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in Health Management

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Future Scenarios for the NHS: **The Uncertainties of Change**

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The Centre for Innovation in Health Management (CIHM) at the University of Leeds

The CIHM's purpose is to improve public service in the UK and to foster innovation and change in health and wellbeing services internationally. Our focus is on systems and organisations – the place and set of relationships in which public service is executed.

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Introduction

Following the recent publication of the White Paper Liberating the NHS it is clear that the NHS faces a significant period of change. In some quarters this has been characterized as the most significant potential reform since the formation of the NHS in 1948. Certainly, debate about the shape and direction of the health service into the future is at fever-pitch.

In order to understand how the system is working with the new direction we conducted 18 long interviews with senior leaders across the health and social care sector in August and early September 2010. The leaders interviewed included both those from national bodies, NHS trusts, PCTs, the private and third sector. It also included senior clinical leaders.

The purpose of this report is to shed some light on this complex picture, and to make visible the current potential future scenarios for the NHS and health provision that are in use in the system, albeit not formally adopted anywhere. We are not saying these scenarios will happen; the key point is that in current leaders views they might happen, and those leaders are constructing their leadership around these scenarios. We found that everyone we interviewed has only a partial picture of what is happening; no single person had a view around how the whole thing works. Everyone is acting from a partial view. This lack of a scenario that works for the whole we find significant, and helps describe the emotional roller coaster and lack of clarity people experience working in the system now. **Without a scenario for the whole, the system cannot function to realise the policy intent**.

The eventual outcome will be dependent upon how a set of identified underlying behaviours, assumptions and dilemmas play out, and how the NHS develops a more coherent scenario for the whole system. Exploring and understanding these underlying behaviours, assumptions and dilemmas is critical in positively influencing change into the future. They exist both at the general system level i.e. they affect the generation of all the scenarios, and specifically within one of more individual scenarios.

Some of these dilemmas are long-standing and have been wrestled with for many years, others are more recent and have been created, or come to the fore, through the current policy dynamic.

Summary

Five scenarios emerged from the interviews. It should be remembered that these are not necessarily mutually exclusive and a mixed picture between them might emerge. As a brief pen-portrait they can be characterised as:

1) **Localism wins:** in this scenario highly engaged GP commissioners drive a revolution in the quality, efficiency and appropriateness of local services to local needs.
2) **Regulator rules:** here, rather than being driven forward in a bottom-up manner the health care system moves forward through the application of strong regulatory and performance mechanisms at national and more local levels.
3) **Providers trump:** rather than seeing the future as being driven by commissioners, in this scenario providers are the dominant entities in determining the shape and outcomes of health services.
4) **Muddle through:** here, the various changes and interventions introduced actually have limited impact, and although certain structural changes may be introduced the system actually carries on much as before.
5) **Dominoes falling:** this is the relative 'doomsday' scenario where things go seriously awry, significant disruption occurs and the NHS as we know it is imperilled.

Scenarios Assumptions

Within each scenario there were a number of specific assumptions shaping the behaviours of leaders. In summary these are:

1. Localism wins

Assumptions:

- GP commissioning is a big win
- PCTs didn't make a difference and if that didn't work something else must
- GPs have the interest and skills to lead the process
- GPs understand and act in the interests of the public and act as a stepping stone to greater community control of resources
- GPs understand their local community
- GPs do more provision
- Managers and doctors are energized by the potential of change
- Doctor/manager partnerships work effectively
- Management styles are good enough and can adapt and look different
- The system connects and is competent
- Social enterprise opportunities bring innovation
- Small is good
- Market leads to greater flexibility and responsiveness
- GP private sector entrepreneurialism wins out
- Patients really involved; choose and scrutinise their care
- People do more of their own care

2. Regulator rules

Assumptions:

- Future will be determined by CQC and Monitor
- Setting standards regulates behaviours and outcomes and safeguards patients and communities.
- Appropriate behaviours: challenging and holding to account, occur
- Accountability processes and mechanisms work
- Local system management exists and the ring is held
- Scrutiny and challenge inherent in regulation process
- GPs understand people's needs.
- Reduction in number of organisations doesn't drown out local voices

3. Providers trump

Assumptions:

