing national policy difficult. These differences may seem trivial when they are viewed from afar, but they often represent significant barriers to success.

This may mean that a preferred national policy solution is not suited to a local context. Taking a micro-level example, the chief executives of NHS England and NHS Improvement sent out a letter in 2017 instructing trusts to ensure that every hospital in England should use hospital-based GPs to triage and redirect patients as they are first seen in A&E (Iacobucci, 2017). The approach seemed well suited to hospitals serving populations that use A&E extensively for primary care concerns (Khan, 2015). But it was unlikely to be as effective in areas where those GPs see a high proportion of emergency cases on the same day. Frimley Park Hospital, which piloted the scheme, argued that the high proportion of patients with complex needs arriving in their A&E department meant that GPs would actually be more effectively used for managing discharge of patients, at the 'back door' of the hospital (Gregory, 2017).

Even if a proposed solution is well designed, the local context may mean that it cannot be implemented. The success of plans to employ GPs for hospital-based screening depends on recruiting GPs with the right skills and experience and being able to provide an appropriate working environment within a well-functioning team. With GPs leaving the service faster than they can be replaced and around half of general practices reporting a vacancy in a recent survey by the British Medical Association (2018), there is a strong possibility that such national proposals will be stymied by local realities.

This does not mean that policy makers should always accept the plea that local context makes change impossible, though – and at times this has been cited as a reason for maintaining the status quo. Those arguments are more likely to be legitimate when changes are more complex; rely more on local relationships, local leaders or local staffing levels; or affect how different organisations work together.

Don't set the people doing local planning up to fail

An exercise in 2013/14 encouraging clinical commissioning groups (CCGs) to work with their neighbours by forming into clusters called 'units of planning' aimed to ensure proposals for a given area were coherent. It also hoped to maximise the value for money of any resources being drawn upon (NHS England, 2013).

But accounts from those involved suggest the project used a great deal of time and effort to create plans that were largely shelved, and the lack of reporting on any outcomes emerging from the work only serves to underscore its evident failure. A lack of clear overall direction, the imposition of planning areas that were not geographically meaningful, the lack of mechanisms to ensure collective ownership of the plan, and an excessive dominance of financial targets have been noted as significant issues.

It is interesting to note that these same issues have emerged in the cases of some Sustainability and Transformation Partnerships, the regional care bodies set up more recently to evolve the planning of care by bringing different parts of the NHS and social care system together (Edwards, 2016). From our experience of working with trusts, commissioners and STPs across England, we can see a lack of 'in-house' planning expertise within the health service has been an issue for many local systems and has led to strategy work being outsourced to management consultants.

Beware optimism bias and pressure for quick results

Complex change requires continual negotiation and often takes place in unpredictable ways and at varying speeds. People need to build new relationships and establish different ways of working, and the logistics of getting clinical staff together are challenging. There is little that can be done to compress the time that is needed for these tasks.

The 'planning fallacy' (or optimism bias) has become a very familiar element of NHS policy proposals over the last 20 years. Alongside natural optimism and ebullience from the people leading changes (who often overestimate the speed with which change will take hold), there remain other important reasons for taking a more cautious approach.

The Better Care Fund, an ambitious government project aiming to improve the integration of health and social care services by pooling local authority and NHS budgets, is a relatively recent example of optimism bias in practice. A key expectation of the initiative was that avoidable emergency admissions

could be reduced by 3.5% in one year by focusing on care for older people and helping them to manage their conditions in the community (National Audit Office, 2014). The planning process for the Fund was delivered a blow when the timescale for preparing plans was shortened from 11 months to 5 months during the process. Instead of a reduction, emergency admissions increased in 2015/16, the first year the Fund was introduced (National Audit Office, 2017).

Likewise, a key aim of the New Care Models programme has been to reduce admissions and reduce the time spent by patients occupying hospital beds. There is some evidence of this occurring, but progress has been much slower and patchier than hoped (The Health Foundation, 2017).

Ultimately, this is not surprising. Equivalent changes in the United States took longer and consumed far greater resources (Jha, 2016). But the electoral cycle in this country has a strong and malign impact on planning in the NHS, and folk wisdom would suggest that it is only possible to achieve major change in the two to three years following an election. This is at odds with the fact that plans often favour major changes such as hospital closures, which require financial input and long decision-making processes, both of which delay implementation. So it is important not to allow pressure to achieve rapid short-term change lead to hubris and rash promises.

Lesson 2
Listen to the public – and don't pretend you will if you won't

Helen Buckingham

Poll after poll has shown that people from across Britain value the NHS above any other public service or institution. They feel a strong sense of ownership of NHS services and buildings, and – sometimes in the teeth of the evidence – have a high degree of confidence in the service's ability to meet the needs of themselves and their families at the times when they are most in need. Consequently, time after time, many attempts to change the way in which services are delivered at a local level have foundered in the face of public opposition.

A brief look across recent history serves to underline the importance, if proposals are to succeed, not only of consulting with the public, but doing so in a way that is meaningful to all parties involved. As the Health Select Committee noted in its 2007 report on patient and public involvement in the NHS (House of Commons Health Committee, 2007), "patient involvement and public involvement are distinct and are achieved in different ways. The conflation of these distinct terms and the confusion about the purpose of involvement has led to muddled initiatives and uncertainty about what should be done". This essay focuses on some lessons from the history of public involvement.

Legal structures for talking to the public are necessary but not sufficient

Although the statutory mechanisms for doing so have changed over the years, legislation requiring the NHS to engage with the public – directly or via representatives – about changes in services has been in place since 1974.

But the existence of these legal duties and mechanisms is not in itself a guarantee that engagement with the public will be effective. The Independent Reconfiguration Panel (IRP) was established in 2003 with a remit to "review proposals for changes to NHS services that are being contested, and… offer support to the NHS and other bodies on achieving successful change." The IRP has produced three reports on learning from reviews. They all summarise themes common to the reconfigurations referred to the panel, with examples including:

- "inadequate community and stakeholder engagement in the early stages of planning change
- proposals that emphasise what cannot be done and underplay the benefits of change and plans for additional services
- important content missing from reconfiguration plans and limited methods of conveying information
- health agencies caught on the back foot about the three issues most likely to excite local opinion – money, transport and emergency care
- inadequate attention given to the responses during and after the consultation".

In 2012 the outgoing Chairman of the panel Dr Peter Barrett noted that "one of the hardest subjects for the NHS to broach with the public is the possibility that their existing services may not be as safe or providing the best quality that they could be." Later in the same paper, he argued that "the challenge to the public is to think more deeply about what the NHS can offer for the money it's given… What is needed, if we are to progress the agenda on patient choice and public engagement, is open and honest dialogue about these issues."

If we are to achieve this, we need to be able to connect with the public around the issues which really matter to the public, and to use that connection as a

route into discussions on the issues which matter to professionals in the NHS. Drawing on the work of Dr Ellen Stewart for an essay on public attitudes to changes relating to NHS buildings, Cowper (2018) suggests the need to:

- appreciate the underlying relationship between the NHS organisation and the population it serves
- engage early, with genuine dialogue
- accept that service change is politically sensitive
- explore disagreement.

Meeting your own requirements isn't always enough

Among other legacies left to the NHS by Andrew Lansley in his time as Health Secretary, he sought to establish a framework against which proposals for change could be measured by local people and their political representatives. The 'four tests' stated that there must be clarity about the clinical evidence base underpinning the proposals; they must have the support of the GP commissioners involved; they must genuinely promote choice for their patients; and the process must have genuinely engaged the public, patients and local authorities.

