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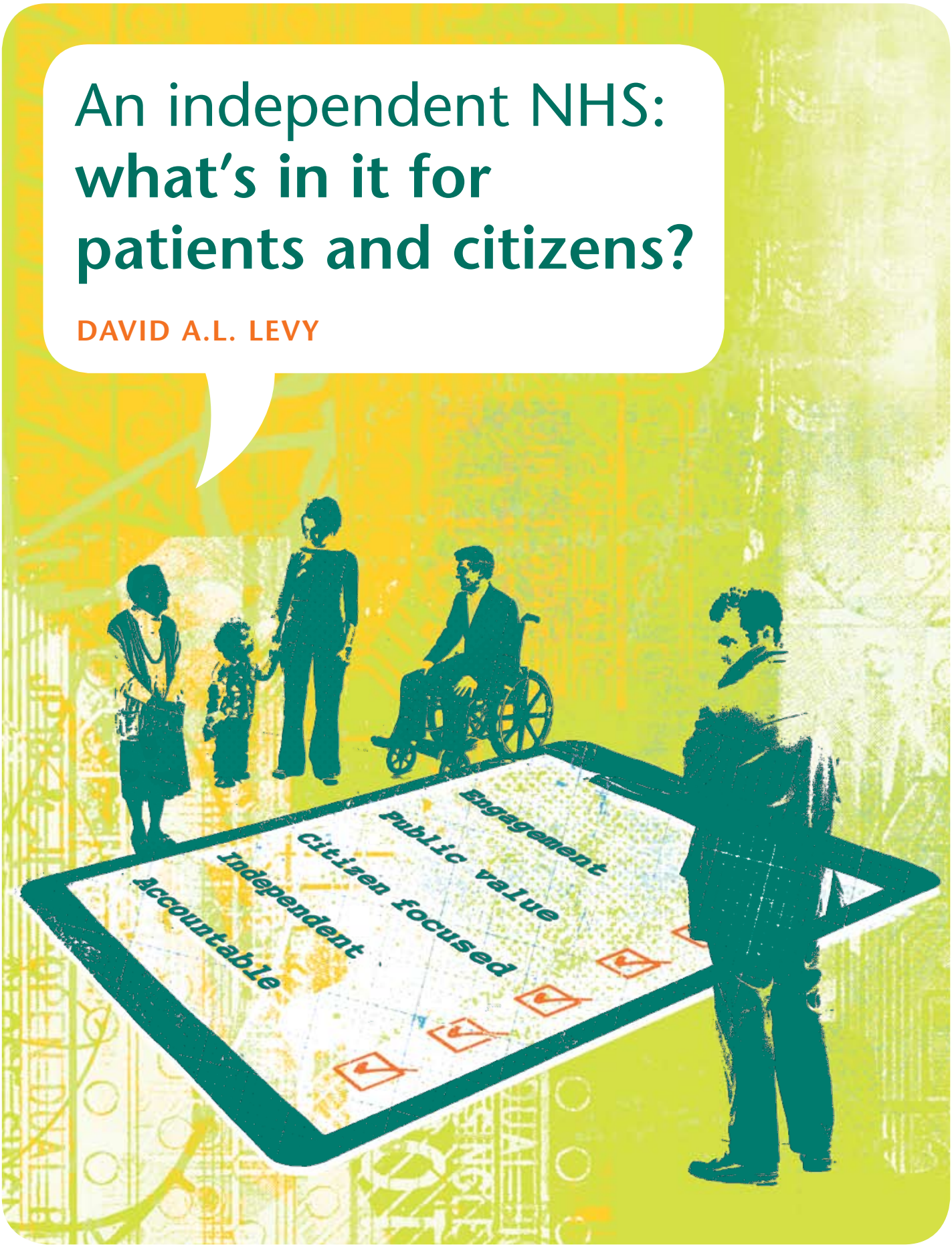
# An independent NHS: what's in it for patients and citizens?

DAVID A.L. LEVY



## Picker Institute Europe

The Picker Institute works with patients, professionals and policy makers to promote understanding of the patient's perspective at all levels of healthcare policy and practice. We undertake a unique combination of research, development and policy activities which together work to make patients' views count. There are three key strands to our work:

- Measurement – researching and evaluating patients' experience
- Improvement – leading initiatives that make improvements happen
- Policy – building evidence to inform health policy.

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Tel: 01865 208100
Fax: 01865 208101
Email: info@pickereurope.ac.uk
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## About the author

Dr David A L Levy is an Associate Fellow at the Said Business School at Oxford University, and a consultant in the areas of media policy and strategy and public service reform. He worked as Controller, Public Policy at the BBC from 2000 until September 2007 where he led the policy dimensions of the BBC's Charter review and was in charge of the BBC's public policy and regulatory strategy in the UK and EU. He previously worked as a journalist; as a radio producer and reporter on *File on 4*; as a TV reporter on *Newsnight*, and as Editor of *Analysis* on Radio 4. He is the author of *Europe's Digital Revolution: Broadcasting regulation, the EU and the Nation State,* Routledge, 2001 and of *The European Information Society,* in Rhodes M (Ed), *Developments in West European Politics*, Macmillan, 2003.

# Foreword

*Angela Coulter, Chief Executive, the Picker Institute*

Whenever the Picker Institute, which researches patients' experience of healthcare and how to improve it, is confronted with new initiatives and reforms in the health service, it asks some simple questions:

- **who benefits?**
- **specifically, do patients really benefit?**
- **has this clearly been done to focus on patient needs?**
- **does it accord with what patients tell us that they value and want?**
- **will it work, for patients?**

In 2007 a debate over whether the NHS should be independent from government, and/or have a formal constitution, reawakened with a vengeance. So we began asking our questions again.

Did patients – as opposed to politicians, or clinicians, or managers – really stand to gain anything from the various constitutional proposals?

In what ways, if indeed any, did such proposals really focus on benefits to patients? Were they paying attention to what patients value and want?

And if we did want to design a new constitutional arrangement, how could we be sure that improved outcomes for patients would be an integral part of its aims? What would be the essential elements that would take us further towards that elusive 'patient-centred NHS' to which everyone subscribes, but which patients experience too infrequently?

To help it with this interrogation, the Picker Institute decided to commission an independent policy analysis which could draw on another recent experience of constitutional review and the redrawing of objectives in a public service – the case of the BBC and its new Charter from 2007 to 2016.

Why? Not because we necessarily want a 'Charter model' for the health service, but because in this particular review we felt there may be lessons and approaches relevant to today's NHS.

The BBC, a longstanding, traditional, paternalistic national broadcaster, was confronted with some challenges that would sound familiar to any analyst of the future of the health service:

- new technological advances and the challenge of getting the best use from them
- changing expectations and behaviour among large sections of its users
- the increasing potential – and user demand – for a decisive shift away from top-down paternalism towards engagement and interaction with users, and responsiveness to their values and preferences
- pressure to redefine the service's purposes, moving away from process (broadcasting) towards outcome measures (impact on the service users and wider society).

Who better, we thought, to ask for help than David Levy, who had recently left the BBC after seven years leading its policy function, helping to steer it successfully through the Charter review.

When, in 2003, a small team was convened within the BBC to map out the legitimising arguments for its future, David was part of that developing, radical conversation about using the approach of 'Public Value' to inform the BBC's mission.

*'Building Public Value'* became the Corporation's future manifesto, determining both the purposes driving all the activities of the BBC, and the means by which its success or failure would be measured.

David is modest about stepping into health sector territory. But we believe he has produced both a highly stimulating analysis and an exciting first description of the essential elements that should be included if we want a true patient focus when redrawing the settlement between government, the health service, health professionals and, most importantly, patients and the public. The Picker Institute agrees with his analysis and takes ownership of its recommendations.

I am delighted to present his analysis here, and believe it deserves very serious consideration by all those who may now or in the near future be called upon to work to establish a new constitution, and/or greater independence, for the NHS.

We stand by to welcome all expressions of interest in debating these ideas further, and all constructive criticism.

# Overview

Greater NHS independence is on the political agenda. But how can we be sure that if it occurs it will actively promote patient and citizen interests?

Past reorganisations have been strong on proxies for these interests – measures which are supposed to result in responsiveness but are only indirectly related to patients' values, whether through focusing on internal markets, top down targets, or greater patient choice. These have fallen short of ensuring that the NHS delivers a completely patient- and citizen-focused service.

Indeed, at times the proxies have distorted incentives and produced perverse outcomes. So while NHS spending has increased and there have been notable improvements in some key areas, we also know that the NHS is insufficiently responsive to the needs of patients and citizens, whether that is judged by access to healthcare, for example through out of hours GP services, or by the nature of patients' engagement with health professionals, or by other indicators.

This paper argues that the theoretical case for greater NHS independence is strong. However, a further wave of reorganisation should **only** be considered if the reformed and more independent NHS can be designed in a way that puts the interests of patients and citizens at its core.

The paper examines recent trends in public service management and the move to a Public Value approach elsewhere, to assess possible lessons for the NHS. It asks whether the BBC of the 2007 Charter might offer a model for the NHS, as an organisation where there are: strong imperatives for arms length relations with government; inbuilt incentives to engage its users; a long term framework agreement and funding settlement; and where we all have interests both as consumers and as citizens.

The paper finally builds on the BBC Public Value model to develop some key criteria for a reformed NHS that could combine much higher levels of independence with clear patient- and citizen-focused objectives, and a new approach to ensuring accountability to patients, citizens and other stakeholders.

## Structure of this report

Section 1 describes how the concept of 'Public Value' may act as a corrective to some of the dangers now apparent in the public service reform agenda of the last decade. Section 2 explores the BBC's approach to Public Value and the way in which independence and accountability to users and citizens operate within the BBC. It then examines the relevance of a Public Value approach to the NHS.

Against this context, Section 3 returns to the theoretical case for greater NHS independence, while Section 4 reviews the similarities and differences between the BBC and the NHS for the purpose of this debate.

Section 5 provides a brief review of evidence about patient/user and public/citizen requirements from the NHS. Section 6 examines the key principles for a more independent NHS.

Section 7 outlines a possible structural design for a more independent and explicitly patient- and citizen-focused NHS. In Section 8 the Picker Institute comments on the analysis. Brief conclusions are in Section 9.

# Introduction[1]

Public services exist to serve the public. But while there is probably greater consensus now than at any time in the last twenty years over **which** services should be publicly funded, **how** they should be organised and provided to serve the public effectively and efficiently, and to command the trust of consumers and citizens, seems to be one of the key issues of our time.

Waves of new public management theory, internal markets, consumer choice, and new approaches to regulation have succeeded each other. But, even when accompanied by dramatic increases in funding, these approaches have done little to boost trust and confidence in the quality of the service being delivered. For some this highlights the 'delivery paradox', where general perceptions of the service in question are lagging behind the positive personal experiences of individual users.

*"There is much scratching of the head in political circles over this apparent paradox: people feel personally optimistic in Britain; but collectively pessimistic. They say their own health care in the NHS is good; but the NHS in general is bad. Their schools are good; but education is bad. They are safer; but the country is less safe. Their future is bright; but the nation's is dark."*[2]

But users themselves are less happy than that might suggest. And there is a wider problem: while policy-driven reforms have focused on trying to create more responsive services, the measures used have been 'proxies', and their link to any impact on consumers and citizens is often unclear. As John Denham MP remarked recently in the context of the NHS:

*"I awoke one recent morning to hear that the Healthcare Commission was reporting that a quarter of NHS hospitals had not done enough to tackle MRSA. As a patient, I wondered what those hospitals would now do. As a politician I wondered how I should respond. As your local MP, I could send a sharp letter to the local health trust, but I can't make anything happen, and no one will criticise me if I don't – with whom, then, does the responsibility lie? Perhaps someone else you voted for? It's certainly not the council's fault. You may have voted for them too, but they don't run the health service. Technically, of course, the hospital trust's board should respond, but they are appointees, every one. Good and diligent people, of course, but only under extreme circumstances will they get sacked for poor performance. And if it's a private hospital under contract to the NHS, God knows who should act. So if nothing happens, you've got two choices: travel to another hospital when you are ill, or complain to the minister, who will undoubtedly decline to become involved in "local decisions." Look across the public services, and it's hard to see who you are meant to hold to account."*[3]

1 References in this document to 'the NHS' should be taken as meaning the NHS in England. The report does not engage with the issue of NHS organisation elsewhere in the UK

2 Tony Blair addressing the Labour Party Spring Conference in Manchester in March 2004, cited in Work Foundation, 2006

3 Denham J, 2007

In many ways the accountability vacuum to which Denham refers has itself been exacerbated by reforms to the NHS, which have tended to fragment responsibility and prioritise choice (in this case, choice of hospital) over patient and citizen voice. Contrast that with the response of the Director General of the BBC when submitting a report to the BBC Trust in July 2007, which revealed the scale of deception of the public that had taken place through a series of rigged competitions:

*"Nothing matters more than trust and fair dealing with our audiences... However, a number of programmes have failed to meet these high standards. This is totally unacceptable. It is right that we are open with the public when we have fallen short and that we demonstrate that we take this very seriously indeed. The behaviour of a small number of production staff who have passed themselves off as viewers and listeners must stop. We must now swiftly put our house in order… We have to regard deception as a very grave breach of discipline which will normally lead to dismissal."*[4]

He went on to announce the immediate suspension of all phone-related competitions on BBC television and radio, with interactive and online competitions to follow as soon as possible, and a programme of mandatory editorial training focusing on the issue of honesty with audiences for all 16,500 programme and content staff. Two months later following a report on the failings surrounding the press launch of the TV programme *A Year with the Queen* – a case of misleading editing by the independent production company and mishandling within and misrepresentation by the BBC – the Controller of BBC One resigned.[5]

Views will differ about the relative seriousness of these two cases as well as the appropriateness of the responses. What is clear, though, is that while NHS structures have been radically reformed in recent years, amid constant political debate and frequent intervention in almost every aspect of the service, it is hard for patients and citizens to know just where the buck stops, how to make their voices heard, and whether and how evidence about their views, fears and experiences will lead to concrete change.

This paper examines whether the BBC Charter might provide an indicative model for moves towards greater NHS independence that incorporate clear responsiveness to, and better outcomes, for patients and citizens.[6]

4 http://www.bbc.co.uk/pressoffice/pressreleases/stories/2007/07_july/18/thompson.shtml

5 Along with the Creative Director of the Independent Production Company, RDF, who had made the film and edited the promotional tape in reverse order. http://www.bbc.co.uk/pressoffice/pressreleases/stories/2007/10_october/05/investigation.pdf

6 As far we know the first person to mention the BBC Charter as a model for the NHS was Will Hutton. Hutton W, 2000

# 1 Public service reform agendas, Public Value and valuing the public

*"Public service reform in Britain since the late 1980s has changed the nature of the relationship between the state and the provider. But the relationship between the provider and the citizen has, in most cases, altered little."*[7]

The reform of tax funded public services in recent years has focused on a combination of top down targets and market mechanisms to incentivise providers to meet government objectives. The rationale for the direction of policy has been to ensure greater efficiency and responsiveness to users. However, the dangers are multiple.

