Collaboration for Leadership in Applied Health Research and Care South London (CLAHRC South London)

30 YEARS OF THE RIGHT TO HEALTH IN BRAZIL

Perennial and New Challenges to Universal Health Systems
……reviewing the NHS – a case of forward to the past

Professor Peter Littlejohns
King's College London

● The Collaboration for Leadership in Applied Health Research and Care (CLAHRC) South London is investigating the best way to make tried and tested treatments and services routinely available. University-based researchers, health professionals, patients and service users are working together to make this happen. ● The collaborating organisations are Guy's and St Thomas' NHS Foundation Trust, Health Innovation Network (the NHS England-funded academic health science network in south London), King's College Hospital NHS Foundation Trust, King's College London, King's Health Partners, St George's University Hospitals NHS Foundation Trust, St George's, University of London and South London and Maudsley NHS Foundation Trust. ● The work of the CLAHRC South London is funded for five years (from 1 January 2014) by the National Institute for Health Research, collaborating organisations and local charities. It is 'hosted' by King's College Hospital NHS Foundation Trust. ● The CLAHRC is also working closely with GPs, local authorities (responsible for public health) and commissioners of health services in south London.

Background to presentation

THE LANCET

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Brazil

Published: May 9, 2011

Executive Summary

Brazil has made significant improvements in maternal and child health, emergency care, and in reducing the burden of infectious diseases. But the news is not all good. The country continues to have a burden of injury mortality that is different from other countries due to the large number of murders, especially using firearms. Obesity levels are increasing and caesarean section rates are the highest in the world.

Brazil now has the opportunity to move closer towards its ultimate goal of universal, equitable, and sustainable health care as enshrined in the 1988 Constitution. To highlight this opportunity, *The Lancet* is publishing a Series of six papers that critically examine what the country's policies have achieved and where future challenges lie. As Cesar Victora and colleagues conclude in the final paper of the Series: "the challenge is ultimately political, requiring continuous engagement by Brazilian society as a whole to secure the right to health for all Brazilian people."

Media coverage

The Economist

"the challenge is ultimately political, requiring continuous engagement by Brazilian society as a whole to secure the right to health for all Brazilian people."

Background to presentation

Economic and political crises, combined with austerity policies, pose a major risk to UHC and health gains achieved Brazil, and elsewhere, with detrimental impact on the poorest and the most vulnerable populations, and require development of resilient health systems.

Analysis

BMJ Global Health

The Brazilian health system at crossroads: progress, crisis and resilience

Adriano Massuda,[1] Thomas Hone,[2] Fernando Antonio Gomes Leles,[3] Marcia C de Castro,[1] Rifat Atun[1]

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ABSTRACT
The Unified Health System (Sistema Único de Saúde (SUS)) has enabled substantial progress towards Universal Health Coverage (UHC) in Brazil. However, structural weakness, economic and political crises and austerity policies that have capped public expenditure growth are threatening its sustainability and outcomes. This paper analyses the Brazilian health system progress since 2000 and the current and potential effects of the coalescing economic and political crises and the subsequent austerity policies. We use literature review, policy analysis and secondary data from governmental sources in 2000–2017 to examine changes in political and economic context, health financing, health resources and healthcare service coverage in SUS. We find that, despite a favourable context, which enabled expansion of UHC from 2003 to 2014, structural problems persist in SUS, including gaps in organisation and governance, low public funding and suboptimal resource allocation. Consequently, large regional disparities exist in access to healthcare services and health outcomes, with poorer regions and lower socioeconomic population groups disadvantaged the most. These structural problems and disparities will likely worsen with the austerity measures introduced by the current government, and risk reversing the achievements of SUS in improving population health outcomes. The speed at which adverse effects of the current and political crises are manifested in the Brazilian health system underscores the importance of enhancing health system resilience to counteract external shocks (such as economic and political crises) and internal shocks (such as sector-specific austerity policies and rapid ageing leading to rise in disease burden) to protect hard-achieved progress towards UHC.

Summary box

- Brazil has made good progress towards achieving Universal Health Coverage (UHC) with improvements in population health, but shortages in public funding, suboptimal resource allocation and weaknesses in healthcare delivery persist.
- From 2000 to 2014, total health expenditure rose from 7.0% to 8.3% of gross domestic product and population coverage with the Family Health Strategy rose from 7.6% to 58.2%.
- Since 2015, public health expenditure per capita has declined in real terms, while 2.9 million people lost private health plan coverage, violent deaths have increased and there have been outbreaks of infectious diseases.
- Economic and political crises, combined with austerity policies, pose a major risk to UHC and health gains achieved Brazil, and elsewhere, with detrimental impact on the poorest and the most vulnerable populations, and require development of resilient health systems.

INTRODUCTION

After 30 years of progress towards Universal Health Coverage (UHC),[1] Brazil's Unified Health System (Sistema Único de Saúde (SUS)) is under major threat from a combination of economic recession, political crisis, ill-conceived austerity policies[2] and political decisions aimed at reversing the right to health.[3]

Conceived in the late 1980s by the civil society as part of the 'Sanitary Reform Movement' (Movimento da Reforma Sanitária) against the military dictatorship, SUS has been widely acknowledged as an example of successful health system reform in Latin America,[4] and has played a major role in the redemocratisation of Brazil and in the re-establishment of citizens' rights.[5] Reforms in health system governance and major expansion of primary healthcare (PHC) have contributed to major improvements in health service coverage and access,[6] and health outcomes.[7 8]

However, Brazilian health reforms were incomplete, and did not fully address structural weaknesses in the health system—namely, challenges at the state government level, inadequate financing and inequitable resource allocation.[9] Consequently, disparities in access to effective care, financial protection and health outcomes persist.[10] These disparities will likely worsen due to the current economic and political crises and the new long-term austerity measures,[11] which are testing health system's resilience,[12] jeopardising the sustainability of SUS[13] and

Background to presentation

NHS history

NHS future

Background to presentation

……I spoke publicly about what would be needed if, in our 70th year, we wanted to sustain a well-functioning National Health Service. I explained that the compound effect of funding and staffing constraints since the 2008 economic crash meant that GPs, community and mental health services, hospitals and social care were under increasing strain. While NHS productivity has been rising far faster than the rest of the economy, over the past five years cumulatively the NHS has operated with £27 billion less than had it been funded at its long term trend funding growth. We are now spending a third less per person on our health services than Germany, on a like-for-like basis

Simon Stevens
CEO of NHS England, and Accounting Officer

Overview of presentation

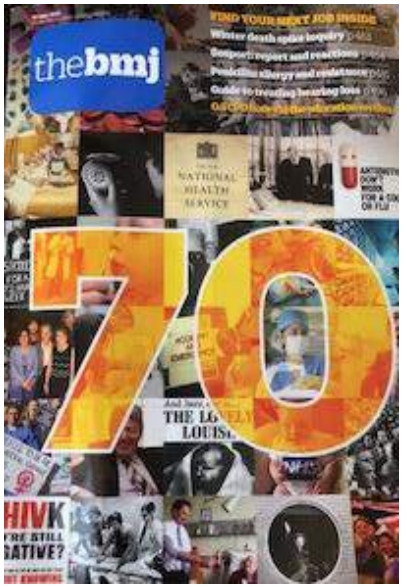
Governance (politics, structures and finance)

Clinical workforce, clinical practice and innovation

Patient and public expectations and involvement

Outcomes and equity

Pondering the future



Based on my 40 years experience of the NHS in UK concentrating on the last 20 years. A personal (political science) perspective based on a series of case studies.

Overview

Governance (politics, structures and <u>FINANCE)</u>

Clinical workforce, clinical practice and innovation

Patient and public expectations and involvement

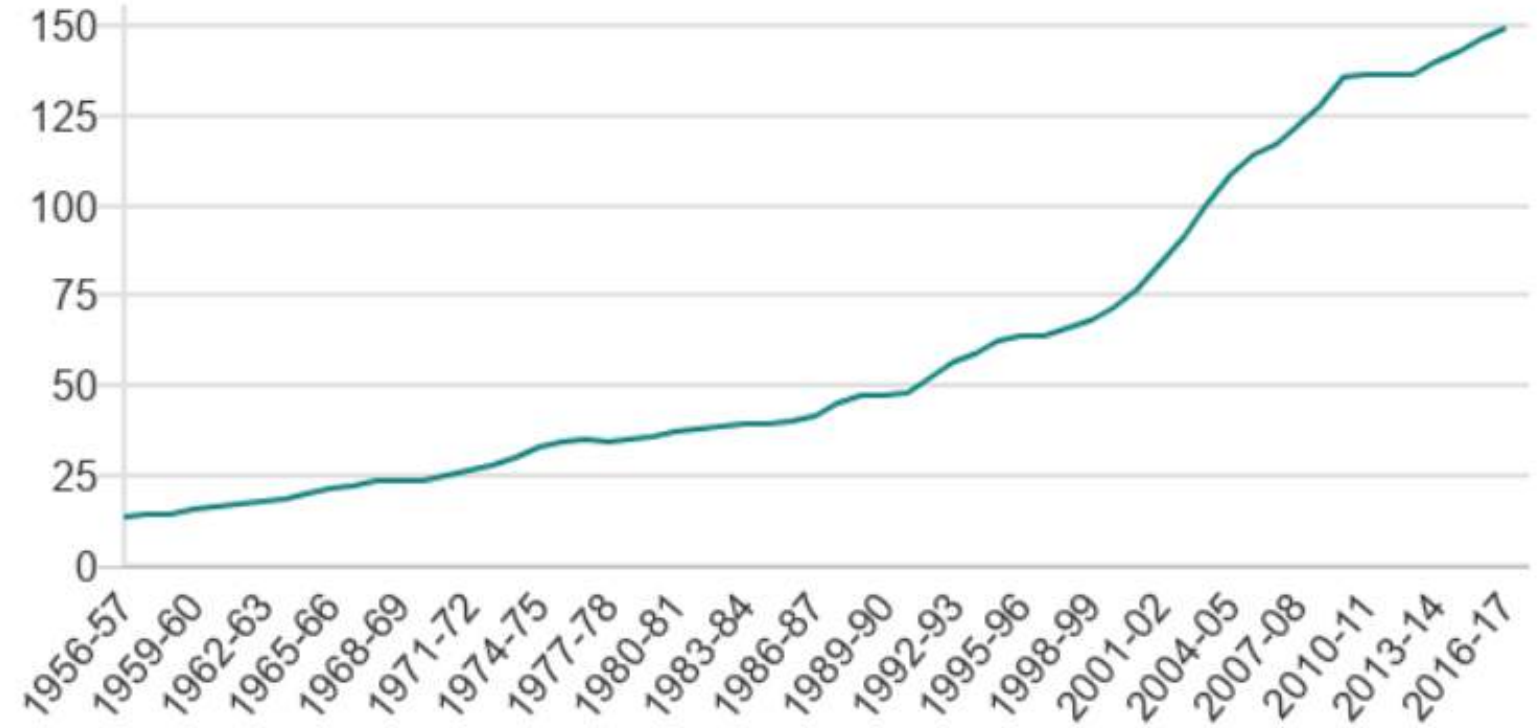
Outcomes and equity

Pondering the future

Based on my 40 years experience of the NHS in UK concentrating on the last 20 years. A personal (political science) perspective based on a series of case studies.