- Commissioning is irrelevant
- People's health identity is with providers
- High emotion/visibility provider services e.g. maternity get more attention and protection
- GPs focus on provision
- People do more of their own care
- Removal of PCT tier enables better linkage between provider clinicians and GPs
- Increasing integration occurs between acute and community services
- Market leads to greater adaptation
- Growth in private sector providers
- Foundation Trust process brings rigour
- Foundation Trusts act as an umbrella for social enterprise development
- Local Authorities get public health and remainder of commissioning follows
- Social care wins and gets a bigger slice

4. Muddle through

Assumptions:

- The NHS is stuck
- No sense of where it's going – can't connect with the purpose
- Organisations work to perpetuate their interests
- Pain of being undervalued means that people can't give energy
- Politics gets in the way of patient focus
- Part of routine political swings to right and left
- Politics gets in the way and its not about what's best for patients
- Everyone is 'too busy looking for jobs' to change anything
- GPs unwilling to cede any autonomy
- GPs carry on doing more of the same and wait til it passes.
- Short-termism wins (lots of change is long-term)
- Good work remains invisible

5. Dominoes falling

Assumptions:

- Adverse unintended consequences of change occur
- Professionals disinterested:
- System disconnects
- Eyes taken off the ball and things go wrong
- GPs don't understand their accountability for public money
- Inability to risk manage the whole system
- Localism means NIMBYism
- No one cares for marginalised and vulnerable groups
- Financial deficits escalate
- Loss of memory, networks and relationships
- GP reactions unpredictable
- GPs don't have time for clinical work
- No effective system management
- Private sector takes over

The Scenarios in more detail

1. Localism wins

In this scenario highly engaged GP commissioners lead a revolution in the quality, efficiency and appropriateness of local services to local needs – GP commissioning is a big win. This is probably the scenario that the White Paper most clearly envisages occurring.

A strong belief running through this scenario is that PCTs didn't really make a significant difference to transforming health services and if that didn't work something else must, with the 'something else' being GP commissioning led localism.

"Health-care needs redefining. In its current state it is broken"

"Why have NHS people taken so long to make any real difference?"

"The burning platform is evident, the waste is ubiquitous"

"Ambiguity and uncertainty is an opportunity to try to shape the system"

In this scenario GPs have the interest and skill to lead this process and understand their community and act in the interests of the public.

"We need to absolutely trust that people have the resources and talent to get there"

"GPs have direct contact with citizens. They are people focussed and have a good understanding of need"

"The perception is that GPs are close to the heart of communities and that they know their patients"

"A lot of doctors love the whole picture"

"GP commissioning could be a big win"

Both managers and doctors are energized by the potential of change, and the best outcome is a result of doctors and managers working together, not separately. This in turn relies on management styles being 'good enough' and that they can adapt and will look different than current NHS management in the future.

"It was the new agenda that energized me"

"Financial grip fully allied to clinical grip is the best way forward"

"If we can get managers and clinicians working together then we are powerful"

"Build trusting and mutually respectful relationships between clinicians and managers"

In this scenario, GPs want and do more practice-based provision, so that their practices become more advanced and diverse in the range of services that they offer.

"Commissioning models allow GPs to be incentivised to provide more services"

and social enterprises are seen as opportunities to bring innovation and energy into health care.

"Social enterprises are a really good idea, the more that you can get staff engaged and create a sense of ownership the better"

"I'm excited about social enterprises. They bring energy, pace and enthusiasm for social good"

The localism scenario is founded on an assumption that small is good as it allows better personal connections between decision makers and the communities that they serve.

"People and circumstances are different. Can't say it worked here and therefore it will work there. We can adapt and accommodate for where we are to get the best from people and from change"

"Even if you haven't designed the policy, you can predict consequences and impact. Even without the policy, you would know as much, if not more than anyone in the centre is ever going to know"

Patients, individuals and their communities are vital elements of a more localised approach. Patients are really involved, and they actively choose and scrutinise their care leading to quality and cost improvement, and people take more responsibility and do more of their own care. Greater community involvement in decision making and community control of resources is possible and desirable.

We need to say to communities, these are the outcomes we want to deliver, give the resources to a community group, use it as best you see fit and measure what happens.

"How do we get communities to do more for themselves?"

The beneficial role of the market is a strong element in this scenario, with stronger market involvement and incentives leading to greater flexibility and responsiveness. This links with the inherent basis of general practice as a small business operation, meaning that GP private sector entrepreneurialism wins out as the model to transform health services.

"More commissioners and more pressure on providers to perform"

This scenario assumes that the system will remain connected at a wider level and will continue to be competent to deliver. The Local Authority Health & Wellbeing Committee at a local level, and the NHS Commissioning Board and regulatory bodies at a national level will provide system connections.

