

A Dutchman in London: reflections of a hospital chief executive from the Netherlands in the NHS

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ABSTRACT

Background The NHS is a fascinating health care system and is enjoying a lot of support from all layers of British society. However, it is clear that the system has excellent features but also areas that can be improved.

Story of self A number of years as a chief executive in one of London's largest hospital has brought me a wealth of impressions, experiences, and understanding about working in the NHS. Contrasting those to my previous experience as chief executive in Amsterdam (The Netherlands) provides an interesting insight.

Observations Very strong features of the NHS are the high level of health care professionals, the focus on quality and safety, and involvement of patients and the public. However, the NHS can significantly improve by addressing the lack of clinical professionals in the lead, curtailing ever increasing bureaucracy, and reducing its peculiar preference for outsourcing even the most crucial activities to private parties. The frequent inability to swiftly and successfully complete goal-directed negotiations as well as the large but from a clinical point of view irrelevant private sector are areas of sustained bewilderment. Lastly, the drive for innovation and transformation as well as the level of biomedical research in the NHS and supported by the British universities is fascinating and outstanding.

INTRODUCTION

After a period of 7 year as chief executive of the Academic Medical Centre of the University of Amsterdam in the Netherlands (and having worked for 30 years in that hospital in various roles), I decided it was time to move on. We were just completing a massive merger with the other academic hospital in Amsterdam (Free University Hospital) and the new Amsterdam University Medical Centre, by far the largest hospital in the country, was formed. As I enjoyed my work as a hospital chief executive and considering there was no better job in the country than the one I was about to leave, the step to think of moving to another country was not so difficult. For various reasons, the UK was high on my list of preferred countries, also because I had been long intrigued by the National Health Service (NHS) and was keen to work within this system to better understand its pros and cons. The vacant chief executive position at University College London Hospitals (UCLH) was especially intriguing and when its chairman Richard Murley invited me to come over and showed me around, I realised I was fascinated and inspired by the place within minutes. I was very pleased when I was offered the job.

The last 4½ years at UCLH in London has been a wonderful and enlightening experience. I have

thoroughly enjoyed working in the NHS and to have had chance to understand better both the things that make healthcare in England exceptionally good, and at the same time form some perspectives on how the system could be further improved.

In the *Commonwealth Fund's* annual health systems ranking the NHS is consistently judged as the best, safest and most affordable healthcare system in a comparison between various countries. This position causes considerable pride among NHS executives and accompanying newspaper articles reinforce the positive reputation of the NHS in British society. However, in other ranking systems (which are for no specific reason mostly ignored in England and will never reach the pages of the national press), such as the *European Health Consumer Powerhouse* or the *American Institute for Health Metrics and Evaluation* the NHS hardly reaches the top 20 of best healthcare systems. As all these rankings use different criteria and parameters, the most likely conclusion is that the NHS is excellent in some areas but does not compare favourably in others. In the following, I will try to highlight what in my (very personal) view are some of the excellent features of the NHS and some areas for improvement.

WHAT IS EXCELLENT IN THE NHS

While real estate agents often say that the top 3 most important issues in the property business are location, location and location, I think one could say that in hospitals the pivotal top 3 would be people, people and people. And the one area where healthcare in the UK really stands out in comparison to any other system globally is in the quality of the staff. The level of graduate and postgraduate training of staff is remarkably high. In addition, the emphasis that is put on working in (multidisciplinary) teams, the comprehensiveness and vigilance of the service, and the importance of kindness when delivering care to patients, are not only slogans but really visible and tangible in day-to-day practice.

Like many healthcare systems, the NHS strives to deliver the highest quality and safety to its patients. Compared with other systems, however, the health service distinguishes itself positively by the continuous and systematic collection of quantitative metrics to measure quality and safety. In addition, metrics related to operational performance, such as access and waiting times, are constantly recorded and reported. In many healthcare systems (such as in the Netherlands), the amount of performance and management information available to the organisation is much more limited and less comprehensive and in some healthcare systems (such as in the US) detailed metrics are collected, but mostly used for



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billing purposes. However, in the UK, these performance figures are monthly discussed in detail at the Board level and receive ample public scrutiny. I think this is rare, if not unique, globally, and is a strong driver for improvement.