How the NHS budget has grown

Real-terms growth, 2017-18 prices (£bn)

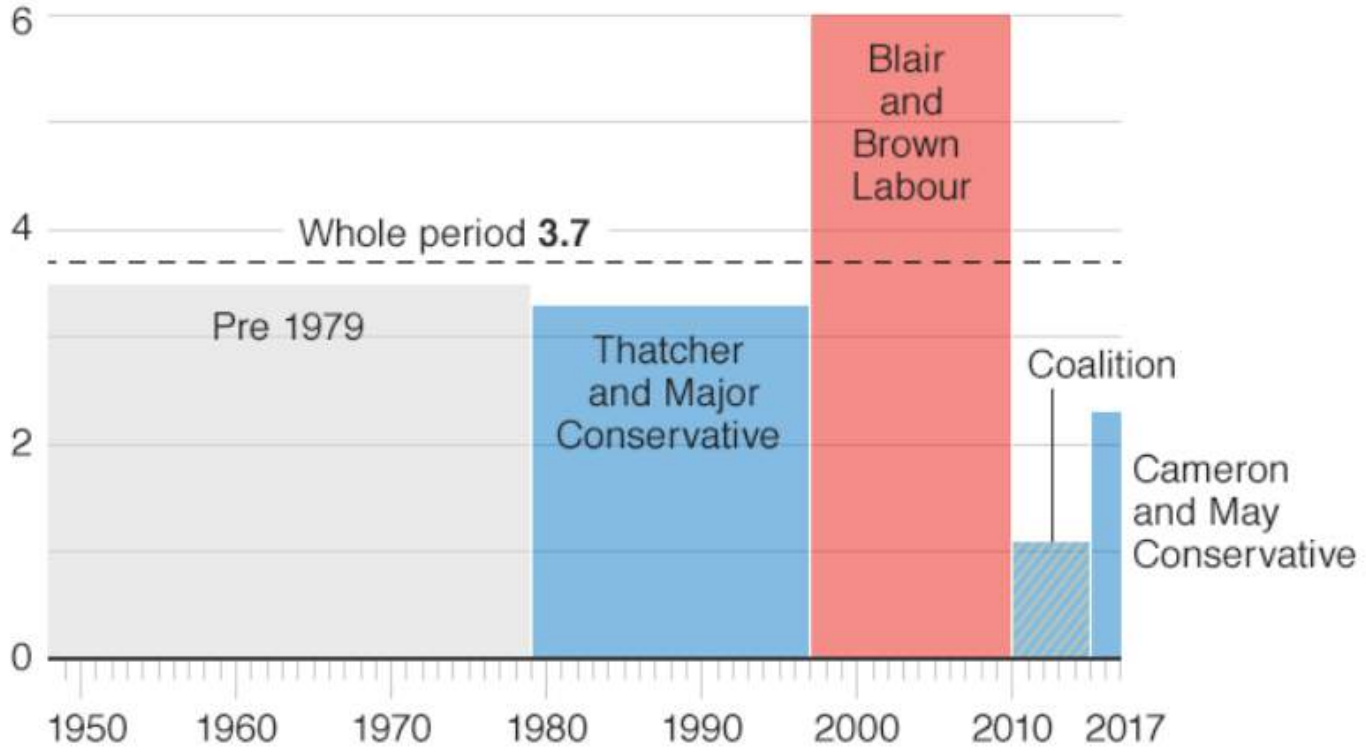


Source: IFS, Government

BBC

Health spending by different governments

Average annual real growth rate (%)



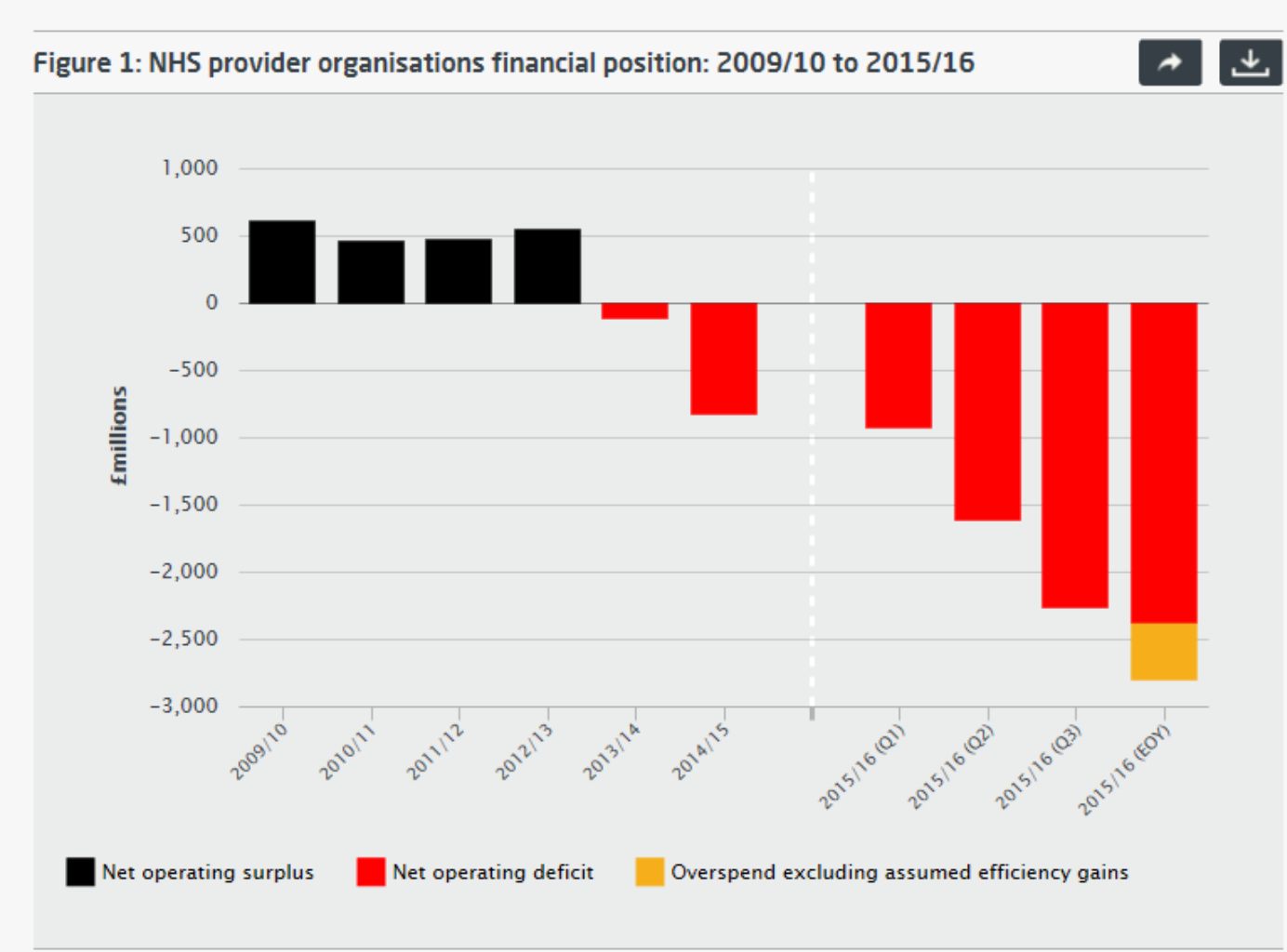
Source: IFS / Health Foundation

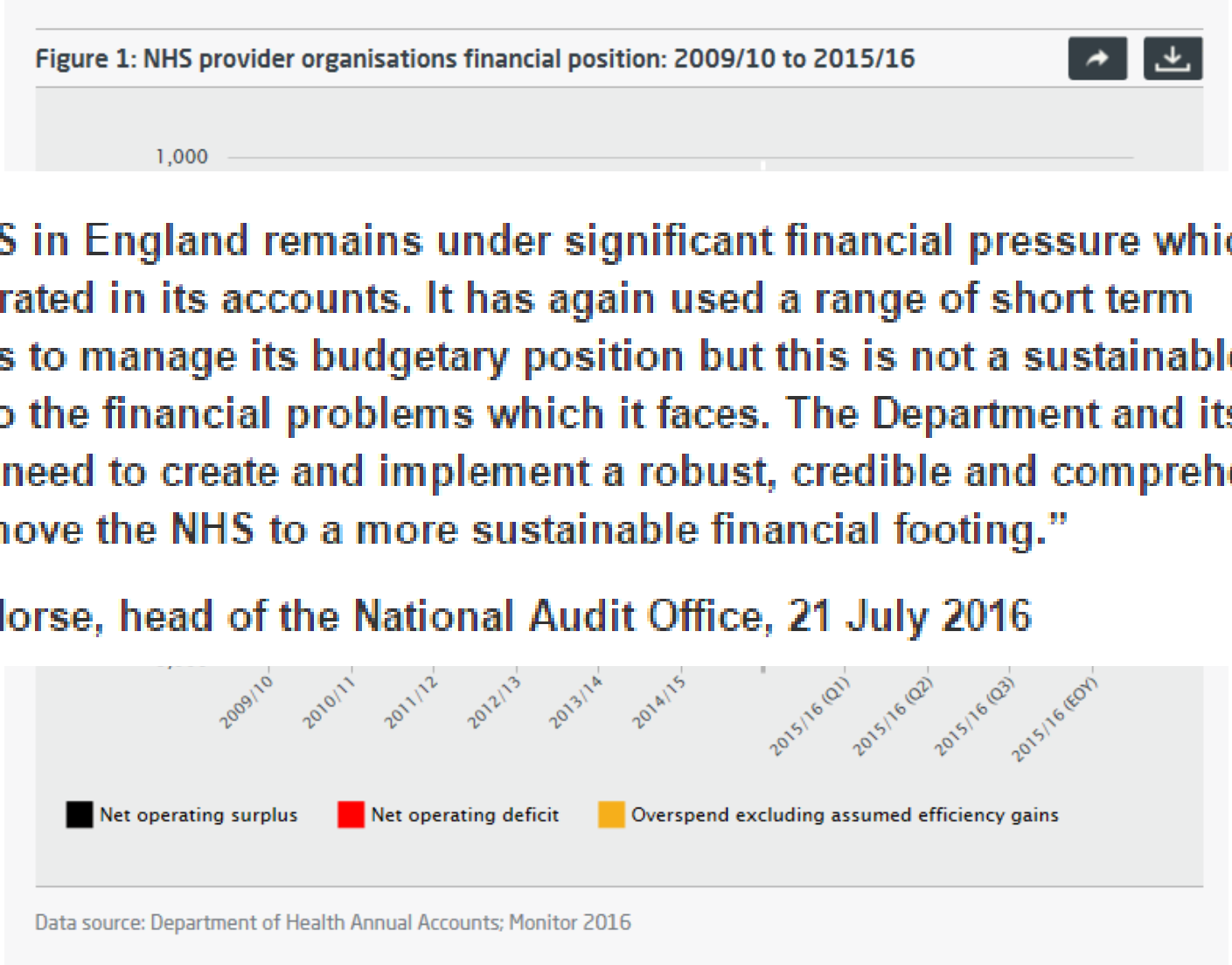
Year-by-year funding increases

- 2019-20 - 3.6%
- 2020-21 - 3.6%
- 2021-22 - 3.1%
- 2022-23 - 3.1%
- 2023-24 - 3.4%

All figures are above inflation

NHS is facing a severe financial crisis





"The NHS in England remains under significant financial pressure which is demonstrated in its accounts. It has again used a range of short term measures to manage its budgetary position but this is not a sustainable answer to the financial problems which it faces. The Department and its partners need to create and implement a robust, credible and comprehensive plan to move the NHS to a more sustainable financial footing."