These tests were announced by the Secretary of State in a speech delivered at Chase Farm Hospital in Enfield shortly after the 2010 general election. But a close examination of this case demonstrates that, as with legal structures, relying on a formalised framework of your own cannot in itself guarantee that satisfactory consultation with the public will take place, and indeed may obscure the need for genuine engagement.

Chase Farm presented an excellent example of a long-standing conflict between the desire of NHS leaders to reconfigure services deemed to be unsustainable, and the desire of local people to maintain local services (Gainsbury, 2011). In 2006 local leaders had developed plans to relocate A&E, maternity and emergency paediatric services from Chase Farm to other hospitals 6–7 miles away. The IRP broadly supported the proposed reconfiguration, but noted that "there was a frequent mismatch between what the Panel heard from the NHS and the apparent knowledge of many of

the community groups and members of the public... there is mistrust and the primary care trusts (PCTs) will need to rebuild relationships and restore the confidence of its community."

With some acerbity the report goes on to say that "The Panel requests the PCTs and the acute trusts to reconsider the benefits of meaningful two-way engagement with both staff and the public as opposed to what was perceived to be a one-way information-giving process."

Following the 2010 election, the proposals for change were once again referred to the IRP. For the second time, the IRP accepted the clinical and financial arguments behind the proposed changes. The recommendation was finally accepted by the Secretary of State in September 2011, even as he admitted that local people and representatives still felt strongly about the issue.

Changes led at a national level are not immune to the challenges of consultation experienced at a local level. Having sought to change the pattern of delivery of services for paediatric cardiac surgery for some time, NHS England's 'Safe and Sustainable' review in 2011 resulted in a collective decision to establish seven clinical networks across England, each led by a specialist centre. This was a reduction from the previous 11 centres, and passions ran high in the areas which were effectively downgraded. Not only were a number of referrals made to the Secretary of State by local health overview and scrutiny committees, there were several judicial reviews of the process. The outcome of the final judicial review, published in 2013, was to quash the collective decision.

In a comprehensive review of the approach to consultation and engagement the IRP found that "much of the opposition to, and flaws in, the proposals originate in the lack of engagement of a wide range of stakeholders in the co-production of network models of care at the pre-consultation stage." It has taken a further five years to develop proposals which are broadly supported by both clinicians and patient representatives.

Reflecting on the four tests, in each of these cases professionals – including GP commissioners – were persuaded of the clinical case for change. The nature of the proposals was in effect to limit choice, but with a strong clinical rationale. However, both of these examples highlight the difficulty of persuading the

public that what they perceive as a loss – a service being moved to a different physical location – may in fact represent a gain, in a better service more likely to save lives.

If you're discussing planned changes rather than involving the public in decisions, say so

In 2010, NHS leaders in both London and Manchester were developing proposals to change the way stroke services are organised. The changes in both areas involved selecting hospitals to run specialist stroke services for a larger region. The hospitals within that region were to be viewed as a network with the specialist stroke site at its centre.

Earlier this year the results of a project looking at patient and public involvement in these reconfigurations were published (McKevitt and others, 2018). The research concluded that public engagement had taken place in an effective way even though citizens had not necessarily contributed to the actual system redesign that took place: the value lay in the fact that citizens felt involved in the changes being made and this was intrinsically a good thing for the process.

The two reconfigurations were approached differently, but in each case there was a recognition of concerns expressed by both professionals and the public from the outset, and the need to engage with stakeholders to ensure effective implementation of change. A range of methods were used to involve patients and the public. Often, assumptions made by professionals about the concerns likely to be felt by patients were flawed, but the act of consultation helped to uncover this. In particular, although in both cases the consultations focused on the provision of acute stroke services, patients were most concerned about the arrangements for longer-term rehabilitation.

Overall, the researchers concluded that, notwithstanding the different approaches adopted (and there were valid plaudits and criticism of each), the most significant benefit of each consultation was that once the process was concluded and decisions had been made, patients and the public accepted

those decisions, even though in many cases they did result in services moving physically further away. In this case NHS leaders were more successful in positioning change as a gain, rather than a loss.

Poor engagement drives suspicion and disengagement

Not all engagement with patients and the public is about detailed service change. Since 2016 local health and care leaders have been working together to develop Sustainability and Transformation Plans. The timescale for the production of the initial plans was uncomfortably tight, and local leaders were actively discouraged from discussing their plans in public – at least in part due to a concern that taking less than fully developed plans into the public domain may raise public anxieties about change.

Unfortunately, the perception of secrecy which arose as a result of this served to fuel anxieties as much, if not more, than a process of sharing plans might have done. In some areas it also drove a rift between NHS leaders and their local authority counterparts, with a number of councils publishing draft plans citing explicit concerns about transparency and public accountability (Bunn, 2016).

Although every area has now published its draft plan, the damage has already been done. Reporting on the results of its enquiry into integrated care, the Health and Social Care Select Committee (2018) noted that "Sustainability and Transformation Partnerships (STPs) got off to a difficult start, with limited time to forge relationships, develop plans and make difficult decisions about changes to local health and care services. National media coverage of 'secret plans', 'developed behind closed doors', reflected the poor communication between local bodies and their communities. This, along with accusations that STPs were a smokescreen for cuts, tainted the STP brand." Many of the recommendations in the report focused on the need for better communication and engagement with the wider public.

But there are some good examples of areas which are setting out to take a different approach, often building on the experience of local authorities.

The Healthier Wigan Partnership (2016) has developed a 'Deal for Health and Wellness' which forms part of a suite of 'deals' developed by Wigan Council with local people. The deals are rooted in transparent and ongoing conversations between local leaders and the wider public about the challenges faced by the public sector, and the needs and wants of local communities. To date, the 'Deal for Health and Wellness' covers relatively uncontroversial topics largely relating to the prevention of ill health. But under the umbrella of the Healthier Wigan Partnership, a 'Shape Your NHS Community' group has been formed, enabling residents to participate in all stages of discussions on service change. Time will tell as to whether this approach will allow us to avoid the pitfalls of the past as we embark on the service changes the essays in this collection discuss.

Lesson 3
Don't treat the workforce as an afterthought

William Palmer and Candace Imison

"There is a workforce gap... which is creating an unsustainably high level of vacancies, work pressures and potential risks to patient care."
NHS Pay Review Body (2018)

The English NHS's 1.4 million staff account for most of its budget, are crucial to everything the service does, and determine the quality of the care it provides. Managing a workforce of this size is inherently complex, requiring accurate forecasting of how many staff are needed and policies aligned to recruit, train and retain staff accordingly. The task is made all the more complex by the evolving nature of health care and the need to respond to the changing health needs of the population.

Yet the workforce has frequently been either neglected or treated as an afterthought in NHS strategic policies and plans. Report after report identifies deficits in workforce planning at local and national levels (House of Lords, 2017; Boyle and others, 2017). For example, a parliamentary committee recently noted that its members:

> "*are concerned by the absence of any comprehensive national long-term strategy to secure the appropriately skilled, well-trained and committed workforce that the health and care system will need over the next 10–15 years. In our view this represents the biggest internal threat to the sustainability of the NHS.*" House of Lords (2017)

We identify here three lessons that can be drawn from this rather poor history.