Another interesting feature of the NHS is the involvement of public and patients. Some colleagues in NHS Foundation Trusts found the presence and position of governors, for a major part patient and local stakeholders, cumbersome. I do not agree. Having a group of 'critical supporters' (as most governors are) and other forms of public and patient involvement in decision-making about local health services is a very strong feature of the NHS and may be a crucial factor in maintaining engagement and support for the NHS across large parts of the population.

WHAT COULD BE IMPROVED IN THE NHS

In contrast to many health systems in the world, the typical NHS executive director does not have a clinical background. They come from the worlds of management, finance or business administration. The associated risk is that a disconnection may occur between the executive team and the clinicians on the shop floor. This is further aggravated by differences in language that the two groups use. Most clinicians despise terms such as 'production' (the managerial term for dealing with sick patients), or 'business units' (their outpatient clinic or hospital ward). The eternal need for business cases creates an artificial reality that is seen by clinicians as a decoy for delay and avoiding difficult decisions. I often wondered why we would need a business case to repair the broken heating system or replace an old decontamination machine: we always need adequate heating and proper decontamination regardless of the outcome of any business case. I was fortunate to work in an organisation that had chosen to put professionals in the lead, an exception in the NHS. This organisational form was based on the philosophy of the board and its consecutive chairmen that it would be suitable for an academic healthcare organisation and was often met with some scepticism (or jealousy) by colleague hospitals. Nurses, doctors and allied health professionals occupied central positions in the higher and middle management of the hospital, properly supported by managers and I am convinced this organisational choice was part of the success of the institution. More overall involvement of clinicians in how the NHS is run would lead to a situation where management is more appropriately and adequately informed what is going on at the frontline, where decisions are more driven by content, where clinicians are more likely to accept difficult choices, and where teamwork across the organisation is easier to achieve. Interestingly, there is a strong appetite in the younger generation of clinicians to be educated and trained in the management side of healthcare provision.

A massive system such as the NHS can easily lead to too much bureaucracy. And that is exactly what happens. There is a limitless appetite for endless committees, boards, partnership executives and consultative bodies with their associated countless meetings, minutes of the last meeting, any other business, and so forth and so on. Many of these meetings are less useful talking exercises without any focus on concrete actions that need to be taken. If we seriously want to improve the productivity of the NHS there is room for a rigorous curtailing of bureaucratic layers, useless meetings, and inconsequential get togethers. This would also be a very timely exercise as the largest risk of the announced (and promising) transformation of the NHS into the direction of integrated care systems is the creation of a bureaucratic monster with a myriad of inimitable and overlapping boards and meetings.

A third item that may need some reconsideration is the strong urge of healthcare providers to outsource as much as possible to external parties. Whereas I can see the logic of outsourcing supporting activities such as cleaning or catering, it is amazing to observe that entire information technology departments, radiological services, or diagnostic laboratories are outsourced. In many cases, the short-term benefit of a financially attractive transaction is immediately counterbalanced by rapidly deteriorating quality of service and complete loss of knowledge and experience within the own organisation, leading to an even greater dependence on outsourced services. Management and improvement of a failing service is being replaced by (often unsuccessful) management of a contract. In addition, outsourcing creates a workforce that feels as if they are second class citizens in the institution, and who may have difficulty in engaging with the organisation and its values and objectives—in really feeling that they 'belong'.

