SOCIAL POLICY RESEARCH FOR CORNWALL

4 April 2022 www.spr4cornwall.net

NHS England's planning in disarray again as management consultants recruited to help with elective recovery

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NHS England has £42m to spend on hiring management consultants to help integrated care systems produce and implement 'plans for elective recovery'.

Since 2014, NHSE has produced a series of 'plans' which have served only to demonstrate that it does not possess a coherent planning methodology. Its latest attempt continues that tradition.

It should use those management consultants (1) to investigate the pathways that patients are currently taking through hospitals (part of applying joined-up thinking to issues of patient flow), (2) to see what can be learned from local initiatives, (3) to discover how the NHS's system of 'command and control' is currently working, and to recommend improvements in all three areas.

The history

NHS England (NHSE) recently announced that it had begun to spend £42m on hiring seven firms of management consultants to help with planning and implementation of 'plans for elective recovery'. This is just the latest twist for NHS planning in England over the past eight years.

Looking back, in October 2014 NHS England published *Five Year Forward View*, which set out a variety of **models of integrated care, drawn from local experience**, that it would support, such as

- The *Multispecialty Community Provider* (MCP), where groups of GPs combined with nurses, other community health services, hospital specialists and perhaps mental health and social care to create integrated out-of-hospital care.
- *Primary and Acute Care Systems* (PACS), where hospital care and primary care are integrated, combining general practice and hospital services.
- *Urgent and emergency care* services, integrating A&E departments, GP out-of-hours services, urgent care centres, NHS 111, and ambulance services'.
- Help for *smaller hospitals* to remain viable, including forming partnerships with other hospitals further afield, and partnering with specialist hospitals.

The suggestion that such models of care be adopted was combined with a **conditional funding approach**, with funding offered as the carrot to induce clinical commissioning groups (CCGs) and provider trusts to provide services in accord with NHSE's favoured models.

In December 2015, **Sustainability and Transformation Plans** (STPs) were announced, in *Delivering the Forward View: NHS planning guidance: 2016/17–2020/21*. Every health and care 'system' – comprising CCGs, provider trusts and local authorities – was asked 'to come together, to create its own ambitious local blueprint, an area-based five-year STP.

But how was the plan to be created? The so-called 'planning guidance' did not provide any kind of manual: there was no step-by-step set of instructions. All it had to say on the subject was this:

> Producing an STP ... involves five things: (1) local leaders coming together as a team; (2) developing a shared vision with the local community, which also involves local government as appropriate; (3) programming a coherent set of activities to make it happen; (4) execution against plan; and (5) learning and adapting.
>
> Success also depends on having an open, engaging, and iterative process that harnesses the energies of clinicians, patients, carers, citizens, and local community partners …
>
> The best plans will have a clear and powerful vision ...

Essentially, then, the STPs were to be **vision-driven.** In contrast to the models of care previously advocated, the thinking was to be blue-sky rather than down to earth and practical. But that still left open the question of who was going to do the necessary envisioning and thinking. What happened was that in many if not all cases firms of management consultants were commissioned by 'partnerships' of CCGs, service providers and local councils to draw up plans.

In some cases these firms went off on what might be described as frolics of their own: in Cornwall what was produced and published was not even called an STP but presented as a 'draft outline business case'. There was no shared vision with the local community, let alone 'an open, engaging, and iterative process' that drew in patients, carers and citizens.

In March 2017 NHSE published another policy document, *Next Steps on the NHS Five Year Forward View*. It described itself as 'this plan', but primarily it amounted merely to a list of **general intentions**, expressed as statements beginning 'we will support' or some variant thereof, of which there were more than 80 in the document, but not setting out the extent of support or the form that it would take and the conditions under which it would be provided.

Less than two years later, in January 2019, yet another policy statement emerged, this one labelled the *NHS Long Term Plan*. The language it used was, on the face of it, more **action-directed.** For example, this document said:

- We will boost 'out-of-hospital' care, and finally dissolve the historic divide between primary and community health services.
- The NHS will reduce pressure on emergency hospital services.
- People will get more control over their own health and more personalised care when they need it.

Oddly, that document contained some 290 statements of intention beginning 'we will' but nowhere did it say who 'we' are. The reader is not told whether the intentions are those of the government, or the Secretary of State for Health, or the Department of Health, or NHS England. The consequence of this denial of authorship is that what look like commitments are nothing of the sort. The Long Term Plan gave no clue as to what NHS England would actually do. It was merely a statement of aspirations, many of them of the unassailable 'motherhood and apple pie' variety.

The situation today

Most recently, in February 2022, we find **management consultants called in** once again to assist with creating and implementing 'plans for elective recovery'.

Contracts have been awarded to seven firms of management consultants: Bramble Hub, Deloitte, Ernst & Young, KPMG, McKinsey & Co, Newton Europe and PwC. They will be involved in elective recovery planning, evidently one for each of NHSE's seven regions (the funding is to be made available on a regional basis), so they will be feeding in to policy making at regional level.

