

The National Health Service in 2012

An interview with Sir David Nicholson KCB CBE Chief Executive of the National Health Service.

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Sir David Nicholson has been the Chief Executive of the National Health Service (NHS) in England since September 2006. From April 2013 he will become the first Chief Executive of the NHS Commissioning Board.

Peter Murphy is Director of Executive Education for Public Services at Nottingham Business School. Between 2000 and 2009 he was a Senior Civil Servant in Whitehall. He is a Non-Executive Director of the Nottinghamshire Cluster of Primary Care Trusts.

In this interview Sir David Nicholson talks to Peter Murphy about the forthcoming changes to the NHS that will result from the 2012 Health and Social Care Act, which will herald one of the most extensive reorganisations of the structure of the NHS since its inception. The interview took place shortly after the passing of the Act in May 2012.

PM. The forthcoming changes to the NHS occasioned by the recent Health and Social Care Act have been described, by both supporters and critics, as one of the biggest systemic changes in the history of the NHS. The NHS is not unfamiliar with large scale organisational change and I know you are very familiar with the history, but by way of introduction can you tell us a little about your personal experience of the NHS prior to your current role?

DN. I'm an NHS manager through and through. I started in the NHS in the mid-1970s so I am the fully socialised article with all the strengths and weaknesses that that has. I started off working in mental health services in the mid to late 70s at a time when there had been a whole series of scandals about the way in which mental health services were being delivered to patients in large institutional asylums. The drive to get them changed, to shift from an institution based model of care to a community based model, with care wrapped around the needs of the patient was something I was really attached to and really felt I could make a difference to. I spent 10 years working in that field and the key lesson I learnt was that transformational change was possible. Transformational change in a public service is often a very difficult thing to do and in the late 1970s we really did have transformational change and changed the model of care for our patients in very significant ways.

For the next 10 years I went to work in a series of acute hospitals and at the time they too were going through significant organisational changes. It was a time where chief executives within the NHS had a very short life span of about 3 years on average. A whole series of people had been through the hospital that I worked in but that was the way that NHS management operated in this period. It was incredibly difficult for organisations to facilitate

transformational change and to get things to happen. One of the things about working in big hospitals is that there is no shortage of short-term distractions to the job that you have to do. However if you can get a shared agenda between yourself and your clinical staff there is almost nothing that you can't achieve, but it takes time and if you don't get that shared agenda it is incredibly difficult. It is easy to see when managerial leaders and clinicians are not working closely together on a shared agenda. I learnt a lot of lessons and spent 9 years in one organisation. What I discovered was to get people's trust and understanding you needed to spend time with them, you needed to work closely with them, you needed to demonstrate a commitment to the service as much they did. After 3 or 4 years of getting that confidence there was absolutely nothing that we couldn't do or changes that we couldn't make to the kind of organisation that we were.

So, the 3rd part of my career was essentially working at a regional level and then at a national level. I worked in the Trent region and then I went off to work as the Chief Executive of the London Strategic Health Authority before I got this job. What I learnt about working at that level is the importance of whole system change. One of the things that you realise when you work in an individual organisation is that you are part of that greater system, if you can get that system to work well together you can achieve fantastic things for our patients and our communities.

PM. In 2006 you became the CEO of the NHS which must be one of the most challenging roles in public services.

DN. A daunting prospect in lots of ways. 1.3 million people work for the NHS, everyone has a view. One of the challenges of my job is that I have a number of patients, ex-patients, patients who've got relatives or people who work for the service that essentially cover the whole population. Having 56 million people who think they can do your job better than you is always a tricky situation. Nevertheless the NHS is a remarkable organisation or phenomena. The NHS is the largest publicly funded integrated healthcare system in the world. If it was a country it would be the 33rd largest economy in the world. Every 24 hours we treat a million people, we've got to have a budget of almost 100 billion pounds.

We have made fantastic progress over the last few years in terms of outcomes, and we have some of the best outcomes for patients in the world. We've also got some real problem areas which we need to tackle but we're onto that. We've also had a few years of driving up standards across the NHS, reducing things like healthcare associated infections, reducing the amount of time for people waiting for treatment and a whole series of great improvements, but we are facing our greatest challenge ever as a system at the moment today.

PM. Although the current Secretary of State, Andrew Lansley, is the public face of the current changes and clearly has had a key role in shaping its design and implementation, in many ways some of the principles and challenges that are addressed in the proposals predate his time in office. What do you see as the key antecedents?