## 1.1 Dangers inherent in reforms to date

Since these policies can only be proxies for the needs of users and citizens, not all of their needs can be accounted for by the new market-based signals, while top down targets can often produce perverse results. All of these elements can be observed in the NHS.

Targets, such as those on waiting times, can drive improvements, but equally can sometimes be met at the expense of other more important objectives. The excess of central edicts has affected staff morale and creativity in responding to patients' needs. Those market signals that can be registered, for example about choice of hospital, can often both lag behind reality (given the information problems in health) and more importantly fail to capture the full range of elements that patients value in the NHS.[8] Meanwhile, internal markets have almost inevitably tended to fragment service provision and accountability for effective delivery.[9]

Whether or not performance has improved, as measured by the targets selected, trust has been in decline. Peter Taylor-Gooby notes that a recent British Social Attitudes survey showed that only 12% of those interviewed had a great deal of trust that NHS hospitals would "spend their money wisely for the benefit of patients."[10] He sees evidence of success in relation to performance, but locates the failure of trust in a fundamental weakness of the recent reform agenda:

7 Diamond P, 2006, p 10

8 Picker Institute for the Healthcare Commission, 2007

9 Diamond P, 2006, p 16, comments how 'Over the last 20 years, governments have imposed new mechanisms that encourage top-down change from the centre, and demanded a stronger role for individual choice and voice in the delivery of public services... This mixing of organisational models has been problematic, and created real obstacles to higher performance. Such contradictions not only demoralise staff and create perverse incentives. An excess of edicts and instructions from the centre prevents public organisations from adapting and responding spontaneously to changing customer demands and preferences". Burnham A, 2007, as Minister of State for Health, stated "that the era of the top-down target has served its purpose, and was right for the time, but in my view is coming to an end and needs to be re-assessed. We need a new way of doing things that is more empowering for staff. We need to say clearly, what was right for this last decade will not be right for the next."

10 Taylor-Gooby P, 2006, compared to 16% for private hospitals

*"trust depends on evidence that the providers have the users' interests at heart. Here the rational incentive-based system fails to engage. The main motivation of service providers is no longer focused downwards, on service users, but is redirected upwards, at the budget-holder. So although the new system is designed to improve service to the end-user, and has done so in the NHS, it does not feel like that in terms of daily interactions. In the past, when there was more professional autonomy, the system was less efficient, but it felt as if the GP or nurse was primarily focused on the individual patient, as opposed to a distant budget holder."*

## 1.2 Public Value as a corrective to recent reform agendas

The problem of ensuring that public services really focus on the public, rather than the fund holder or others, underpins the development of the notion of Public Value by the Harvard professor, Mark Moore, among others.[11]

Interpretations of Moore's work vary, but his conception of Public Value has been usefully summarised as comprising two elements:

- the practice of 'co-production', whereby providers work **with** users to produce outcomes that genuinely meet users' needs, and
- focusing public bodies on the ends rather than the means, thereby aspiring to go beyond 'hitting the target but missing the point'.[12]

Benington defines Public Value as being first, what the public values and second, what adds value to the public sphere.[13] The Work Foundation's recent Public Value project focused attention on a new approach to accountability, describing Public Value "as an orientation of public services towards ends that are **authorised** by service users and their communities" (our emphasis).[14]

Public Value's focus on outcomes, rather than conventional input and output measures; on 'co-production'; and on user and citizen engagement in defining the goals of public services and in helping to achieve those goals, is highly relevant to the NHS.

Public Value approaches contrast with many aspects of the New Public Management (NPM) agenda which has dominated public service reform over the last two decades. A Cabinet Office Strategy Unit paper of 2002 discussed these contrasts. It noted how the NPM agenda was premised on the idea that to "the extent that government created value it would do so by mimicking organisational and financial systems used by business".

11 Moore M, 1995

12 Collins R, 2007; Horner L, Lekhi R, and Blaug R, 2006

13 Benington J, 2007

14 Horner L et al, 2006 summarise Mark Moore's notion of Public Value strategy as comprising the following elements within a "strategic triangle":
- a declaration of the mission or purpose of the organisation (cast in terms of important Public Values)
- an account of the sources of support and legitimacy that will be tapped to sustain society's commitment to the enterprise (the authorising environment)
- an explanation of how the enterprise must be organised to deliver the declared objectives

While the paper noted that this had led to some benefits, there were also risks. These included emphasising "narrow concepts of cost-efficiency over other things" with the result that:

*"things that were easy to measure tended to become objectives and those that couldn't were downplayed or ignored. Hence within some public services 'efficiency' measures represented the average cost of processing a given output (e.g. finished consultant episodes in hospitals), regardless of what mattered to the public. In these circumstances it was possible for measures of efficiency to improve without there being a concomitant improvement in the service as experienced by the user (as occurred under the internal market when measured outputs increased substantially but service quality did not). Improvements in efficiency in this sense were not synonymous with increases in Public Value."*[15]

Measurement also features significantly in Public Value approaches, but with a new angle: "Public Value provides a broader measure than is conventionally used within the new public management literature, covering outcomes, the means used to deliver them as well as trust and legitimacy. It addresses issues such as equity, ethos and accountability." [16]

The Work Foundation studies supported the idea of Public Value as a corrective to New Public Management theory, noting that: "Public Value challenges NPM's emphasis on reducing what is valuable to what can be quantified."

According to this view one key element of Public Value is to distinguish between individuals' aspirations as **consumers** and as **citizens**. Another is to focus on the 'authorising environment' or the way in which public managers engage users and the public in priority setting about the use of public resources. As one recent contribution to the debate about reform of the NHS explains, a Public Value approach to the process of authorisation for priority setting would aim to engage the public in the really difficult decisions:

*"Central to the public value framework is the idea of 'opportunity cost': that is, an activity is only desirable if the public is prepared to give up something – for example a tax increase to pay for a better service. It also highlights the importance of people feeling connected with public services and having trust in them. This approach reveals what the public values, rather than what it wants, unconstrained by the price to pay or the sacrifices that required. It is not particularly revealing to ask the public what it wants as this is too open-ended a question. More illuminating is to establish what the public would want if it had to sacrifice another public good; this process reveals what is of significant value."*[17]

15 Kelly G, Muers S, & Mulgan G, 2002. Other weaknesses of NPM that are identified in the paper include:
- the focus on improving functionally defined services rather than meeting the overall service needs of different groups
- a pre-disposition towards piecemeal improvement rather than larger scale innovation
- a tendency for micro-management and reduced discretion for front line workers with high costs created by detailed inspection from the centre
- a lack of attention given to democratic engagement with citizens and stakeholder groups

16 ibid

17 Rankin J, Allen J, & Brooks R, 2007, p 38

A third key element identified in the Work Foundation research is the idea of 'co-creation', an:

*"ethos of co-production between citizens and providers, [which] combines downward accountability with recognition of users as citizens rather than subjects or recipients (command and control), or as just consumers whose desires and wishes simply need to be added up and measured via satisfaction ratings."*[18]

Taken together, this Public Value approach stands in marked contrast to much of the NPM agenda that has driven NHS reform over the past decade.

18 Horner L et al, 2006

# 2 The BBC, Public Value and its relevance to the NHS

The BBC is the most significant public sector organisation wholeheartedly to have adopted the notion of Public Value, beginning with its 2004 document, *Building Public Value*. Essentially the BBC's manifesto for the next ten year Charter starting in 2007, this document identified the creation of Public Value as the BBC's key goal.[19]

## 2.1 Public Value concepts applied to public service broadcasting

The BBC sees itself as creating Public Value by serving people both as **individuals/consumers** and as **citizens**. At the individual level, its aim is to provide a range of programmes that people enjoy and that inform, educate and entertain. But the BBC also sees itself as having a role in providing value to people as citizens over and above the individual value it delivers.

Citizen value depends on universal and equitable access to the service, and according to the BBC, is about "contributing to the wider well being of society, through its contribution to the UK's democracy, culture and quality of life". Examples of this in practice might include the case of news programmes (where consumption by others could contribute to the quality of debate and democracy) or children's programmes (helping to build the skills and knowledge of the next generation, for the benefit of society as a whole).

The BBC argues that this dual role at the individual and citizen levels can be compared with that of another great national institution, stating: "The NHS helps to make the UK a healthier society. The BBC aims to contribute to the wider social, democratic and cultural health of the UK through the range and quality of its broadcasting".[20]

In this sense, Public Value offers the BBC a way of articulating, and measuring – something many of its supporters had often felt, but had rarely been able to document in a systematic way – the wider beneficial impact of the BBC on UK society.

The BBC manifesto document detailed six areas where the BBC was meant to deliver Public Value to the UK. These areas were formally codified in the subsequent Charter and Agreement[21] as the six 'public purposes' (see Box 1) towards the achievement of which all BBC activities should be directed for the ten years from 2007 to 2016.[22]

19 BBC, 2004

20 ibid

21 BBC Charter and Agreement, 2006

22 The BBC exists because of a ten year Royal Charter which provides the broad framework for its activities. These are then governed in more detail according to an 'Agreement', made formally between the BBC and the Secretary of State at the same time that the Charter is renewed. The Agreement can be changed within the fixed life of the Charter, but only with the consent of both parties and the approval of parliament

Box 1: The BBC's Public Purposes 2007–2016

1. Sustaining citizenship and civil society
2. Promoting education and learning
3. Stimulating creativity and cultural excellence
4. Representing the UK, its nations, regions and communities
5. Bringing the UK to the world and the world to the UK
6. In promoting its other purposes, helping to deliver to the public the benefit of emerging communications technologies and services and, in addition, taking a leading role in the switchover to digital television.

Source: BBC Charter and Agreement, 2006

The BBC also sees itself as sharing three key elements with other public services:

- **universality** – it is freely available to everyone without any additional payment over and above the licence fee
- **fairness and equity** – public ownership and funding requires meeting the needs and interests of all its users
- **accountability** – collective ownership gives the British public the right to hold it to account, to monitor its performance and to guide its future.

All three features are important in the NHS. Arguably accountability is the hardest to deliver, but also the one that is vital to the delivery of patient-centred, rather than provider-centred independence.

The BBC's comparison between itself and the NHS was controversial for some, who argued that the case for universal, publicly funded provision of broadcasting was far weaker than that for other public services such as health and education.[23] It was perhaps for this reason that the BBC's approach to Public Value also incorporated a dimension of economic value. This refers to:

a) the potential for the BBC to deliver **positive** economic value through, for example, stimulating the creative economy or take up of new digital technologies

b) the danger of the BBC having a **negative** economic impact on the commercial communications market by reducing audiences, and hence revenues, for a rival service.[24]

23 Cox B, 2004

24 Inclusion of this economic dimension was prompted by industry accusations that the BBC's significant audience share (of around 40% in TV and over 50% in radio) and moves into new digital services had an adverse competitive impact by crowding out commercial provision. These accusations had a degree of political salience in broadcasting which has never been the case in debates over other areas of state provision such as health or education even though public provision in these areas accounts for over 90% of the market. However there are some signs of similar tensions beginning to emerge as new providers enter various sector of healthcare, and issues are raised about fair access to the market and fair terms of trade

## 2.2 Putting the concepts into practice

From 2007 to 2016 all BBC activities are to be judged according to how they fulfil the public purposes, at both individual and citizen levels. Each BBC service has a service licence or statement of 'remit' that explains how it will do this, and these have been subject to public consultation. Their performance is monitored quarterly by BBC management, and assessed annually by the governing BBC Trust. Success is measured in four ways – audience reach, the quality of the content, wider impact on society, and value for money.[25]

A potent mechanism to ensure that the BBC implements the Public Value approach in practice is the new Public Value Test (PVT). If the Corporation wishes to introduce a new service or make significant changes to existing BBC services, its management must make a detailed case in Public Value terms. It must be able to demonstrate that the change will meet the public purposes across the four measures.

Under the 'value for money' heading, the management is obliged to compare the proposed new service to alternative uses for the licence fee, such as investing more money in existing services or not making any investment at all. This approach is highly relevant to complex resource allocation decisions in other parts of the public sector where overall funding is constrained and where the focus is on the most effective way to deliver Public Value.

In the BBC's case the ultimate decision about whether a new proposal goes ahead is made by the governing BBC Trust, but only after consideration both of the management case and of other evidence, including regulatory market impact assessment and extensive public consultation.

## 2.3 Competition, regulation and structural incentives to ensure a Public Value approach

It could be argued that the degree of competition between the BBC and commercial broadcasting[26] is one reason why the BBC's incentives to focus on user satisfaction are greater than those for other parts of the public sector. For consumers of broadcasting, switching to other providers is as easy as a flick of the TV remote control or a turn of the radio dial. It does not require the expense of private insurance contracts or the fees needed to opt out of the NHS or the state education system. While 11% of the population are covered by private health insurance[27] it exists within the context of NHS provision; the percentage of the population making no use at all of the NHS is probably under one per cent.

25 After the Trust has consulted the public on their proposed interpretation and application of these purposes: BBC, 2004 and see also "Trust sets strategic priorities for the BBC", 18th December 2007, http://www.bbc.co.uk/bbctrust/news/press_releases/2007/purpose_remits.html

26 The BBC has faced competition since 1955 with the creation of ITV, but this has intensified greatly over the past decade

27 Laing and Buisson, 2006 cited by BUPA at the Independent Healthcare Convention September 2007

One of the motives for recent NHS reforms has been to create sufficient possibility of choice of provider within a publicly funded service so as to exercise pressure on the costs, quality and behaviour of health providers. Advocates of these reforms differ in their opinion about the percentage of actual patient switching that is necessary to have the desired outcome. Issues of information asymmetries, travel and trust, however, are always going to mean that the exercise of choice within healthcare will be more complex and rather 'stickier' than within broadcasting.

But ease of channel choice is just one among many incentives for the BBC to focus on its users. The Corporation also faces the discipline of regular and wide ranging Charter reviews every seven years or so.[28] At such times, and because it is funded by a clearly identifiable hypothecated fee, it must undergo a thorough and very public examination of its purposes, performance, scale, scope and funding.

