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Review

'Why is large scale change to health service delivery difficult?: the case of the 2019 NHS Plan'

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Abstract
This commentary paper reviews issues in the management of large scale or strategic change in health care systems. Such efforts often have limited or even perverse consequences. To make the analysis more concrete, it examines some issues which may arise in the implementation of the 2019 NHS Long Term Plan in the English health system.

1 Introduction

There appear to be important obstacles to achieving macro level change in health systems, with the result that desired national policies may be imperfectly implemented. This paper examines policy driven attempts at large scale service change and their complex implementation.

To make the analysis more concrete, the paper considers firstly if a formal national strategy for large scale service change currently exists in the English NHS (taken as the system the author knows best). It is concluded that a candidate strategy is present (the 2019 NHS Plan) and the paper then discusses potential barriers to its ready implementation.

2 Taking a strategic management perspective

A strategic management perspective is taken to analyse the NHS Plan. An influential strategic management text [22] defines strategy as reflecting 'the long term direction of an organization' (p9), often expressed and codified in a corporate plan. Within a classic 'design and planning' approach Ferlie and Ongaro [5], such plans are based on a data informed analysis of external forces which informs organizational choice. Once defined, the overall corporate strategy should be underpinned by annual operational plans and functional strategies (e.g. workforce, finance), well aligned with the corporate strategy. The ready implementation of strategy—especially in cases involving major strategic change—should not be assumed; but is a managerial achievement, often imperfectly occurring given high uncertainty. Implementation deficits are common, including in health care settings.

Bryson's [2] 'strategic change cycle' model designed specifically for public and not for profit agencies helpfully brings in softer factors into the strategic management toolkit, such as: visioning, active leadership, organizational learning, change management skills, periodic reflection on the process and staff involvement and ownership. These forces may all assist implementation and a reflective evolution of the strategy.

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3 Do national policies for large scale service change exist? If so, are they nevertheless badly thought out, poorly framed and soon abandoned?

The first question is: do national policies to improve health service delivery exist? Secondly and if so, are the national policies announced readily capable of implementation? The system may be so overloaded by operational crises that it cannot articulate a formal strategic framework. Where they exist, such policies may be poorly informed by data and/or badly framed analytically. They may not be resourced enough to meet the 'double hump' problem (i.e. running down the existing service while bringing the new one on stream). Ever shifting national policy agendas may mean that policies for service change are announced only to be abandoned.

In the UK, political and ideological shifts often occur when government and ruling political party changes which may then produce further top down reforms to NHS organization and policy, as it is always important to government as a politically visible and taxpayer funded service. Given this ever swinging pendulum, there are indeed examples of self cancelling policy shifts in the English health care system when seen in the long term. Successive reorganizations reflect preferred and ideologically informed models of public/health management espoused by different governments and ministers.

For instance, there was a major move away from a vertically integrated NHS and a Traditional Public Administration (TPA) tradition to quasi markets, a provider/purchaser split, empowerment of general management and the creation of NHS Trusts led by pro New Public Management (NPM) Conservative governments in place (1979–1997). This period was followed by increased investment and a (partial) move back to different principles of managed networks, collaboration, evidence informed policy and joined up government under New Labour (1997–2010). Then there was a move to the more market and productivity centred 'age of austerity' under Conservative or Conservative led governments (2010–2018) [6] with expanding private sector provision. There has been more recently an easing of financial pressure in the 2018 funding agreement with the NHS (event though Conservative governments were still in place 2018–2022). The latest policy iteration favours networks and collaboration again with new Integrated Care Systems (2022) on the commissioning side.

However, there are important areas of stability. NHS Trusts have remained in place since their creation in 1990 as autonomised and delivery focussed organizations. An expanding non state sector in adult social care has been consolidated. General and clinical management systems have endured so that large elements of the current system appear as stable. How politically and organizationally controversial—and hence fragile—should the NHS Plan 2019 be seen?

4 The 2019 NHS plan as a statement of strategic intent

The 2019 NHS Plan [15] is a recent statement of overall health strategy, published through NHS England (NHS's operational HQ). How can this text be best characterised? It (pp 136) contains a substantial set of 190 references to academic articles, policy documents and data sources. Brief tables of data appear. This serious and sustained document contains separate financial and workforce chapters (despite important challenges, as explored below).