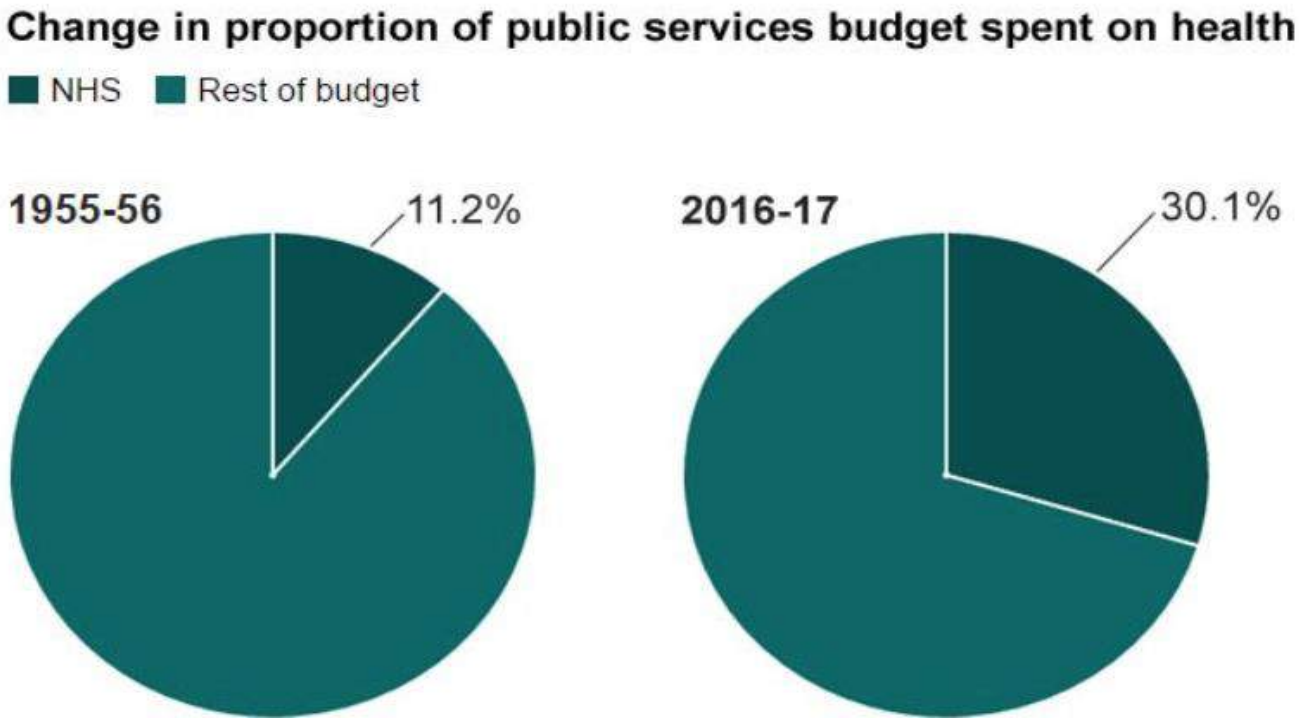
Amyas Morse, head of the National Audit Office, 21 July 2016

Bigger proportion of public spending goes on health

Governments over the years have had to invest more and more of the public purse into it. Today 30p out of every £1 spent on services goes on health.

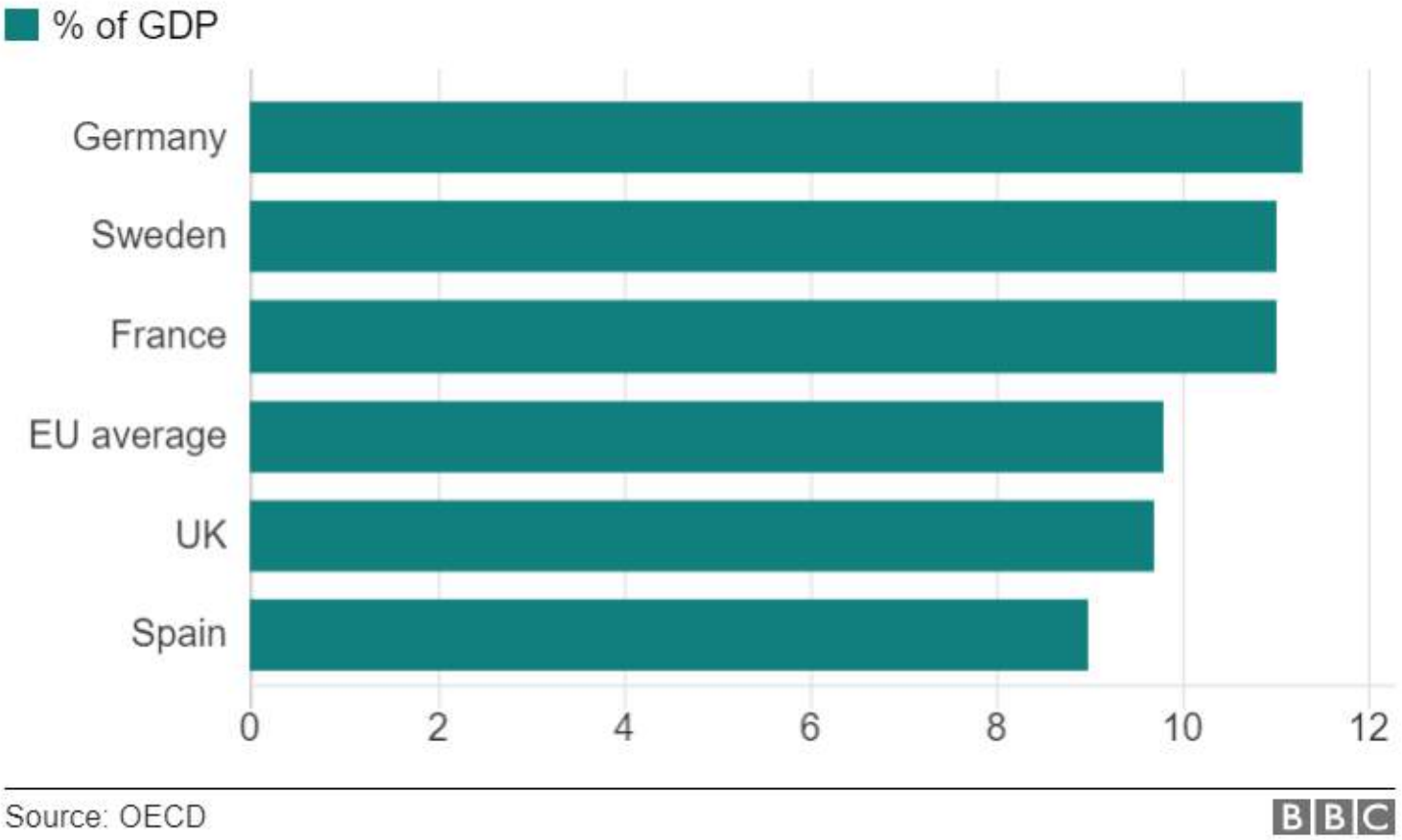
Even during years of deep austerity in the UK, extra money has been found for the health service - £8bn more this parliament in England alone.

Change in proportion of public services budget spent on health



How the UK compares

Comparison of spending on public and private health and care as a percentage of GDP in 2014

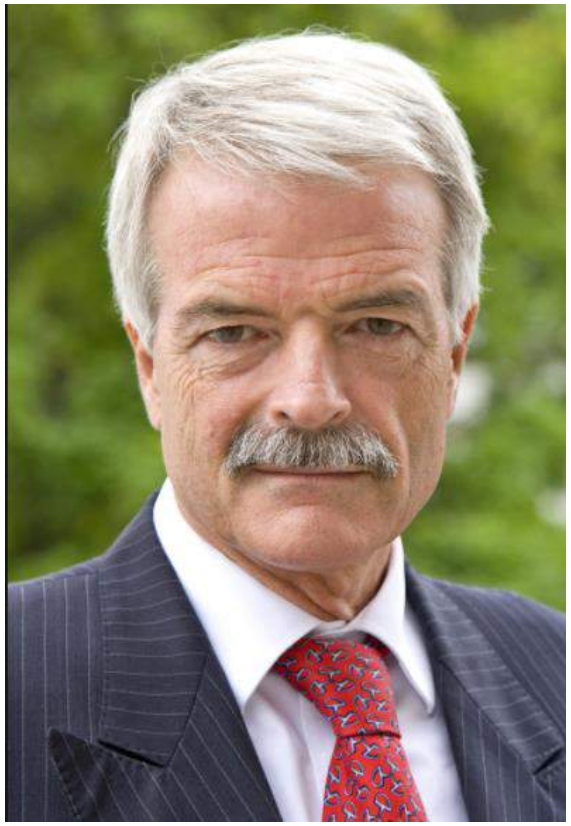


The result, as you would expect, is fewer beds, doctors and nurses per patient in the UK than the big spenders.

The NHS response to a £1.6b boost in Budget

"The extra money would go only some way towards filling the accepted funding gap…… but the country could no longer avoid the difficult debate about what the health service could deliver for patients".

NHS England chairman Sir Malcolm Grant 2017

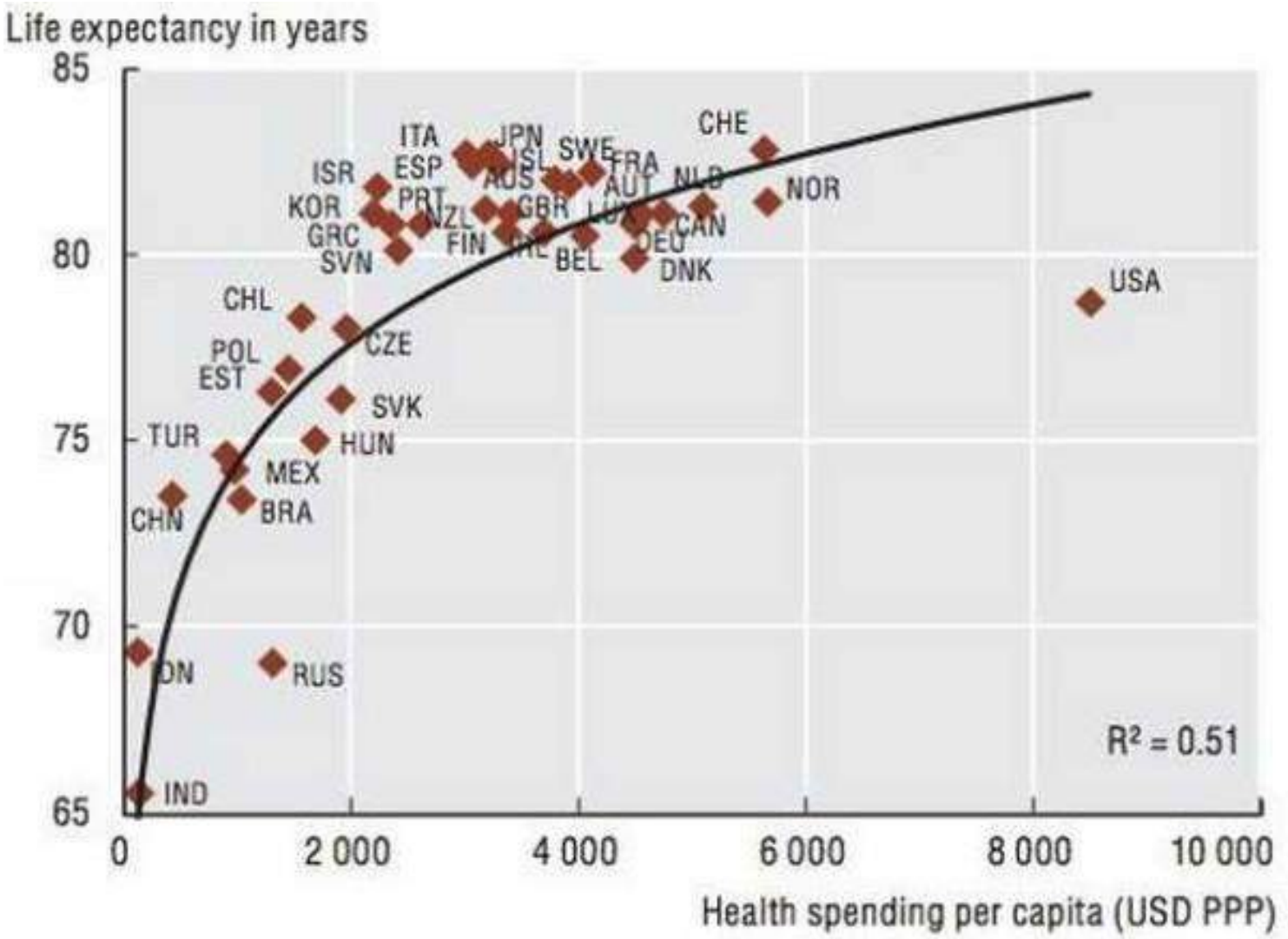


The NHS response to a £1.6b boost in Budget

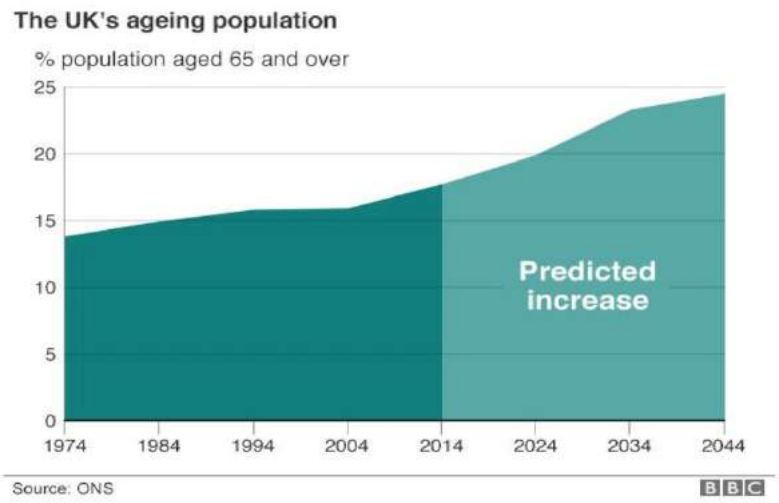
"tough choices and trade offs would now need to be made…..It is difficult to see how the NHS can deliver everything,"