The outcomes in terms of a renewed Charter, a new detailed Agreement, and any changes to the level of funding are, as with all public services, decided in the political arena. But the extent of its use – currently over 90% of the population use a BBC service every week – and the views of those users, form the underpinning for any political settlement.[29]

So in terms of delivering individual Public Value the BBC has very strong incentives to focus on the needs of its users, rather than simply seeing government policy as a proxy for those users. Indeed, fears that the BBC might be tempted to chase ratings by 'dumbing down' its programmes express a rather different concern from the NHS: namely, that the BBC's incentives are so focused on individual users that it needs counterbalancing incentives in its Charter and regulatory regime to ensure it really delivers its citizen dimensions and higher purposes.[30]

## 2.4 Independence and accountability

The BBC is far more independent of government than the NHS. Its Charter specifies that "The BBC shall be independent in all matters concerning the content of its output, the times and manner in which this is supplied, and in the management of its affairs".[31]

But that independence is still politically conditioned. Each new Charter is accompanied by an Agreement between the Corporation and the Secretary of State which specifies the manner in which the Charter will be delivered. In the framework for 2007-16 it is in the Agreement that the Public Value approach and the six high level public purposes are formally codified. Thus the Agreement is a meeting place between the creative and strategic aspirations of the BBC and broader public policy objectives.

28 Even though BBC Charters tend to last 10 years the debates always start several years ahead of the expiry of the previous Charter

29 The latest BBC Charter review included three rounds of extensive audience research and public consultation in a way not often seen in other sectors. 5,000 people responded to the first Government consultation on Charter Review, 400 to the Green Paper consultation and around 200 to the White Paper. Perhaps more significantly there was extensive qualitative and quantitative research conducted by the government and around 110,000 downloads of the BBC's document, *Building Public Value* within weeks of publication. Political debate about the BBC always starts from an assessment of the extent of use of BBC services. Although 92.5% of the population make use of a BBC service each week, the figure is much lower among some groups

30 Though arguably the dimension of delivering citizen value against its public purposes, takes the BBC into more difficult territory. While some areas, such as improving life skills, will be non-contentious, other tests of the BBC's positive citizen outcomes may be more so

31 BBC Charter and Agreement, 2006, paragraph 6 (1)

This, together with negotiations on the level of the licence fee to fund its activities, engages the independent Corporation at the time of Charter renewal with the political and public policy process. Such engagement is often not understood when the BBC's operational and editorial independence from politicians is discussed. The BBC is also regularly scrutinised by more than one select committee.

With regard to accountability, there is far greater clarity in the BBC than in the NHS over who is in ultimate charge, both to carry the can when things go wrong, and to change things, ideally before rather than after a major disaster. It is the Director General (DG) as the Editor in Chief and Chief Executive. Perhaps that is why BBC DGs tend to be dismissed before they complete a full term.

The DG reports to the BBC's new regulator and supervisory board, in the shape of the BBC Trust, which took on formal responsibility for the BBC in January 2007. The Trust has explicit responsibility to appoint the DG, to set the strategic direction of the BBC, to ensure it delivers on its remit, and to act as trustees of the licence fee and of the public interest in delivering the BBC's public purposes.

Accountability is one of the biggest challenges facing the BBC Trust. It has a specific duty to face outwards to licence-fee payers and other stakeholders. But the Trustees are appointed by government, not elected by licence fee payers, so the system depends on the Trustees' independence of mind and, apart from the requirement to have a Trustee for each of the nations of the United Kingdom, they are chosen primarily on the basis of their expertise rather than as representatives of specific groups. The Trust's new system of Audience Councils (one for each nation), offers one route for greater accountability. It is complemented by an extensive research programme and public consultations. Both the management and the Trust can order special reviews of particular subjects or areas of content, including audience research; and other market research is regularly provided by the industry regulator, Ofcom. But these are early days and there is clearly more progress to be made in terms of these accountability mechanisms.

Another route to accountability is audience feedback to BBC management. There are one million contacts with the 'BBC Information' call centre each year. An innovative daily online survey of 5,000 people allows for rapid and detailed feedback on individual programmes, not just asking for audience satisfaction ratings but also measuring the quality and impact of programmes.

Increasingly, impact is assessed not just through the passive reception of a programme, but by the extent to which people go on to take action or seek out opportunities in response to it. On this model, the knowledge and engagement that result from a programme are jointly created between the production team and the public.

## 2.4 Co-creation in broadcasting

Traditionally BBC journalists and editors have seen a tension between the principle of accountability and their own professional values, in particular their creative and journalistic independence and authority. That is beginning to change. Authoritative and expert journalism is still highly valued, but it can no longer afford to remain aloof from its audience.

It is not just that audiences have more choice. Increasingly, digital technology and the internet give them access to similar technologies and information sources as to those of professional journalists, and enable them to become part of or to 'shape' the story. Some go on to become 'citizen journalists' – especially in moments of crisis – as the logic of co-creation hits the newsroom.[32]

At the production end the BBC now positively seeks active engagement – linking, reacting to and reusing BBC stories, and encouraging user-generated content. BBC editors, who previously were often wary of individual audience members, are now revealing and sharing their editorial decisions, priorities and sometimes even their prejudices through their blogs.[33]

None of this changing culture of broadcast production, and management efforts to understand the audience better, can substitute for effective accountability structures and engagement. Nor can it replace the litmus test of accountability – who is called to account and what changes as a result. But it does reflect a shift in policy as well as in cultural terms in the way BBC management is engaging with audiences.

## 2.5 The relevance of Public Value to the NHS

Based on the above analysis, together with some of the work conducted by the Work Foundation's Public Value research project, it seems that a Public Value approach could have several benefits for the NHS, which can be summarised as follows:[34]

- providing a new **focus on serving users** – ie patients and citizens – rather than funders
- an emphasis on **ensuring overall positive outcomes for society** through a more joined up approach to health rather than simply meeting targets within any one area
- public and patient engagement to ensure **authorisation** for the right funding levels, goals, values and priorities for the NHS
- as part of that authorisation, greater understanding of and **public engagement in the trade-offs** between different NHS decisions, treatments and priorities

32 The term 'citizen journalist' is now used to recognise people who supply broadcast content from their own witnessing of potential stories. High profile examples include the photos and videos, often taken on mobile phones, that ordinary people sent to broadcasters in the immediate aftermath of the 7th July 2005 bombings in London, and the Asian Tsunami. For a discussion of citizen journalism by Peter Horrocks, Head of BBC TV News, see http://www.bbc.co.uk/blogs/theeditors/2008/01/value_of_citizen_journalism.html

33 See http://www.bbc.co.uk/blogs/theeditors/ and http://www.bbc.co.uk/blogs/nickrobinson/

34 This draws on but differs slightly from the Work Foundation approach which presents (Mahdon M, 2006) a Public Value approach to the NHS as meaning:
- connecting with citizens and professionals, not just service users, to involve them in the Public Value process
- ensuring choices are real
- enabling patients and the public to be involved in health care in general as well as their own healthcare
- measuring more than just management efficiency targets
- ensuring the measures meet good practice standards, are appropriate, relevant and trusted by citizens and staff; for example, services must be equally accessible by all, efficient and trusted

- a focus on 'what the public values' in the **process** of service delivery – ie in the ways that professionals engage with patients, as well as through health outputs and outcomes

- and finally, integration of the idea of **co-production/co-creation** of health with patients, with clear shared responsibility for health outcomes.

The idea of co-creation is highly relevant at a time when there is an increasing recognition that professional encounters only form a relatively small part of the ways in which most health outcomes are achieved. Individual lifestyle decisions about issues such as diet and exercise affect our health. When we fall ill self care is also important. As Coulter points out, most of us cope with minor illnesses without professional help, and even people with long term conditions spend far more time looking after themselves than under the care of health service professionals.[35] Even in doctor-patient encounters, one estimate is that patients contribute at least 85% of the information on which diagnoses are based.[36] The simple provider-consumer model is far less relevant to healthcare than was once imagined. As Benington notes, looking at co-creation in the public sector more generally:

*"the focal point for the production of value in education, health or social care lies in the inter-relationships between teachers, pupils and parents; doctors, nurses and patients; clients, carers and local community organisations. This blurs the traditional distinction between producers and consumers, and focuses on the quality of the interrelationships established."*[37]

35 Coulter A, 2007a

36 Tudor Hart J, 1998. Tudor Hart may be one of the first commentators to draw attention to the importance of co-creation in health

37 Benington J, (a)

# 3 The theoretical case for increased NHS independence

Consumer – or patient – and citizen focused services require some direct connection between service providers and the public as their ultimate funders and users. In the case of the NHS, historically the strongest link has been to the political process in Whitehall, with government as the democratic representatives of citizens, rather than directly to users and citizens themselves. In the historic model political control was a necessity, because of the need for the political accountability and oversight of an organisation whose commitment to universal healthcare remains a core part of the ethos of UK society, and whose funding takes up such a large slice of public expenditure.

Having discussed above the relevance of a Public Value approach to the NHS, we must now examine recent debates about the degree of independence from government that is desirable for the NHS.

## 3.1 The political process and the NHS

The political process has proved itself adept at designing the founding principles of the NHS and securing continued public support for the NHS to a point where a poll in 2000 found that for the great majority of people it was the "most valuable institution in the country", way ahead of parliament, the police and the royal family.[38] But it has been far less successful at delivering real accountability between the political level and the public level, in important decisions over funding, service design, reform and provision.

Writing at the turn of the century, Hutton argued that the NHS "has never been a properly democratically accountable organisation" and that while the doctrine of ministerial responsibility was meant to fill the gap, "if it was ever possible for a single minister to take responsibility for all that took place in the health service, it most certainly is not possible now".[39]

Recent reforms to the NHS have, in theory at least, been designed not to reinvigorate political control but rather to reduce it, while extolling the virtues of greater choice and public and patient involvement. Simon Stevens, a former health adviser in No 10, notes how:

*"numerous functions traditionally overseen by health ministers are already now undertaken at arm's length from the Department of Health: independent quality inspection is carried out by the Healthcare Commission,*

38 Hutton W, 2000: 63% for the NHS as against 12%, 11% and 3% for the others respectively

39 ibid

*rationing decisions by NICE, foundation trust governance by Monitor, board appointments by the Appointments Commission and pay negotiations by the NHS confederation."* [41]

But while politicians have sought more distance, through delegating more power to independent regulators, market mechanisms and a choice agenda, this has come at a cost as these have been applied in an inconsistent way and with very uneven results. The system has become more fragmented as politicians try to withdraw in different ways. They have created, variously: the purchaser/provider split; a proliferation of different kinds of providers; a range of regulators (Healthcare Commission, Monitor); expert advisers (NICE); and the rapid succession of different local accountability structures adding to the NHS's alphabet soup of acronyms (moving from CHCs to CPPIH, to LINks in the period since 2003 alone). This has done nothing to increase transparency within an already highly complex and inaccessible system.

The result has been that the very powerful and popular idea of 'the NHS' is in the process of becoming diffused in practice. Greater fragmentation and longer chains of command are leading to less control and potentially greater confusion about what 'the NHS' is, who is responsible, and what it will deliver to patients and citizens.

Meanwhile, even as they have proclaimed the need for distance, politicians have in practice intervened when it suits them. Examples include hospital closures, setting tariffs for the internal market, overriding the advice of NICE in certain cases,[42] and taking unilateral action on matters that most people might assume were issues for local management or the regulator. The prime minister did the latter at the 2007 Labour Party conference when he announced his plan to 'deep clean' every hospital. The effect has been to compound the sense that national politicians are indeed 'responsible' for an ever more complex and fragmented system, thus undermining local responsibility, and sending very mixed messages to those trying to make the increasingly devolved system work.

One view sees this continued political involvement as inevitable, given the sums of money involved, another as excessive interference. While there is no doubt that many aspects of the NHS will continue to require political oversight, the real question is whether it is possible to move towards **greater** independence and accountability to deliver a better service for patients and citizens, without the same degree of day to day political involvement. That question informs the range of proposals for NHS constitutions, charters, independence and local control which are currently being tabled (See Table 1).

All these proposals differ but most seem to involve a greater degree of NHS independence from central government, albeit with differing controls. At the time of writing it remains to be seen whether the government's advocacy of a 'constitution' for the NHS will or will not put it at greater arm's length.

40 Stevens S, 2007

41 See comment by Professor Joe Collier in Boseley S, 2005, re the accelerated decision to provide Herceptin: "It is unacceptable that the minister should be pressurising the licencing authority or dictating to NICE about the proper use of medicines. What they should certainly do is make sure the decision by NICE is very fast. That would be reasonable. But this is a dangerous precedent and Patricia Hewitt should back off." In this case a court case and public campaign prompted a ministerial instruction to health authorities to make the drug available to early stage cancer patients, but without any additional funding for this. The case highlights the lack of any systematic public involvement in priority setting within the NHS, the ambiguous relation of politicians with NICE, and the peculiarity of NICE recommendations that come without any funding being attached to them. See also Rankin et al, 2007, p21. On deep cleaning see http://www.number10.gov.uk/output/Page13521.asp 17th October 2007

Table 1: options regarding independence proposed by political parties and other stakeholders

| | |
|---|---|
| NHS Independence | Conservative proposals for NHS autonomy and accountability:[42]<br>• greater NHS autonomy through an independent NHS Board reporting to parliament<br>• duties of Secretary of State transferred to Board wherever possible<br>• Government and Board agree a set of objectives based on measurable outcomes<br>• Board given duties to promote patient choice and patient and public involvement; deliver safe, high quality services; achieve efficient, effective and economical purchasing of services<br>• NHS becomes mainly a commissioning body with a mixed market<br>• commissioning led by GPs<br>• national 'HealthWatch' body to act as patients' voice. |
| NHS Independence | Andy Burnham, MP,[43] when Minister for Health, proposed a BBC Charter model for the NHS:<br>• NHS constitution with ten-year review, codifying the values and principles<br>• more operational independence and lighter touch regulation<br>• decisions made locally wherever possible and subject to accountability through public involvement<br>• stronger partnership with local government<br>• more power and ability for staff to innovate. |
| NHS Constitution and Independence<br><br>(legally binding) | The BMA proposes:[44]<br>• a Constitution for the NHS, enshrining its core values, and acting as a charter to identify what individuals can expect (including the right to be involved in their care), what the NHS expects of them, and the core list of NHS funded services<br>• reduced political control, with an independent Board of Governors responsible for achieving the constitution's aims, answerable to parliament and which appoints the key NHS executives<br>• commissioning led by professionals across primary and secondary care<br>• no split of purchasing and providing<br>• private sector role strictly limited<br>• local health councils elected to act as patients' voice. |

42 Conservative Party, 2007

43 Burnham A, 2006

44 British Medical Association, 2007

| | |
|---|---|
| Constitution and Local Control | The Liberal Democrats propose[45] a new model based on local democratic accountability and devolved decision-making involving:<br>• constitution to enshrine core principles<br>• Patient's Contract outlining minimum standards of access<br>• Care Guarantee for elderly people setting out entitlements when using co-payments<br>• elected Local Health Boards to replace PCTs<br>• independent commission to allocate funds to the local Boards<br>• replace SHAs with new regional body federating local Boards to commission specialist services<br>• duty for Health Boards and local authorities to integrate health and social care<br>• variable local income tax to raise a local contribution towards the costs of the NHS. |
| NHS Constitution<br><br>(may not be legally binding) | The Government's preferred option: 'a new constitution of the NHS setting out for the first time the rights and responsibilities associated with an entitlement to NHS care'. Gordon Brown 1st January 2008. Work in progress under NHS Next Stage Review. |
| Constitution perhaps, but no Independence | The Kings Fund,[46] an independent policy institute:<br>• an independent Board is a misguided solution<br>• strengthen role of parliament and of local accountability<br>• adopt principle of 'subsidiarity' – decisions made at most local level possible<br>• an NHS Constitution 'has potential' but needs more thought – however, it could clarify roles and relationships within the system. |
| No NHS Independence | The NHS Confederation,[47] representing all NHS institutions, is sceptical:<br>• an independent Board does not provide all the answers to problems<br>• there should be political accountability for the NHS<br>• independence could perpetuate the hierarchical approach to top-down service delivery, when devolution is what's required<br>• change relationships, not the constitution, by devolving power and creating more autonomy<br>• retain collaborative system not competition<br>• more local decision-making. |

45 Liberal Democrats, 2008

46 Dixon A and Alvarez-Rosete A, 2008

47 NHS Confederation, 2007a

## 3.2 Roots of discontent: current problems for various stakeholder groups

The pressure towards independence stems from the serious problems that the status quo presents, for professionals, politicians, patients and citizens.