Projected changes involve both a retilting of service balance and content and also extensive service process changes (namely, digitalisation and personalisation). Chapter 1's first three themes [15] are helpfully summarised as follows: (i) 'we will boost 'out of hospital' care and finally dissolve the historic divide between primary and community services' (i.e. shift the balance of provision away from the acute sector); (ii) 'the NHS will reduce pressure on emergency hospital services' (i.e. tackle a key pressure point in the acute sector) and (iii) 'people will get more control over their own health and more personalised care when they need it' (i.e. reinforce a more recently established personalization agenda and across many service pathways). Sections also consider the more widespread digitalization of health care delivery and a recent move towards subregional Integrated Care Systems (ICSs) to promote whole system working, involving local government and social care. These strategic themes are mostly long running, well established (over decades in some cases) and not highly party political sensitive.

The new ICSs are being rolled out on the commissioning side: 'ICSs are central to the delivery of the Long Term Plan. An ICS brings together local organisations to redesign care and improve population health, creating shared leadership and action.' (15, p29). They succeed the old Sustainability and Transformation Partnerships (STPs). While local government is a key partner in the ICSs, however, its autonomous status remains intact. NHS England, the regulators and NHS Trusts are largely undisturbed as is private and voluntary sector provision. So the organizational architecture remains largely intact and even the ICSs are just the latest iteration in a long standing policy stream.

So there is a serious plan in place which includes many non party political objectives and offers supporting financial and workforce strategies. National and local NHS organizations (NHS England, regulators, NHS Trusts; the new ICSs) will be expected to deliver the plan. Nevertheless, some serious implementation challenges could emerge.

4.1 Financial constraints

within change management, it is easier for the centre to provide more resources than to manage retrenchment. 'Buying change' was possible in the buoyant New Labour period (1997–2010) with earmarked extra funding for the NHS (2000 onwards) [4] but became difficult in the post crash/austerity period (2010–2018, [6]. Resource flows became constrained, service change objectives limited and narrow productivity improvement programmes dominant.

However, the NHS Plan (15, p 100) notes that following the 2018 financial settlement: 'revenue funding would grow by an average of 3.4 per cent in real terms a year over the next five years' (up from 2.2 per cent earlier). This figure assumed the NHS could make productivity savings and reduce growing demand. Gerslick et al. [8] estimate that meeting the plan's full goals implied a higher annual growth rate of 4.1 per cent and highlighted reduced adult social care funding of more than £12B since 2010/11. COVID has since added to demands. So while financial constraints have eased, they have not disappeared.

4.2 Workforce constraints

Even if policy and financial regimes are supportive, workforce shortages pose a significant constraint [8], especially in services with growing demand (e.g. primary and social care). Skill mix may need to change with service rebalancing. The background picture is alarming. A recent report [9] noted about 100,000 vacancies in both the NHS and social care sectors in 2021. The target of recruiting 6000 more GPs had not been met: many GPs were rather deciding to take early retirement or work part time. A detailed workforce plan promised [15] had still not been produced by DHSC. It concluded (p3): 'the persistent understaffing of the NHS now poses a serious risk to staff and patient safety for both routine and emergency care', for example in maternity services which exhibited various scandals.

5 Continued high politicization of some decision making

The NHS is not purely a science led or technocratic organization but also characterised by politicization of strategic level decision making, especially in cases of service rationalization. Losers are often more vocal than winners and may have 'veto power' which is readily mobilized. In particular, local proposals flowing from national policy to centralise services on centres of excellence and close small local hospitals (even with poor clinical outcomes) often meet strong community and local resistance [13]. So if shifts to primary care lead to proposed hospital closures, then intense political resistance is likely. The more explicit rationing of services (e.g. tougher eligibility criteria for social care) can also provoke strong public pushback.

5.1 Weakened top down power

The hierarchical and vertically integrated organization (as found, for example, in the military) provides a simple and readily understood governance mode. Until the 1990 reorganization, the NHS was (at least formally) such an organization, moving down from the Department of Health, through the regional, district, and then hospital tiers. The major 1990 reorganization by contrast brought in autonomised NHS Trusts, a provider/purchaser split and local primary care fundholders as micro commissioners, along with a slow growth of non NHS providers. The Regional tier (e.g. NHS London which was effective in supporting stroke service reconfiguration across London) was abolished. More independent providers have entered the delivery system, just as policy (2012 Health and Social Care Act) indicated.

This long term shift from one vertically integrated organization to a more open sector meant that direct command (however imperfectly exercised, due to the role of professionals, see below) gave way to broader sectoral regulation. Key regulators include the Care Quality Commission on the quality side and NHS Improvement on the financial and governance side. Regulators focus on quality, governance or financial control issues within single Trusts or primary care organizations but may have less competence in shaping cross organizational service change in networks of providers.