DN. Let me go back to 2004 which was the time when we had a reforming Government. Tony Blair was the Prime Minister and he decided that the NHS needs money but that it also needs reform. He set out to reform the NHS with foundation trusts, payment by results, commissioning services and a whole set of structural changes around the system. Everybody got terribly excited about these reforms but what happened was we lost control of the money, we ended up with a billion pound deficit across the NHS as a whole and we ended up with some really difficult problems in relation to basic patient care in some of our hospitals. Mid Staffordshire Hospital for example was an organisation that got so concentrated on becoming a Foundation Trust that it forgot the reason why it was there. My analysis of that time, and I was part of the national leadership group and I absolutely take my fair share of responsibility, was that the NHS at that time lost the plot. We lost our collective understanding and focus on why we were there. Excited by the technical aspects of the change, the different ways in which people were going to work, the new jobs to be created, we lost the point of why we were there - which is improving the quality of care of our patients, improving the health of our population.

Out of that time came some really important lessons for us. Just at the time I became Chief Executive of the NHS we really needed to have a new look at what the NHS needed to do. The first and most obvious thing was to rediscover our purpose. It is so obvious but the numbers of businesses and organisations that lose their way and their sense of purpose is rife across the economy and across healthcare systems. Keeping a handle or a focus on our purpose while significant systemic changes are happening is really, really important.

There is a similar scenario now around radical reform by a Government involved in making a whole set of technical changes to the way in which the NHS operates. The lesson of keeping hold of purpose while we make those changes is absolutely critical. The previous Government appointed Lord Darzi to lead a review of what it would mean to have quality as the organising principle for the healthcare system in this country. Everyone was in favour of quality, but it meant something different to different people, so the first thing that we did at the beginning of that process was to be really clear about what quality was. Quality was effectively patient safety and patient experience, which may seem very simple, but it was very powerful for us throughout the NHS. The old idea that the surgeon could say that the operation was a great success but the patient died simply cannot be part of our lexicon.

So defining quality and then measuring quality and regulating for quality and organising for quality was central to what we tried to do and we engaged literally tens of thousands of people to implement a whole set of changes on the basis that it would radically improve the quality of service in our hospitals and in our health service organisations. However it also became clear to us around 2008 that increasing the resources and budget of the NHS year on year was coming to an end. We had had huge growth in our expenditure over the previous few years but this was coming to an end. We thought the best we could possibly achieve was tiny real terms growth, so essentially our funding would be flat over the next few years. That might appear to be a comfortable position to be in, but for the NHS it is a unique and

untried and untested challenge. From 1948 up to 2009 the NHS on average, every year has had 4.5% real terms growth. There were years when we've had less than that and there have been years that we've had more than that but we've never had more than one year of really low growth or flat expenditure. So from having on average 4.5% growth (and in fact in 2006/07 having nearly 10% growth) to nothing was a real shock to the system. Yet the reason that growth is required in the NHS is obvious. Demographic changes and in particular the way that the structure of our population is changing, coupled with expectations of our patients, what our parents or grandparents may have thought was appropriate for healthcare simply is not appropriate for people these days. Expectation is for services to be more defined around the individual and of course the drive of technology and the ambitions of our clinicians. There are more and more technologies available, more and more drugs, more and more opportunities to treat people than we have ever had before. If you add all of that up it comes to about 3 or 4% demand drive on the system overall. Trying to operate with no growth can be quite a big challenge.

PM. If quality is established as the organisational principal and static revenues and increasing costs are the financial parameters, how will the NHS approach the future and how, to borrow Geoff Mulgans' phrase, can the system learn to improve itself? (Mulgan G 2009)

DN. We need to improve productivity and cash release by about 20 billion pounds over the next 3 or 4 years, which has never been done before. We looked right across the world at developing healthcare systems and we couldn't find any developed healthcare systems that had done this. The closest was the Eastern European healthcare systems after the fall of the Berlin Wall when there was a devastating reduction in expenditure on healthcare but whole health systems were taken apart and it had a massive impact on the quality of outcomes for patients. Life expectation in some of these countries went down by 10-15 years.

What we did find around the world were particular health care communities or hospitals or bits of healthcare systems that had done some of it. We scoured the world to find the best general approach to ask the question „Was it possible? and then to put in place a set of plans to make it possible. We then asked all of the commentators to look at the plans, the big think tanks, the journals, the big accountancy firms to take it apart. We then came up with a set of approaches that we would banner under the idea of Quality, Innovation, Productivity and Prevention.

One of the things we learnt when we thought about productivity in healthcare terms was that some health people measured quality in terms of how much money you spent on something. Indeed many people still do, they want to announce how much money is being spent on them. This was one of our biggest challenges within both the managerial and clinical leadership of the NHS. The basic lesson that it is perfectly possible to improve quality and improve productivity without increased expenditure was simply not internalised within the system. The idea that spending too much on things can actually have an adverse effect on quality and outcomes was an anathema. Yet the implementation of technology does not necessarily mean an increase in cost, in fact technology should help us to reduce costs in the system as a whole.