**Professionals** complain about the degree of political interference leading to fads, media-driven initiatives and inconsistent decisions, together with a lack of long term planning and funding, and the disruption that accompanies successive waves of reorganisation.[48]

**Patient**-centred care has been slow to develop. The top down nature of recent reforms delivered through targets has accorded little importance to the patient process and experience, or to issues such as continuity of care. It has done little to combat the paternalistic traditions of some health professionals, whilst sometimes producing perverse results.

In 2003 the House of Commons Public Administration Select Committee heard some classic examples of target culture leading people to 'hit the target but miss the point'. At one hospital, targets for outpatient waiting times were only achieved by cancelling follow up appointments, and the hospital's clinical director estimated that 25 patients had lost vision as a consequence of the delays in follow up that resulted. The committee heard other evidence that wheels had been removed from Accident and Emergency department trolleys, reclassifying them as beds in order to meet waiting time targets; and that on occasions patients were inappropriately reclassified so that an ambulance service could meet its response time targets.[49]

At the **citizen** level, there is a very strong attachment to the concept and values of 'the NHS',[50] but this has been at risk of being undermined by the impact of repeated reforms creating increasingly fragmented and impenetrable structures:

- the idea of patient choice of hospital in general is popular with the public at large, but has been shown to be relatively low in most patients' priorities[51]
- repeated reforms of NHS accountability structures have done nothing to increase either their visibility or impact; if anything the effect of change has been to **reduce** some of the key elements of effective accountability[52]
- the fact that many NHS public consultations take place after decisions have already been made, or are effectively impervious to change, is calculated to lead to greater cynicism about the consultation process itself

48 Cf Work Foundation IPSOS/MORI research on low morale of health workers compared to others in the public sector and quote from Andy Burnham, see page 26

49 Public Administration Select Committee, 2003

50 Hutton W, 2000. A poll conducted in March 2000 asking which basic rights should be included in a Bill of Rights found that 'the right to free medical treatment at a time of need' was endorsed by 97% of respondents, putting it just behind the rights to privacy, to free speech, and to vote

51 for example, Picker Institute for the Healthcare Commission, 2007

52 Hogg C, 2007

- over-claiming of success by politicians and top management has a similar impact, as when it was claimed that mixed-sex wards had been eliminated, when a recent inpatient survey showed that at least 11% of patients were still sharing.[53]

- the NHS has been slow to engage with the practical concerns of most citizens on ease of access to healthcare.[54] It is true that some new forms of primary care access such as NHS Direct and walk-in centres are popular, but their cost effectiveness is unproven since many patients go on to consult their GP about the same problem, and they have had little, if any, impact on the continuing rise in referrals to Accident and Emergency.

For most patients their GP is the focal point of their relationship with the NHS but in spite of increased health expenditure and increased pay for GPs, access has become more difficult and the number of Saturday surgeries has declined. The issue of access to GPs has become a key concern, with government requiring that Primary Care Trusts ensure that from 2008 50% of the practices in their patch are offering extended hours in accordance with patients' wishes.

The 2006 national survey of primary care patients found that:

*"One in four (25%) of all those in the survey stated that in the last 12 months they had been put off from going to the practice because they found its opening hours inconvenient for them. This shows a decline in perceived convenience of opening hours over recent years – in 2005, 21% of patients reported finding opening times inconvenient, with similar proportions reporting this in 2004 (22%) & 2003 (20%)."*[55]

While citizens have huge interest in aspects such as waiting times, ease of access, quality of care and adequate NHS provision and funding, they may often find political exchanges over the NHS are hard to grasp. That applies particularly to debates over funding, where the amounts of money are so huge, and the debates over proposed funding levels so arcane, that it tends to undermine trust in anything politicians say about 'spending on the NHS'.

Interestingly, as is evident from the direction of recent policy, many **politicians** themselves seem to want greater distance from the day to day operation of the NHS, even if they disagree about how much distance is appropriate. Government ministers often feel they are held responsible for things over which they cannot any longer exercise real control; that public expectations of the NHS can be unrealistic in terms of funding levels; and that even when expenditure is increased dramatically, as has happened in recent years, any perceptible improvement in public attitudes can be slow to be manifested.

53 Healthcare Commission, 2007

54 Recent proposals about greater personalisation of health are a rather belated response to this. The most recent comparative study of the UK versus 6 other countries by the Commonwealth Fund shows that 39% of UK respondents reported no routine access to their GP practice out of weekday working hours or at weekends, putting the UK among the bottom two countries on this indicator: Schoen et al, 2007

55 Department of Health, 2007a. It is worth noting the demographic characteristics of patients who reported problems in getting appointments. Those who said they had been put off going to the GP because opening times were inconvenient were predominantly working age people. Not surprisingly, demand for flexible opening hours reflected a similar age profile. Asked what additional times they would most like their GP surgery to open, half of the over-65 age group said they did not want additional times. However, if the issue of ease of access to GPs for younger people of working age is not addressed there is a risk that it could have a significant longer term impact on their support for the NHS

Meanwhile, others have noted that public attitudes are often more affected by the nature of millions of dialogues between patients and professionals – over which government has no effective control – than government policy itself; and that the dissatisfied professionals can have a detrimental impact on public perceptions of the NHS.[56] As the previous Health Minister, Andy Burnham put it:

*"Meeting challenging targets has put staff under pressure. As some trusts struggle to bring overspends under control, staff have been left uncertain about what the future holds and about where Labour is taking the NHS in the long term. This mood of uncertainty explains the 'perception gap'. As individual patient satisfaction rises, so does collective pessimism about the state of the system. Put bluntly, NHS staff have achieved great things in recent years but they don't feel good about it."*[57]

Some politicians suggest that putting the NHS at arm's length to deliver services would enable the government to concentrate greater attention on public health, which is often perceived as inappropriately neglected.

So, greater independence could respond to many of the concerns about the status quo. But is it appropriate to something as large and significant as the NHS? And how can we be sure it will deliver a better result for citizens and patients?

## 3.3 Objections to NHS independence

There is no shortage of objections to greater independence for the NHS. Patricia Hewitt when Secretary of State for Health commented in summer 2007 that:

*"The NHS is four times the size of the Cuban economy and more centralised. That is part of its problem, and the problem can't be solved by proposing that a modern health service be run like a 1960s nationalised industry."*[58]

Similarly, the current Minister of State for Health, Ben Bradshaw, responded to recent Conservative calls for an NHS constitution and an independent board to take on the Department of Health's responsibilities, and free the NHS from 'political tinkering', by saying that:

*"It is simply wrong to suggest that taxpayers should invest £90bn in the NHS but there should be no political accountability for how that money is spent... Under Tory plans, ministers would be powerless to intervene where a hospital is failing."*[59]

56 Rankin et al, 2007, p 22: "There is considerable evidence that NHS staff influence patient satisfaction and negative opinions from some staff are a key driver of overall satisfaction. NHS staff who transmit 'bad news' about the service reduce overall satisfaction." This view has been expressed by others who have been responsible for public service delivery and reform

57 Burnham A, 2006

58 Hewitt, 2007

59 http://news.bbc.co.uk/1/hi/uk_politics/7075524.stm

The former No 10 health adviser Simon Stevens was very clear in his condemnation of a BBC-type model of NHS independence in 2007, saying that it risked reversing previous market-based reforms:

*"..what we do not need is NHS 'independence' understood as an attempt to convert it into some sort of arm's length hospital national management board – a 1970s, British Leyland-style nationalised industry or a stereotyped version of the BBC. The de facto creation of an inward-looking and unresponsive provider monopoly, even accompanied by the inevitable but gimmicky appointment of a few business types to an NHS 'supervisory board', would be an act of recentralisation masquerading as the granting of freedom. By itself it would remove accountability to politicians without adding any to patients. It would therefore produce more inflation, a return to longer waiting times, services organised around the most powerful vested interests, a strictly limited regard for patients' preferences and a progressively disillusioned public."*[60]

Both the NHS Confederation[61] and the Kings Fund[62] have stated their view that independence is the wrong solution to the identified problems, and prefer to emphasise devolution of power, with a redrawing of relationships between the current decision-makers in the system.

There are legitimate arguments about the best **form** of independence to guard against these dangers. However, most of the arguments against greater independence – on grounds of size, political responsibility, and hence the impossibility of politicians 'getting out' of the NHS – are misplaced.

There are precedents for the government taking important issues out of the political arena. The independence that Gordon Brown, as Chancellor of the Exchequer, granted to the Bank of England over interest rate levels in 1997 is the most obvious example. In that case, the distance from government has undoubtedly increased the credibility and effectiveness of the Bank of England, and interestingly it has been accompanied by a much more transparent approach, with the minutes of the monetary policy committee being published a month in arrears.

The NHS is far more complex, and political accountability, far from being a liability as with interest rates, is an essential ingredient of a publicly funded NHS. But this means that discussion should focus on a **relative** but nevertheless very significant increase in independence, rather than absolute independence.

In practice the issue is about the extent to which it would be beneficial for politicians to withdraw from day to day decisions, while creating a strategic framework within which management operates for the benefit of, and is held to account by, the public.

60 Stevens S, 2007, p267: Stevens does note that the requirement on the BBC to source 25% of its programmes from independent producers might provide a useful precedent for the NHS. He goes on to offer an alternative model to generate 'the trust and transparency that independence is designed to achieve'. See below

61 NHS Confederation, 2007a

62 Dixon A and Alvarez-Rosete A, 2008

Edwards[63] has produced an impressive examination of the full range of models of greater independence (See Table 2, Appendix, page 61). However, his primary focus is on setting out the different structural solutions and their relation to the current policy framework, rather than assessing their possible impacts on patients and the public.

The focus in this paper is not on critiquing various models, but on examining whether the lessons from the BBC's Public Value approach could help the NHS to create better results for patients and citizens. We should therefore next examine the comparability of the BBC to the NHS.

63 Edwards B, 2007. See summary of these models in Appendix, page 61

# 4 The BBC and the NHS – similarities and differences

The BBC offers a more useful model than the Bank of England for a more independent NHS, and one that was singled out as a possibility by Andy Burnham, when he was Minister of State for Health:

*"One way to give permanent reassurance about our enduring values without stifling local innovation may be an NHS Constitution, perhaps along the lines proposed by Will Hutton in his book New Life for Health: The Commission on the NHS. This would set out the values and principles we share and that are not up for debate, while providing the framework within which any changes could take place. In a similar way to the BBC Charter process, the NHS Constitution could be renewed every 10 years through a wide-ranging and inclusive debate about what we want our NHS to be in the future."*[64]

The scale of the BBC cannot compare with that of the NHS. But it holds a similar place in public affections. And the BBC is, like the NHS, a public service organisation with a complex range of goals, where the decisions over its statutory framework, funding method and level of funding (in the BBC's case the Charter, the Agreement and the Licence Fee) are absolutely made in the political domain, but importantly on a fixed and relatively infrequent timetable. Thereafter, politicians are obliged to stay at one remove, while the organisation focuses on **delivery** to consumers and citizens and wider **accountability** to citizens and parliament, rather than government.

## 4.1 Journalistic and clinical independence

The BBC case contains a particularly strong imperative for political distance in terms of the editorial independence of the organisation, and the need for its news coverage to be politically impartial. While this impartiality requirement in news applies to all broadcasters, the legitimacy of the BBC depends on it being a genuinely independent and public service broadcaster, focused on serving the public, rather than a state broadcaster under government control.

The public has absorbed these values. Perceived government attempts to exert pressure on the BBC tend to be resented by the public and can rebound on the government of the day. Following the publication of the Hutton report in January 2004 and the departure of the Chairman and Director General, one poll found that 67% of respondents trusted BBC news journalists to tell the truth, compared with only 31% who trusted the government.[65] Together with the other factors mentioned above,

64 Burnham A, 2006

65 Daily Telegraph 30th January 2004 reporting a You Gov opinion poll

these features tend to increase the BBC's operational independence and its accountability to its users, rather than to government (see Section 2).

The NHS is clearly different from the BBC, and its links to government are very strong, but there are some areas of crossover that are worth considering in the debate over greater independence. While the notion of editorial independence is particular to the BBC, the broader notion of respect for professionalism and operational independence is not. The extremely high levels of public trust in doctors seem likely to be based on the notion of the primacy of their professional judgement rather than political control in deciding how best to treat their patients.[66] And the levels of trust in doctors – more than four times higher than for politicians or the government itself – suggest that attempts to place the health service under greater political control might undermine, rather than build trust.[67] The highly prized concept of 'clinical independence', which has often seemed under pressure from the target culture, therefore appears to have public support.