6 The autonomous role of professionals

The autonomy enjoyed by a range of professionals, including the powerful bloc around medicine, is key. Professional dominance is apparent not just in micro level clinical practice, but also at meso level strategic planning within hospitals [3, 17] which puts a local 'spin' on national policies. There may be many different professional segments involved in service change with possible jurisdictional tensions between, for example, acute and primary care or between medicine and nursing in relation to proposed shifting of tasks.

Strong professional ownership of the national change agenda would aid implementation. Expanding this capability includes developing a group of clinical managerial hybrids (e.g. Medical and Clinical Directors) willing and able to lead organizational level change, along with more cross professional arenas and multi disciplinary teams.

In some services (notably primary care and dentistry with its large private provision), nationally negotiated contracts with clinical professionals further restrict direct central power to enact desired policies and increase the use of indirect financial incentives in rewarding behaviour. These settings are often small businesses and owned by senior clinicians as partners.

7 Multi agency settings with many organizations

Many different services and agencies are involved in service delivery. Services for older people, for instance, may involve: acute, community and primary health care; adult social care which is commissioned but not delivered by local government; social security as a funder, a large private sector and the voluntary and informal sectors and housing. The problematic interface between health and social care can easily lead to delayed discharge from hospital if social care packages are absent. These stand alone agencies have their own objectives, accountability and financial regimes which may be incompatible.

The new ICSs are meant to be subregional system integrators but how effectively they will involve non NHS players—especially local government and social care—is unclear. One encouraging recent change is the restyling of the Department of Health as the 'Department of Health and Social Care' so hopefully leading to greater central policy alignment.

8 Organizational and managerial change technologies have weaker impact than initially heralded

Another continuing development has been the importing of various organizational change programmes, often drawn from manufacturing settings and supported by American sources and texts. Interest in Japanese inspired ideas of productivity, consistency and quality improvement (e.g. the Toyota way) has been long sustained. The NHS firstly experimented with Total Quality Management, then Business Process Reengineering and then Lean. Lean was seen as a useful management technology in the austerity period (2010–2018) as it suggested that efficiency, productivity and quality could simultaneously be improved. Evaluations suggest that their NHS impact proves weaker than originally thought (e.g. [19] on Lean).

Recent iterations include importing the Virginia Mason production system from a hospital in Seattle and the so called GIRFT ('Getting It Right First Time') programme. GIRFT was picked up in the NHS Plan to: 'implement best practices that can improve quality and efficiency and reduce unwarranted variations in performance' [15], p101). Timmin's early study [21] was relatively optimistic about its likely impact, perhaps due to its combination of active clinical leadership and strong top level support, although fuller evaluation is needed.

9 Desired process changes may be technologically or behaviourally complex

The desired process changes in the NHS Plan may well be complex and difficult to implement. As far as digitalization is concerned, large scale IT investment programmes often generate unintended consequences, low clinical ownership, system failures and cost overruns (e.g. the NPfIT programme, [10]). Personalised care also represents a different way of working for staff:

'Personalised care represents a new relationship between people, professionals and the health and care system. It provides a positive shift in power and decision making that enables people to have a voice, to be heard and be connected to each other and their communities'. (https://www.england.nhs.uk/personalisedcare/what-is-personalised-care/).

Personalisation implies a move to co production rather than traditional staff led production, raising fundamental questions of changes to staff values, culture, communication modes and shifts in the balance of power.

10 But also some cases of higher impact

So there are many obstacles to strategic service change in the health care sector. However, some strategic change exercises are more successful, such as the local 'the receptive contexts' found in Pettigrew et al. [18], also [12], the more successful managed networks in the 2000s (e.g. cancer, [4] and large scale stroke services reconfiguration in London [7, 20].

At a more macro level, might there also be a relatively benign health policy process better able to support major service change? It might at first glance be thought that New Labour's NHS plan 2000 [1] is a promising candidate. It was accompanied by buoyant funding and a mix of extensive stakeholder consultation, strong clinical ownership but also clear top down political will. Attention was paid to delivery mechanisms. Strongly informed by evidence, the resultant National Service Frameworks (NSFs) helped lead major service changes underpinned by clinical evidence (e.g. cancer services, [4].

11 Concluding discussion

Clearly, managing large scale change in health care systems is a demanding task with no guarantee of success [5, 11, 14, 16]. Implementation deficits may be frequent. This short personal review pointed to some factors make such implementation difficult, with especial reference to the concrete example of 2019 NHS Plan in England.

Some relevant studies and literature were cited but the corpus is limited. More contemporary organizational and policy related research is needed on the important concepts surfaced here of receptive settings and benign policy systems for change (where the 2000 NHS Plan was presented as a possible example to examine), within England, the wider UK and also inter nationally.

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Declarations

Competing interests The authors declare no competing interests.

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