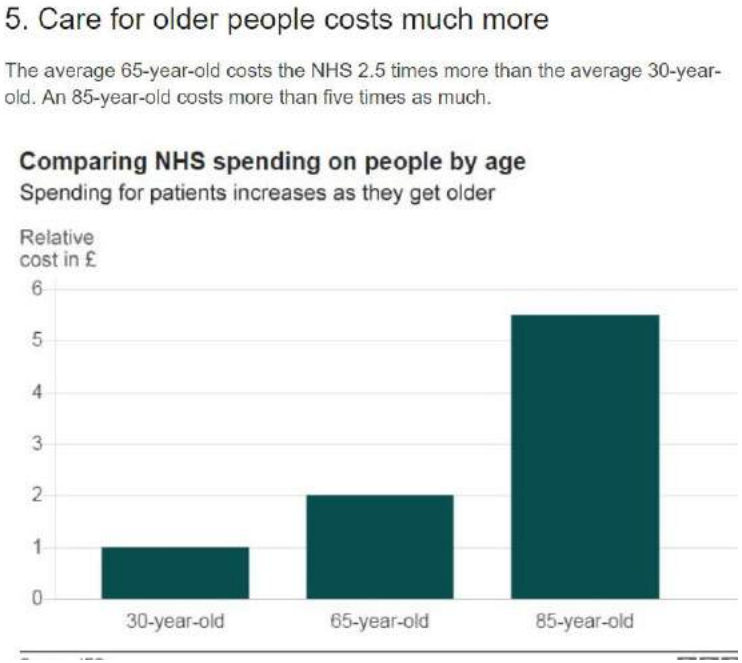
Chris Hopson, chief executive of NHS Providers, which represents health service managers 2017

But it is not just a question of amount of money spent on health…… how it is spent……but also public health.

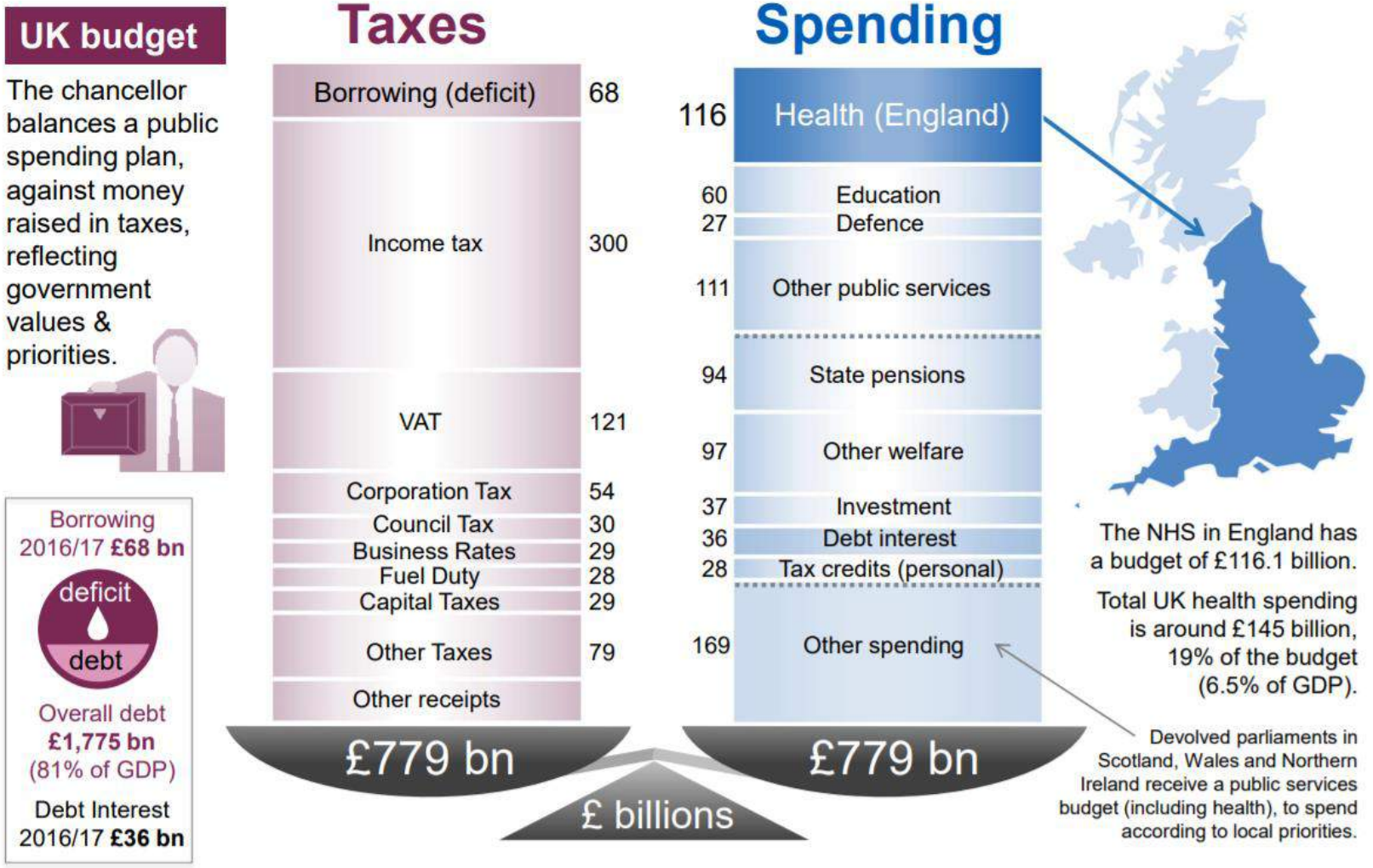


A key reason for the deficit (plus innovation)

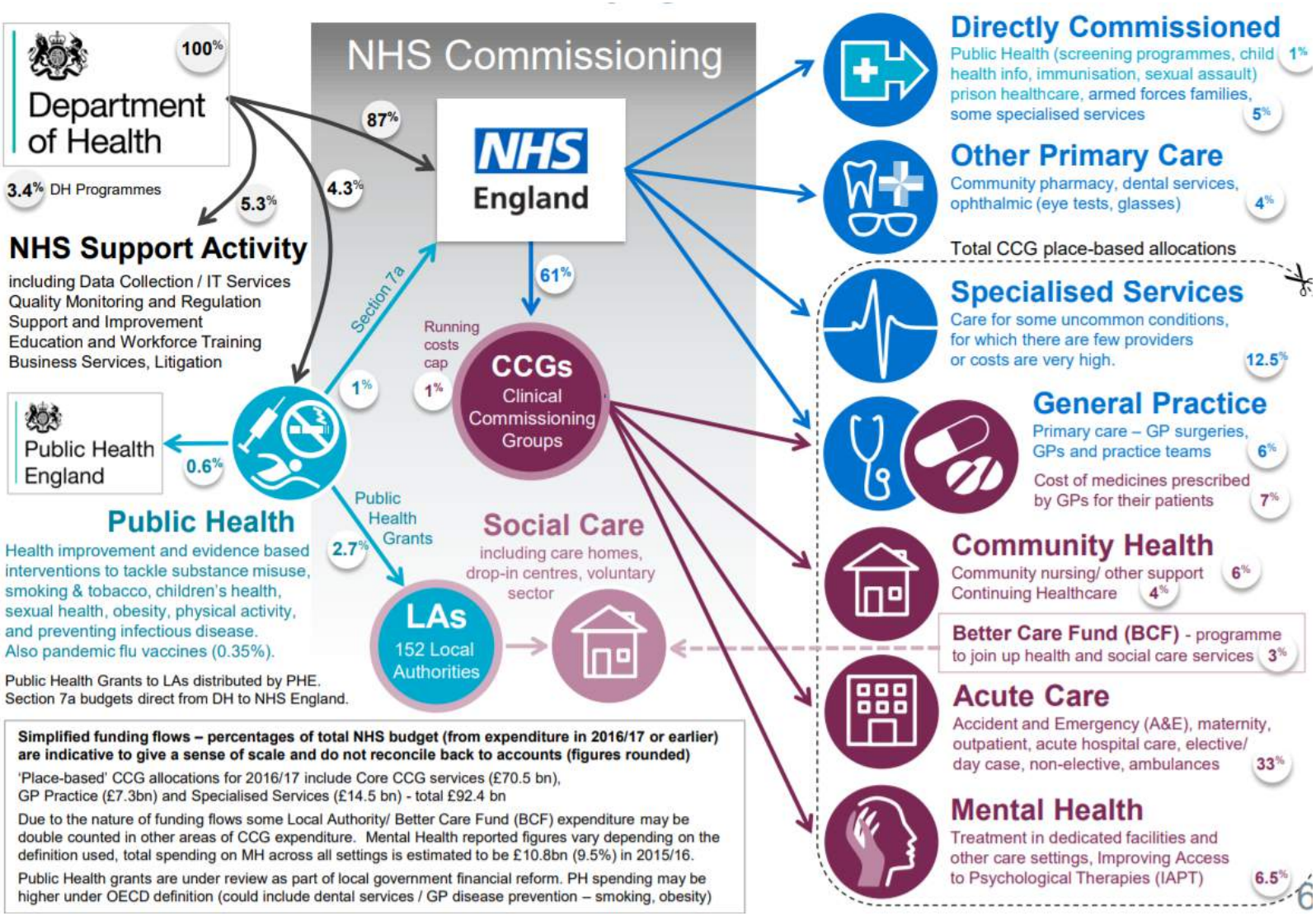




Public Expenditure in England
(Wales, Scotland and Northern Ireland separate)



Allocation of Health Budget



Funds allocated to Clinical Commissioning Groups

What are CCGs anyway?

Led by GPs and nurses, **Clinical Commissioning Groups (CCGs)** work together with patients, communities and GP practices within their area to ensure that the right NHS services are in place to support people and help improve their health and wellbeing.

CCGs fund health services for their population: Hospitals, community care etc. Annual allocations to CCGs are not ring fenced. It is for CCGs to decide their priorities for spending, balancing local priorities and planning guidance, to commission (process of planning, agreeing and monitoring) services from a range of providers.