You can't change the model of care without changing the workforce to support this

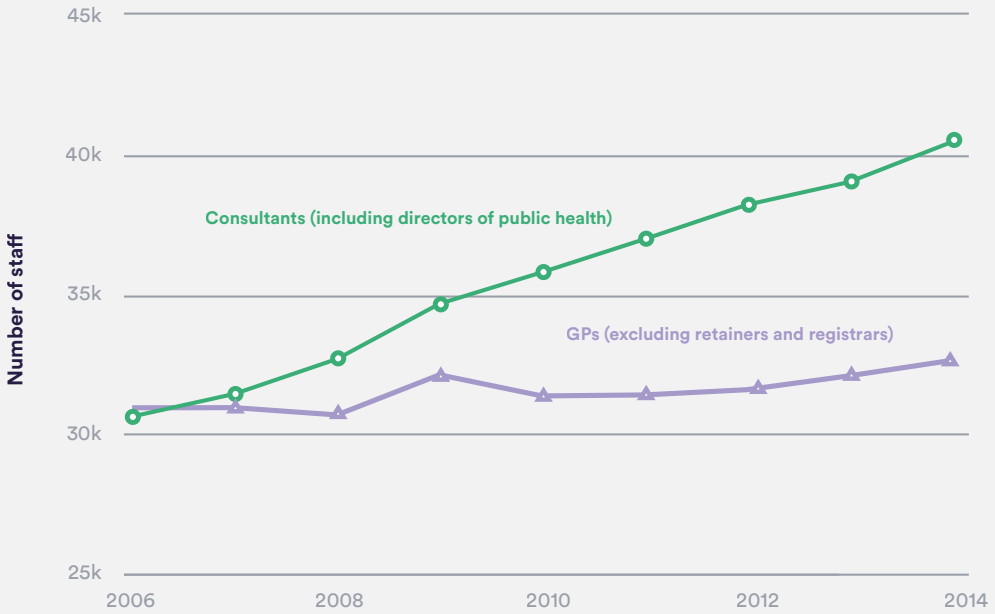
"We can design innovative new care models, but they simply won't become a reality unless we have a workforce with the right numbers, skills, values and behaviours to deliver it." NHS England (2014)

Health policies and guidance that suggest changes in the model of care will not be successful unless they explicitly consider the workforce implications, both in terms of numbers and skills. This was clearly acknowledged in the 2014 Five Year Forward View. Yet two-thirds (30/44) of the Sustainability and Transformation Plans (STPs) produced in 2016 to make this national vision a local reality contained no detailed workforce plan to ensure the right staff would be there to deliver on the service changes they outlined (Boyle and others, 2017).

History is littered with examples of what can happen when the workforce is forgotten. In 2016, a parliamentary committee concluded that "no coherent attempt has been made to assess the headcount implications of a number of major policy initiatives such as the seven-day NHS" (Public Accounts Committee, 2016). As a consequence, progress on seven-day services, a flagship manifesto policy of the last government (Conservative Party, 2015), has been slow and patchy.

But perhaps the starkest examples are the failed attempts to shift care outside of hospital. In 2006 the Department of Health published *Our health, our care, our say*, which set out the ambition to shift a significant proportion of care out of hospital. This goal has been reiterated again and again since. Yet, in fact, in the eight years following the 2006 publication, the number of hospital consultants increased by almost a third (32%) compared to just a 5% increase in GP numbers (see Figure 1).

Figure 1: Number of full-time equivalent consultants and GPs, 2006 to 2014



Source: NHS Digital

This was, in part, a legacy of the workforce targets set in the NHS Plan which, despite saying that "changes in primary care will help ease the pressure on hospitals", aimed for nearly four times the growth in the consultant workforce compared with that of GPs (Department of Health, 2000). The imbalance was never properly addressed. As a result, general practice was left under more and more pressure even as services out of hospital were supposed to do more. A Nuffield Trust review concluded that this policy is unlikely ever to be realised unless the staffing picture shifts (Imison and others, 2017).

Build in a margin for error to avoid costly gaps in the professional workforce

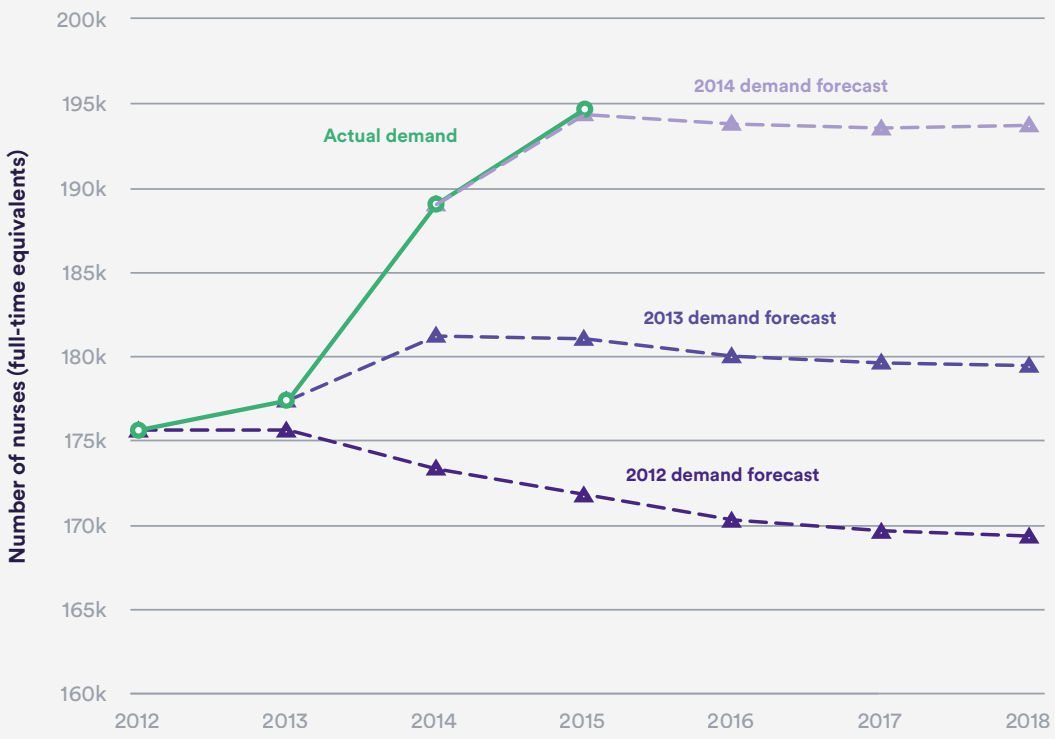
Workforce planning in England has traditionally tried to land "a jumbo jet on a pin" (Dickson, 2007) – it has aimed for exact numbers as targets for staffing and recruitment rather than recognising the uncertainty in supply and demand for staff. Moreover, national bodies have actively sought to avoid delivering an oversupply of staff. In addition, in recent years, workforce plans have been driven by financial plans which have consistently underestimated expenditure and, therefore, actual demand for staff.

Predicting the exact demand for, and supply of, staff is inherently challenging, with a large degree of unpredictability. Factors outside the ability of the NHS to control or predict have had a huge impact. For example, the EU referendum vote and new language tests for nurses meant the numbers migrating to the UK fell by thousands year on year (The Health Foundation, 2018), while the Francis report into failures at Stafford Hospital meant demand for nurses jumped as hospitals tried to return to a safer level (Buchan and others, 2017).