## 4.2 Usage and user experience

We described above how the BBC's audience reach and the satisfaction of its users feeds back into management, into governance and ultimately into the political decisions at Charter renewal. While a much lower percentage of the population has first-hand experience of the NHS every week than is the case with the BBC, taken over a year usage figures are high, and rising:

- on average people see their GP four times per year; and even those in the lowest usage groups (five to 15 year olds) see the GP twice a year[68]
- in 2006 there were around 290 million GP consultations in England, a rise from 220 million in 1995[69]
- in the 2004 General Household Survey 14% of adults and children had seen a GP in the previous two weeks; and 14% had attended an outpatient or casualty department in the previous three months[70]
- in 2005-06 there were over 15 million first attendances at outpatients[71]
- in 2006-07 there were 14.8 million 'finished consultant episodes' in English hospitals[72]
- around eight per cent of the population report an inpatient stay in a given year.[73]

As citizens we all place huge importance on the 'option value' of the NHS: that is, the value of knowing that it is there and that we can use it when need arises. It is true that, in contrast to the BBC, very few people have the possibility of entirely opting out of NHS services, but that might be seen as increasing people's stake in it.

66 Ipsos/Mori 2004 found more than nine in 10 members of the public (92%) are satisfied with the way doctors do their jobs, compared with fewer than three in 10 (27%) for politicians. Most believe doctors are hardworking (87%), committed (85%) and helpful (83%). A third (33%) do not think that doctors are supported by the NHS, compared with 46% who say they are. More than four in 10 (43%) believe doctors are supportive of the NHS, compared to 34% who think they are critical of the NHS. http://www.ipsos-mori.com/polls/2004/bma.shtml

67 Ipsos/MORI figures for 2006, which also show that 92% of respondents generally trust doctors to tell the truth, compared to 20% for politicians and 22% for the Government. http://www.ipsos-mori.com/trust/truth.shtml More recently an Ipsos/MORI survey for the BBC, published in January 2007, showed that the most trusted institutions are as follows: BBC 49%, NHS 46%, media in general 14%, government 10%, big British companies 8%. Asked whether they trusted the BBC to sort its situation out and 'do the right thing', 76% of the public said yes in December 2007 – up by 3% on August 2007. See speech by Mark Thompson http://www.bbc.co.uk/pressoffice/speeches/stories/thompson_trust.shtml

68 Office for National Statistics, 2006

69 Information Centre for Health and Social Care, 2007a

70 Office for National Statistics, 2005

71 Information Centre for Health and Social Care, 2007b

72 ibid

73 ibid

## 4.3 Public debate about funding

With the BBC, there is a basic contract between it and its users in the form of a hypothecated payment (the Licence Fee). The fee's existence obliges the BBC to account to its payers, to explain clearly what users can expect to receive, to be sensitive to feedback, and to uphold principles such as universality and equity.

But when it comes to NHS funding, while most people know the sums of money involved are very large, very few people have any understanding of how that money compares to their weekly or annual household expenditure. The result is that one of the preconditions of independence, a sensible public debate over the right level of public funding, and over the uses to which that funding should be put, is at present almost impossible to achieve.

However, before turning to discuss how funding might be treated differently one must first consider some of the evidence on what citizens and patients want from the NHS and the extent to which greater NHS independence might help meet these expectations.

# 5 What do citizens and patients want from the NHS?

What patients want from healthcare has become increasingly well understood over the last decade, not least through the increasingly routine use of patient experience surveys. The Picker Institute pioneered the use of these surveys in the UK, and is acknowledged as a leading authority on what patients want.

## 5.1 What patients want

From this and other research the Picker Institute has described eight 'domains' of care which are of the highest priority for patients:

- fast access to reliable health advice
- effective treatment by trusted professionals
- shared decisions and respect for preferences
- clear information and support for self-care
- attention to physical and environmental needs
- emotional support, empathy and respect
- involvement of and support for family and carers
- continuity of care and smooth transitions.

**Access** has been one of the biggest issues in UK healthcare reform. Patient surveys show significant improvements in patients' experience of waiting times. For example, 74% of patients said they got their GP appointments within 48 hours in 2006 (and half of those who did not had decided to wait longer, perhaps to see the GP of their choice or at a better time).[74] Some 77% said their primary care appointment was 'as soon as necessary', while in acute hospital care 74% said the same – both figures being improvements on previous years.

Nevertheless, frustrations remain. As noted earlier, one quarter of patients, mainly in the working age groups, are sometimes put off from making GP appointments because of the perceived inconvenience of surgery opening hours.[75]

Access also has other elements, in particular equality. Access to GPs, for example, remains stubbornly unequal, with fewer GPs in the most deprived and therefore needy areas.

Whether patients receive the other seven aspects of a patient-centred health service is dependent on the quality of their relationships with the health professionals they encounter during episodes of care.

74 Department of Health, 2007a

75 ibid

Evidence from patient experience surveys shows that these relationships are generally seen by patients as very good. There are high levels of **trust** and confidence in doctors and nurses ('trusted professionals'), and patients rate them highly for their humane approach ('emotional support, empathy and respect').[76] They also say that professionals are good at listening, and at explaining information in terms the patient can understand.[77]

However, patients report significant room for further improvement in these professional-patient transactions. For example, there are many ways in which **information** could be improved, including provision:

- that supports patients to manage their own health
- about how to access services that patients may need, especially non-medical services[78]
- about medication options, and about the reason for choosing certain courses of medication – especially with regard to the medicines people take home from hospital.[79]

One of the biggest areas for improvement identified through all the patient experience surveys is in the **sharing of decisions** or in the language of Public Value, health professionals' openness to the idea of co-creation. Despite the high regard for professionals and their communication skills, at least one third of patients in any survey of the NHS to date have said that they were not as involved in decisions as they would like to be. This figure rises to half of all hospital inpatients and more than half of people with mental health problems.[80] Likewise, **family and carers** are often not involved in the sharing of information and decisions.

**Continuity** of care and smooth transitions between different stages are weak areas in the NHS. Patients and the public experience significant barriers to moving between different care settings, and to accessing services across geographical or sectoral boundaries.[81] Hospital discharge arrangements leave many patients without sufficient information about their medication, what to do if things go wrong, or how to get the services they will need in the community.[82]

## 5.2 What patients value

In a Public Value approach, policies for healthcare, and the design of services, should be more securely based on what is **important** to patients. There are a number of studies that ask patients to rank what is important to them from a range of factors affecting their care. These reinforce the eight domains outlined above, and show that patients often prioritise them far above the 'consumer' demands that policy makers believe are increasingly important in driving patient behaviour.

76 Richards N and Coulter A, 2007

77 ibid

78 Swain D et al, 2007

79 Richards N and Coulter A, 2007

80 ibid

81 Swain D et al, 2007

82 Healthcare Commission, 2007

For example, with regard to choosing your hospital, although patients and the public welcome the availability of this choice they do not make it a high priority in relation to other aspects of service.[83] Likewise, in 2006, 76% of patients who were referred to hospital without being offered a choice 'did not mind'.[84]

## 5.3 What the public/citizens value

As we've seen in discussions of the BBC case it is natural that there should be differences between citizen and patient goals. In practice while there are differences between the two perspectives there are also some overlaps between them. For example, while patients want fast access to reliable health advice, citizens also place an 'option value' on knowing that that is available to them and others, should they need it – hence the importance of universality and equity.

Julian Le Grand argues that the 'ends' that we seek in public services generally are quality, efficiency, responsiveness and equity.[85] This comes close to the citizen agenda for health. Recent Department of Health research[86] reveals:

- strong public support for the NHS with over three quarters of the population consistently agreeing in annual surveys since 2000 that 'the NHS is critical to British society and we must do everything we can to maintain it'
- strong positive support for increasing tax support for the NHS
- equally strong support for equity – an NHS based on need rather than ability to pay
- a desire that the NHS should be there when the public need it
- but a lack of public confidence that the NHS spends its money well.

Whereas the eight areas of importance that patients identify are related to the individual, personal experience of receiving treatment and care, by contrast, as citizens we are more likely to prioritise collective values and qualities such as:

- affordability – free at the point of care
- universality and equity
- safety and quality
- health protection, disease prevention
- participation in service development
- transparency, accountability and the opportunity to influence decisions.

83 Picker Institute for Healthcare Commission, 2007

84 Department of Health, 2007a

85 Le Grand J, 2007

86 Department of Health, 2007b

With regard to the opportunity to participate in and influence decisions there should be two sets of related, but often distinct discussions. If one purpose of involvement is to ensure that the NHS is accountable, this is likely to relate much more to **public** involvement. By contrast, if another 'purpose' is to improve the effective delivery of care by health professionals, this is more likely to relate to **patient** involvement.

The studies of public expectations of the NHS are of uneven quality which makes it difficult to be definitive about what 'the public' wants in relation to accountability. However there are some common features in this literature.

The public demands and expects that there should be effective systems of scrutiny, monitoring and regulatory action with regard to health services, whether that relates to hospital safety and cleanliness, the quality of primary care, or the performance of individual professionals. The public believes that professionals should work to demanding codes of standards, which emphasise 'humaneness'.

A clear majority of the public say that they should be involved in decisions about health services, especially those involving 'system-level' choices such as whether to close and centralise Accident and Emergency departments in a particular locality. The 'involvement' that the public expects is the opportunity to be consulted – but consulted meaningfully, and with the results communicated back to them. The public quickly sees through token consultations and develops consultation cynicism.[87]

The public sees meaningful consultation as an important aspect of the accountability of health authorities. Accountability is viewed as 'giving an account' and also 'being held to give that account'.

There is no reason in principle why a change in the **means,** through greater independence, will automatically deliver the **ends** sought by patients and citizens. Introduction of targets for citizen and patient interests, and their regulation within the existing system, are at least theoretically possible (even if there are legitimate questions about the ability of regulation alone to impact on behaviour).

However, insofar as greater independence addresses some of the concerns identified above, it could focus responsibility and accountability, allow for a more 'joined up' approach to the NHS, and – if it adopts a Public Value approach, placing patient and citizen interests at its heart – could lay the ground for a greatly improved service.

87 For example, Litva A et al, 2002

# 6 Organising principles for a more independent NHS

We would argue that any move to greater NHS independence needs to combine independence and accountability, within a framework that sets funding levels and overarching patient and citizen focused goals. It needs to ensure accountability to citizens (both nationally and locally), work better for patients and citizens, and really motivate and engage health service workers/providers rather than being 'captured' by the concerns of its service providers. In addition we must be certain that a more independent NHS can deliver something for patients and citizens that is **so much better** that it justifies the further round of organisational change that it would involve.

The current service has suffered from confusion over goals, micro management, focus on targets – not outcomes and patients – and the failure to engage the public in any meaningful way over the big decisions about the NHS. It follows that any plan for greater NHS independence must start with real public engagement in a political debate about its values and goals, and then create a structure or structures which can be held to account and where there is clarity over the different roles of the key players.

In this section we look first at the organising principles for a more independent NHS, and then at the roles of different players.

## 6.1 Goals of independence

The broad organisational goals of a move to greater independence should include those in Box 2, below:[88]

Box 2: Goals of NHS independence

- **citizen and patient engagement** in the political choices around the values, priorities, levels of funding and key resource allocation criteria within the NHS nationally and locally
- clear **objectives** and **budgets** and **responsibility** for delivery
- **organisational coherence** – to deliver integrated and improved health encounters and outcomes, and help consolidate strong public, patient and professional attachment to the core values of the NHS
- **effective accountability** to patients and citizens.

These goals are now discussed in more detail.

88 These objectives differ from the criteria proposed by Edwards for assessing models of independence (Edwards B, 2007, 47-8):
1. perception of independence by public and staff
2. a managerial rather than political culture
3. ability to respond quickly to changing patterns of clinical practice, and to reshape delivery systems appropriately
4. ability to make difficult and sometimes controversial decisions
5. visibility of leadership
6. respect from health professionals
7. transparency and openness

## 6.2 Citizen and patient engagement in the goals and values

The NHS is very popular, but there has never been widespread public engagement in the key decisions about the goals, funding and values of the NHS.[89] This must be the precondition for any move to greater independence for the NHS. After all, if there is no agreement about what it is for, and its core values, there is no chance of holding anybody to account for what they are delivering.

Similarly, without some effective national debate on funding levels, and criteria for treatment, there can be no political consensus on overall levels of funding for the NHS, or on the rationing decisions that determine which treatments are within scope and which are not.

A BBC Charter-type national conversation on the NHS would have the virtue both of engaging large numbers of people, since there is huge interest in the NHS, and of getting agreement on a long-term way forwards, both in organisational and funding terms. New forms of engagement would be needed to decide the core values of the NHS, as well as its purposes and priorities.

Deciding on NHS goals and values is something that has never been done in a serious way since the creation of a national health service after the second world war. Much of the recent debate over market mechanisms, patient choice, foundation trusts, and so on, has been presented as a discussion over delivery, rather than over values. The reality is that many of these issues go to the heart of the values within the NHS, but have not been addressed as such.

A national debate over the goals and values of the NHS could help to build:

- a new settlement over the balance between public and private provision and over the relative merits of a fully integrated NHS versus the purchaser/provider split
- a broader understanding of what a service offering treatment free at the point of delivery means in an age of constrained resources
- a foundation for the political decisions that need to be made about the NHS
- a remit for those charged with leading a more independent NHS
- a set of core values for providers and people working in the health service that has the legitimacy of public engagement rather than being seen as simply another departmental decree.

89 See above and Hutton W, 2000

## 6.3 Engaging with funding and resource allocation

There remains the problem that NHS levels of funding are so huge that few people can grasp the sums of money involved. A mature debate about NHS funding needs to start with wider public understanding of what current levels of expenditure (£87.1bn in 2007/8 for England) mean. This could be expressed in terms of choices between different forms of public expenditure, and perhaps more important, in terms of average taxation per household. Transparency and the need to promote a mature debate mean there is a strong argument for expressing NHS expenditure in either an average sum per person or per household. At current levels of expenditure, the UK wide figure would approximate £4,000 per household.[90]

Hypothecation, through earmarking tax revenues in this way, is something that has long been resisted by the Treasury, but in one sense the principle was conceded when the government decided to increase national insurance contributions specifically to bring UK health spending up to European levels.

Pure hypothecation along the lines of the BBC licence fee, where there is a flat fee per household which cumulatively leads to a total sum of money for the BBC, cannot be applied to the NHS.[91] The sums of money involved are so large that it would be highly regressive and impractical.

However, the creation of an NHS Fund, based on a publicly declared average tax figure per household, and expressed as a percentage of government receipts, could deliver some of the benefits of hypothecation. It would help to increase public understanding and endorsement of NHS funding, and a long term fixed budget for the NHS, without the disadvantages of having to pay a flat fee per household. The creation of a ring fenced NHS Fund would provide longer term security and the basis for holding an NHS authority to account for living within its means. This approach could increase responsibility: both among citizens, who would have to think through the implications of what they wish for regarding levels of NHS provision, and amongst those entrusted with commissioning and providing that service.[92]

Proposals for significant extensions of the scope of the NHS, whether in terms of major new treatments or better standards of care, would require costings to be produced, and the implications to be debated in terms of the average contribution per household, and in terms of trade-offs against other forms of government expenditure.

