CRITICALEYE
The peer to peer Board Community

Leadership in Healthcare

Over the next 12 months, £200 million will be invested in new approaches to care and a further £250 million in primary care. But is this enough given the scale of the changes required to modernise the NHS? **Marc Barber** reports

Delivering a healthcare model that meets the needs of an ageing population takes strong leadership, an appetite for innovation and a willingness to collaborate. It also has to be built on the understanding that quality of service and care cannot be compromised in the effort to meet financial targets.

This is the challenge faced by the UK's NHS. "Far more needs to be done to bring health and social care together in an integrated way to both prevent and better manage long-term conditions in a home and community setting," said **Tom Wright**, Group Chief Executive of Age UK, speaking at the recent Criticaleye Discussion Group, Optimising the Opportunity within the NHS Five Year Forward View.

The volume of services the NHS provides is set to increase and yet if the organisation tries to maintain its current level of activity, it's estimated that there will be a funding gap of £30 billion in the next five to six years. The proposed solution involves 'cost efficiencies' of £22 billion, £8 billion of additional funding from the Government and a radical overhaul of service delivery at a regional and local level from General Practitioners (GPs), hospitals, home and mental health care providers and community nursing.

At the event, hosted by Big Four firm EY, attendees welcomed many of the ideas on healthcare delivery described within the Five Year Forward View, published by NHS England. It suggests that greater investment in primary care is needed, particularly through the GP-led Clinical Commissioning Groups. This will allow for a redistribution of funding from acute and secondary care, such as hospitals and emergency services, towards community and other primary care services.

> *"The healthcare model is extraordinarily fragmented at present and needs to be more joined-up"*

In large part, this is necessary due to the type of healthcare required. "What's fundamentally changed is that our population in the UK is living longer and has a life expectancy of 81, which compares to 75 in 1990," explained **Tom**.

"As we live longer, surviving traditional infectious diseases, we're encountering many long-term conditions and disabilities, which need a different type of healthcare to what the NHS was originally designed for. Frailty and dementia don't lend themselves to purely clinical and acute hospital interventions."

Turning an oil tanker

Since the beginning of the year, new care models have been trialled across the UK through the funding of 'vanguard sites'. The first wave of vanguards consisted of integrated primary and acute care systems, enhanced services in care homes and multi-specialty community providers, moving specialist care out of hospitals and into the community. In July, a second wave was announced for urgent and emergency care.

One such site, the Vitality Partnership in Birmingham and Sandwell, was identified by some attendees as having made significant advances. It has attempted to integrate general practice with specialist clinics and services from local hospitals, and invested in technology to share information between different parties. It's being watched as a positive example of how integration and an appetite for innovation can lead to more effective service delivery.

While welcoming such pockets of progress, attendees of the Discussion Group also expressed concern about how difficult it can be to contest entrenched positions across the wider healthcare system unless contracts, financial incentives and rewards are reconfigured.

Jo Pritchard, Chief Executive Officer of community services provider CSH Surrey, said: "Issues exist around integration versus competition. There are vast blocks of healthcare where providers are given long-term contracts, and then there are others on no contract at all.

"Longevity in the contract would allow for greater investment and people will be more interested in new types of service delivery and care, including digital solutions. But if contracts remain short term, they don't encourage risk-taking and innovation. It's one of the big issues."

Good leadership is essential if there's going to be a breakthrough. **Lewis Doyle**, Non-executive Director of Brighton & Sussex University Hospitals NHS Trust, >

commented: “In my view, the healthcare model is extraordinarily fragmented at present and needs to be more joined-up.

“The question of talent is an important one as, while there are many excellent, committed healthcare professionals, I wonder if there is the depth of talent to really make the changes happen at the required scale and for such reforms to be sustainable.”

A potent mixture of political interference, austerity economics and the sheer size of an organisation with 1.6 million employees, makes the prospect of transformation a formidable task.

Tom said: “The challenge is where the leadership and operational capacity for change will come from on the ground, particularly when it’s up against the vested interests of the pre-existing component parts. How can that be transformed when the bulk of the resources already go to the big hospitals?”

> *“The average tenure of an NHS chief exec is now around 18 months”*

Jo said: “When we talk about moving people around and introducing different ways of working, we can forget how challenging it can be to get a team to work effectively with another team. Co-designing and co-developing new service delivery can be very exciting, but it can also be a difficult thing for people to get their heads around.”

Given that the NHS is clearly in need of leaders who understand interdependent systems, it’s alarming that the number of senior vacancies keep rising. **Joe Stringer**, Partner of Healthcare Advisory at EY, said: “The average tenure of an NHS chief exec is now around 18 months and there’s a worrying lack of talent coming into the system.

“There’s also no incentive at the moment to bring in successful chief execs who are able to turn an underperforming organisation around.”

Quazi Haque, Group Medical Director of mental healthcare provider Partnerships in Care, says that there is already a drain on talent: “A lot of the people who have left had allowed for a good assessment of capacity and flow. This loss of organisational memory is a real risk in terms of getting to where we want to be on this journey.”

A lack of speed remains a fundamental problem. Although the vanguard sites are beginning to show what integration may mean in practice, there is a long way to go when put into the context of such an intricate healthcare system.

Joe Berwick, Business Development Manager at Criticaleye, said: “The NHS is incredibly sophisticated but also highly fragmented. In order to deliver truly integrated pathways that utilise community-based care effectively, a more collaborative mindset is needed and that’s why leadership remains a serious issue.”

The clock is ticking. ■

PROTOTYPES OF CARE MODELS OUTLINED IN THE FORWARD VIEW

1. Multispecialty community providers (MCPs) – GP group practices are expanded, bringing in nurses and community health services, hospital specialists and others to provide integrated out-of-hospital care
2. Integrated primary and acute care systems (PACS)
3. Additional approaches to creating viable smaller hospitals. This may include implementing new organisational forms advocated by the Dalton Review, such as specialist franchises and management chains
4. Models of enhanced health in care homes

Featuring Commentary From:


Joe Berwick
Business Development Manager
Criticaleye


Lewis Doyle
NED, Brighton & Sussex University Hospitals NHS Trust


Quazi Haque
Group Medical Director
Partnerships in Care


Jo Pritchard
CEO
CSH Surrey


Joe Stringer
Partner
Healthcare Advisory
EY


Tom Wright
Group Chief Executive
Age UK

Contact the contributors through:
www.criticaleye.com