The NHS White Paper: licence for radical cultural reform of the NHS?

Aidan Halligan

University College London Hospitals – Corporate Trust HQ, 250 Euston Road, London NW1 2PG, UK
Email: aidan@patientsmatter.org

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No expert to start with and, therefore, 'not knowing any better', he thought, 'What if?' Sir Christopher Cockerell was like that. He would never have been able to invent the hovercraft, he said, had he been trained as a naval architect, because he would have 'known' it couldn't work.

Radical cultural reform of the NHS is needed but the traditional NHS architects 'know' it's not possible. The White Paper commits the NHS to 5–6% efficiency savings, adding up to £20 billion over four years against a historical reliance on 5% annual real growth in the past. It amounts to the biggest ever cost savings challenge for the NHS. This is coincident with the biggest ever structural change, with GPs taking control of commissioning and the budget. And, both these enormous challenges are overlaid with the extraction of a large amount of management capacity. The transformation is nothing less than seismic. The sheer scale of the proposed change is huge – 1600 pages of new policy have been published by the Department of Health since 30 November. And yet, all focus to date has been on the technical issues, reducing structures and management despite the enormity of the cultural changes involved. Seventy percent plus of NHS spending is on long-term conditions, end of life needs, frail elderly and long-term mental-health care. There is a clear need to reduce physical bed-based capacity (hospitals) by shifting care into the community, backed up by new applications of IT and new ways of working. Wholesale, radical, cultural workforce change is necessary for this strategy to work. No such change has happened previously. In this context, unprecedented progress over the past decade has resulted in a chaotic and fragmented NHS due to an explosion of innovation, redesign and knowledge, which, together with institutional blindness, has outstripped the NHS' ability to implement this new knowledge and bridge that knowing–doing gap.

People drive performance. What will be needed for the White Paper to be a success? The principal requirement is for a sufficient number of GP leaders with a motivation to improve care for patients. Substantial numbers of GPs need to be actively involved and effectively supported if the NHS is to be transformed. What will inspire and motivate them will be the emergence of leaders driven by a genuine but skilled desire to improve care. However, any financial arrangements that allow GPs to make substantial personal profits from commissioning will be counterproductive. Any refreshed commissioning policies will need to heed the clarion call that safety and quality must be safeguarded at all costs. Unless the emerging clinical leadership is convincing, the cynical bystander of such initiatives will believe that the priorities will be as before: money, targets and gaming.

Our regulatory bodies do not have teeth and despite a plethora of complex performance scorecards, they have allowed catastrophic care as exemplified by Mid Staffordshire Foundation Trust to occur on their watch. Ironically, the developing commissioners will be exposed, day by day, to the never-ending cultural lessons from the simultaneous Mid Staffordshire Inquiry.

The overriding lesson at the heart of the inquiry will be the issues around people and relationships and the well-documented consequences, including disempowerment of staff, poor communication, professional isolation, inadequate leadership and inadequate systems and processes. Underpinning these headline themes will be active covering up, indecision, disconnection, a culture of fear and poor HR practices. These same themes are not unique to the Mid

Staffordshire debacle but have been the constant finding of all such inquiries since the founding of the NHS in 1948. There are whole departments that have suffered from poor leadership for many years, who are numb to spin, have flattened emotions and crushed potential, have a blame culture, have no hope and find it difficult to believe that anything can change. And yet, the biggest lesson learnt over all these years is that there is invariably more emphasis on analysis than implementation, on elegant prescription than on specific curative actions. Throughout the era of money and targets, it has been the well measured truth that has told the darkest lie. There has not been the will to address the real obstacles.

