Planning and change management within the UK National Health Service

The UK National Health Service (NHS) was formed on 5 July 1948 with the founding principle that the NHS would provide healthcare for all the UK population, based on need, not the ability to pay.

In 2000, the “NHS Plan: a plan for action, a plan for reform” was published; this NHS ten-year modernization plan intended to provide far-reaching changes that would give the population of Britain a health service that is fit for the twenty-first century: a health service designed around the patients.

Additionally, the plan ensured restructuring, modernization and considerable investment for the NHS in England. These initiatives were brought about to shift the balance of power within the NHS and were complemented by the Health and Social Care Act that imposed a duty for NHS Trusts to consult with patients and the public on NHS issues. New General Practitioner (GP) and Consultant contracts were negotiated and the remainder of the NHS workforce pay and conditions were reconfigured through the “Agenda for change” programme along with “better ways of working” initiatives.

Commitment to the service provision

Patient waiting times are one of the major concerns towards the NHS. In 1997 there were over 280,000 patients waiting more than six months for elective inpatient or day case treatment with over 335,000 patients waiting more than three months for outpatient consultations. Consequently, the Department of Health (DH) set about imposing rigid targets to ensure that waiting times were not exceeded: By the end of 2008, all outpatients should have a maximum wait of 18 weeks from General Practitioner (GP) referral to secondary care prior to the start of definitive treatment, a so called “18-week patient pathway” (18 WPP = patient to be seen initially within six weeks and treatment to start within 18 weeks). To facilitate these initiatives, the NHS has increased its workforce by 39,000 and is now the largest employer in Europe with approximately 1.3 million employees in over 300 careers.

While the NHS may benefit from unprecedented amounts of financial provision from Government, it is also under a strict regime of financial accountability. NHS organizations are now accountable for incurred costs and expected to balance their books through income generated by a system known as “Payment by results” (PbR); a transparent rules-based system that rewards efficiency with payments linked to activity rather than through historical budgetary bids. This ambitious attempt by the NHS of adopting PbR will not only offer the healthcare providers high-powered incentives to expand capacity, but will also increase the importance of managing patient demand.

However, access to extra capacity and care is not the same as access to high-quality care and the ability to choose to be treated is not the same as choosing how and where to be treated. Promoting choice provides benefits; if a service provider performs unsatisfactorily, the purchaser (or patient in this case) can go elsewhere. Consequently, patients who are referred to a specialist consultant by their GP, now use the NHS “Choose and book” (CB) system, allowing them to choose where they want their specialist appointment also to
select the date and time. Underpinning CB and patient choice is the 18 WPP, a DH Public Service Agreement national target.

The NHS Trust

The NHS Hospital Trust studied is responsible for multiple hospitals, it provides healthcare to an area of approximately 1,150 square miles with a population of around 2.38 million. Focus was on outpatient clinics across two hospital sites and a number of specialties. Among them they see approximately 25,000 patients per year. Twelve senior physicians (medical consultants) run the clinics, assisted by their clinical teams. The size and structure of these teams varies greatly according to the available staff and the preference of each physician.

Articulating change in the NHS

Change is not new to the NHS, with organizational and structural change being a major feature within it since the mid 1980s. Provision has now been made to ensure clinicians have increased accountability along with increased responsibility for managerial and administrative staff. Non-clinical managers are also encouraged to take advantage of in-house training opportunities to increase the scope and scale of their roles. Private sector company style management boards, with non-executive directors to bring influence to the NHS by using tools and techniques used in the business environment, have been implemented by the Trust.

Despite the good intentions to bring about cultural change, not all initiatives were welcomed by clinicians; several claimed the new managerial “power” has overtaken their professional authority and status, and that changes have been achieved but at the cost of creating a driven, “top-down”, and “control-centred” system. The feeling among clinical staff was that this system puts considerable pressure on meeting political targets without allowing for local ownership or any real innovation.

Several members of the Trust Board of Directors stated that the Strategic Health Authority (SHA) acts as an “umbrella organization” that has not been constructive in providing direction in achieving change objectives. Consequently, the Board remain aware of the demands outside the Trust as well as focusing on the management of the two hospitals.

One method of management has been ensuring that employees are kept aware of the changing environment by publishing monthly “Team briefing” bulletins. The intention is that senior managers’ cascade information to all staff members within their area of responsibility, using “the same language and phrases”, to ensure that core messages get through undiluted.

The medical consultants believed that changes within the NHS were for the good, but with the lack of real time finance, the expectation was to “achieve more with less”. The consultants identified themselves as physicians working with patients and not as managers or administrators; they did not enjoy the apparently endless paper trails for audit and statistic purposes.