A similar principle could be extended to discussions of long term care, where in contrast to Scotland there has been no public discussion of the principles and affordability issues in England, aside from that which surrounded publication of the Royal Commission's report in 1999.

90 All figures here from NHS Confederation, 2007b. The same source provides a figure of £1540 per head in England for 2005/6

91 There is provision in the BBC Charter for some of the licence fee to be used for other public service broadcasters if that were to prove necessary

92 This idea was advocated by Julian Le Grand six years ago (Le Grand J, 2001). Recently Charles Clarke advocated hypothecation as a more general approach: "This means increasing the proportion of taxation which is hypothecated to a particular purpose such as health, green sustainability or particular infrastructure investments. The Treasury has conventionally rejected this proposal, including under this Government, on the fundamental grounds that it does not want any restrictions upon its freedom to act. I think that they do not give sufficient weight to the downside of that attitude, which is that the citizen does not feel any particular connection to or ownership of the way that their taxes are spent". (Clarke C, 2007)

The nature of demand for health services means that there is likely to be some growth element within any publicly endorsed level of long-term funding for the health service, but it is right that any attempts to increase this level should be the subject of renewed debate – along Public Value lines – informed by a full understanding of the goals sought and the costs and benefits involved.

## 6.4 Clear objectives and responsibilities

There would need to be clear objectives for the health service that were publicly endorsed, along with the funding.

As with the BBC's six public purposes (see Box 1, page 13), there is a strong argument for establishing a very short list of high-level objectives, in order to focus accountability on delivery. This list should include objectives focused on:

- the overall health of the population
- the patient experience and patient-reported outcomes
- clinical quality and safety
- and the efficient use of resources.[93]

In addition there would need to be clarity over the boundaries between decisions taken in the political arena, and those delegated to an operational delivery arm (see Box 4, page 42). The high-level objectives would need to be defined, and responsibilities for them spelt out, for a reasonably lengthy period – say, seven to ten years. As with the issues of funding, goals and values this would both ensure a really effective public debate, and set long-term objectives and responsibilities for which people could be held to account.

## 6.5 Organisational coherence and improved accountability at national and local levels

Two linked objectives of any reform programme should be greater organisational coherence and improved accountability at local and national levels. This approach stands in contrast to recent reforms which have tended to prioritise Choice over Voice; and where some of the enablers of Choice have led to a fragmentation within the NHS that has impacted on both its organisational coherence and the ability to hold anybody to account for NHS-wide delivery as opposed to single incidents.[94]

The aim would be to replace the fragmentation of recent years, with a really unified and integrated NHS delivering improved health encounters and outcomes.[95] But this would also help to consolidate strong public, patient and professional attachment to the core values of the NHS. There should be simpler structures and goals that are understandable by patients and citizens alike. Empowered managers and health professionals should operate within an agreed NHS framework that engages them in a common purpose while allowing them to make sometimes difficult and controversial decisions.

93 Glasby J et al, 2007, propose a very similar list but include 'Ensuring staff are satisfied and that staff experience improves year on year'. While staff satisfaction is clearly important, it is questionable as to whether it should appear in a very short list, of four or five high-level patient- and citizen- focused objectives

94 In this sense the approach here differs from that taken say by Julian Le Grand or Simon Stevens who tend to see choice and market mechanisms as providing the most effective route to a responsive NHS: Le Grand J, 2007; Stevens S, 2007

95 This call for coherence resonates to some degree with that proposed by Chris Ham and others who recommend the development of 'clinically integrated systems' with a move towards 'closer collaboration between providers' in place of what they note has been a situation where 'to date more emphasis has been placed on the development of competition than collaboration': Ham C, 2007

New and more effective mechanisms of accountability at both national and local levels would be required. This would be the very basis for the legitimacy of a national framework for the NHS. As noted above, accountability mechanisms would be used both to endorse ('authorise', in Public Value terms) the objectives, values and funding levels of the NHS as a whole, and as a way of holding any NHS authority to account. There would also need to be a way of addressing, accounting, and hence gaining public acceptance for, the inevitable variations in local needs within any national system.

There are, of course, some locally organised accountability mechanisms within the current system. But the record is very uneven.

Foundation Trusts were heralded as offering greater responsiveness to local communities and better services. But there is as yet no rigorous evidence that the changes in governance in Foundation Trusts have resulted in either better accountability or improved services for patients. Evidence early on from Foundation Trusts suggested that elections were characterised by low turnout and that elected Board members sometimes feel they have little real influence.[96]

While some might suggest that these things may only have been teething problems, Monitor, which regulates Foundation Trusts, recently reported to parliament that "improvements in governance and financial strength are currently driven by the assessment process and the pace of improvement is not generally sustained after authorisations". In other words the trusts seem to gear themselves up to the process of becoming authorised but cannot keep up the momentum thereafter.[97]

In terms of accountability more generally, it would appear that community involvement has been weakened, and according to one commentator "in spite of government commitment and additional resources, the formal arrangements for the involvement of patients and public, which existed in the UK since 1974, have become fragmented and unstable following the abolition of Community Health Councils in 2003."[98]

Meanwhile, PCT accountability is at best uneven.[99] The Picker Institute reported that PCT efforts to involve patients and the public in commissioning showed there was a great deal of progress still to be made and that more support was needed.[100]

At a time when PCTs are expected to play an increasingly important role in the NHS, it is a serious matter that, as one recent study noted, "PCTs find themselves behind hospitals and general practice in the public's conception of *what the NHS is*". The authors state that it seems likely that "substantial sectors of the population, will at any time be unaware of the PCT area to which they belong", adding how "the challenge for PCTs is therefore to go from 'faceless bureaucrats' to the public embodiment of the NHS for a given community and place".[101]

96 Day M, 2005 reports a year long study of Homerton Hospital, one of the first Foundation Trusts, revealed that many of the Trust's governors felt they had no or little influence on how the hospital was run; Brettingham M, 2005 found serious deficiencies in the representativeness of electorates, since people were required to opt in to vote in trust elections, with the result that electorates might be only a few thousand and most of those voting were elderly

97 Monitor found no significant differences in the performance of longer-established FTs compared to those authorised in the last year. While overall patient satisfaction is higher in FTs (by 3%) than non-FTs, this is not necessarily due to the governance structure. These were hospitals with higher standards of care even before becoming FTs: Monitor, 2007

98 Hogg C, 2007

99 Cf Andy Burnham's comment that while "We want PCTs to be strong commissioners .. it is something of an unfinished question in our reform package about how those local decision-makers be held to account for the vitally-important decisions they will take on our behalf, and the behalf of the communities we live in". Burnham A, 2007

100 Chisholm A et al, 2007

101 Williams I et al, 2007

Rapid institutional reform can undermine the legitimacy and credibility of attempts to involve the public. All representative structures need time to build their profile and credibility and the recent pace of change in patient and public involvement has clearly not provided that. Perhaps for that reason, some have proposed that local authorities should take a much greater role in providing accountability for local health decisions. But while the proposal to delegate more power to the local level may be right, handing over local and regional funding to local authorities could well backfire.[102] It might do nothing to increase current very low levels of participation in local elections, whilst undermining the effective accountability of a new more independent NHS.

In addition, the levels of funding involved in the NHS are so huge, that they would overwhelm local government expenditure, and simply exacerbate the existing mismatch between local government's statutory responsibilities and its ability to raise its own funding through local taxation.

The model proposed here, and explored further below, is one where there would be clear national guidelines and criteria that would be susceptible to variation and refinement in the light of local consultation. What is clear is that the mechanisms for that consultation need to improve markedly compared to those that have been used to date.

Accountability within the NHS needs to be thought of in a new way. Less as a token nod towards 'patient and public involvement' in a service essentially run by politicians, managers and clinicians, and more as something that could really make a difference at each level of the NHS.

One might think of increased accountability within a more independent NHS along three axes.

### Box 3: Three axes of accountability

1. Serious and wide ranging national democratic debate and engagement in agreeing the overall objectives, values, policies and resources accorded to the NHS. A Charter-type discussion but on a larger and more intense level than anything seen to date.

2. Public and patient involvement at both national and local levels in service design and delivery through the authority leading the more independent NHS, the SHAs and PCTs. This would need to be of a kind that was visible, best in class and made a real impact – all things that are notably absent from the recent record.

3. A commitment to shared decision-making with patients at the level of service delivery, in the spirit of co-creation discussed above. If that can really be achieved then service design, delivery, effectiveness and responsiveness should all improve. In other words patient involvement could help in the definition and delivery of NHS objectives rather than simply being an afterthought.

102 Lamb N, 2007 and subsequently Liberal Democrats, 2008

## 6.6 Distinguishing the political and strategic from the operational

As noted previously, complete independence for the NHS is impossible to envisage, as long as it is publicly funded. So, the organisational debate really focuses on the **degree** of autonomy that would be provided to the central NHS authority.

Linked with that are the questions of distinguishing:

- political and strategic issues which relate to the framework for the central NHS authority, from operational issues
- amongst those operational issues, which should be decided centrally, from those which should be decided locally
- how these arrangements might be best designed to deliver a more patient centred health service.

There are some who argue that this distinction between the political/ strategic and the operational is an impossible one to accomplish in practice. This was the argument put forward in a recent ippr pamphlet:

*"... it is notoriously difficult to split strategic and operational decisions in health, where even the most seemingly technical decisions have highly political implications, for instance setting the payment by results tariffs. It is important to retain ministerial accountability in highly political decisions about resource distribution and allocation, health system performance and health outcomes..... If an independent board would be given a powerful role, then its legitimacy would likely to be called into question as soon as it began to make controversial decisions."*[103]

But in any structure there will be difficult distinctions to be made. The critical issue is that there is political legitimacy for those elements that remain within the political arena, **and** for the structures to which power is delegated. In addition, the accountability mechanisms for each need to command widespread credibility and support.

There will be cases where contentious issues that have been delegated to the NHS authority will prompt campaigns, with requests that they be overturned at the political level. But this reinforces the argument for a widespread public debate to create, in the language of public value, the 'authorising environment' for the legitimacy of the overall framework and policy, the delivery structures that are created, the accountability structures that feed into each tier, and the clear visibility of leadership and credibility and authority of those in charge of the NHS.

103 Rankin J et al, 2007, pp35-36

Box 4: Political vs delivery issues

**Issues that should remain in the political arena**

The following elements should remain in the political arena, and can be compared with the role that the government takes in establishing the Charter framework for the BBC, together with a separate, more detailed Agreement, and its funding through the licence fee.

1. Setting a long term overall framework for seven to ten years, and overall agreed funding levels for the NHS – this requires a long enough period to provoke real public debate and encourage fiscal responsibility, both on the part of the government and of any delivery authority.

2. Setting broad objectives for the NHS. Creating a clear regulatory framework for the NHS.

3. Holding any NHS delivery body to account.

**Issues that could be delegated to an NHS delivery body**

1. Holding responsibility for the NHS.

2. Managing within long term fixed funding (as well as inputting to debates over future funding needs).

3. Budgeting and resource allocation.

4. Organisational/structural issues not addressed at the political/ strategic level.

5. Devising national criteria and strategies for levels of provision (both nationally and locally) in the light of expert advice and extensive nationwide public engagement.

## 6.7 Options for greater independence

There are a variety of options for giving greater independence to the NHS. They range from the government's notion of a constitution setting out fundamental rights and goals, to greater delegation to local PCTs, to the acceleration of existing reforms leading to all hospitals becoming Foundation Trusts and more scope for independent providers to operate within the NHS,[104] to the creation of a separate and new NHS board sitting within a BBC Charter-type framework.

104 Stevens S, 2007, p267-8

These proposals vary in the extent to which they involve more or less choice and competition, situate accountability in market-based mechanisms or in political accountability either at national or local level, and whether they build on existing structures or create new ones. They all share the assumption that creating greater distance between the politicians and the process of delivering health services will be beneficial; but they differ on how much distance is feasible or desirable.

Few of these proposals meet all the criteria outlined in Box 2, page 36 – that is, a patient- and citizen-focused approach to creating full engagement in the choices and priorities facing the NHS; clear objectives and budgets; organisational coherence; and effective accountability to patients and the public.

Accepting the need for continued political accountability, and a role for choice and markets, the danger of some of the options that favour a very high degree of continuity with the status quo is that they will do nothing to address some of the very serious deficiencies within the current system, from the point of view of patients and citizens.

Arguably the Public Value approach and many aspects of the current BBC Charter offer the closest match to the criteria outlined here and for that reason, in Section 7, we discuss in a little more detail a possible structure within which those approaches could be pursued.

7

# An outline structure to deliver patient and citizen interests within a more independent NHS

Section 6 identified the organisational goals of any move to greater independence as including:

- **citizen and patient engagement** in the political choices around the values, priorities, levels of funding and key resource allocation criteria within the NHS nationally and locally
- clear **objectives** and **budgets** and **responsibility** for delivery
- **organisational coherence** – to deliver integrated and improved health encounters and outcomes, and help consolidate strong public, patient and professional attachment to the core values of the NHS
- **effective accountability**, to patients and citizens.

Applying lessons from the BBC's Public Value approach, a more independent NHS Authority (NHSA) might operate along the following lines, primarily in regard to the first three of those criteria.[105]

1. As with the BBC it could have a Charter or formal Memorandum outlining its high level responsibilities, objectives and mode of operation for an agreed fixed term of seven to ten years. This document would identify the key purposes of the NHS and would be approved by parliament but only after widespread public, citizen and patient engagement.

2. In addition to a Charter/Memorandum there could be a secondary document providing more detail about the functioning of the new system and the detailed responsibilities of the NHSA in delivering NHS objectives. The extent to which this document was agreed with the NHSA or simply imposed on it, might depend on its record both in terms of competence and patient and public engagement.

3. The NHSA would have at least a three to five year funding settlement and would be held accountable for operating within that to deliver agreed outcomes and objectives, subject to any funding changes (probably increases) introduced after public discussion.

105 This discussion draws on the work of (Edwards B, 2007)

4. The NHSA would have a chief executive, produce an annual plan and an annual report, hold an annual general meeting open to the public and available on the web, and be answerable to parliament and subject to scrutiny by the Public Accounts Committee, as at present, and by a House of Commons Health Select Committee with substantially increased expert resources.

5. NHSA objectives would include (as above):

   a. improving the overall health of the population as measured by a limited number of indices – both clinical and public health ones – as authorised through public debate and by independent verification
   b. improvements to the patient experience and patient outcomes – with the role of co-creation to be recognised through measures of healthcare quality including as far as possible:
      i. patient engagement in decisions about care and treatment
      ii. outcomes measured in terms of the patient experience
      iii. patient-reported outcome measures
   c. clinical quality and safety as based on publicly available measures
   d. the efficient use of resources.