Providers

137 acute non-specialist trusts

17 acute specialist trusts

56 mental health trusts

7,674 GP practices

34 community providers - 11 NHS trusts, 6 foundation trusts and 17 social enterprises

853 for-profit and not-for-profit independent sector organisations, providing care to NHS patients from 7,331 locations

Patients

57.7 million patients registered with a GP practice in England (NHS Digital 2014)*

54.3 million people estimated in England (ONS 2014)*

Commissioners

~~211 CCGs (2013)~~
~~209 CCGs (2015)~~
207 CCGs (2017)

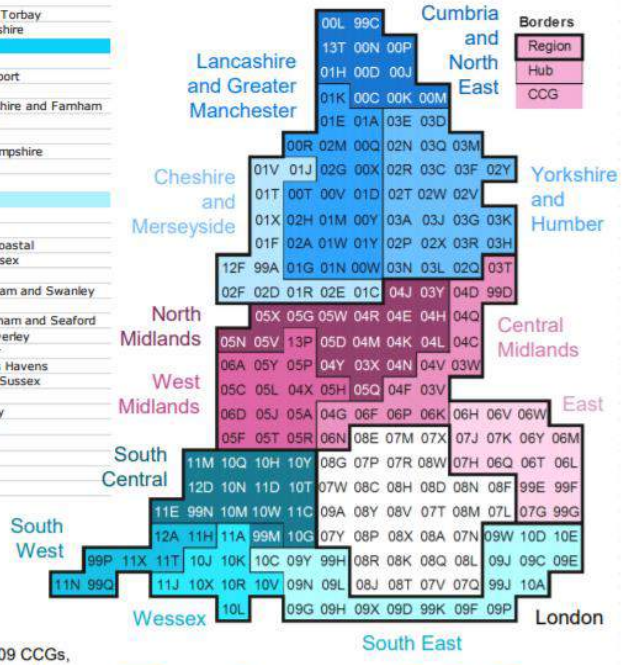
NHS England
Direct commissioning
Co-commissioning

* The allocations model described is based on populations from 2014. Newer GP/CCG populations are published monthly by NHS Digital.

Note: Differences between resident and GP populations possibly due to temporary migration and some GP 'list inflation' (plus cross-border flows with Wales and Scotland). See slide 'Issues with GP populations'

People encouraged to identify this own Clinical Commissioning Group

00D	NHS Durham Dales, Easington and Sedgefield
00K	NHS Hartlepool and Stockton-on-Tees
13T	NHS Newcastle and Gateshead
00J	NHS North Durham
99C	NHS North Tyneside
00L	NHS Northumberland
00M	NHS South Tees
00N	NHS South Tyneside
00P	NHS Sunderland
Q73	**Lancashire and Greater Manchester**
00Q	NHS Blackburn with Darwen
00R	NHS Blackpool
00T	NHS Bolton
00V	NHS Bury
00W	NHS Central Manchester
00X	NHS Chorley and South Ribble
01A	NHS East Lancashire
02M	NHS Fylde & Wyre
01E	NHS Greater Preston
01D	NHS Heywood, Middleton & Rochdale
01K	NHS Lancashire North
01M	NHS North Manchester
00Y	NHS Oldham
01G	NHS Salford
01N	NHS South Manchester
01W	NHS Stockport
01Y	NHS Tameside and Glossop
02A	NHS Trafford
02G	NHS West Lancashire
02H	NHS Wigan Borough
Q72	**Yorkshire and Humber**
02N	NHS Airedale, Wharfedale and Craven
02P	NHS Barnsley
02Q	NHS Bassetlaw
02W	NHS Bradford City
02R	NHS Bradford Districts
02T	NHS Calderdale
02X	NHS Doncaster
02Y	NHS East Riding of Yorkshire
03A	NHS Greater Huddersfield
03D	NHS Hambleton, Richmondshire and Whitby
03E	NHS Harrogate and Rural District
03F	NHS Hull
02V	NHS Leeds North
03G	NHS Leeds South and East
03C	NHS Leeds West
03H	NHS North East Lincolnshire
03J	NHS North Kirklees
03K	NHS North Lincolnshire
03L	NHS Rotherham
03M	NHS Scarborough and Ryedale
03N	NHS Sheffield
03Q	NHS Vale of York
03R	NHS Wakefield
Q75	**Cheshire and Merseyside**
01C	NHS Eastern Cheshire
01F	NHS Halton
01J	NHS Knowsley
99A	NHS Liverpool
01R	NHS South Cheshire
01T	NHS South Sefton
01V	NHS Southport and Formby
01X	NHS St Helens
02D	NHS Vale Royal
02E	NHS Warrington
02F	NHS West Cheshire
03X	NHS Erewash
03Y	NHS Hardwick
04E	NHS Mansfield & Ashfield
04H	NHS Newark & Sherwood
04J	NHS North Derbyshire
05G	NHS North Staffordshire
04K	NHS Nottingham City
04L	NHS Nottingham North & East
04M	NHS Nottingham West
04N	NHS Rushcliffe
05N	NHS Shropshire
05Q	NHS South East Staffs and Seisdon Peninsular
04R	NHS Southern Derbyshire
05V	NHS Stafford and Surrounds
05W	NHS Stoke on Trent
05X	NHS Telford & Wrekin
Q77	**West Midlands**
13P	NHS Birmingham CrossCity
04X	NHS Birmingham South and Central
05A	NHS Coventry and Rugby
05C	NHS Dudley
05F	NHS Herefordshire
05J	NHS Redditch and Bromsgrove
05L	NHS Sandwell and West Birmingham
05P	NHS Solihull
05R	NHS South Warwickshire
05T	NHS South Worcestershire
05Y	NHS Walsall
05H	NHS Warwickshire North
06A	NHS Wolverhampton
06D	NHS Wyre Forest
Q78	**Central Midlands**
06F	NHS Bedfordshire
03V	NHS Corby
06K	NHS East and North Hertfordshire
03W	NHS East Leicestershire and Rutland
06N	NHS Herts Valleys
04C	NHS Leicester City
03T	NHS Lincolnshire East
04D	NHS Lincolnshire West
06P	NHS Luton
04F	NHS Milton Keynes
04G	NHS Nene
99D	NHS South Lincolnshire
04Q	NHS South West Lincolnshire
04V	NHS West Leicestershire
Q79	**East**
99E	NHS Basildon and Brentwood
06H	NHS Cambridgeshire and Peterborough
99F	NHS Castle Point and Rochford
06M	NHS Great Yarmouth & Waveney
06L	NHS Ipswich and East Suffolk
06Q	NHS Mid Essex
06T	NHS North East Essex
06V	NHS North Norfolk
06W	NHS Norwich
06Y	NHS South Norfolk
99G	NHS Southend
07G	NHS Thurrock
07H	NHS West Essex
07J	NHS West Norfolk
07K	NHS West Suffolk
10G	NHS Bracknell and Ascot
10H	NHS Chiltern
11M	NHS Gloucestershire
10M	NHS Newbury and District
10N	NHS North & West Reading
10Q	NHS Oxfordshire
10T	NHS Slough
10W	NHS South Reading
12D	NHS Swindon
99N	NHS Wiltshire
11C	NHS Windsor, Ascot and Maidenhead
11D	NHS Wokingham
Q80	**South West**
11H	NHS Bristol
11N	NHS Kernow
11T	NHS North Somerset
99P	NHS North, East, West Devon
11X	NHS Somerset
99Q	NHS South Devon and Torbay
12A	NHS South Gloucestershire
Q70	**Wessex**
11J	NHS Dorset
10K	NHS Fareham and Gosport
10L	NHS Isle of Wight
99M	NHS North East Hampshire and Farnham
10J	NHS North Hampshire
10R	NHS Portsmouth
10V	NHS South Eastern Hampshire
10X	NHS Southampton
11A	NHS West Hampshire
Q81	**South East**
09C	NHS Ashford
09D	NHS Brighton & Hove
09E	NHS Canterbury and Coastal
09G	NHS Coastal West Sussex
09H	NHS Crawley
09J	NHS Dartford, Gravesham and Swanley
09L	NHS East Surrey
09F	NHS Eastbourne, Hailsham and Seaford
09N	NHS Guildford and Waverley
09P	NHS Hastings & Rother
99K	NHS High Weald Lewes Havens
09X	NHS Horsham and Mid Sussex
09W	NHS Medway
09Y	NHS North West Surrey
10A	NHS South Kent Coast
99H	NHS Surrey Downs
10C	NHS Surrey Heath
10D	NHS Swale
10E	NHS Thanet
99J	NHS West Kent
07N	NHS Bexley
07P	NHS Brent
07Q	NHS Bromley
07R	NHS Camden
07T	NHS City and Hackney
07V	NHS Croydon
07W	NHS Ealing
07X	NHS Enfield
07Y	NHS Hounslow
08A	NHS Greenwich
08C	NHS Hammersmith and Fulham
08D	NHS Haringey
08E	NHS Harrow
08F	NHS Havering
08J	NHS Kingston
08K	NHS Lambeth
08L	NHS Lewisham
08M	NHS Newham
08N	NHS Redbridge
08P	NHS Richmond
08Q	NHS Southwark
08R	NHS Merton
08T	NHS Sutton
08V	NHS Tower Hamlets
08W	NHS Waltham Forest
08X	NHS Wandsworth
08Y	NHS West London (K&C & QPP)
09A	NHS Central London (Westminster)



Note: Codes and boundaries shown for 209 CCGs, which were included in 2016/17 allocations.

Cartograms show CCGs (not hospital Trusts, which may have more familiar local names).

Find my CCG

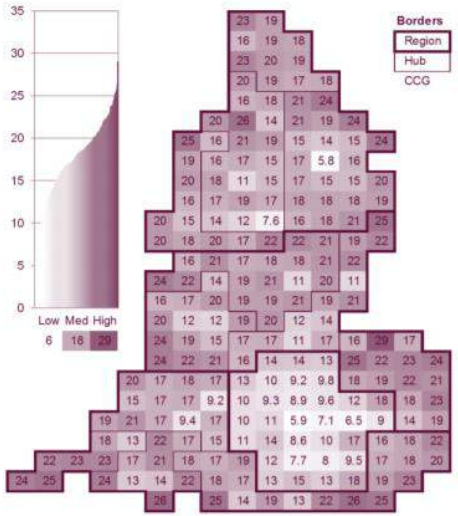
Allocated according to formula based on need

Examples of need variation in England

Ageing population

Patients registered with a GP Practice (Oct 2016)

GP Populations by CCG - % Aged 65+



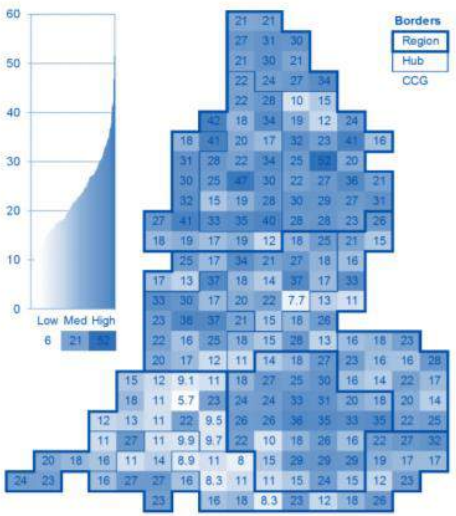
darker colour = more elderly people

The biggest adjustment is based on age, due to evidence that the elderly and very young have a higher need for healthcare.

Deprivation

Index of Multiple Deprivation 2015

Average IMD2015 Score by CCG



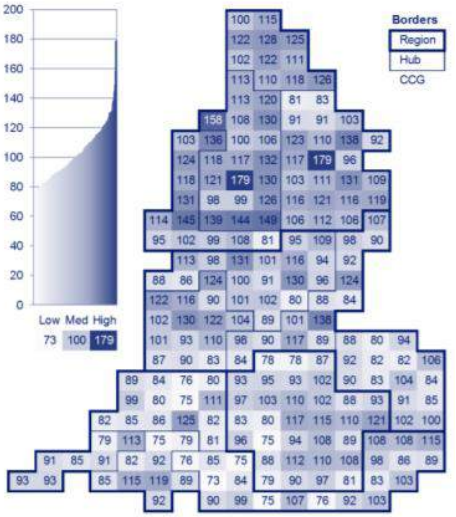
darker colour = more deprived

Poverty also seems to make a big difference to healthcare need, so we use this to make an adjustment.

Mortality

Standardised Mortality Ratio Age <75

SMR <75 (all causes)



darker colour = more deaths

Patterns of excess death rates in persons aged under 75 appear to closely reflect deprivation.