However, history shows that the financial and quality implications of an undersupply are not the same as for an oversupply of staff. For instance, in 2017/18 trusts spent £5.4 billion on temporary staffing, much of which could be eliminated with sufficient supply of permanent staff (NHS Improvement, 2018). The implication, given the difficulty in hitting a precise target, is that policymakers should err on the side of an oversupply.

Recent history also suggests a pervasive optimism bias. Forecasts have tended to overestimate the number of staff that will be available, and underestimate the number that will be needed. This latter phenomenon is, in part, due to workforce plans being linked to agreed financial plans, which tend to overstate likely cost reductions. For example, in 2012 the NHS forecast that the demand for adult acute nurses would fall by over 6,000 staff to around 169,000 by 2018. Subsequent forecasts suggested this was a vast underestimate of demand: a year later the NHS uplifted its prediction for demand by some 10,000, followed by more than a further 14,000 by the time it made its forecast in 2014. In reality, even by 2015, the actual level of demand had risen above this higher prediction (Figure 2).

Figure 2: Forecasts of demand for adult acute nurses



Source: Data extracted from graph in Health Education England (2016)

The underestimate of the future demand for adult acute nurses was compounded by overly optimistic predictions on the supply of staff. In 2015, Health Education England's supply forecast was for between 181,000 and 193,000 by 2018. In reality, the most recent count of adult nurses – 179,000 – is below even the 'worst case' scenario.

The costs and benefits of contractual changes are often not as expected

Under the pay modernisation programme of the early 2000s, the Department of Health succeeded in getting a vast number of staff on to new contracts. However, the experience of the development, negotiation and implementation of these contracts offer some key lessons for the future.

The NHS Plan

The NHS Plan, a 10-year strategy for the health service published in 2000, outlined significant changes to how the NHS was to be organised and outlined the need for more and better paid staff using new ways of working. The Plan recognised that such reforms would require 'pay modernisation'. This resulted in three new contracts, introduced in 2003 and 2004, covering consultants; general practice; and, under the Agenda for Change contract, nurses, other health care professionals and infrastructure support staff.

The first is that the effect of financial incentives can be hard to predict. In the first three years GP services cost £1.76 billion more than was expected when the contract was negotiated. One of the main causes of the overspending was the failure of the Department of Health to accurately predict how well practices would perform against the new Quality and Outcomes Framework (QOF), which paid them extra for meeting quality targets (National Audit Office, 2008).

Secondly, where the key parties involved are not aware of goals or not incentivised to meet them, changes might fail to have the impact hoped for. For example, the Department of Health's business case in 2002 estimated that Agenda for Change would result in net savings over the first five years of at least £1.3 billion. However, the Public Accounts Committee deemed this to have been unrealistic as trusts and staff were not required to achieve any efficiency improvements as part of the implementation (Public Accounts Committee, 2009). Similarly, a survey suggested that only half of NHS trusts were clear about the aims of the consultant contract (National Audit Office, 2007).

Lastly, contracts need to be based on an accurate understanding of current working practice. Prior to development of a new consultant contract, research suggested that consultants were working on average between 50 and 52 hours a week. However, the Department of Health modelled the new contract based on a diary exercise from 2000 which suggested that consultants were working only 47 hours. Factoring in the intention to decrease consultants' workload, funding of the new contract was then based on consultants

working an average of 43 hours a week. This assumption proved to be an underestimate: consultants worked more and therefore cost more, with the National Audit Office (2007) finding that 84% of trust chief executives thought the resulting costs were not covered by the money available.

Clinical grading

Clinical grading was introduced in 1988 with the intention of rewarding nurses for providing front-line care and offering an alternative career development route to moving into management or education. The system moved all nurses on to grades with pay dictated by tasks performed rather than rigid job titles.

Reforms to nurse pay a decade earlier also highlight that pay reform is difficult to define, difficult to cost, and inherently challenging. The clinical grading framework introduced in the late 1980s allowed for different interpretations of tasks such as 'supervision' and 'being in charge'. The result saw employers try to manage the spiralling cost of having nurses in more senior grades than they had envisaged, while individual nurses sought to ensure they were not missing out on the pay increases that some of their peers were receiving. As a result, around 100,000 decisions on grades were contested and it took until 2003 for all of the claims to be dealt with (O'Dowd, 2008).

Lesson 4

Make sure the funding follows the plan

William Palmer and John Appleby

The new NHS long-term plan is intrinsically linked to the £20 billion funding commitment which gave rise to it. One of the primary questions it must answer is how that money will be used to support its goals and objectives. The design of these financial flows should, at a minimum, avoid creating unnecessary barriers and, ideally, should provide the right incentives and balance of resources to achieve the outcomes of the plan.

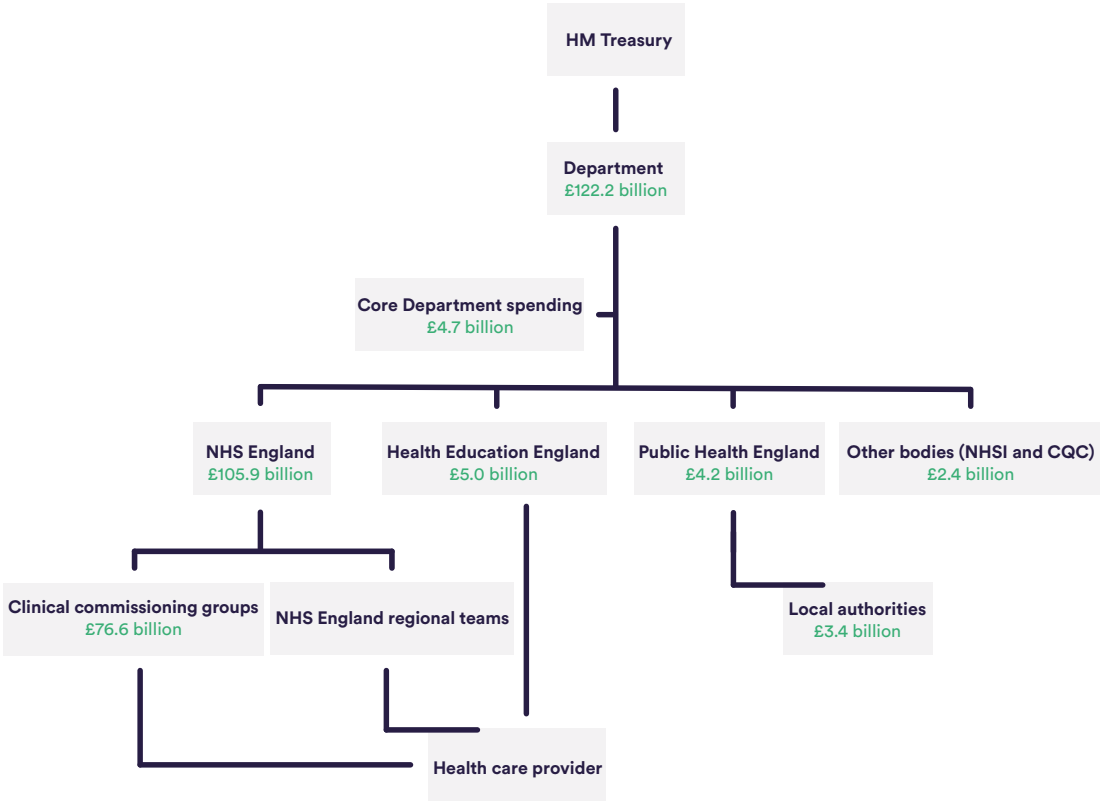
The NHS has a long history of experimenting with ways to allocate its funding to support policy goals. Initiatives to distribute funding at a large scale include using needs-based formulae to decide the size of budget that local areas get, and the Payment by Results system for NHS trusts, discussed below, which aims to increase activity and reduce waiting times. More specific financial policies have been designed to incentivise particular improvements or provide funding pots for new reforms, resulting in services like general practice being funded by complex combinations of different funding streams. This essay will look at the successes and failures of these initiatives and what these say about the options now facing the NHS.