They are evidently to have a dominant role in designing elective recovery plans: 'Consultants will set strategy, provide analytics and help lead the creation of integrated care systems' elective recovery plans,' as a leak to the Health Service

Journal revealed. They are to provide 'tailored skills and expertise', covering programme management and delivery, strategy and planning support, and analytics and modelling.

There is also to be a 'national co-ordination function' hosted by a regional commissioning support unit, which will 'ensure ICSs have access to the required skills and expertise from delivery partners'.

The contracted management consultants have been given 'objectives'. These include:

- Delivering or exceeding the expected performance ambitions … 'triangulated across activity, finance and workforce capacity';
- Making 'full use of transformational opportunities' to manage demand, increase capacity or improve productivity;
- Having a clear link to the health inequalities agenda;
- Maximising elective activity through all available options including making use of the available independent sector capacity.

Clearly these objectives imply targets, and they assign to the management consultants the role of specifying these targets in practical terms and then enforcing them, using their 'tailored skills and expertise' to do so. So the consultants are being used to reinforce what Chris Ham describes as the top-down 'command and control' system of NHS governance, one where the centre will set targets for ICSs and uses regional bodies to monitor their performance.

What the consultants *should* be asked to do

There are three things that are conspicuously not being asked of the consultants, but should be:

- To carry out an investigation of the pathways that patients are currently taking through NHS hospitals, from admission to eventual discharge
- To explore what can be learned from local initiatives
- To identify and address any aspects of the NHS governance structure itself that can get in the way of maximizing elective activity.

Investigate the pathways that patients are currently taking through hospitals

One thing that we know at present is that there are many people in hospital beds at the moment who are categorized as 'Medically fit for Discharge' (MffD). They

are also frequently described as 'they don't need to be there', with local authorities' social care departments and families blamed for not removing them.

What we don't know is what pathways people who are labelled MffD subsequently follow. If clinicians are no longer interested in them, are they put on a reablement programme to improve and sustain their physical and mental health, which may have been badly damaged in the course of their treatment? Or are they parked in whatever wards have a spare bed or two and given the bare minimum of attention, as we know sometimes happens? Those on a reablement programme will clearly stand a much better chance of moving on with minimal delay, thereby freeing up beds for elective cases.

Management consultants – who, one hopes, have a clear understanding of how patient flows are affected by many factors and can summon up the joined-up thinking required to tackle them – should be given the task of investigating these pathways in individual hospitals, and documenting the lessons they learn.

Learn from local initiatives

Unlike the *Five Year Forward View* of 2014, there is no suggestion in the management consultants' brief that experience in a variety of localities, especially those where trusts have already shown themselves effective at holding down and reducing the elective backlog, should be investigated and drawn upon. But these 'grassroots' initiatives show how local knowledge and understanding can make a valuable contribution to solving problems of patient turnover. It should surely be part of the consultants' brief to investigate such initiatives and learn from them.

Discover how the NHS's system of governance works in practice

Recent studies of hospital discharge policy have revealed the inadequacy of the NHS's system of command and control in that respect. That is the story of Delayed Transfers of Care (DTOCs).

In 2019 the Government Mandate to NHS England instructed it to reduce 'NHS-related delayed transfers of care' from hospitals. The 2019 NHS Long Term Plan duly set as a target 'to achieve and maintain an average Delayed Transfer of Care figure of 4,000 or fewer delays'. NHSE provided hospital trusts with guidance on how to prepare their DTOC figures. This guidance attempted to combine two different approaches, one of which did not even offer a procedure to follow: it was so unclear that it left trusts with considerable freedom as to how they compiled and recorded their DTOC figures.

NHSE said this latest guidance would remove ambiguity, but it plainly did not. NHSE said it emphasized local collaboration, but it removed an injunction to that effect that was present in the previous version. NHSE claimed that it would offer 'good practice examples' from around the country, but it presented none at all.

Worst of all, perhaps, NHSE instigated a 'comply or explain' reporting system for hospital trusts which required them to submit figures to statisticians working for NHS Digital, who set reporting standards. If trusts did not comply with those standards their submission was rejected as 'unsuccessful'. So trust staff were led into playing a game of 'satisfy the statisticians', finding a method of compiling figures which showed them in a good light.

It followed, of course, that figures from different trusts could not meaningfully be added together. So they did not provide a sound basis for making policy and setting goals. This situation has been known about at local level for several years, and concerns have been relayed upwards. But NHSE has made no visible attempt to rectify it. One can only conclude that as long as a figure – any figure that made NHS Digital happy – could be produced, the higher echelons of the NHS and the Department of Health and Social Care would be satisfied.

It would be good if the bright sparks of the management consultant firms could bring some rationality and rigour to the data-gathering needed to support NHSE's planning.

In conclusion

NHS England is giving the management consultants that it has recruited terms of reference that place limitations on them and amount to an attempt to use them as part of NHSE's command and control system of governance.

Instead it should use those management consultants to investigate the pathways that patients are currently taking through hospitals, to see what can be learned from local initiatives, and to discover how the NHS's system of command and control is working today, and to recommend improvements in all three.

One would hope that the seven firms of management consultants can combine their forces to provide a much better information base and fuller understanding for NHSE's policy making than it has enjoyed up to now.