The dangerous gap between 'best care' and everyday care has largely been ignored. The greatest barriers to systematically improving the quality and safety of medicine are not technical but cultural and political: custom, practice and tradition alongside vested interest and tribalism, and buttressed by shibboleths and sacred cows. Why should the incoming GP commissioners be any different? Why should the lessons of Mid Staffordshire not remain unlearnt, as they have done for several generations? Acting on the lessons learnt will require us to change the behaviour of professionals. This will need to be achieved without over-reliance on hierarchical command and control and making realistic allowance for the messy details of people's real lives and experiences, which have invariably been missed from any policy framework to date.

Commissioners need to identify what actually works in practice and how to scale it up. Commissioners who are fit for purpose will not follow conventional ways of working. Their view of our new NHS world should begin with people, passion, experience and story – not policy, statistics and theory. The impact of their new found power and responsibility must influence those healthcare moments in which medicine actually happens, the moments when practical everyday medicine comes up against the complexities of individuals' lives. The moments in which we can see and begin to think about the workings of things as they are. Those moments that remain mostly hidden and often misunderstood. Commissioners must show moral courage and do the right thing on a difficult day and, beyond that and more than any other thing, they will need to enable others to achieve the best possible patient-centred care. Their example and their leadership will not be the major factors, they will be the only factors.

The NHS desires leaders but structures itself in ways that kills leadership. The rhetoric and jargon abounds. And yet, so many of our trusts are built for the destruction of leadership – without malice and with the best of intentions. They often encourage unsuitable individuals with an impoverished sense of who they are and what they stand for. And, naturally, this gives rise to legions of disenchanted followers, producing the deepest organizational malaise of modern times: cynicism. That cynicism is like the wind – you can feel it but you can't see it. It was Montgomery who famously declared that there is nothing more difficult to manage than a subtle withdrawal of enthusiasm.

Mid Staffordshire Foundation Trust suffered from this disease and the condition is much more prevalent than has been publicly acknowledged. It is present to a greater or lesser extent in every hospital and primary care trust in the NHS. Everyone knows it but very few say it. The only measurement tool available to detect this disease is patient experience and although we purport to pay attention to this critical and evidence-based indicator, it is not taken seriously. We say we value patient experience and we actually think we value patient experience, but, we don't. Patients are not customers. To become a patient, they willingly relinquish a part of themselves, and are received into a system, which, however benign, subtly robs them of initiative, almost of will. They have to trust us. We so often betray that trust. Guilty knowledge is everywhere.

The only barrier preventing the implementation of the White Paper is the willingness of doctors and management to change. It is for that very reason that the NHS would benefit from taking the development of leaders seriously – moving it from a 'nice to do' function to a 'must do'. To lead radical cultural change is to live dangerously, because when leadership counts, when you lead people through difficult change, you challenge what people hold dear – their daily habits, tools, loyalties and ways of thinking. You place yourself on the line when you tell people what they need to hear, rather than what they want to hear. Although you may see, with clarity and passion, a promising future of progress

and gain, people will see with equal passion the losses you are asking them to sustain. The hope of leadership lies in the capacity to deliver disturbing news and raise difficult questions in a way that people can absorb, nudging them to take up the message, rather than ignore it. The current system for leadership selection in the NHS has not been successful. There is such a marked difference in the quality of appointments that a new method needs to be found. This is common knowledge. The evidence is all around. Had the NHS invested in careful selection and proper leadership development, as in the armed forces, the police and the civil service, we would be better able to implement the inevitable cultural transformation that now needs to occur.

With the changing nature of the strategic context, there is an opportunity to understand how best to transform the NHS without destroying it. The solution lies in realizing the potential of our greatest asset, frontline doctors and nurses.[1] It is possible to sharpen the intellectual edge and energize the intangible vitality and willingness to engage of so many hard working, decent, understandably sceptical individuals. There really needs to be a focus on people and relationships and on behaviours, attitudes and culture. Saying how good we are doesn't say how good we could be if we could recruit the legions of vibrant, imaginative individuals who could be the force multiplier for what lies ahead.

Reference

1 Halligan A. The need for an NHS staff college. *J R Soc Med* 2010;**103**:387–91