The starting point is the way money is passed from the taxpayer to front-line services today, shown in Figure 1. The Secretary of State for Health and Social Care decides how much of the Department's[1] total budget (£122.2 billion in

1 Hereafter in this essay, by 'the Department' we mean the Department of Health and Social Care and its previous incarnations, the Department of Health and the Department of Health and Social Security.

2016/17) should be allocated to the NHS (and under what conditions) and how much to public health. NHS England in turn decides how its budget (£105.9 billion in 2016/17) should be allocated between primary care, general hospital and community services, and specialised services that it directly commissions. The Department and NHS England also decide to further delegate control over spending to commissioners, to those who run services, or to groups of patients themselves through rolling out personal health budgets.

Figure 1: Overview of financial flows from the Department, 2016–17



Source: Adapted from National Audit Office (2017).

Allocate spending in a way that supports your goals, rather than undermining them

Through their roles deciding how funding is distributed, the Department and the NHS can influence the balance of funding between different parts of the system – for example between GPs, hospitals and public health. They can also rebalance funding between different geographical areas.

These are potentially powerful ways to drive and enable changes. However, history suggests funding decisions have been out of kilter with key long-standing policy ambitions.

In the 2006 white paper *Our health, our care, our say* Prime Minister Tony Blair and Health Secretary Patricia Hewitt made shifting care out of hospital a particular priority, saying that "increasingly, our primary, community and social care services will need to take the lead" (Department of Health, 2006). However, in the years around and after the white paper the movement of funding was in exactly the opposite direction.

Before the 2013 reforms a local commissioner in each area (primary care trust) would receive a single aggregated allocation and decide, in theory, how to apportion it – although in reality national bodies still took important decisions about the rates at which hospitals and GPs were paid. In the nine years up to 2012–13, the proportion spent on core hospital services increased (from 46% to 48%) and the proportion spent on community and primary care services combined fell (from 36% to 34%).

The commitment to focus increasingly on prevention has also not been reflected in the use of resources. In 2010, the Department committed to protect funding for the public health services whose core role it is to prevent ill health. Allocations to local authorities for public health were increased by a total of over 10% in the two years to 2014–15. However, the Department then cut budgets in-year by £200 million (6.2%) in 2015–16 (Calkin, 2015). In early 2016 the government then announced its intention to further reduce this budget by an average of 3.9% every year in real terms until 2020. The public health allocations remain a small proportion of the overall money allocated through funding formulae.

Remember that money matters for tackling inequalities

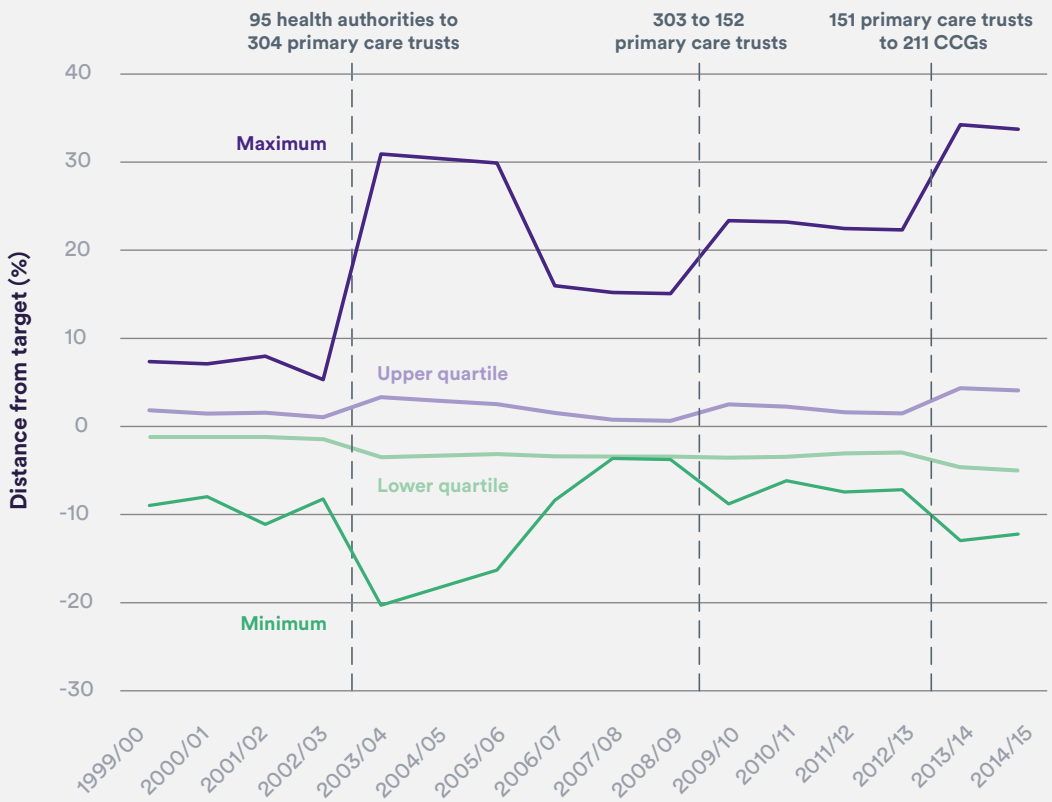
Another long-standing ambition in the NHS, reiterated in many white papers and strategies, is to address inequalities. The powers the Department and NHS England have to allocate funds to different areas provide an apparently powerful lever. Over time, since the late 1970s, the needs-based allocation formulae have developed into some of the most sophisticated ways of distributing public money anywhere in the world.

However, the actual amount local commissioners receive is determined by a compromise between what the formula says and what they received last year, with local areas moving only gradually towards their 'fair share'. This is done with the intention of avoiding destabilising local services, but the so-called 'pace of change' decisions are not based on evidence about, for example, what changes in funding a commissioner can tolerate without being financially destabilised or, in the case of large increases, spending inefficiently.

Over a decade ago the Department made a commitment to ensure that no primary care trust should be more than 3.5% below their target fair share by 2007–08 (Figure 2) (Department of Health, 2005). However, although a like-for-like comparison is impossible due to reorganisation, the level of variation today appears to be higher, with some clinical commissioning groups 5% below their target shares as of 2018–19 (NHS England, 2018a). Data on distances from fair shares for public health allocations are hard to find but, in 2014–15, they ranged from -43% to +530% between local authorities (National Audit Office, 2014).

Research suggests this makes a real impact. A 2006 study found that commissioners who receive higher levels of funding relative to their calculated 'fair share' tend to have shorter inpatient and total A&E waits (Jacobs and others, 2006).