So quality, productivity and prevention connected together by innovation was the set of proposals we took forward and that's what we are currently in the second year of rolling out across the NHS as a whole.

PM. But then in 2010 the government changed and a new Secretary of State arrived ?

DN. The new government wanted to radically change the nature of the system to shift power from a managerially led system to a clinically led system to introduce more choice and competition into the NHS. In a sense that political debate had been going on over us while we were trying to drive the change into the NHS. Now I'm sure you've all got your views about the Health and Social Care Act and what it means and how it should work but now it is law it seems to me the only question that we need to ask is how can it help us deliver continuing, improving outcome for our patients within the limited amount of money that we've got available? How can we use the levers the Act gives us to enable us to make the changes that we need to make.

When we approached this whole productivity dimension, we came to the conclusion that there were three ways in which we can improve productivity in the NHS. The first one is to significantly attack our overheads, so the cost of the commissioning system, the cost of the management and administration in the system, the amount of money that is held at the centre for its own use, its rules around procurement, the way we paid our staff so pay freezes and that sort of thing. We thought about a third of the 20 billion could come from that and we are well onto that and obviously delivering results. The second area was what you might describe as a kind of basic efficiency in the system to make the organisation as efficient as you possibly can and for us in the NHS that often means reducing the length of stay for patients in hospital, increasing the number of day cases, improving the way we procure a huge amount of items in the NHS - all of those sorts of things and we think that we can drive about a third of our savings from that.

The third area and an increasingly important area is by transforming the way in which services are delivered. If you look at the last couple of years we have done really well on the first two. We have delivered everything we said we were going to deliver. The first year we delivered 4.3 billion pounds worth of savings and last year we delivered 5.9 billion and in this year we are planning to deliver 5.8 billion, mostly through attacking overheads and driving efficiency improvements. So as we address the next couple of years of the challenge we need to address service change. Ironically, one of the most important political announcements over the last year or so for us was not the passing of the Health and Social Care bill, but the announcement by the chancellor in the Autumn Statement, who said that this austerity was not for 3 or 4 years, it's actually for 8 or 9 years. Austerity for the NHS will be over a much longer period than people previously thought and that for me is a game changer for the NHS. If we had to survive austerity over another 2 or 3 years we may be ok with the things we have been doing, but in terms of healthcare delivery, long-term austerity brings service change right to the heart of what we need to do.

PM. Service change can be a whole variety of things and I really wouldn't want to ask you to go into too much detail but can you give us some examples .

DN. I'll give you three to consider. One of the biggest challenges is the burgeoning number of people with one or more long term conditions. About one third of the people on hospital wards will have some kind of exacerbation of a long-term condition that has resulted in their

admission to hospital. It makes a huge impact on our system as a whole and it will increase exponentially if we don't do anything about it. Getting services wrapped around those individuals with long-term care needs, to support and help them to manage their own health and health care is a really important part of what we're doing. Being much more pro-active about the way in which we support and empower people with long-term conditions will make a difference but it needs investment, it needs organisation and it needs planning.

The second great area of service change is around the concentration or centralisation of services. We simply can't deliver everything, everywhere, anymore. In London just 5 years ago we had 32 different hospitals all admitting patients with a stroke and those patients had some of the poorest outcomes in the country. Today we have 8 hospitals admitting stroke and London has some of the best outcomes in the country. This drive to concentration and specialisation is absolutely essential.

The third area of service change is the way we use technology to support change and that means tele-medicine or tele-health. We have the largest random control trial in the world giving us huge lessons and potential benefits both in terms of outcomes for patients and the experience, confidence and resources for a widescale implementation of tele-health and tele-medicine across the NHS.

PM. So will the Health and Social Care Act help us to take that forward and how will it be facilitated by clinical commissioning?

DN. One of the things we've learnt over the last few years is that to get real change and to make real service changes in a way that supports the needs and requirements of patients, clinical leadership is absolutely essential. There are a whole series of pilot studies around the practical aspects of commissioning which show that this is the case. We need to base this in general practice as general practice in lots of ways is at the forefront of much of what we do in the NHS. 90% of the contact with the NHS is with Primary Care and our GPs have a unique position within the NHS. They help people navigate through the NHS, they move patients around the system they have the ability to make micro changes in primary care which can make a huge impact on the NHS overall.

General Practice is critical to delivering clinical commissioning and general practice itself is based on a local population. GPs are responsible for a significant amount of the healthcare in your community and that understanding of the needs of their population base is critical to getting services right. So we are bringing those GPs together into clinical commissioning groups. There are just over 200 around the country giving complete coverage, although they vary in size some with populations of around 100,000, some over 800,000.

