BMJ 2018;362:k2605 doi: 10.1136/bmj.k2605 (Published 6 July 2018)

FEATURE

ESSAY

New era for health services will focus on systems and creativity—an essay by Nick Black

Despite improvements from better monitoring and accountability over the past 30 years, healthcare remains beset with difficulties. Health services are human systems, reminds **Nick Black**, and they should now focus on encouraging and embracing the creativity of staff

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In 1988 Arnold Relman, editor of the *New England Journal of Medicine*, described how attempts to control the costs of the vast array of new diagnostics and treatments that had transformed medical care had had only limited success.[1] He recognised how the quest in all countries for "an equitable health care system, of satisfactory quality, at a price we can afford" was having to contend with the countervailing interests of both the medical-industrial complex and unfettered professional autonomy.

Unfettered autonomy was apparent in the geographical variations in clinical practice being revealed, reflecting inconsistency in professional judgments. Relman suggested that a new, and much needed, era of healthcare was dawning, one that would tackle these challenges through rigorous assessment of clinical practice together with greater public accountability of doctors and services.

That era of assessment and accountability dominated the next 30 years. Evidence based medicine, clinical guidelines, clinical audit, surveys, and regulation have achieved much. The gains can be seen not only in improved outcomes and greater adherence to guidelines but also greater productivity.[2] Underlying these has been considerable success in challenging medical paternalism and undue professional autonomy.

Yet despite all that has been achieved, health systems are still beset with problems. In England, regulators report the quality of many providers needs to improve, the productivity of services varies widely, administrative complexity bewilders patients and staff alike, lack of integration across sectors persists, staff are dispirited, and progress in developing patient centred care has been disappointing.

Why is this? The widely held view is insufficient funding. Although additional funds will no doubt provide some welcome relief, experience suggests any benefit will be short term, and propping up the existing system might further delay the need to tackle the underlying causes.

Instead, what is needed is a new era, one that adds to and supplements the three earlier ones, which were focused in the 1950s and 60s on technological developments, on cost containment in the 1970s and 80s, and on assessment and accountability since then. By themselves these approaches are no longer sufficient.

Shortcomings of era of assessment and accountability

Consider the shortcomings of the era that has dominated recent decades, assessment and accountability. The approach was based on the market oriented tools of new public management, which in turn depended on management solutions developed in the early 20th century to improve manufacturing.

These broke down production into the constituent parts and then sought to control variation by standardising processes. These processes were then centrally driven using incentives, targets, and sanctions, all of which was predicated on the assumption that patients (seen as customers) act rationally in their own interest in response to provider choice.

It is not surprising that application of this model to healthcare had unintended consequences. Regulation has become not only a bureaucratic burden but also an intellectual and emotional burden, at times causing hostility to inspectors. A low trust system has been created that discourages risk taking and threatens the job security of managers.

Staff initiative has been discouraged and their intrinsic motivation crowded out along with their commitment and solidarity to the system. Organisational silos have been perpetuated, limiting the development of links between organisational components. And finally, progress has been

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stymied in rebalancing healthcare towards patients' needs and priorities.

So what is needed?

Health and care services must be able to adapt to complexity, uncertainty, and non-linearity. To achieve this, the new era needs to encompass two features that may seem incompatible: systems and creativity. We need to supplement existing achievements by introducing a greater recognition that health and care services are "human systems," in which the focus should be on the relations between constituent parts (primary care, hospitals, social care, and so on). At the same time we need to accommodate and support social entrepreneurs, the creative disruptors who will instigate innovation.

Given that systems thinking has been around for years, how can it be portrayed as something novel? In the past the approach focused on the organisational components of systems. Solutions were then sought through trying to get each part to do better. This inevitably perpetuated existing ways of delivering care and, when improvements didn't occur, the organisations were blamed (such as by sacking the manager). But health and care services are human or living systems in which the connections between components are fundamental to its success. These may be between departments, wards, hospitals, or whole sectors. A shift of focus away from organisations and to their interconnections requires exploiting the resourcefulness of staff and being truly responsive to the healthcare needs of patients and the social care of clients. It also needs the development of systems leaders, people who recognise that problems cannot be solved by single organisations but by building relationships based on listening without preconceptions.[3]

Leaders must encourage and allow creativity to emerge by drawing together relevant people to tackle any given problem. This takes courage and insight because these people may not be in formal positions, such as medical directors, but be staff who in the past have had no voice. This is vital because creative solutions will reflect who is involved and the space they are afforded to think afresh.