Preparing for the 18-week patient pathway (WPP)

Legacy working practices that had manifested waiting lists would have to be redesigned by clinicians, managerial and technical staff. Diagnostic testing, conducted on an availability basis, was outside the remit of the 18 WPP. Consequently, for managing the cardiology OPD 18 WPP, the cardio respiratory department (CRD) also had to be managed to ensure that diagnostic tests would be available on a demand basis requested by the consultants. The disconnection between the two departments allowed a “bottleneck” to develop and was responsible for the waiting list that had accrued within the OPD.

The consultants acknowledged procedural changes would be required if the hospital was not to be held to account for breaching targets in the OPD. Interestingly, a recommendation made that “one-stop” clinics should be conducted to provide diagnostic
tests and results on the same day, met with a mixed reaction. However, one consultant identified positively with the recommendation as this method had been used in a Scottish hospital. Rather than expect a patient to undertake travelling significant distances for tests and then subsequently an appointment, both were combined into one visit. The OPD appointments staff stated they were just managing to meet the 13-week deadline for a first appointment and they very much welcomed a plan to facilitate a first appointment within six weeks.

Choose and book: managing patient demand

One of the reasons for encouraging a patient to choose the day and time of their appointment is that the patient should make every effort to attend; therefore, the expectation is that the non-attendance percentage rate should significantly reduce in OPDs. Patients have a number of methods of arranging their first OPD appointment: directly with their GP or through a member of the practice team; by telephoning a central CB appointments number; using the internet; or telephoning the hospital of their choice direct. However, this system assumes that all patients can read and write, and have access to IT and telephones. The expectation from hospital staff was that patients would still rely on GPs to arrange appointments and default to the time honoured local secondary care provider. However, the Trust conducted a poll and found that only four per cent of interviewees stated that they would not travel and this was predominately from an over 60 age group.

The Trust has made a considerable investment in the CB system and while the system may appear to favour the patient, it is very much a “demand management” tool in that if appointments are not available when a patient enquires, they will ultimately take one that is still available. Also, several staff acknowledged that to meet the demand and availability of patients, the OPD may need to consider a move away from traditional working hour clinics to late evenings and even weekends. This would achieve “competitive advantage” over other providers and ensure a good level of income under the payment by results system.

Payment by results: financial accountability at all levels

As the NHS undertakes this ambitious attempt to introduce market mechanisms into a publicly funded health care system, providers are offered high-powered incentives to improve productivity and increase their activity. Trust financial staff stated that based on the predicted income from PbR for the cardiology OPD, the department would be in deficit unless there was more patient throughput to compensate for the running costs. However, the financiers admitted that this was based on raw calculations as accountability at this level had never been undertaken beforehand. Understandably, the OPD undertakes numerous types of clinics during the working day and while there may be specialist staff, other staff may also work in more than one type of clinic during the day. Allied to this is the cost of using CRD resources and consultants who are seconded to the cardiology clinic from another directorate in the hospital.

PbR will offer healthcare providers high-powered incentives to expand capacity along with managing patient demand. However, there is currently no indication that if the Trust does provide extra capacity to increase the volume of patients that the PCTs will actually fund the new level of activity. According to many participants the introduction of PbR will allow for NHS organizations to account for services commissioned as the money moves with the patient. However, unlike a commercial organization competing for business from a number of sources, the money for NHS services comes from one source: the Department for Health (DH). Therefore, the money is being moved around the NHS with NHS organizations managing budgets to stay in-balance, which is the equivalent to, as one financier put it, “shop-keeping at a higher level”. Consequently, organizations will look after their own interests to make savings or stay in balance, despite losses incurred elsewhere within the NHS as services are withdrawn.
Appropriate change

While change is the major theme running throughout the NHS, the 18-WPP is a significant culture change for the OPD and failure to react to the fast moving timelines will see a continual breech of DH driven targets. Patients now have a choice of their provider and this may mean that the Trust OPD could be second best to another more popular provider. Closely allied to this is PbR where clearly if patient demand should fall, so will revenue to the OPD. Should demand increase, and the OPD can match the capacity through an efficient procedure of handing patients, so will the PbR revenue. However, looming in the omnipresence is PBC, where there is a deliberate attempt to reduce funding to secondary care and encourage treatment within the primary care environment. This is moving money around when the source remains constant; the belief is that there are no longer any “sacred cows” within the NHS.

The transformation and modernization programme within the NHS is very much a living subject with numerous changes undertaken and more to be achieved by 2010. However, it is clear that providing free healthcare and treatment remains a founding principle to all sections of the NHS community. Moreover, modernization and appropriate change is accepted as necessary as long as efficiency is not impaired.

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