One of the things they share is that there is no right population for commissioning of health care. For some services you need a population of 10,000, very localised, but for others you need 56 million in order to make sensible commissioning decisions. The key thing about commissioners is how flexible and agile they are. They need to come together when they need to and talk about big and important specialties but also work really closely together to create local services, often with social care and housing. That flexibility is a really important part of the system and process.

This on its own won't give us really great clinical commissioning. We also need a whole series of services that transcend primary, secondary and tertiary care with cancer care being

an example. One of the things that we have learnt about cancer is to make change and improvement happen you need to develop a cancer network. People across a wider geography need to work together to improve the various elements of the service. So we need a whole series of efficient and effective networks across the system to support clinical commissioning and reconfigure our services. So over wider geographies, such as the East Midlands we need to think about the pattern of service between Leicester, Nottingham, Derby and the rest of the region. We need, groups of commissioners, clinical senates and multi-professional groups of clinicians that can think of the totality of care within any given service. That way we can build a really powerful clinical commissioning system based on general practice, bringing general practitioners together and building through networks to create a clinical commissioning system which can really drive change.

PM. I am sure a great clinical commission system is necessary, but clearly is one part of a bigger transformed health and care system - how do you see the rest of the new system coming together as we go forward?

DN. I agree, a commissioning system on its own won't make the changes that we need. We also need a really responsive and organised provider system of hospitals and community services. Some of this we are tackling through the foundation trust process. A foundation trust has to show that the organisation is financially and clinically sustainable. Every hospital trust is going through a process to get them to be clinically and financially sustainable. Thinking about the financial challenges, the clinical challenge, the reconfiguration of community services, the specialisation and concentration of services - even that won't make the changes that we need on the provider side. We need responsive providers in the system and this hasn't always been a strong characteristic of some providers in the past. Some areas have not had the focus that other parts of the NHS have had. The kind of focus and attention that make them better. It is really important for the NHS to bring in innovative and new ways of working from the independent, the private and the third sector to enable us to revolutionise some of the really significant services which make a massive difference to individuals but don't get the kind of focus that we've been able to give them over the past few years. So transforming the providers side is important and at least as important as that is re-thinking the whole system of how we provide health care.

I was a hospital manager and those people who think that they are still running hospitals have to challenge their assumptions about provision of services. If you think about the kind of change I am talking about, which is driving services out into the community, releasing the capital in hospital, reducing the number of services that individual hospitals will be providing, what people increasingly need to think about is that they are running healthcare systems. It was never the case, but people used to think if you have great commissioners then you will have fantastic services. Lord Darzi used to reflect that people thought that if they could get a great surgeon then they would get great outcomes, but you don't. What you need is a population that understands the signs and symptoms of bowel cancer, you need a screening programme, you need practitioners who are trained and educated and know what to do and have access to diagnostic services. You need multi-disciplinary teams who can look at the totality of the needs of that individual patient and plan their care, you do need in-patient services to do some of the work but you need fantastic community services to bring support for these people out into the system and you need great end of life care for those people who need it. To get great outcomes for your patient you need all of those things together, hospitals are just one bit of it and it's the bit that's got to be driven - by the logic, the tariff and the efficiency agenda - into thinking outside of itself. It's so important that people

understand that, that's why many providers are thinking about this very carefully. About a third of them have already decided to start managing and organising community services to vertically integrate services across the system.

But you don't need to have structural change to make that integration happen, you can do it through partnership and collaborations but this is a whole different way of thinking and organising the provision of healthcare in this country and there are already some great examples around the country. I was in Rotherham a few weeks ago and they have a fantastic set of systems operating based on a complete supply chain approach in the way that services are delivered. They are revolutionising outcomes for patients in that part of the country.

So you need great commissioning, tremendous support and flexible, adaptable provision. But even those things together won't make the service changes that we need. We need to connect far better with our population and our patients. If you think about the challenge of long-term conditions, much of that is in the hands of the patients themselves. We need to support and help and give them the self-confidence to manage their own health and their own healthcare.

Working at a local level developing Health and Wellbeing Boards, connecting with local government is a critical part of grounding that work in our local communities. We will need local leaders to lead that work and we will need local government to engage and to work with us to make that happen.

Service change is vital to transformation within the NHS, it is vital to being able to deliver a "free at the point of use" health care system. Great clinical commissioning, revolutionising provision and connecting better with our local populations is the way to do it. This is a tremendous leadership challenge for the NHS, for clinicians and managers and others who work within the NHS. Success is not guaranteed by any stretch of the imagination but the prize is really worth having. The idea of improving outcomes for patients in this time of austerity is a real prize for the NHS and I'm certainly looking forward to the next few years of leading the NHS.

Reference

Mulgan, G. (2009) *The Art of Public Strategy: Mobilizing Power and Knowledge for the Common Good*. Oxford University Press Oxford.