Allocated according to formula based on need

The calculation of each segment within the model follows this sequence

1	**Based on population**	GP registered patients
2	**Adjust for age**	evidence that the elderly and the very young have a higher need for health care services
3	**Adjust for additional need over and above that due to age**	evidence of higher need due to health status, morbidity, deprivation
4	**Adjust for unavoidable differences in cost**	Neutralise cost of providing services due to geographical location
5	**Combine adjustments**	bring together all adjustments within a segment, formula or model to get weighted population or target shares
6	**Apply shares (weighed populations) to available money**	weighted population shares determine target allocations – compare with current budgets to get 'distance from target'
7	**Apply 'pace of change' policy**	pace of change aims to maintain budget stability, while giving additional resources to those CCGs requiring the most growth

Overview

Governance (politics, structures and finance)

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Pondering the future

Based on my 40 years experience of the NHS in UK concentrating on the last 20 years. A personal (political science) perspective based on a series of case studies.

A major change in1998

The new NHS

The new NHS

Modern • Dependable

Foreword by the Prime Minister

Creating the NHS was the greatest act of modernisation ever achieved by a Labour Government. It banished the fear of becoming ill that had for years blighted the lives of millions of people. But I know that one of the main reasons people elected a new Government on May 1st was their concern that the NHS was failing them and their families. In my contract with the people of Britain I promised that we would rebuild the NHS. We have already made a start. The Government is putting an extra £1.5 billion into the health service during the course of this year and next. More money is going into improving breast cancer and children's services. And new hospitals are being built. The NHS will get better every year so that it once again delivers

Tony Blair in 1998. Photograph: Martin Argles

A new national way to set standards and monitor improvement

National Institute for clinical Excellence

7.11 A new National Institute for Clinical Excellence will be established to give new coherence and prominence to information about clinical and cost-effectiveness. It will produce and disseminate:

- clinical guidelines based on relevant evidence of clinical and cost-effectiveness
- associated clinical audit methodologies and information on good practice in clinical audit
- in doing so it will bring together work currently undertaken by the many professional organisations in receipt of Department of Health funding for this purpose
- it will work to a programme agreed with and funded from current resources by the Department of Health.

A new national way to set standards and monitor improvement

Commission for Health Improvment

7.13 To ensure the drive for excellence is instilled throughout the NHS, the Government will create a new **Commission for Health Improvement.** It will complement the introduction of clinical governance arrangements. Past performance on quality has been variable, and the health service has sometimes been slow to detect and act decisively on serious lapses in quality. As a statutory body, at arm's length from Government, the new Commission will offer an independent guarantee that local systems to monitor, assure and improve clinical quality are in place. It will support local development and 'spot-check' the new arrangements. It will also have the capacity to offer targeted support on request to local organisations facing specific clinical problems.

Over the next 15 years there were to be significant improvements in quality eg waiting times but also a series of high profile failures

Winterbourne View: Abuse footage shocked nation

By Rebecca Cafe
BBC News

26 October 2012 | Bristol

It was the programme that shocked the nation.

BBC One's Panorama showed patients at a residential care home near Bristol, being slapped and restrained under chairs, having their hair pulled and being held down as medication was forced into their mouths.

The victims, who had severe learning disabilities, were visibly upset and were shown screaming and shaking.

Secret filming caught patients being dragged and slapped by support workers

Morecambe Bay Investigation Report published

From: Morecambe Bay Investigation
First published: 3 March 2015

Independent investigation into maternity and neonatal services in Morecambe Bay makes far-reaching recommendations to prevent future unnecessary deaths.

The Report of the Morecambe Bay Investigation

The Morecambe Bay Investigation was established by the Secretary of State for Health in September 2013 following concerns over serious incidents in the maternity department at Furness General Hospital (FGH).

Covering January 2004 to June 2013, the report concludes the maternity unit at FGH was dysfunctional and that serious failures of clinical care led to unnecessary deaths of mothers and babies.

The Investigation Panel also reviewed pregnancies at other maternity units

Families demand resignations over Southern Health NHS Trust deaths

, aimed

11 January 2018 | England Share

up

Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry

Executive summary

Report results were similar…….

Dr Kirkup said:

" There was a disturbing catalogue of missed opportunities, initially and mostsignificantly by the Trust but subsequently involving the North West Strategic Health Authority, the Care Quality Commission, Monitor, the Parliamentary and Health Service Ombudsman and the Department of Health.

" Over the next 3years, there were at least seven opportunities to intervene that were missed. The result was that no effective action was taken until the beginning of 2012."

The report's recommendations are far reaching, with 18 aimed at the Trust and 26 for the wider NHS and other organisations. Many contain specific target dates for completion.

THE MID STAFFORDSHIRE
NHS FOUNDATION TRUST
PUBLIC INQUIRY

Chaired by Robert Francis QC

HC 947

Letter to the Secretary of State

Mid Staffordshire NHS Foundation Trust Public Inquiry
Skipton House
Room 204A
80 London Road
London
SE1 6LH

The story would be bad enough if it ended there, but it did not. The NHS system includes many checks and balances which should have prevented serious systemic failure of this sort. There were and are a plethora of agencies, scrutiny groups, commissioners, regulators and professional bodies, all of whom might have been expected by patients and the public to detect and do something effective to remedy non-compliance with acceptable standards of care. For years that did not occur, and even after the start of the Healthcare Commission investigation, conducted because of the realisation that there was serious cause for concern, patients were, in my view, left at risk with inadequate intervention until after the completion of that investigation a year later. In short, a system which ought to have picked up and dealt with a deficiency of this scale failed in its primary duty to protect patients and maintain confidence in the healthcare system.

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was in part the consequence of allowing a focus on reaching national access targets, achieving financial balance and seeking foundation trust status to be at the cost of delivering acceptable standards of care.

The story would be bad enough if it ended there, but it did not. The NHS system includes many checks and balances which should have prevented serious systemic failure of this sort. There were and are a plethora of agencies, scrutiny groups, commissioners, regulators and professional bodies, all of whom might have been expected by patients and the public to detect and do something effective to remedy non-compliance with acceptable standards of care. For years that did not occur, and even

Politicians quick to respond

Stafford Hospital: 'I am truly sorry' - David Cameron

6 February 2013 Last updated at 13:12 GMT

Prime Minister David Cameron has apologised to the families of patients who were subjected to years of abuse and neglect at Stafford Hospital.

Speaking in the House of Commons he said he was "truly sorry" for what happened at the hospital which was "not just wrong, it was truly dreadful".

Mr Cameron announced that a new post of chief inspector of hospitals would be created in the autumn.

"…it is not a question of money but of values."

Jeremy Hunt Health Secretary in response to Francis Enquiry 6th January 2013.

Why did this occur ? Was it really about values ?

- I undertook a research study to understand the contributions of political and organisational influences in enabling the NHS to deliver high quality care through exploring the experiences of two of the major new organisations established to set standards and monitor NHS quality.

- I undertook a two phase study using mixed methods

- Interview and content analysis

- Principal Agent Analysis

Principle Agent Modeling

- The principal and agent theory emerged in the 1970s from the combined disciplines of economics and institutional theory. The theory has come to extend well beyond economics or institutional studies to all contexts of information asymmetry, uncertainty and risk.

- The principal–agent problem arises where one party (the principal) commissions another (agent) to act on its behalf. The two parties goals may differ and there are asymmetric information capabilities (usually the agent having more information). The principal may not be able to ensure that the agent is always acting in its (the principal's) best interests.

- In the UK Health System Quangos are a manifestation of Agents and Government the Principal

The Waterman and Meier Approach

Challenges the assumption of normal Principal-Agent modeling that goal conflicts and information asymmetry are constants.

Using these as variables (instead of constants) creates 8 states of principal agent interactions.

In our study using the themes identified by the interviews it was possible to locate the organizations within the Waterman and Meier framework and track their changing position in the 8 possible states over time.

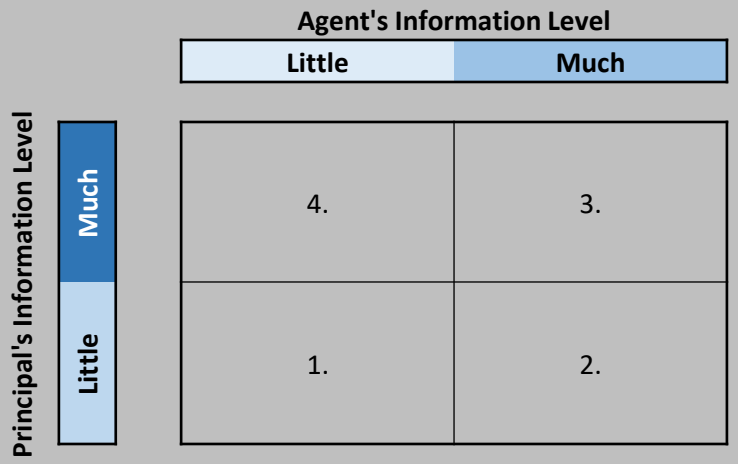


Figure 1: The Waterman and Meier expanded Principal-Agent model (i) ***Goal Conflict***

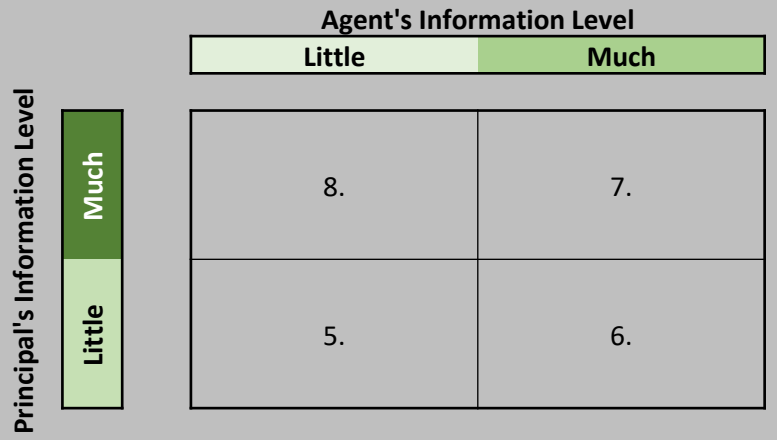


Figure 2: The Waterman and Meier expanded Principal-Agent model (i) ***Goal Consensus***

NHS Quality Organisations Evolution

- **The Commission for Healthcare Improvement** (CHI) was established in 1999. Five years after its establishment CHI was subsumed by the Healthcare Commission (officially the **Commission for Healthcare Audit and Inspection** (CHAI). CHAI was in existence for another five years until its responsibilities were taken over by the **Care Quality Commission** (CQC) in 2009.

- **The National Institute for Clinical Excellence** (NICE) was established in 1999. In 2005 it became the **National Institute for Health and Clinical Excellence**, having taken over the public health functions after the Health Development Agency was disbanded. In 2014 as part of the legislation enacting the NHS reforms, having been given new responsibility to produce guidance in social care, NICE was reconstituted as a non-departmental public body called the **National Institute for Health and Care Excellence.**

Other Quality Organisations
(many now gone.. with important exceptions)

- National Service Frameworks
- Modernisation Agency
- Clinical Governance
- NHS University
- NHS Institute for Learning Skills and Innovation
- NHS Institute for Innovation and Improvement
- Skills for Health Organisation
- National Patient Safety Agency
- National Clinical Assessment Service
- National Confidential Enquiries x 4
- Quality Outcomes Frameworks
- National Clinical Audits
- Special Incident Reports
- General Medical Council
- Royal Colleges
- DH Performance and outcome indicators

People Interviewed

Professor Sir Michael Rawlins (Chairman of NICE, 1999-2012)
Sir Andrew Dillon (Chief executive of NICE, 1999-present)
Professor Sir David Haslam (Chairman of NICE, 2013-present; Healthcare Commission: National Clinical Adviser : 2005-9; Care Quality Commission: National Professional Adviser: 2009-13)
Professor Sir Ian Kennedy (Chairman of the Healthcare Commission, 2004-2009)
Andy McKeon (Director General of Policy and Planning, Department of Health, 2002; Managing Director, Health, Audit Commission, 2003-2012; Non-executive Director of NICE, 2009-present)
Dr. Linda Patterson (Medical Director of Commission for Health Improvement, 1999-2004)
Dr. Peter Homa (Chief Executive of Commission for Health Improvement, 1999-2004)
Andrea Sutcliffe (Deputy Chief Executive of NICE, 2001-2007; Chief Care Inspector for Social Care, Care Quality Commission, 2013 – present)
Professor Albert Weale (Professor of Political Theory and Public Policy at University College London; Chair of the Nuffield Council for Bioethics 2007-12; Author of “Democratic Justice and the Social Contract”.
Professor Sir Michael Richards (Chief Inspector of Hospitals Care Quality Commission 2013- present)
Cynthia Bower (Chief Executive of Care Quality Commission, 2009-2012)

Three disinterested judges undertook conventional qualitative content analysis to identify patterns of responses (categories) within and across interviews

- The analysis comprised of three main stages.
- First independent coding schemes were developed by each data judge.
- Second, the three independent coding schemes were combined into a single composite coding scheme that captured all of the insights from the individual coding schemes. These were then assessed by the auditor who recommended alterations to the coding scheme The audited coding scheme was checked against the interview data independently by each of the judges, who met again to discuss whether the categories were appropriate, and comprehensive. This process continued for 6 iterations until a final coding scheme was developed that was endorsed by each of the data judges and the auditor.
- Third, the three data judges independently applied the final coding scheme to the interview transcripts.