Figure 2: Distances from 'fair shares', 1999–2000 to 2014–15



Source: National Audit Office (2014)

Progress in moving money around to increase fairness has also been slow when we look at financial flows more specifically targeted to reduce inequality. For almost two decades health funding formulae have included specific adjustments to move money towards areas with lower life expectancies, with the aim of reducing health inequalities (National Audit Office, 2014). However, looking back, the priority placed on inequalities has changed. The Department allocated 15% of its funding to primary care trusts based on health inequalities in 2009–10 and 2010–11, but today only 10% of funding for core hospital and community services is allocated by NHS England in this way.

Research published in 2014 suggested that such adjustments for inequalities are effective. It found the policy of increasing the proportion of funding allocated to deprived areas was associated with a reduction in absolute health inequalities from causes amenable to health care. Specifically, in the decade

to 2011, NHS resources increased by £244 more per person in real terms in the most deprived areas compared with the most affluent. Over this period, the difference in mortality amenable to health care between deprived and affluent areas was shown to have nearly halved from, for example, 95 deaths in males per 100,000 population in 2001 to 54 deaths per 100,000 in 2011. These allocations explained 85% of the total reduction of absolute inequality in mortality amenable to health care. Conversely, there was no statistically significant association between absolute increases in NHS resources and improvements in mortality amenable to health care in more affluent areas (Barr and others, 2014).

Across different areas of care, and in different areas of the country, the history of using large-scale financial flows to deliver change has all too often been one of not actually implementing and maintaining the changes that should be possible. Planners this time should look closely at how to back up their words with financial action.

Financial incentives may have an effect, but not always the one you want

The NHS has also experimented with more specific uses of funding to encourage people to meet strategic goals, by giving out money to reward particular behaviour. Do initiatives like this provide a more direct way to use spending to make plans a reality?

Two of the largest incentive schemes are Payment by Results (PbR) in secondary care and the Quality and Outcomes Framework (QOF) in general practice. These have been in place for well over a decade and account for around one-third of the total budget of the NHS (Appleby and others, 2012).

PbR was introduced in 2003. By paying hospitals based on a set rate for each different procedure, it aimed to incentivise them to do more work more efficiently, and to encourage them to compete on quality, rather than price. An evaluation suggested that it led to reductions in lengths of stay in hospital, and an increase in the proportion of day cases. The authors felt that these changes suggested greater efficiency.

However, the authors also sought to explore the effect on quality of care, which the document introducing PbR set out as a long-term goal of the system (Department of Health, 2002). Using proxy measures based on mortality and readmission rates, they found little measurable change attributable to the policy (Farrar and others, 2009). The evidence on these effects is limited, with that evaluation being the only one identified in a recent systematic review. But that review also concluded more generally that there is mixed evidence on the effect of paying financial incentives to hospitals for providing higher-quality care (Mandavia and others, 2017).

The QOF was introduced in 2004 as part of a wider set of contract reforms for general practice. It gave out extra payments for GPs meeting a wide range of quality standards – for example, for reducing the proportion of teenagers with asthma who smoke, or keeping a register of obese patients.

GP practices were successful in undertaking the activity funded by the framework, which resulted in a spend on the scheme over the first two years of nearly £1.8 billion compared to an allocation of £1.4 billion – an overspend of around a third of a billion pounds.

A study looking at its immediate effect suggested improvements in performance on quality measures against some clinical indicators. But the QOF seemed to have had unintended consequences too, with GPs appearing to game the system to increase their income (Gravelle and others, 2007). The evidence on the effect on outcomes has been mixed, although a number of studies identified a pattern of rapid improvement followed by a plateau in achievement (NHS England, 2018b).

Special financial schemes have continued to be rolled out more recently. For the 2015 Spending Review, the Chancellor promised a £10 billion increase in funding over the course of the parliament with £3.8 billion available for 2016–17. Some of this – £2.1 billion in 2016–17 – was put into a special 'Sustainability and Transformation Fund'.

The Fund is provided directly to trusts, with decisions on the funding largely taken by NHS Improvement, who oversee them. The original intention was for it to have a dual purpose of stabilising finances and transforming services – including work to integrate local services.

Yet the Fund has largely been used to reduce providers' deficits, by giving out funding only if they keep overspending to a minimum. Undoubtedly, trusts appear to have responded to this incentive. But the design of the system may have further increased the gap between the financially stable and the financially struggling. Over a fifth of the Fund was withheld from 114 trusts for not accepting or meeting their financial or performance targets. A significant proportion of the Fund was allocated to trusts already in surplus (Gainsbury, 2017).

The prioritisation of achieving financial balance was also apparently at the expense of longer-term sustainability. The cost of maintenance work left undone despite creating high or significant risks almost doubled in the four years to 2016–17 (to £2.7 billion).

Meanwhile, the amount of the Fund taken up by controlling deficits meant little was left for transformation. Only £1 in £7 was committed to this transformation agenda in 2016–17, despite this being one of the dual purposes of the Fund. The National Audit Office warned that trusts became more reliant on one-off savings over this period. Despite improving access being an objective of the Fund, performance against key standards fell in 2016–17 (National Audit Office, 2018).

Across all these ambitious schemes, one clear lesson is that the NHS will often respond to financial incentives. But it often does not respond as much as policymakers hoped, or in the direction they intended. As they consider responses to the recently published consultation on amendments to the national tariff, NHS Improvement and NHS England may reflect that aligning incentives to policy goals rarely goes entirely to plan, and the track record of using them to achieve multiple goals at once is poor. In particular, history suggests a degree of pessimism about using financial levers to achieve complicated, longer-term aims like increases in the standard of care.

Lesson 5
Don't overrate structural reorganisation

Mark Dayan

If staffing and financing have sometimes been changed less than might be expected to support NHS reforms, structural reorganisation – in the sense of changing the existence, duties or powers of NHS bodies – has been the lever policymakers pull again and again. Depending on exactly how big a change has to be to count as a reorganisation, the last twenty years have seen at least ten.

It has been used to try to achieve a wide range of policy goals including introducing more market forces, getting rid of them again, making hospitals more accountable, and making the health service work better with social care.

The Health and Social Care Act (2012)

During his time in opposition, Conservative health spokesman Andrew Lansley hoped to build on New Labour's market-based reforms by putting GPs in charge of buying care and taking the Department of Health out of decisions to create a competitive, 'self-improving' system.

As the Tories formed a coalition with the Liberal Democrats in 2010 with Lansley as Health Secretary, these plans were amended to create an even more radical Bill that abolished the main NHS regional and local bodies – strategic health authorities and primary care trusts.

Following great controversy, the legislation was 'paused' in 2011 while a 'Future Forum' of eminent figures looked over the proposals. They made changes including limiting how free GPs were to decide how they purchased care and stopping the regulator Monitor from having a duty to promote competition. The result was an Act that, despite very wide-ranging changes, created something far from the purist free market envisioned by its creator.

A recent example is the major overhaul brought about by the 2012 Health and Social Care Act. The introduction of Sustainability and Transformation Partnerships (STPs) last year to bring together health and social care bodies at a regional level was also a form of reorganisation, although it had no legislative footing. Proposals for more are frequently discussed. The official legal duties and structures of the Act are now quite divorced from the co-operative way in which local NHS bodies are now expected to behave (Lamb, 2016). The Labour Party is committed to a repeal of the Health and Social Care Act and a reorganisation back to what existed before (Farley, 2018; Stewart, 2016).

Remember structural reorganisation carries costs

Compared to increasing funding or staffing, one possible attraction of structural reorganisation is that it is a lever for change that does not simply involve paying for more from the Treasury pocketbook. There is often a hope that it will cut the costs of 'bureaucracy'. But history tells us that it too has real costs which should not be underestimated. As the most recent major legislative reorganisation in England, the Health and Social Care Act of 2012 provides a series of examples.