Leaders of systems don't have to feel that they must solve problems themselves. The solutions will come from the social entrepreneurs among the workforce, of which there are potentially many. They are motivated by altruism (rather than profit making), with ideas that traditionally have had little opportunity to be realised. The system needs such entrepreneurs to create necessary disruption given the intrinsic intransigence to change. The challenge is how to release the creativity that lies dormant within the system and then channel the best ideas into practice. We need all involved in health and care services to "think like a system and act like an entrepreneur."[4]

Era of systems and creativity is already here

This may sound too demanding and unrealistically ambitious: but the era of systems and creativity has already dawned. Brilliant examples abound in many countries, not least in the NHS in England, where the essence of the Five Year Forward View strategy in 2014 and the emerging integrated care systems is a shift in emphasis towards focusing on the relation between component parts of the system and encouraging local creativity to transform services.

Denis O'Rourke is assistant director for integrated commissioning in mental health at Lambeth Clinical Commissioning Group in London. He has brought together patients, carers, primary care, commissioners, hospitals, and social care to transform services. The Living Well Network they created has led to better patient experiences plus a 43% reduction in referrals to specialist care and less need for admission to residential care.[5]

Meanwhile, in Frome, Wiltshire, the general practitioner Helen Kingston and health trainer Jenny Hartnoll have brought together general practice, social services, charities, and the community hospital to develop the Compassionate Frome Project to address loneliness. This has been associated with better quality of life for patients and a 17% reduction in emergency admissions.[6]

Reductions in the need for emergency hospital care have also been seen in Nottingham, where the introduction of a falls rapid response team has reduced the number of elderly people transferred to hospital by paramedics by 44%,[7] and in Gateshead where specialist community nursing for older people in a large general practice has reduced emergency admissions by 54%.[8] A similarly large reduction of 36% has been achieved among care home residents in east London by improving GP support.[9]

Local creativity can also be seen in hospitals. In Wrightington, Wigan, and Leigh Trust the incidence of severe acute kidney injury has fallen by 28% and mortality by 57% after the appointment of a specialist nurse, who raised awareness of the condition among ward staff.[10]

These are just a few examples. Much can be and is being learnt from other countries. "Shared dialysis," in which patients take greater control of their clinic treatment resulting in improvements in outcomes, efficiency, and patients' experience, was initiated in Sweden not by staff but by an enterprising patient. The approach is currently being piloted in England.[11] So is a radical new way of organising and managing district nursing, based on the Dutch experience with Buurtzorg, with benefits for patients and staff.[12] And the carers of people with Parkinson's disease and other long term conditions could learn much from ParkinsonNet, an interactive website shared by patients and staff in the Netherlands that has shifted the focus from clinicians' to patients' concerns, halving the rate of hip fractures and the overall cost of care.[13]

Implications for government, staff, and the public

Like all healthcare systems, the NHS has relied heavily on national strategies and central mechanisms in its quest to achieve universal, high quality services that meet the needs and expectations of the public at a reasonable cost. Although there have been notable successes, it is not sufficient to rely principally on central guidance, rigorous assessment, and public accountability.

Inadvertently, this approach has tended to suppress and discourage one of the NHS's great assets, the creativity and commitment of its staff and patients. By releasing their energy and recognising the importance of the relations between organisational components, the health and care system can flourish. The changes needed, however, pose profound challenges for government, staff, and the public. As with any paradigm shift, people will find it difficult and even uncomfortable.

Firstly, government and other national and regional organisations (commissioners, regulators, and so on) may struggle to cope to accommodate the new era because central authorities will have to relinquish some control to enable local creativity to redesign local systems.

Secondly, after years of seeking consistency in service provision throughout the country, the new era will result in more not less diversity. That is inevitable if changes to improve care are going to emerge from local initiatives. Government must have the courage to welcome, support, and defend changes even if they result in greater variation between places. Government's concern must be with areas that are standing still rather than those creating increased variation.