2. Regulator rules

Here, rather than being driven forward in a bottom-up manner the health care system moves forward through the application of strong regulatory and performance mechanisms at national and more local levels.

The basic assumption here is that the setting of clear standards regulates behaviours and outcomes and safeguards patients and communities.

"The future will be determined by CQC and monitor"

"The NHS Commissioning Board will have to take responsibility for the system"

"To give the best possible service we need to focus on outcomes; focus on rights; focus on information, and shoring up the least powerful against the most powerful"

"System focussed on what it should be achieving for you as a patient/user, not just getting processes right"

The actions of GPs in their commissioning and provision roles are shaped by the regulatory environment, which ensures they act in the best interest of patients and communities.

"There's a need to work out the relationship between GP commissioners, CQC, the NHS Commissioning Board and Monitor"

"We won't all wake up and the system be competent"

"Primary care will be commissioned by the NHS Commissioning Board and there will be a new GP contract... they will be contracted and they will no longer be independent because most of the GPs will become salaried. Once that happens, then you're in a nationalised primary care service and one thing that's quite interesting is that the players in the GP commissioning circle will be driving through the National Commissioning Board back down onto their colleagues, the standards which they wish to see applied"

Although the majority of regulatory work is carried out by national bodies, it is assumed that effective local system management exists and that the 'ring is held' in holding health organisations to account, and that appropriate behaviours occur, enabling challenge and holding to account.

"The direction is holding to account for quality and outcomes"

"I think improvement is a product of scrutiny and challenge"

Accountability processes and mechanisms are well ingrained and sustainable within the system and these continue to work. Appropriate scrutiny and challenge is inherent and established in the regulation process.

"The NHS is dominated by risk assessment and systems that deal with that risk"

The role of patients and communities in providing feedback and alerts is significant. It is assumed that changing local organisational structures and processes won't adversely affect the ability of patients and communities voices to be heard.

"We are there to support the power position of the end user – more effective advocates on their behalf"

Regulation becomes more effective by being based on outcomes which are relevant to staff providing care and patient's views.

"Front-line staff don't connect with targets and financial performance. They are interested in care"

"There's a need for better measurement; away from activity and towards what patients think"

Regulation is the key enabler to allow a freer market in health care to evolve.

"Effective regulation is needed and belongs in a devolved pluralistic system"

3. Providers trump

Rather than seeing the future as being led by commissioners, in this scenario providers are the dominant entities in determining the shape and outcomes of health services.

Here people and communities dominant health identity is with providers of health services (particularly hospitals).

"People identify with acute services as a community"

"Connect people within the [hospital] organisation in dialogue with communities"

In this scenario commissioning is largely irrelevant. It is providers that determine the future. Increased amounts of GP provided services are an important element of this. This scenario recognises that certain high emotion and high visibility provider services e.g. maternity get more attention and protection, as they are removed from local responsibilities and commissioning through the National Commissioning Board.

"GPs need to do more provision and take more responsibility"

"Need to harness knowledge and expertise particularly in provider units"

"Less strategic planning and more agile and opportunistic as a provider"

"Organise for quality care – that's all you have to do"

Formal commissioning is less relevant as people take more responsibility for their health and do more of their own care; in a way they become micro-providers.

"A big change needs to be how we get people and communities to do more for themselves"

The removal of PCT tier is positive as it enables better linkage between provider clinicians and GPs and this enables increasing integration between acute and community services, resulting in more accessible and seamless care for patients.

"Local people need to know who is responsible for their health service provision"

"The only way to deliver is to get close to GPs"

"Acute services should run community services as this will allow seamless transition between primary and secondary care"

Here market competition naturally leads to greater flexibility, innovation and adaptation. As well as improving existing services, this also gives a growth in the number and utilisation of private sector providers. The cultural differences of the private sector are embraced.

"My hope is that this will really shake up the cosiness of quite a lot of secondary care provision and if it works, new providers will come in [and] provide excellent services"

"We manage doctors [in the private sector] but we don't own them, it's a different relationship from in the NHS"

"Using private sector to deliver health improvement, rather than just providing facilities for private doctors to use"

The extension of Foundation Trust status to all acute services ensures rigour in management and allows the provider scenario to flourish. The foundation trust regime acts as an umbrella for social enterprise development.

"[The FT] Can act as an umbrella social enterprise under which there could be multiple social enterprises in the one trust"

"Could we have a mixed model, with part of the organisation a charity?"