The direct financial cost was estimated at £1.5 billion, primarily made up of paying for redundancies, office space and IT. However, a National Audit Office (2013) review found this was based on self-reported data which looked impossible in some cases. It also failed to take into account the costs of staff time and several other sources of extra spending, meaning the real figure was probably higher.

The Department of Health believed this £1.5 billion would be counterbalanced by savings of £1 billion a year in lower administration costs. However, the National Audit Office (2013) suggested this had been inflated due to an assumption that administrative costs would have otherwise risen – despite the fact that they had actually been falling.

Data since the Act throw further doubt on these savings. The number of NHS managers fell around the reforms, from around 39,000 in 2010 to 34,000 in

2013. However, this drop started well before the Act was passed (Walshe, 2014). In fact, after the reforms were fully implemented in 2013 the number of managers began to rebound: today there are once again around 39,000 in NHS trusts, regulators and commissioners (NHS Digital, 2018). Meanwhile, the years of the reforms saw spending on management consultants spike to nearly £600 million a year, having earlier been cut to below £200 million (Department of Health, 2011; 2013).

Perhaps even more important was the opportunity cost: the loss of leadership and staff time to focus on other problems. Looking back, The King's Fund concluded: "it seems likely that the massive organisational changes that resulted from the reforms contributed to widespread financial distress and failure to hit key targets for patient care" (Ham and others, 2015).

A study of an ambitious NHS transformation programme in the North East of England, which imported new management ideas to try to improve safety and efficiency across all NHS bodies, became a chronicle of the local impact. The authors reported that the unexpected reforms "seriously disrupted" progress, which was slowed or halted at 10 of the 14 trusts they looked at (Hunter and others, 2014).

The experience of the Health and Social Care Act is a lesson to weigh any similarly sized reorganisations against a cost likely to be measured in hundreds of millions of pounds, and substantially slower progress against important health service aims.

Moreover, the mechanisms which cause this do not appear only to be relevant to root-and-branch legislative overhauls. Nearly all the main sources of costs – distraction, the call on staff time, the cost of hiring and firing, consultants and IT – seem likely to be repeated on different scales in smaller changes without legislation.

Don't overestimate the difference changing NHS structures actually makes

Before the 2012 Health and Social Care Act, two earlier waves of reorganisation aimed to bring market forces and local purchasing power to bear on providers of NHS care. Both were controversial and played a dominant role in national debate around the NHS at the time. Yet studies and reviews have tended to conclude that they had less impact on the delivery of care than expected.

The reforms of the 1990 NHS and Community Care Act first brought an 'internal market' into the English NHS. On one side of the market, services like hospitals and mental health support were put under the control of newly created 'NHS trusts' which were to operate somewhat independently and compete to provide care. On the other side, local health authorities and individual 'fundholding' GP practices were given the power and duty to buy care from these trusts and others on behalf of patients. The reforms were meant to deliver efficiency, quality of care, consistently shorter waiting times and a "patient-friendly and patient-led service" (Clarke, 1989).

However, a wide-ranging review of evidence by Le Grand and others (1998) found that "despite some changes in culture, measurable changes were small and perhaps not as great as was predicted (or feared)". The authors suggest that this might partly have been because other forces outweighed the market incentives the reorganisation created. The NHS retained its tradition of centralised, hierarchical rule, which limited the scale of decisions that were really left to the market. For example, health authorities as purchasers were instructed to bail out hospitals in financial difficulty. Boom and bust in funding appeared to drive waiting times and satisfaction more than the relatively subtle effects of changing the organisational make-up (Le Grand and others, 1998).

Fundamental forces can drown out your clever redesign

The New Labour government initially dialled back the internal market, but from 2000 they started their own reorganisations to reintroduce it. Primary care trusts took over the role of local purchasing, now rebadged 'commissioning', and NHS trusts were encouraged to move to a new and even more autonomous 'foundation trust' model. These structural changes formed part of a much wider set of changes which aimed to strengthen market forces and reduce waiting times (Mays and others, 2011).

Reviews at the end of this period suggested the impact of these structural changes was subtle at best. On the purchasing side, The King's Fund noted "a consistent finding that NHS commissioning has had a limited impact in shifting services out of hospital, reducing avoidable use of hospitals, and developing new forms of care" (Smith and Curry, 2011).

Likewise, a Nuffield Trust study found that commissioners had struggled to bring about new or reshaped services. Reasons for this included a wariness of destabilising hospitals, a lack of data (or lack of awareness of data), and lack of funding. Towards the end of this period, the reorganisation of the 2012 Health and Social Care Act added to the difficulties of getting local areas to move towards a strategic vision (Smith and others, 2013).

This period did indeed see dramatic falls in waiting times, and rising public satisfaction. But academic and think tank studies have tended to highlight centrally enforced targets, financial incentives and sharp rises in spending and staff as the most important factors, rather than structural change (Ham, 2010; Mays and Dixon, 2011).

On the other side of New Labour's reforms, foundation trusts were created with the aim of making hospitals and other local services radically more independent and accountable to local people. They had new powers to accumulate and spend capital and to vary workforce pay and conditions; they were governed by an arm's-length regulator instead of the Department of Health; and boards of governors from local communities were appointed to oversee them locally (Allen and Jones, 2011).

But these rights have been undermined by national decisions and policies which reassert central control and treat foundation trusts in exactly the same way as other trusts. Secretaries of State continued to intervene in key decisions (Timmins, 2018) and the recent introduction of control totals, described above, meant central bodies signing off on financial plans. Encoding this change into NHS structures, the independent regulator of foundation trusts, Monitor, was merged with the regulator of other trusts to form NHS Improvement in 2016 (Clover, 2015).

Meanwhile, foundation trusts had never made much use of their notional power to vary pay and conditions, perhaps because of the NHS's strong tradition of national pay bargaining and the political implications of challenging this (Allen and Jones, 2011). Studies found that governors from local communities often felt they struggled to use their skills and experience to hold trusts to account (Allen and others, 2012).

In hindsight, the introduction of the structures of the internal market seems to have led to only fairly limited actual changes at the front line. So those in favour of reversing these changes should think realistically about the impact this is likely to make in turn.

More broadly, changing the shape, duties and powers of organisations has often turned out to be a policy lever of limited strength compared to funding and financial incentives; targets and diktats from the centre; culture and behaviours; and staffing. Where structural changes clash with these they have often been on the losing side. This suggests there should be a premium on making sure structural reorganisation, where it is necessary, pulls in line with more fundamental forces.

Lesson 6

You need a plan that staff can follow

Rebecca Rosen

Decisions about money, staff and reorganisations in the NHS often steal the headlines. But the real test of a plan is the much less nationally visible question of whether it changes the day-to-day behaviour of NHS staff. Does it succeed in genuinely getting front-line workers behind changes, encouraging effective leadership, and bringing people together to tackle common problems?

Success requires front-line staff and local leaders to behave differently

Attitudes and relationships are particularly important when the changes desired involve working across different organisations: bringing together GPs and hospitals, and the NHS and social care, to create systematic improvements. This has been a national priority for years and is likely to remain one. While the main policy goal is to make front-line staff work better together, it is also essential for the national policy that those who lead collaborating organisations are supportive of planned changes; that they sign up to shared goals; and that they are willing and able to make compromises about their own organisation's outcomes.