SUSTAINED BEWILDERMENT IN THE NHS

Coming from a country where result-driven negotiations, limitless giving and taking, and infinite compromising is a national hobby, I remained perplexed by the complexity of British-style contract transactions. I often experienced that deals beneficial to all sometimes did not cross the finish line because parties could not agree on a minuscule detail and neither was willing to give in even the smallest concession. Quite frequently sustained fighting could occur over a tiny bit of money or benefit, already three times offset by the mushrooming need for legal support during the prolonged contracting phase. I do realise this might be a reflection of a national style of doing business and therefore very hard to change, but the benefits of a more goal-oriented and contracts based on mutual trust and understanding (and maybe a little less detail) could be very large.

Another mesmerising feature of English healthcare is the existence of a thriving private sector. With the presence of a high-quality national system it is amazing people want to spend quite a lot of money to receive private care which is equal (or in some cases inferior) to the care afforded by the NHS. Apart from accessibility and avoidance of waiting lists, it is hard to see substantial and tangible benefits of private healthcare above NHS care. Interestingly, the care is usually provided by exactly the same doctors as the ones working in the NHS. From a managerial point of view private healthcare is also cumbersome. It is hard to work with physicians and surgeons who are dividing their time between their NHS hospital and their private practice. It is often not crystal clear which part of the time is devoted to which activity. More importantly, there is also a confusing conflation of interests, where easy and cheap parts of the care are done in a private setting (with a large profit margin), whereas more complex parts (eg, sophisticated imaging, or treatment of complications) is referred back to the NHS. Even more convoluted is the shuttling of patients by the same doctor between NHS care and private practice. In a healthcare environment where adequate staff resourcing will be increasingly difficult, one could argue that the number one priority from a national perspective would be mobilising all healthcare workforce for the NHS. By abolishing the private sector, the substantial amount of money in that part of the system could be used to improve accessibility or reduce waiting lists, improve clinician's salaries, and promote equality in the provision of healthcare. An interim solution could be to incorporate

all private practice under an NHS provider umbrella, as is successfully executed by some large specialised providers such as The Royal Marsden cancer hospital or Great Ormond Street Hospital for Children.

SUSTAINED FASCINATION IN THE NHS

The drive for innovation and transformation in the NHS is impressive. Quality improvement and innovation are obligatory parts of post graduate training of doctors and (sometimes) nurses and allied health professionals, and managers. Due to its rather hierarchic and central management structure, service reconfiguration (eg, to achieve concentration of high risk and low frequency interventions) is more rapidly achieved than in any other healthcare system. Ironically, as cost saving is often a driver for transformation, the most important hindrance to transformation is usually lack of money to fund a transitional period. With proper investment to facilitate transformation, the system would be able to change even more rapidly and better address the healthcare needs of the population. If the formation of integrated care systems will not be accompanied by serious funding of transformation, the success of this system will be at risk.

Biomedical research in the UK is by far the best in Europe. In every European ranking of life sciences and health research output, the UK occupies at least six of the top 10 positions and invariably the first four spots. The formation of Biomedical Research Centres, funded by the National Institute of Health Research, has given a fantastic impulse to the translation of university research into better care for patients. In those places where universities and NHS hospitals work together well, the hospitals are increasingly occupying worldwide leading positions in the introduction of new diagnostics and treatment modalities. Systems that would stimulate and facilitate doctors in training, nurses and other healthcare professionals to more intensely

participate in this research would further embolden the synergy between universities and hospitals.

CONCLUSION

More than 70 years after its formation, the NHS is far from ready to retire. The health service provides universal and freely available high-quality healthcare under difficult circumstances, such as lack of capital investment and funding, or insufficient social care unhelpfully driving a lot of activity to NHS hospitals and other health providers. Distinguishing strengths of the system are its high quality staff, focus on performance, and public involvement. I dare to say that the NHS could be even more effective by having more clinical health professionals in leading positions, by establishing a continuous focus on cutting bureaucracy, and by reducing outsourcing. More results-oriented business transactions and reconsideration of the private health sector in the country would be further issues that might have a positive effect on the health service. By maintaining the strong drive of the NHS to implement innovation and further stimulating the translation of excellent biomedical research into clinical practice, the NHS will undoubtedly retain its role as an exemplary health service in Europe.

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