"The FT model brings rigour, and we need rigour around business. Treat it as your own money"

Local Authorities have a bigger role in the development of the provider scenario as they receive responsibility for public health and remainder of commissioning follows. GPs are not expected to play a major role in pro-active commissioning and the integration into local authorities further weakens the influence of commissioning. Indeed, through the local authority the hand of social care provision is strengthened, resulting in it getting a bigger resource slice.

"Local Authorities will be commissioning a lot more and delivering less"

"Social care is a sector that's growing; the knowledge economy is growing in social care"

"Social care will become increasingly important"

4. Muddle through

Here the various changes and interventions introduced actually have limited impact, and although certain structural changes may be introduced the system actually carries on much as before.

"Let's not pretend this is Armageddon"

"75% of what we do will still be here in five years time"

Here the NHS system is fundamentally stuck and impervious to external reform. Service provision will roll forward through regulatory inertia.

"The NHS is stuck"

"How can we move forward and not be dragged back by the old world?"

"Essential services will continue because of our statutory responsibilities"

"People have a very strong 'to the barricades' position because they have stayed in one place too long and lost touch"

"The resistance to change is phenomenal... we will plan for the one in ten million patient event, disregarding the other nine million nine hundred thousand and ninety-nine. So when you go to say, "We need to do this" someone will say, "Ah, but I remember in … there was this one patient." Well, we shouldn't be having those conversations, we should be saying, "What's the greatest good?""

Muddle through is a direct result of health leader's inability to connect with the purpose of this change, both because the reason to change is unclear and there is no understanding of where the reforms are going.

"There's no sense of where it's really going, and that's terrifying"

"There's a need for a clear sense of common purpose that we can all get behind"

"I don't know how this transition will be managed"

"This is different to past reorganisations as the end point and process is not defined at the start. The new arrangement of the deck chairs isn't clear"

Disillusionment with politically led change compounds this. The motivation to introduce change is seen as political, and part of routine political swings to right and left. Politics gets in the way of patient focus and patient-led change.

"Politics gets in the way and it's not about what's best for patients"

"We are limping into the future"

"I haven't detected any appetite for this new thing... What they do is destabilise the whole system and get everybody upset again"

"If it's about safe and effective care for patients, why don't we first continue to steer this middle course and continue to make improvements"

"We have a kind of pendulum – it swings to the right, and then it's like: Oh no... that's too far right, let's all swing to the left kind of thing"

"Policy as a donut – there's a hole in the centre re content"

A major factor in this scenario is the pain of being undervalued, which means that people can't give energy to change. In addition everyone is 'too busy looking for jobs' to change anything.

"Staff need to be valued, recognised and respected if we want to improve things"

"There are a lot of bruised people, who have invested careers in making a success of the PCT, only now to be told it was a waste of time"

"We are just starting to make a difference and it is insulting and frustrating to be told we aren't needed"

GPs are inherently conservative, and remain unmoved and conflicted in the reform process. They are unwilling to cede any autonomy in developing collaborative arrangements across practices, and carry on focussing on their role as service providers and wait till the current fad passes. If any positive movement is to be achieved it will require significant time and effort in support and training.

"Not a lot of evidence that GPs do innovation. They don't do exciting things with budgets"

"Different types of GP consortium will exist. The system will demand some loss of autonomy from practices to give a greater good"

"If GPs are to have a future role in commissioning, we need to give them the wrap-around they need"

The emphasis on short-termism exemplified by the delivery of new structures and immediate (often financial) priorities, actually works against building the long-term change processes which are needed to make reforms sustainable.

"One of the barriers is that at the end of the day governments are short-term and a lot of this is dictated by a government to have a result. They are incredibly short sighted about this, it is our system"

The emphasis on visible objectives also means that much good work in really changing services for the better remain invisible (the underlying story of many small things that positively change patients lives never get acknowledged). Communities are not effectively linked to the change process and so little happens.

"NHS services are about people. If you haven't got them on board then this isn't going to happen"

"The system can just ignore bits of work"

The new structures that are put in place hinder rather than accelerate the pace of local decision making.

"I worry about decision making getting slowed down; local government governance is very different to the NHS"

"By all means make us accountable, but not just through a political method which is all about point scoring and adversarial politics rather than informed decision making"

"The NHS is going to be consumed with new arrangements; this will make it difficult to progress"

5. Dominoes falling

This is the relative 'doomsday' scenario where things go seriously awry, significant disruption occurs, patients suffer and the NHS is imperilled.