The Advancing Quality Alliance ran system improvement projects in the north of England for many years. A study of their work found having 'the right types of leaders' to carry out complicated changes across multiple organisations – people who coped without hierarchy and co-operated for the long term rather

than undercutting other local organisations – was paramount. There needs to be 'distributed leadership' where staff at every level take the initiative to improve or transform care. This means a clear 'common goal' is needed that is widely shared and understood (Fillingham and Weir, 2014).

When these relationships are lacking, the consequences can be serious. A recent Care Quality Commission report on older people being passed between health and social care found that areas without good relationships and shared goals between executive leaders experienced problems including refusal to share data with other services, patients being sent to the wrong place, and attempts by services to blame each other for problems. Patchy progress had been made despite an array of national initiatives aiming to integrate care during this period (Care Quality Commission, 2018).

Research into high-performing US health systems that were succeeding at improving care for long-term illness demonstrated that good relationships and common purpose are vital within organisations too. This means senior leaders must have a good relationship with both the front-line workforce and their executive colleagues, and clinical and non-clinical managers must work well together. In case studies of successful US provider organisations, clinical leaders barely recognised a distinction between the roles of doctors and managers (Dixon and others, 2004). Unfortunately, a much more divided ethos is common throughout the NHS (Dickinson and Ham, 2008)

What can national policy makers at the centre put into an NHS plan that makes these attitudes and behaviours more likely to emerge? One obvious conclusion is that a national plan needs to be something that can form a 'common goal' for NHS workers, clinicians and managers alike. The goals of reform should be wrapped into a coherent narrative that explains and justifies the experiences of staff living and working through the period of change.

This means listening to staff and reflecting their values and motivations in the targets that are selected. The plan should not feel like a transmission of political priorities into clinical work. It means being careful about relying on managers to win over or control clinical staff, which risks emphasising the divide between the groups.

One approach likely to help create a narrative that staff can get behind is to involve them in actually designing reforms, as was done with the 2008 strategy High Quality Care for All. This was based on more than 2,000 clinicians and other front-line staff meeting locally, agreeing 'visions' and then feeding these in to the central review team (Department of Health, 2008). However, in many other reforms such as the initial introduction of the internal market, both front-line staff and the academics and organisations that work with them have barely been involved in policymaking (MacKillop and others, 2018). While this can be because of legitimate worries about their acting as vested interests, the risk of ending up with changes that cause unnecessary disaffection should also be considered.

History also provides two more specific lessons about how to make policies staff are willing and able to follow.

Don't make it more complicated than it needs to be

Health Action Zones were partnerships between different agencies in disadvantaged areas, a national policy rolled out under New Labour in 1998. They aimed to understand health needs, improve the responsiveness of services, improve health and reduce health inequalities.

Academics hired to evaluate them by the Department of Health later made some useful observations that pertain to the ability to engage people and maintain their involvement in an article entitled 'Lessons from a policy failure':

> *"Too many hugely ambitious, aspirational targets were promulgated. The pressure put on local agents to produce 'early wins' was debilitating. A sense of disillusionment began to set in relatively early in their lifespan".*
>
> Judge and Bauld (2006)

By 2003, they had been abandoned. Ambitious targets required by the centre were intended to galvanise local staff and leaders, but by going so far as to be unachievable, they ultimately led to the opposite. There are signs that this risks being repeated in the recent Sustainability and Transformation Plans, which

have complex and ambitious goals assuming reductions in activity that may be impossible (Ham and others, 2017).

The NHS Action On initiatives, which aimed to reduce waiting times and increase access to the best treatments in areas like cataract surgery, hip and knee replacement and dermatology offer a contrast. They were much more focused in their ambition and with a narrower range of stakeholders to be involved in design and implementation (NHS Executive, 2000; Roland, 2005). Several elements proved successful, and waiting times fell sharply.

Evidence from our studies of clinical commissioning groups, introduced under the 2012 Health and Social Care Act to plan and fund care locally, found several factors tended to erode the initial enthusiasm of clinicians. These were a lack of autonomy to take decisions that meet local needs; a lack of funding for research and advice to support decisions; and a lack of support from the NHS hierarchy for tough decisions about priorities or rationing (Robertson and others, 2016). This suggests giving local areas more capacity and responsibility to set their own goals and decisions could help maintain engagement and collaboration over time, which is crucial to getting through an often slow start-up phase to longer-term benefits.

Don't just talk about freeing up time, actually do it

There is plenty of evidence about the processes through which the working relationships, shared processes and shared goals needed for effective integration can be built. Evaluations of the care trusts which brought together community services and hospitals in the last decade demonstrate that more is needed than simply putting people in the same building or organisation (Glasby and Dickinson, 2008). As Richard Bohmer (2016) has noted, for genuine transformation to occur there needs to be sustained change in individual behaviour, team interactions and design of operations. Techniques for this "relentless hard work" of redesign include getting staff and patients together to design services from a starting point of what is needed, and 'action learning sets', which are regular meetings to jointly discuss problems, suggest solutions, and go over whether they have worked.

One important role for policymakers is to recognise that these take up significant time from front-line staff who have little to spare. With workforce shortages, funding shortages, growing waiting lists and rising patient expectations, finding this time is very difficult, and national plans must take account of this. In the context of establishing US accountable care organisations, US academic Elliott Fisher (2013) equated the stresses of coping with change while continuing with normal activities as "remodelling the house while you are still living in it". Some nationally supported projects, like the 'Primary Care Home' initiative, did include specific funding for this – but the amounts were not large, and our evaluation still found that leaders struggled to find the necessary time (Kumpunen and others, 2017).

The NHS Vanguard sites received significant funds to 'back fill' this kind of development time. This is positive, but it sets a precedent where a small cluster of sites might be picked out for additional funding, while the majority will have to achieve integration with few additional resources and for these the options are limited.

One possibility would be to negotiate in advance reductions in performance (along with a proposed recovery line) associated with creating time for professionals to participate in designing and implementing changes. Another might be to reduce the range or intensity of services provided by staff who are involved in designing and developing integrated services.

In a national health service funded by the taxpayer, big decisions about the direction of travel will always tend to be taken at a national level. But this is a service based on human contact, with a high level of professional discretion for its skilled staff. If leaders in the NHS forget that changes actually consist of millions of small behavioural changes on the part of staff, they should not be surprised if the levers they pull sometimes feel as if they are not attached to very much.

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Glossary of abbreviations used in the timeline

CCG	Clinical commissioning group
CHC	Continuing healthcare
CHI	Commission for Healthcare Improvement
CQC	Care Quality Commission
DHA	District health authority
FHSA	Family health services authority
GMS	General Medical Services
ISTC	Independent-sector treatment centres
LA	Local authority
LTC	Long-term condition
NICE	National Institute for Health and Care Excellence (formerly National Institute for Clinical Excellence and also National Institute for Health and Clinical Excellence)
NPSA	National Patient Safety Agency
PCT	Primary care trust
QOF	Quality and Outcomes Framework
RHA	Regional health authority
STP	Sustainability and Transformation Partnership (also/formerly Sustainability and Transformation Plan)

Nuffield Trust is an independent health charity. We aim to improve the quality of health care in the UK by providing evidence-based research and policy analysis and informing and generating debate.

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ISBN: 978-1-910953-57-0

Design by Soapbox: soapbox.co.uk

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