6. As well as these patient focused objectives the NHSA would have a specific duty to engage and consult patients and citizens over their priorities, experiences and expectations; and for their consultation exercises to accord with accepted best practice (as verified through independent audit). Consultation findings would not be binding on the NHSA but 'exception reporting' would be the norm – that is, in cases where the NHSA chose to ignore the findings of a public consultation, it would be obliged to give its reasoning for this.

7. The NHSA and the NHS as a whole would be funded through an earmarked ringfenced budget (an 'NHS fund') expressed in terms of £ per household.

8. The NHSA would aim to introduce greater organisational coherence into the NHS. The NHSA would set the NHS framework nationally with the commissioning bodies, the PCTs. PCTs – as the bodies responsible for the vast majority of NHS spending – would in the first instance be answerable to the NHSA, but with a strong local accountability dimension too. This would need to involve serious approaches to effective patient and public engagement – in governance of the PCT, commissioning and service design.[106]

9. The NHSA could in theory either be responsible for (a) both commissioning and NHS provision, or (b) commissioning only.

   a. The first model would greatly aid coherence and effective responsibility and accountability, and should help in a more joined up approach to the patient experience and health outcomes, but this would represent a radical change in the direction of recent NHS policy. As such it would present problems with Foundation Trusts and independent service providers – requiring reinforced regulation to ensure fair competition and access. It could also involve very substantial structural upheaval in the NHS.

106 NHS and Foundation Trusts can and should engage with the public and patients but most local decisions about local choices/priorities within the national NHS framework should rest with PCTs with more effective accountability structures. Ham C, 2007b, writing about New Zealand offers some interesting reflections on the accountability structures adopted within their local health boards

b. The second model would mean that the NHS Authority was limited to being a planning, commissioning and inspecting organisation. PCTs could be made accountable to the NHSA and do most commissioning, while all providers could operate under an external regulator. This model would clearly be more in tune with current policy, and as such involve far less upheaval to existing structures, but some might fear that it could fragment responsibility and accountability.

   Edwards points out that it also poses the more general challenge of "whether the commissioning levers are strong and flexible enough to deliver a modernised service to patients, and how long it would take to develop the skills to use them".[107] The Department of Health's recent announcement that private firms can be employed by PCTs to do their commissioning for them, is indicative of the weakness of some PCTs and means they could lose out on the opportunity of building learning from their commissioning experience.[108]

10. On model (b) above the NHSA would produce a national commissioning framework – with local freedom within that. There would be an important role for local consultation in decisions over resource allocation and service configuration, but concern for quality, efficiency and equity between regions, would limit the scope for major divergences from the national framework that could not be objectively justified because of specific local features.

11. Changes in response to medical developments/treatments would reflect advice from NICE on effectiveness.[109] In the case of significant funding implications flowing from NICE recommendations this should be combined with a Public Value approach, where the NHSA would have to make trade-offs within existing funding in the light of public consultation, before offering additional funding to PCTs for new treatments recommended by NICE.[110]

12. A single regulator for health and social care to produce published reports on NHSA performance and that of individual commissioners and providers (and to report on best practice regarding consultation and patient and citizen engagement).

    The argument in favour of this structure is that it should provide the citizen and patient engagement outlined above, together with clear objectives, budgets and responsibility for delivery, and greatly improved organisational coherence around an explicit statement of values.

    An empowered NHSA is a precondition for effective accountability, but delivering that accountability both to patients and citizens will require some further specific measures as well as a radically changed mindset.

107 Edwards, 2007

108 Walker D, 2007

109 NICE should advise the NHSA on effectiveness of new and existing treatments, advising after consultation, on what is approved nationally, what is not eligible for NHS funding, and what may be left to local PCT discretion

110 In cases where changes in technology/NICE recommendations might have a dramatic impact on overall NHS funding one might allow the NHSA to request that its 3-5 year funding settlement be reopened to allow for an increase, but this would require a further round of public discussion and consideration about overall levels of NHS funding and consideration of the trade-offs between the NHS and other forms of public expenditure

# 8 Commentary by the Picker Institute

The Picker Institute's original question when commissioning the policy analysis by David Levy was: can greater independence for the NHS deliver appreciable benefit to patients?

It is exciting to be able to say, that on the basis of this analysis's features, the answer is yes.

The project was designed, not to provide yet another single, bespoke 'model' for a more independent NHS, but to help identify:

- in what circumstances, and under what conditions, could greater independence and/or a formal constitution create better outcomes for patients?
- what would be the essential features that **any** new model would need to contain in order to deliver appreciable benefits to patients?
- what useful lessons from the BBC's recent history should be absorbed into any discussion of a constitution or greater independence?

Levy's analysis is his own. But the Picker Institute accepts it, and here we offer our commentary for the benefit of our audiences, including all those patient-oriented organisations that may be wondering 'what is the big deal about a constitution?'

In this response we focus on four features of David Levy's analysis the Picker Institute wishes to see carried forward in the continuing debate about independence and accountability in the future NHS. These are:

- the Public Value approach
- the driving concept of 'co-production' or 'co-creation' of health
- the need for an unprecedented, deep and widespread public debate **as a precondition** for any new settlement
- other detailed features including high-level objectives, and accountability through PPI.

Finally we discuss some additional accountability mechanisms for the NHS, applicable in any model, about which we have already been in discussion with like-minded organisations.

## 8.1 The Public Value approach

For a number of years the government has been straining to create what its policy documents call a 'patient-centred NHS'. This rhetoric is increasingly shared by all main political parties and by stakeholders within the system. Despite some undoubted advances, however, there remain yawning gaps between rhetoric and reality.

These gaps are most obvious in two areas: the high numbers of patients who have consistently continued to report that in recent encounters with the service they were not as involved in decisions about their care and treatment as they would have liked;[111] and the gap between the aspiration to create 'world class commissioning' and the very patchy and partial success of 'patient and public involvement' mechanisms.[112]

There are several reasons for these gaps. Levy highlights the 'proxy' nature of reforms, in which their relationship to the goal of patient-centredness has often been obscure.

Furthermore, good ideas for patient-centred policy often fail in translation to practice, either because the implementing arms of the NHS are focused on other priorities (for example, financial management), or because the ideas are poorly understood, or because the methodologies are undeveloped and underinvested, or simply because they are isolated initiatives that are overwhelmed by bigger reform processes.

It is in this context that the concept of 'Public Value' should become indispensable to the NHS.

As discussed by Levy, Public Value should focus the NHS on 'what the public values' – in this case, what patients and the public value about the NHS and its services – and on 'what value is added to the public sphere', that is, the creation of better health throughout society and better outcomes from care and treatment.

A Public Value approach should be all-encompassing. Like the BBC, the NHS should adopt Public Value as its 'key goal'. In contrast to the current piecemeal approach of trying to insert a few patient outcome measures into pre-existing structures, the whole of the NHS should be refocused on outcomes for patients and the public. All services would be required to show how they build Public Value in order to justify their allocation of resources and trust. All systems of incentives and sanctions, performance management and commissioning objectives should be bent to this goal. All significant proposals for new services, or for the redesign of services, should be scrutinised as to whether they meet a Public Value test.

111 Richards N and Coulter A, 2007

112 Chisholm A et al, 2007

Such an approach could not be cooked up overnight. For the BBC it took almost four years from the first conceptualisation of Public Value in broadcasting to the inception of a new Charter in which it was codified; and it will take at least five years of implementation, with continual adjustment along the way, to prove its impact.

Treated as the 'key goal', however, a Public Value approach could become the 'lodestar' toward which all NHS reform and modernisation is driven, giving sense and coherence to policies that too often seem disconnected from actual benefits to patients and citizens.

**Note:** David Levy's analysis proceeds from the basis that some degree of greater independence for the NHS is required because of various problems within the system, and then discusses Public Value as a potential solution. We would note that taking a 'Public Value approach' **in itself requires** greater independence for the NHS, for two reasons. First, no government of any political party is likely to be able to stand back from its own agendas to lead the impartial development of a Public Value approach to health and healthcare. Second, the Public Value approach implies a deep interactive relationship between citizens and patients on the one hand, and the various levels of the NHS on the other, which would be undermined by the continued week by week seizing of the agenda by politicians.

## 8.2 Co-production of health

As Levy notes, an integral part of the definition of Public Value is the concept of 'co-creation' or 'co-production'. This means that the public service works **together** with the public and with those who use the service, in order to change outcomes for the better and to meet the Public Value objectives.

For the BBC this meant an end to the era of the top-down, national, paternalistic broadcasting model, and a series of innovations that bring audiences into the process of creating the content of its services, and encourage rapid responsiveness to their values and demands.

Health services face similar challenges. As Secretaries of State have noted – without knowing quite what to do about it – the era of paternalistic healthcare, delivered from the top down by the people 'who know best' is, if not exactly over, strictly time-limited. New technologies in information, new patterns of living, new expectations from the public are all putting pressure on the old model. A clear majority of patients want involvement in decisions about their care and treatment; a majority of the public think there should be public involvement in setting health service priorities.

If anything, 'co-creation' is even more apposite to health than to broadcasting. Securing good health and good health outcomes can never be a one-sided process. Patients and citizens bear the most responsibility for their healthy behaviours and for managing with illness and disease; and patients share at least equal responsibility for bringing information

and assessments of appropriateness into the consultation about their care and treatment. Professionals may be experts on medicine, but patients are experts on themselves.

For the Picker Institute this concept chimes with everything we have long argued about the need to evolve the professional-patient relationship into a partnership making shared decisions. It corresponds to solid international evidence that 'patient-focused' health interventions are likely to be more appropriate to the patient and deliver better outcomes.[113] It aligns with our experience that any drive to improve the quality of services and of information will have greatest success if it has user involvement from the start.[114]

'Co-creation' or 'co-production' should therefore be adopted in any new NHS settlement as the main **process** by which the Public Value objectives are achieved. Any new statement of the 'contract' or 'compact' between patients and the public and the NHS should be only one element in a thoroughgoing approach that enables citizens to make the best use of the NHS, containing ambitious proposals on, for example, building health literacy and reforming the nature of the interaction between patients and professionals.

Since professional behaviours are often the key obstacle to 'co-creation', a very potent nettle may have to be grasped, and sooner rather than later – that of performance managing professionals towards patient- and citizen-focused objectives. This would, however, happen within a Public Value approach that gave the professionals themselves a powerful understanding of the 'ends' and 'values' driving the service.

## 8.3 The unprecedented debate

Throughout Levy's analysis there is a recurring emphasis on the need for a Public Value approach to be securely based upon 'what the public values', and on the need for accountability to values and objectives derived from extensive consultation.

The Picker Institute welcomes these emphases and believes they must be part of any action by any government to settle the NHS with a new constitution or greater independence. Deep and wide public debate is the fundamental pre-requisite for such a settlement. No government – and equally, no NHS Board or executive body – should feel it can deliver a 'pre-cooked' package to the public, even if it then attempts 'consultation'.

Given that the current government now clearly identifies the need for a new constitution to mark the 60th birthday of the NHS in June 2008, we urge it to take deep breaths and proceed with due deliberation and modesty. It should pause before ruling things in or out for the new settlement. It should aim to establish a long, clear interval for this public debate to develop, sponsored by the government, but jointly led by the NHS and some of the key professional and patient groups (perhaps even with cross-party approval).

113 Ellins J and Coulter A, 2006

114 Coulter A et al, 2006

The 60th birthday of the NHS should mark the **beginning**, not the end, of the debate about its constitutional future as a service building Public Value.

## 8.4 Other matters

We agree with David Levy that the effectiveness of a Public Value approach will partly rest upon the ability, following public debate, to identify a very short list of very powerful high-level **objectives** for the whole service. The list he suggests seems to us a good starting point for debate (see page 46).

All the proposals advanced by political parties and others regarding constitutions and independence emphasise the aim of better accountability. Levy continues those discussions in a new context here. The Picker Institute would want additionally to note that the public believes such accountability is desirable, that it should be involved in determining priorities, and that 'meaningful consultation' is a key aspect of that accountability. Thus 'patient and public involvement' has a continuing role to play in ensuring accountability, **whichever** new model flows out of the public debate.

There is a pressing need to raise the quality and frequency of public involvement in both commissioning and service provision. In its submission to the Darzi Next Stage Review of the NHS[115] in January 2008 the Picker Institute argued the need for the NHS to:

- develop a clear statement of the purposes of patient and public involvement in the local NHS
- develop and disseminate a coherent framework for measuring and evaluating the effectiveness of local patient and public involvement work against the statement of purposes
- commission research to identify effective strategies for engaging patients and local people
- incentivise effective patient and public involvement in service development and performance monitoring arrangements
- require NHS Trust Board-level engagement with, and responsibility for, patient and public involvement strategies and activities
- incentivise clinicians to share decisions with patients, and reward clinical teams who innovate.

It further placed this in the context of the Review's theme of Innovation, arguing that 'research' and 'innovation' in the NHS should not just be about new health technologies but about new ways of doing business with patients and the public – both through public involvement and through the involvement of individuals in their own care and treatment.

115 Picker Institute, 2008

## 8.5 Other accountability mechanisms to be considered

The force of some commentators' arguments that a more independent NHS could simply become an unresponsive, centralising, paternalistic and inefficient body, somewhat like a 1960s nationalised industry, is undoubted. The Levy analysis overcomes many of these objections by placing the new settlement firmly in the context of a Public Value approach with outward-facing institutions.

In addition we suggest some further accountability mechanisms to 'copper-bottom' Levy's proposals. These could be applied to any model of NHS organisation, including the current one.

1. The NHS authority should have a 'principal duty' to protect and promote patients' interests in relation to securing the delivery of health services. In fulfilling this principal duty, the governing body should 'have regard to' the agreed core values of the NHS (currently defined as ten 'core principles' for all organisations providing NHS care, but having no statutory force).

2. The NHS authority should include a significant number of appointees with demonstrable experience and understanding of patient-centred healthcare.

3. The work of the NHS authority should be monitored and scrutinised by a 'citizens' panel' with a mandate to further citizens', patients' and service users' interests. This panel should have operational and financial independence from the authority, and sufficient resources to conduct its own research. It should have statutory rights to scrutinise certain categories of policy before implementation (such as commissioning frameworks) and the power to make pre-implementation recommendations to the governing body. It should be enabled to establish relationships with Local Involvement Networks (LINks) in order to receive feedback about patients' interests from the local level.

4. Statutory arrangements for the scrutiny and accountability of the NHS should include periodic public and patient consultation on its strategies and plans. This may include, for example:

   a. the publication of a draft annual plan for public consultation;
   b. the involvement of the full range of stakeholder groups in decisions about future national commissioning strategies and guidance.