"This current reorganisation has thrown more of the current NHS in the air than, I think, all of the rest put together"

In this scenario, many of the positives that exist in other scenarios turn out negatively. Professionals are uninterested, have other priorities, fail to build a sense of accountability, and even if they can be engaged behave in unpredictable ways.

"Doctors have antibodies"

"Big issue is assumption that NHS would be better run by doctors. But you can't do both clinical and managerial work simultaneously"

"GPs behave in ways that nobody could have predicted. We won't be able to predict the scenarios that emerge. They'll be a massive risk as they get up to speed"

"GPs are wayward. They are not very biddable"

"General practice is unlike any other part of the health service. Some don't think of themselves as part of the NHS"

"Danger that GPs won't get organised and be accountable"

Even if GP commissioning does take off, this is not positive as they act in their own interests and have no understanding of being accountable to the public for public money.

"There can't be winners without losers. Who will lose if GPs win?"

"GPs will engage with their practices, not the public"

"Doctors have been trained into dealing with the patient in front of you, ... but not to step back and say, "But what about the population?""

Marginalised and vulnerable groups are disadvantaged, resulting in greater inequalities, loss of voice, and an erosion of care and provision for such groups.

"Where's the GP consortium that's going to want to commission for the homeless, the asylum seekers and the prostitutes?"

"Reduction in the number of local and regional organisations will risk drowning out voices at local level and reducing overall impact"

"I'm hugely concerned that what is happening now will affect the gap between rich and poor"

Greater localism means greater variation and 'NIMBYism' in the delivery of care.

"Non-working people are not exactly loveable. Nobody wants them. We have to bother about them"

A significant contributory factor is the upheaval that will occur in the system as re-organisation occurs, resulting in leaders being diverted away from patient care, and financial deficits escalating.

"Everybody is too busy tarting up their CVs and applying for jobs to pick up quieter noises that something isn't right"

"Eyes will be taken off the ball and things go wrong"

The level of imposed change results in system disconnection at many levels, due to loss of memory, networks and relationships.

"How do we keep organisational memory given the scale of change and job losses?"

"Effective Local Authorities need deep relationships with other leading players"

"You got mentored and moved into appropriate jobs, there is no connectivity in that way now"

In turn, this leads to inability to risk manage the whole system, and new models to provide accountability and system management are ineffective.

"Are GPs really going to want to police each other?"

"The NHS doesn't, in system terms, risk manage"

"We will fail patients if we can't get our act together"

"There will be a vacuum in managing system tensions without regional authorities"

"It's going to be really hard to bring local councillors together with GPs – very different cultures and a high likelihood of clashes around power"

System weakness means that financial deficits escalate. This is compounded by GP's unwillingness to recognise and understand their wider accountability for public money.

"It's unclear if GPs really comprehend accountability for resources and outcomes"

The furthest extension of this scenario is that the NHS as we know it ceases in large part and private sector insurance based care takes over as the dominant model.

"Will we have a national health service at the end of it?"

"This is a dismantling of the NHS and a transfer to the private sector"

"Humana sees it as a business opportunity. How will they commission for people they don't understand. That's scary"

"Current reform questions our understanding of what the NHS is about"

"The current reforms are nationalising general practice for the first time ever and privatising secondary care"

"I think about the NHS a bit like I think about the fire service. It is a national service, there are local influences but it is a national service. But it may be that we're moving towards a fire service that was present in the 18th century when you had your insurance plaque on the front of your house that said Sun Life Insurance and if your house caught on fire, the Sun Life Insurance fire brigade would turn up, horse drawn"

"The money has now run out, we've now got to use different levers and in secondary care, one of the levers might be privatisation"

Common Behaviours & Dilemmas

All of the potential scenarios are affected by a common set of behaviours and dilemmas. The resolution of these one way or another, give the assumptions that drive the different scenarios.

Many of these dilemmas have always been with the NHS but remain important in shaping the scenarios, other are new or have been given a significant new impetus by recent policy announcements.