Ten themes were identified as influencing the functioning of the NHS regulatory institutions

1. Socio-political environment
2. Governance and accountability
3. External relationships
4. Clarity of purpose
5. Organizational reputation
6. Leadership and management
7. Organizational stability
8. Resources
9. Organizational methods
10. Organizational performance

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5484322/

Conclusions of content analysis of interviews

We concluded -

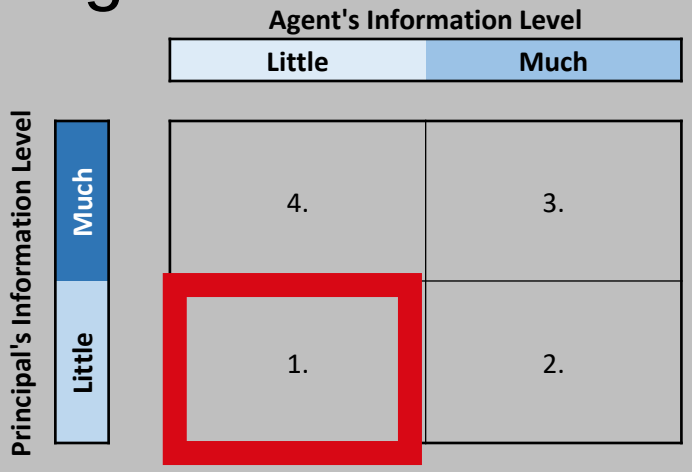
that differing policy objectives for NHS quality-monitoring resulted in central involvement and organizational change that had a disruptive effect on the ability of the NHS to monitor quality.

Constant professional leadership, both clinical and managerial and basing decisions on best evidence, both technical and organizational, helped one institution to deliver on its remit, even within a changing political/policy environment.

Application of expanded Principal-Agent models to standing setting and monitoring in the NHS

Commmission for Health Improvement (CHI)

starts at 1 as there is goal conflict and neither Principal or Agent had a clear understanding on methods.



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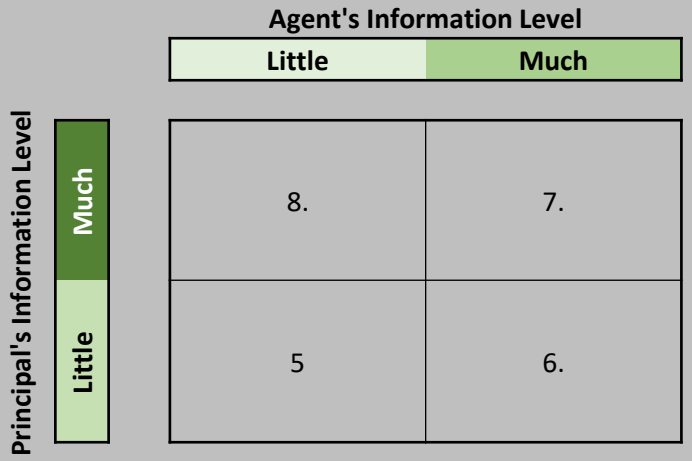

Figure 2: The Waterman and Meier expanded Principal-Agent model (i) ***Goal Consensus***

Application of expanded Principal-Agent models to standing setting and monitoring in the NHS

Commission for Improvement (CI

starts at 1 as there conflict and neithe Agent had a clear understanding on

"what ministers wanted was a policeman; what they got was a social worker".

Andy McKeon ,Director General of Policy and Planning, Department of Health, 2002; Managing Director, Health, Audit Commission, 2003-2012; Non-executive Director of NICE, 2009-present

Agent's Information Level		
	Little	Much
	4.	3.
	1.	2.

man and Meier expanded Principal-
l Conflict

Agent's Information Level		
	Little	Much
	8.	7.
	5	6.

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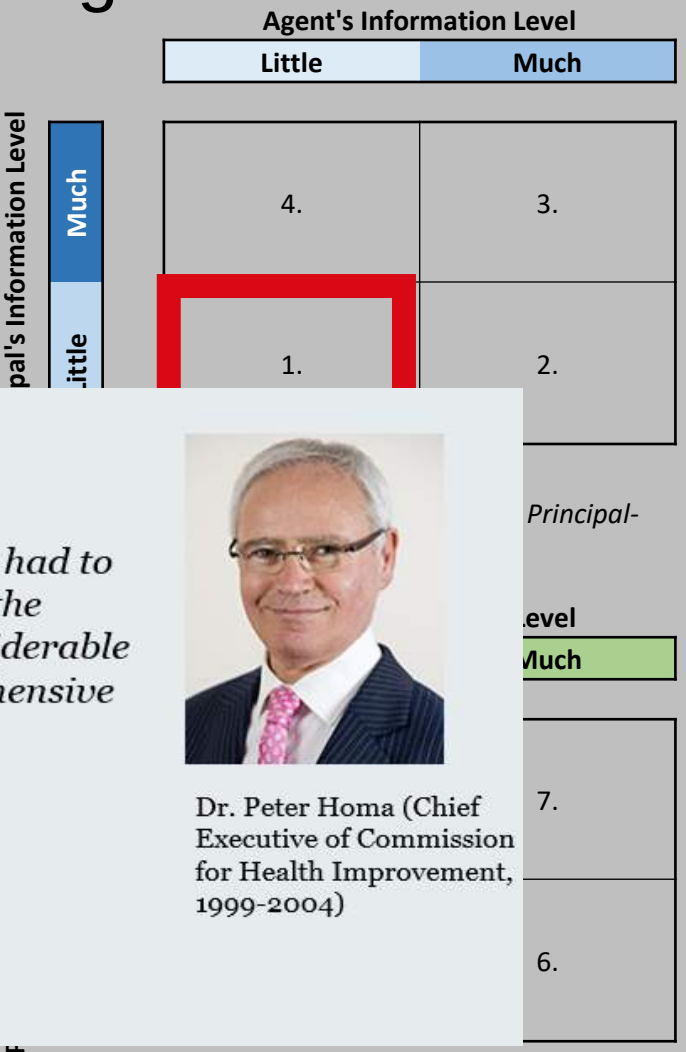
Application of expanded Principal-Agent models to standing setting and monitoring in the NHS

Commission for Health Improvement (CHI)



it was a bit like building a plane whilst flying it, because we had to assemble, at very short, within a very short period of time, the inspection methodology. And then we had, under very considerable pressure from the Department of Health, to deliver comprehensive coverage of the inspections across the NHS,

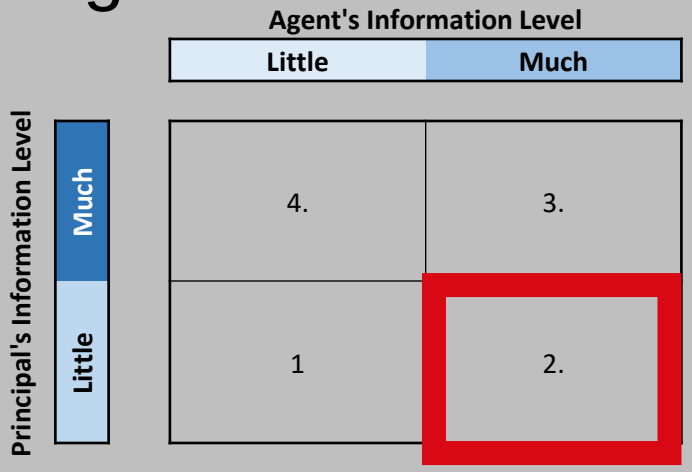
Dr. Peter Homa (Chief Executive of Commission for Health Improvement, 1999-2004)

Figure 2: The Waterman and Meier expanded Principal-Agent model (i) ***Goal Consensus***

Application of expanded Principal-Agent models to standing setting and monitoring in the NHS

CHI

CHI moves to 2 as Agent knowledge improves



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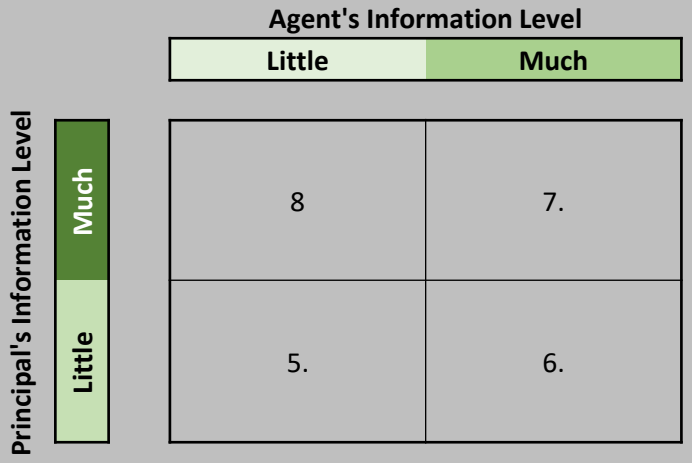

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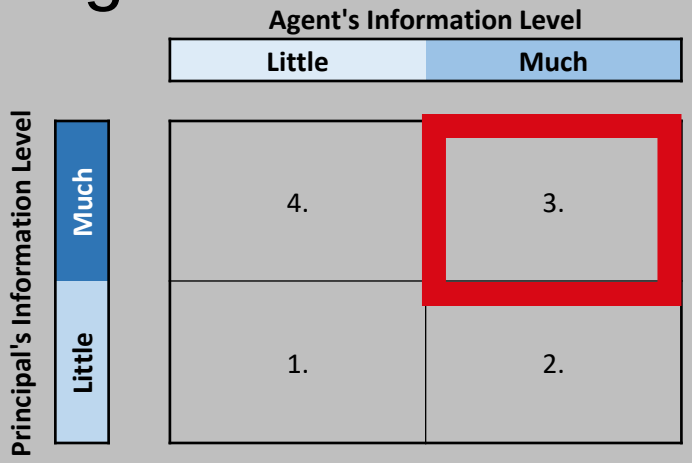
Application of expanded Principal-Agent models to standing setting and monitoring in the NHS

CHI

But then moves to 3 as the Principal's perceived knowledge improves.