5. Regulators should be given statutory mandates to work on behalf of patients and service users. The components of healthcare 'quality' that the Care Quality Commission is required to monitor should be clearly defined and must include, so far as possible:

   a. patient engagement in decisions about care and treatment
   b. outcomes measured in terms of the patient experience
   c. patient-reported outcome measures.

# 9 Conclusion

This paper has argued that while there have been many positive developments in the recent history of the NHS, much of the reform agenda has increased the tendency to 'hit the target but miss the point'.

If the service has not been particularly good at focusing on patient and citizen interests it is because it has been largely designed around satisfying the demands of its funders, ie the government of the day, rather than its users. Among the many useful lessons from the current BBC Charter, is the way in which it provides inbuilt incentives to avoid that trap.

What has been proposed here for the NHS is a move towards a Public Value approach, using aspects of the current Charter model. This is not just a 'structural solution' but a radical change in orientation, with a strong focus on the notion of Public Value, with the idea of co-creation at its core, and where **citizen and patient involvement are seen as critical to the design, values, funding, objectives and delivery of the service**, rather than merely inconvenient add-ons.

Greater independence is a **necessary** though not sufficient condition for moving in this direction.

Paradoxically, by creating greater distance between day to day political debate and the fundamental choices required over the NHS, greater independence can actually **increase** real democratic control by promoting mature debate over values, funding levels, and delivery options, thereby giving effective 'authorisation' (a democratic mandate) to a more 'independent' NHS Authority.

The Authority can then both be empowered to get on with the job for an agreed period **and** be held to account at the national and local levels, and at the individual patient and public/citizen levels.

Experience to date suggests that day to day political control has undermined rather than increased real responsibility for delivery and effective citizen and patient engagement, in part because politicians have changed the goalposts too frequently and have created structures that most citizens do not understand.

The move towards a more patient- and citizen- focused NHS needs to start with an agreement that, 60 years on from its creation, the way to build on the massive support for the founding principles of the NHS, is to combine much greater public debate and engagement in determining its future direction with a simplification of its structures. The aim is to achieve widespread understanding of what the NHS is trying to do, what level of funding per household is acceptable, and who, after a decent interval, should be held to account for that delivery.

Greater independence and a Public Value focus together offer the best route to a more mature debate over what we want from the NHS, a more patient- and citizen- focused service, a better balance between public health and conventional clinical interventions, more effective accountability, and possibly in time, continued funding growth, if public debate was to judge that to be necessary.

# References

Alakeson V, 2007: *Putting Patients In Control: the case for extending self-direction into the NHS.* London: Social Market Foundation

Anderson E, Tritter J and Wilson R, (undated): *Healthy Democracy: the future of involvement in health and social care.* London: Involve and NHS Centre for involvement

BBC, 2004: *Building Public Value: renewing the BBC for a digital world.* London: BBC

BBC Charter and Agreement, 2006: HMSO available at http://www.bbc.co.uk/info/policies/charter/

Benington J, undated, a: *Creating and Sustaining Public Value in the Health Service.* University of Warwick Health Service Partnership. Coventry: Warwick Business School.

Benington J, undated b: *From Private Choice to Public Value.* Warwick, unpublished chapter in Benington J and Moore M (forthcoming) *From Private Choice to Public Value*

Boseley S, 2005, *NHS will pay for breast cancer drug, promises Hewitt.* Guardian 6 October

Brettingham M, 2005. *Local control over foundation trusts is "rhetoric".* British Medical Journal, 330:1408 18 June

British Medical Association 2007: *A rational way forward for the NHS in England.* London: BMA

Britnell M, 2007: *A freedom framework will unite former foes.* Health Service Journal, 1 February

Burnham A, 2006: *A Health Constitutional.* London: Progress

Burnham A, 2007: *Speech to Social Market Foundation.* London 15 May available at http://www.dh.gov.uk/en/News/Speeches/DH_074730

Chapman J, 2003: *Public Value. The Missing ingredient in Reform?* In Bentley T and Wilsdon J, *The Adaptive State.* London: Demos

Chisholm A, Redding D, Cross P, and Coulter A, 2007: *Patient and Public Involvement in PCT Commissioning.* Oxford: Picker Institute

Clarke C, 2007: *Economic Policy and Taxation After Blair:* LSE lecture. London, LSE 7 February available at http://www.lse.ac.uk/collections/LSEPublicLecturesAndEvents/events/2007/20061218t1920z001.htm

Collins R, 2007: *Public Value and the BBC.* London: Work Foundation

Conservative Party, 2007: *NHS autonomy & accountability: proposals for legislation.* London: Conservative Party

Corrigan P, 2005: *Registering choice: how primary care should change to meet patient needs.* London: Social Market Foundation

Coulter A, 2006: *Engaging patients in their healthcare. How is the UK doing relative to other countries?* Oxford: Picker Institute

Coulter A, 2007a: *Informed and empowered individuals, families and communities.* Paper to WHO Symposium 'People at the Centre: Reorienting Healthcare in the 21st Century' 25 November available at http://www.pickereurope.org/page.php?id=69

Coulter A, 2007b: *Patient engagement: why is it important?* in Andersson E, Trittter J and Wilson R, *Healthy Democracy. The future of involvement in health and social care* (pp. 27-35). London: Involve & the NHS National Centre for Excellence

Coulter A, 2005: *Patients' experience of choosing where to undergo surgical treatment: evaluation of London Patient Choice scheme.* Oxford: Picker Institute

Cox B, 2004: *The BBC is not the NHS.* London: Prospect, 101 August

Crabtree J, 2004: *The Revolution that started in a library.* London: New Statesman , 23 September, p. 54.

Day M, 2005: *Foundation hospitals are not accountable to their communities.* British Medical Journal, 331:926, 22 October

Denham J, 2007: *Elect the inspectors.* London: Prospect, August (137)

Department of Health, 2007a: *2006 National patient survey of primary care,* London: DH

Department of Health, 2007b: *What matters to patients, public and staff.* London: DH

Department of Health, 2007c: *World Class Commissioning: Vision.* London: DH

Diamond P, 2006: *Conundrums of Reform. Efficiency, Public Virtue and the delivery of World-Class Public Services.* London: Policy Network

Diamond P, 2007: *Public Matters: The renewal of the Public Realm.* London: Politico's

Dixon A and Alvarez-Rosete A, 2008: *Governing the NHS: alternatives to an independent board*, London: Kings Fund

Edwards B, 2007: *An Indendepent NHS: A Review of the Options.* London: The Nuffield Trust

Ellins J and Coulter A, 2005: *How engaged are people in their health care?* Oxford: Picker Institute

Glasby J, Peck E, Ham C and Dickinson H, 2007: *"Things can only get better?" - The argument for NHS independence.* Birmingham: University of Birmingham, Health Services Management Centre

Ham C, 2007a: *Clinically Integrated Systems: the next steps in English Health Reform.* London: The Nuffield Trust

Ham C, 2007b: *The fruits of Kiwi health reform.* Society Guardian, 7 November 2007

Healthcare Commission, 2007: *The views of inpatients in England: key findings from the 2006 survey*

Hewitt P, 2007: *Speech on the future of the NHS*, London: LSE 14 June available at http://www.lse.ac.uk/collections/pressAndInformationOffice/newsAndEvents/archives/2007/PatriciaHewitt.htm

Hogg C, 2007: *Patient and Public Involvement: what next for the NHS?* Health Expectations, 10, 129-138

Horner L, Lekhi R, and Blaug R, 2006: *Deliberative democracy and the role of public managers.* London: Work Foundation.

Hutton W, 2000: *New Life for Health: The Commission on the NHS.* London: Virgin Books

Information Centre for Health and Social Care, 2007a: *Trends in Consultation Rates in General Practice*, 1995-2006

Information Centre for Health and Social Care, 2007b: *Hospital Episode Statistics 2006-07*

Kelly G, Muers S, and Mulgan G, 2002: *Creating Public Value: an analytical framework for public service reform.* London: Strategy Unit, Cabinet Office

Klein R, 2006: *The Values of the NHS in England.* London: Nuffield Trust

Lamb N, 2007: *Localism, Fairness and Empowerment in the NHS.* London: Liberal Democrats

Le Grand J, 2007: *The Other Invisible Hand: delivering public services through choice and competition.* Princeton & Oxford: Princeton University Press

Le Grand J, 2001: *We can save the NHS – if we're ready to pay for it.* Society Guardian, 21 October

Liberal Democrats, 2008: *Empowerment, Fairness and Quality in Health Care.* London: Liberal Democrats

Litva A, Coast J, Donovan J, Eyles J, Shepherd M, Tacchi J, Abelson J, Morgan K, 2002: *The Public is too Subjective,* Social Science and Medicine, 54 1825-1837

Mahdon M, 2006: *Public Value and Health.* London: Work Foundation

Monitor, 2007: *Annual Review and Accounts 2006-07*

Moore M, 1995: *Creating Public Value: strategic management in government.* Cambridge, MA: Harvard University Press

NHS Confederation, 2007a: *From the Ground Up.* London: NHS Confederation

NHS Confederation, 2007b: *The NHS in the UK in 2007/8: a pocket guide.* London: NHS Confederation

NHS Confederation, 2007c: *Consultation: PCT accountability and the democratic deficit.* London: NHS Confederation

Office for National Statistics, 2005, *General Household Survey, 2004*

Office for National Statistics, 2006, *General Household Survey, 2005*

Picker Institute for the Healthcare Commission, 2007: *The 2006 inpatients importance study.* London: Healthcare Commission

Picker Institute, 2007: *Putting patients first. Memorandum to the House of Commons Public Administration Select Committee inquiry into "Voice" in public services.* Oxford: Picker Institute

Picker Institute, 2008: *Policies for Patients,* Oxford: Picker Institute

Public Administration Select Committee, 2003: *On Target? Government by Measurement.* London: The Stationery Office Limited

Rankin J, Allen J, and Brooks R, 2007: *Great Expectations: achieving a sustainable health system.* London: Institute for Public Policy Research

Richards N and Coulter A, 2007: *Is the NHS becoming more patient-centred?* Oxford: Picker Institute

Schoen C, Osborn R, Michelle M, Doty M, Bishop, M., Pugh J, and Murukutia N, 2007: *Toward Higher-Performance Health Systems: Adults' Health Care Experiences in Seven Countries.* Health Affairs, 26 (6), w717-734

Stevens S, 2007: *A Healthy Future?* in Diamond P, *Public Matters* (pp. 251-269). London: Politico's

Swain D, Ellins J, Coulter A, Heron P, Howell E, Magee H, Cairncross L, Chisholm A, Farhat R, 2007: *Accessing information about health and social care services.* Oxford: Picker Institute

Taylor-Gooby P, 2006: *Trust vs efficiency.* Prospect, April (121)

Timmins N, 2007: *Backpedalling from Blair's privatisation agenda.* British Medical Journal 335:781-832, 20 October

Tudor Hart J, 1998: *Expectations of health care: promoted, managed or shared?* Health expectations, 1, 3-13

Walker D, 2007: *Strained Bedfellows.* Guardian, 17 October

Weale A, (undated): *What is so good about citizens' involvement in healthcare?* in Andersson E, Tritter J and Wilson R, *Healthy Democracy. The future of involvement in health and social care* (pp. 37-43). London: Involve & the NHS National Centre for Involvement

Williams I, Durose J, Peck E, Dickinson H and Wade E, 2007: *How can PCTs shape, reflect and increase public value?* Birmingham: University of Birmingham, Health Services Management Group

Woodin J and Wade E, 2007: *Towards World Class Commissioning Competency.* Birmingham: University of Birmingham Health Services Management Group

Work Foundation, 2006: *Public Value, Citizen Engagements and User Expectations.* London: Work Foundation

# Appendix:

## Models for NHS independence

Table 2: models for independence examined by Professor Brian Edwards[116]

| | | |
|---|---|---|
| Model 1: modernise the NHS Executive but stay within Department of Health | NHS acts as an Agency. Strategy remains with ministers and department. Agency responsible for day to day delivery. | Danger of blurred lines; need for explicit delegation of powers and authority; temptation for ministers to 'cross the lines'. Could be a 'transition' model to greater change. |
| Model 2: NHS Commissioning Authority | NHS is a non-departmental public body at arm's length from DH. Appointed Board with stakeholder representation. Would agree with ministers the annual objectives and allocation of resources to commissioners. | Model closest to current policy trends. Difficulty in separating principal policy framework (ministers) from the planning functions of the Authority. Requires high levels of trust between politicians and Authority. |
| Model 3: BBC-type NHS Corporation | All public assets transferred to Corporation which is responsible for both commissioning and providing. Established through Charter and Act of Parliament. Relates to ministers through a formal memorandum agreed every 3-5 years. Hypothecated health tax. SHAs may not be required. | Would need robust boundary between its commissioning and provider arms – possibly an insurmountable problem. Strong control over the whole system (organisation, standards, IT systems, providers, etc). Could be too centralist, too large, and too controlling of Foundation Trusts and private sector. But strong public identity and visible leaders. |

116 Summarised from Edwards B, 2007

| | | |
|---|---|---|
| Model 4: NHS Corporation for commissioning only | Similar to Model 3 but with a purchaser/provider split nationally and locally. PCTs commission vast majority of services. All provider trusts become Foundation Trusts. | Challenge is whether the commissioning levers are strong enough to deliver seamless and effective services to patients. |
| Model 5: regionalised NHS | DH creates broad health policy framework but statutory regional organisations develop their patch within it (cf Spain and Sweden). These bodies could be non-departmental public bodies or public corporations, open to scrutiny. Need for solid democratic platform, therefore close relationship with local government. Might pool purchasing, risk insurance, IT, etc. | Fits best if England moves more generally to regionalised government. Would create significant variations in regional provision and investment. |
| Model 6: local government commissions the NHS | Local government could 'franchise' the NHS, therefore operating under NHS rules eg in London the PCTs could become accountable to the mayor. | Suggests this would need to be trialled first in a city or conurbation. |
| Model 7: NHS as a public insurance company | Licensed independent organisations commission services for individuals, based on a core national entitlement. Such organisations could include PCTs or GP commissioners as well as insurance companies. NHS providers would become full-fledged not for profit organisations. | A 'very different' NHS which does not necessarily undermine the NHS principles but would be challenging to all political parties. |

Picker Institute Europe
King's Mead House
Oxpens Road
Oxford OX1 1RX

Tel: 01865 208100
Fax: 01865 208101
Email: info@pickereurope.ac.uk
Website: www.pickereurope.org

Charity Registration no: 1081688
Company Registration no: 3908160

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