Dilemmas that have always been with the NHS

- The tension between national vs local decision making: Where will the power lie?
- How to meet short term needs vs concentrating on long term impact in effecting change and seeing outcomes
- It's people that do it vs structures that do it
- Diversity vs Standardisation
- Doing the right thing [ethical decision making] vs ticking the boxes
- Privatisation/competition vs cooperation/ networking
- Big (umbrella organisations) vs small (enterprises)
- Financial incentives change behaviour vs staff are motivated to care
- The NHS is accountable vs the NHS doesn't know how to be accountable

Dilemmas that have a new impetus or are new

- Throw the whole thing up and the right thing will land vs it all falls apart
- Purpose and direction should be emergent vs it should be pre-determined? Which works?
- Are GPs innovative or not?
- Can GPs act as both commissioners and providers?
- Engaging through inherent stereo-types vs engaging through openness to new understandings
- Is politics (local and national) an enabler or a disabler?
- Leaders are energised by the new context vs leaders are disabled by the new context

The Dilemmas unpacked

Underlying Dilemmas: Dilemmas that have always been with the NHS

The tension between national vs local decision making: Where will the power lie?

"Even if you haven't designed the policy, you can predict consequences and impact. Even without the policy, you would know as much, if not more than anyone in the centre is ever going to know"

How to meet short term needs and deliver outputs vs concentrating on long-term impact in effecting change and seeing outcomes

"The immediate need of the government to have a result is short-sighted"

"It's the long-term preventative stuff in the NHS that will save the money"

It's people that do it vs structures that do it

"My approach is that you change things through people"

"You approach things through people"

"It is in relationships that change happens"

"National clinical audits may be one of the things we have to ensure continue to ensure that the system still works"

Diversity vs Standardisation

"Diversity is absolutely key because people aren't hearing things"

"Different cultural contexts and a diversity of perspectives is the key to innovation"

"Everybody wants a universal service, with any variation only at the margins, for example the convenience of appointment times"

Doing the right thing [ethical decision making] vs ticking the boxes

"System needs to remember that it's there to deliver best services and not follow professional concerns and interests"

Privatisation/competition vs cooperation/ networking

"I just don't get how you can create individual FT business models at the same time as creating a network of high quality sustainable service delivery for a local population. I think there is some fundamental incompatibility in there"

Big (umbrella organisations) vs small (enterprises)

"Keep identities small but organisations big. Bigger is better for service delivery"

"What's right here won't be right somewhere else"

Financial incentives change behaviour vs staff are motivated to care

"Front-line staff don't connect with targets and financial performance. They are interested in care"

"Chief executives who only manage the organisations budget may have a business agenda but the lose most of the community and clinicians"

The NHS is accountable vs the NHS doesn't know how to be accountable

"The NHS is not accountable"

"I don't understand the accountabilities between commissioning and managing the budgets"

"I quite like asking the question, "So if this all goes wrong, who can I sack?" And you get some very, very interesting answers. It's not being aggressive about it, it's just what is the line of accountability is the polite language"

Dilemmas that have a new impetus or are new

Throw the whole thing up and the right thing will land vs it all falls apart

"The NHS does change and adapt, but not through violent reaction or mis-informed thought"

Purpose and direction should be emergent vs it should be pre-determined? Which works?

"Spend time with users and front-line staff regularly. It's energising and keeps 'the point' in focus"

Do GPs have system perspective or not?

"GPs are not used to managing big systems, they run corner shops"

Can GPs act as both commissioners and providers?

"How will performance management of GPs work, as they can't police themselves?"

"I'm nervous about too much distinction between GPs as commissioners and providers"

Engaging through inherent stereo-types vs engaging through openness to new understandings

"The professional is the biggest stumbling block within the health service"

Is politics (local and national) an enabler or a disabler?

"I've got a real nervousness about locally elected members"

"Theory is that Local Government should take responsibility for the health of the population. It doesn't work; working in health doesn't get you elected"

Leaders are energised by the new context vs leaders are disabled by the new context

"Ambiguity and uncertainty is an opportunity to try to shape the system"

"I don't know how this transition will be managed"

Communities are best represented by GPs and local politicians vs need for new and different models of community representation

"What's the best way to represent and involve communities?"

"As a GP you are only seeing a tiny proportion [of the community]. There are thousands you've never met. And if you don't live in your community do you really know your people or do you just think you do?"

"To replace NHS execs with elected members is fool-hardy"

"Can we acknowledge that there's more than one form of democracy and it's not all elected?"

"The membership model allows us to be publicly accountable"

Behaviours

How you see yourself in these scenarios, i.e. the one you are adopting, affects your behaviour (in terms of leadership choices and where you pay attention).

The issue that you should be addressing in the whole is: 'What's the leadership going to look like in the future?

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