Rather than agree on a new methodology the DOH creates a new organisation



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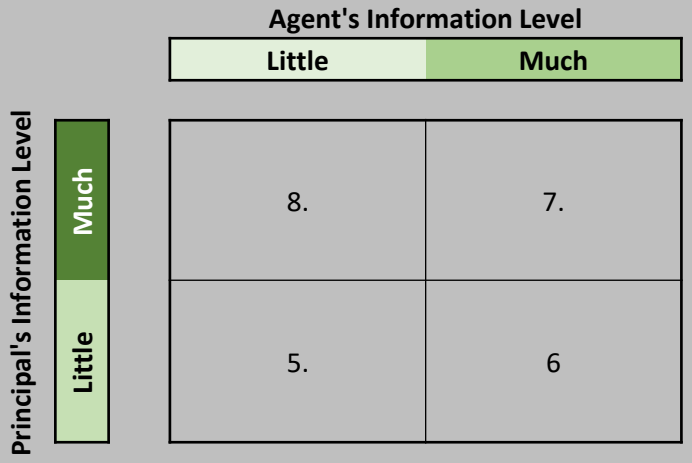

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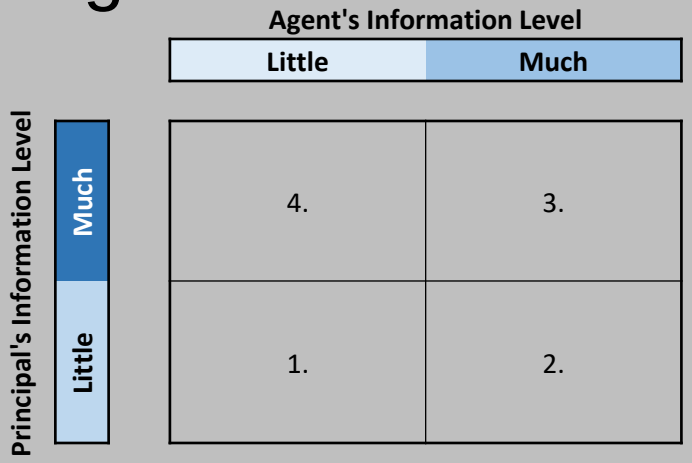
Application of expanded Principal-Agent models to standing setting and monitoring in the NHS

Health Commission

The Health Commission starts at 7 as there is goal consensus and agreement on methodology



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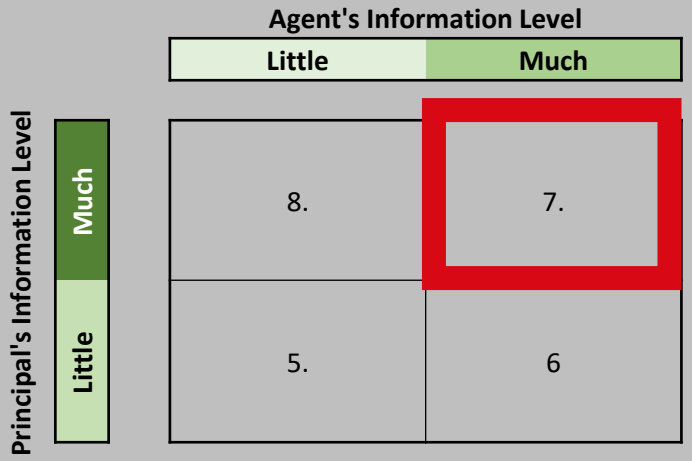

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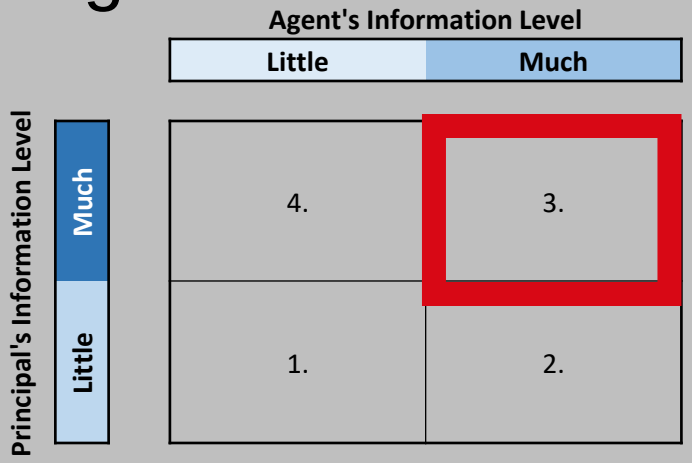
Application of expanded Principal-Agent models to standing setting and monitoring in the NHS

Health Commission

The Health Commission moves to 3 because of multiple Principals and conflict of aims (DOH, Treasury) and new Agent's (Monitor).

Rather than reconcile the differences the DOH creates another a new organisation



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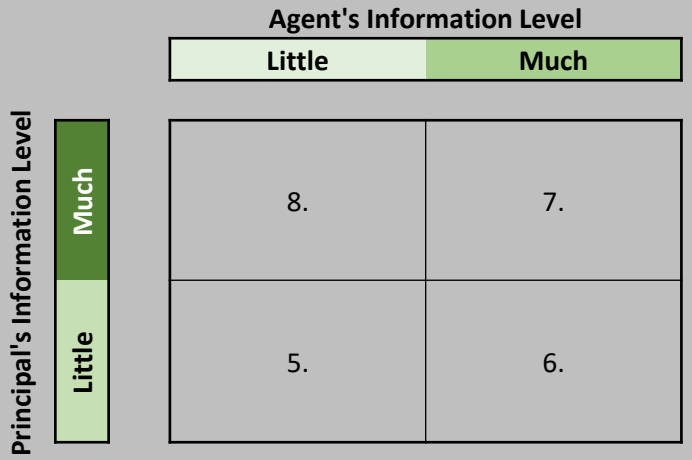

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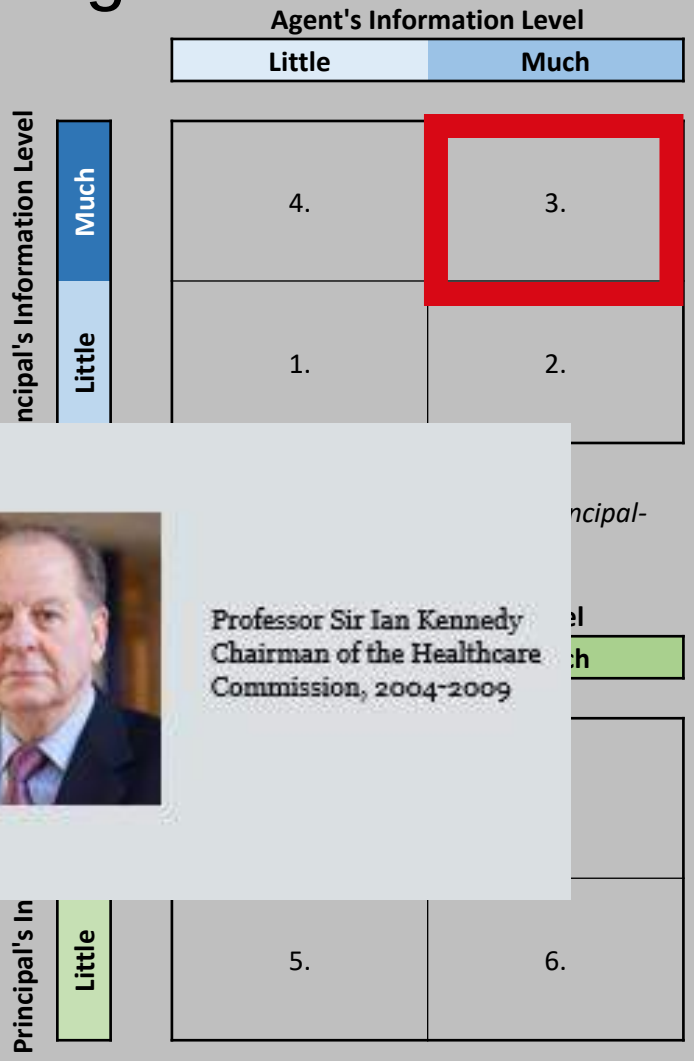

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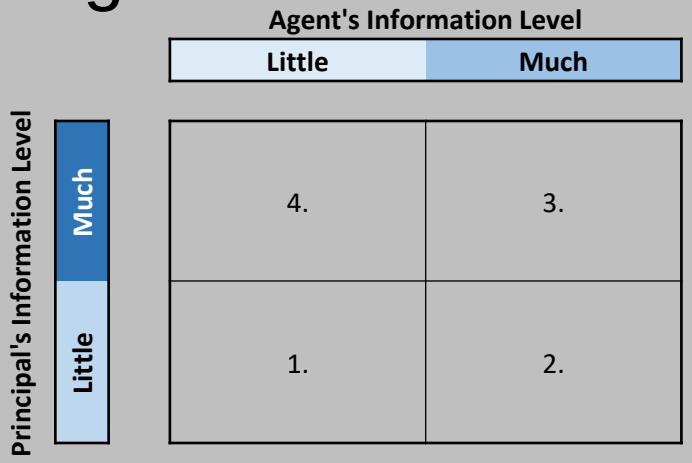
Application of expanded Principal-Agent models to standing setting and monitoring in the NHS

Care Quality Commission (CQC)

CQC starts at 7 as there is consensus on aims and common understanding of methodology



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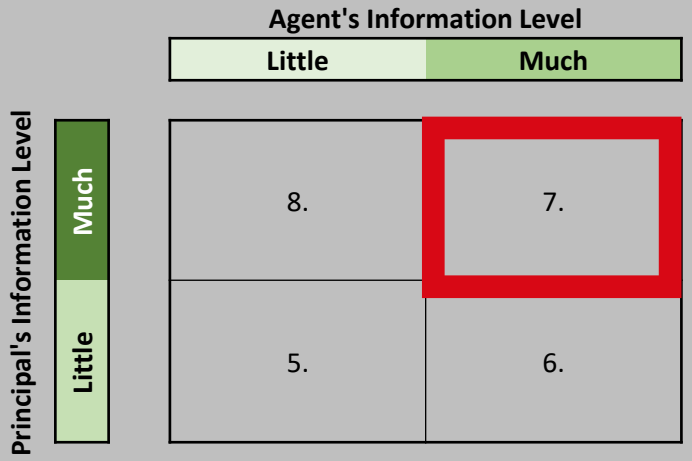

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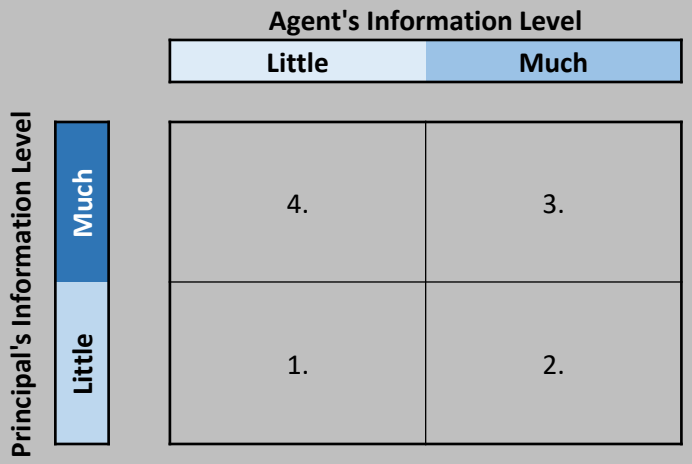
Application of expanded Principal-Agent models to standing setting and monitoring in the NHS

Care Quality Commission (CQC)

CQC moves to 8 as methodology is challenged by DOH and resources are limited.



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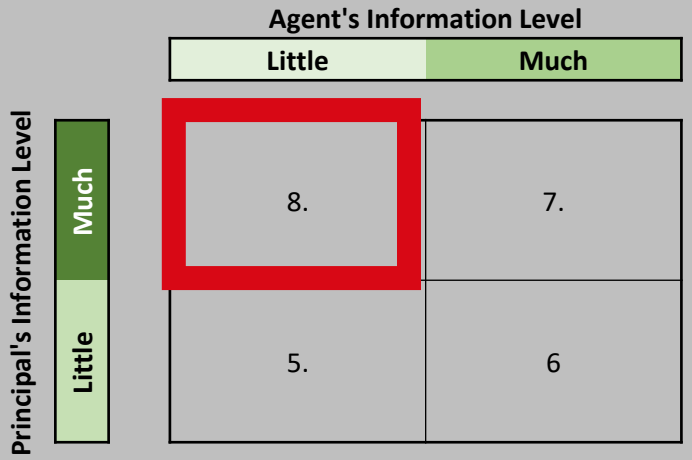

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