Thirdly, staff will face the challenge of adapting to a world in which the focus is on systems. That requires the ability to think across healthcare sectors and social care. Narrow sectarian interests must be relinquished. This is essential for those in formal managerial positions, but all staff need to orient towards the whole healthcare system and what is best for the public. In practice, staff may find this less challenging than managers.

And finally, the greatest challenge might be for the public. Long held and cherished visions of what healthcare looks like and how it functions—doctors, nurses, hospitals, general practice surgeries—will be challenged. Fear of loss of the familiar needs to be understood and tackled as part of the new era. Given that a feature of the new vision is greater involvement and engagement of patients and the public, from shaping services to self management of health conditions, responding to the public's concerns about emerging changes is vital.

Heralding the dawn of the era of assessment and accountability in the late 1980s, Relman warned that "No one should underestimate the size and difficulty of the task. However, the logical necessity of this new initiative seems clear."[1] Over the past 30 years those difficulties have been overcome, resulting in many benefits. But it hasn't proved to be sufficient. The same warning applies to the new era as does clarity about the need for it. The new era offers the opportunity to supplement past successes in ways that will reinvigorate services and ensure they meet the aspirations and needs of the public and of staff over the next few decades.

Biography

Nick Black has had a long career in health services research. He has been a strong advocate of assessment and accountability and contributed to its implementation. He chaired the Department of Health/NHS England national advisory group on clinical audit and enquiries for a decade and has served on several other national and international advisory bodies on quality assessment and improvement.

This essay is based on the 32nd Annual Health Services Research Lecture given at the London School of Hygiene and Tropical Medicine on 6 March 2018.

Competing interests: I have read and understood BMJ policy on declaration of interests and have no relevant interests to declare.

Provenance and peer review: Commissioned; not externally peer reviewed.

1 Relman AS. Assessment and accountability: the third revolution in medical care. *N Engl J Med* 1988;319:1220-2. 10.1056/NEJM198811033191810 3173460
2 Black N. Declining health-care productivity in England: the making of a myth[PubMed]. *Lancet* 2012;379:1167-9. 10.1016/S0140-6736(11)61782-0 22333946
3 Senge P, Hamilton H, Kania J. The dawn of system leadership. *Stanf Soc Innov Rev* 2015;(Winter):27-33.
4 Burbidge I. Altered states. *Royal Society of Arts Journal* 2017;1:10-5.
5 O'Rourke D. How lessons from the building industry are transforming mental health services. *Guardian* 2015 Apr 15. https://www.theguardian.com/society/2015/apr/15/new-alliance-contract-for-mental-health-services-transformed-in-lambeth
6 Brown M. Compassionate community project. Resurgence & Ecologist 2018 Mat/Apr. https://www.resurgence.org/magazine/article5039-compassionate-community-project.html
7 Foster C, Khendek U. Falls rapid response team: the integrated ambulance and urgent care service model in Nottingham. https://www.kingsfund.org.uk/sites/default/files/media/Falls%20Rapid%20Response%20team.pdf
8 Stansfield S. Fab, 2 May 2015http://fabnhsstuff.net/2015/05/02/oxford-terrace-rawling-road-medical-groupmanaging-frailty-community-though-personalised/
9 Sherlaw-Johnson C, Crump H, Curry N, Paddison C, Meaker R. Transforming health care in nursing homes. An evaluation of a dedicated primary care service in outer east London. Nuffield Trust, 2018.
10 Moore A. Investment in quality saves NHS trust millions. *Nurs Stand* 2017;32:23.
11 Yorkshire and Humber Health Foundation. Shared haemodialysis care. Improving outcomes. https://www.shareddialysis-care.org.uk/
12 de Blok J. Buurtzorg Nederland: a new perspective on elder care in the Netherlands. *The Journal* 2011(Summer):82-86. http://omahasystem.org/AARPTheJournal_Summer2011_deBlok.pdf
13 Gray BH, Sarnak DO, Tanke M. ParkinsonNet: an innovative Dutch approach to patient-centred care for a degenerative disease. Commonwealth Fund, 2016. http://www.commonwealthfund.org/publications/case-studies/2016/dec/~/media/files/publications/case-study/2016/dec/1921_gray_parkinsonnet_case_study