Implementing the White Paper

Pitfalls & opportunities

A KING'S FUND
POLICY PAPER

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Implementing the White Paper

Pitfalls and opportunities

A King's Fund analysis of Labour's plans for the NHS

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Introduction

If we have learned anything from the 1991 reforms of the National Health Service, it is that implementation is all. The battle of words that preceded the introduction of the reforms revolved around the principles that shaped the changes. In the outcome, the process of implementation created a new agenda, demonstrating unexpected problems and creating new opportunities. The internal market that has emerged is, in significant respects, very different from the blueprint that launched it.

In contrast to the 1989 Conservative White Paper, *Working for Patients,* the Labour Government's White Paper, *The New NHS,* has aroused no great passions. It is a self-proclaimed pragmatic document – 'what counts is what works' – and has not prompted a major debate. Its rhetoric is reassuring, stressing continuity. In this lies a danger. It is that acceptance of the general line of change will also mean a lack of discussion of the radical implications if the White Paper's proposals are to be carried through successfully.

This review of the White Paper therefore concentrates on the challenge of implementation, drawing on the collective experience and work of the King's Fund. The common theme of all the contributions is that while the aspirations of the White Paper – for a primary care-led, quality-conscious NHS that works in a spirit of partnership and collaborates closely with other agencies – are to be applauded, translating aspirations into achievement is going to be difficult.

The emphasis throughout is on exploring the ambiguities in the proposals and on identifying the problems that will have to be solved if the hopes of the White Paper are to be realised. The tone is critical; the aim, however, is to be constructive. For it is only by identifying the difficulties that are likely to be encountered – by drawing out the implications for the way in which doctors, nurses, managers and indeed everyone in the NHS will have to work – that we are likely to manage the process of implementation successfully.

The White Paper has provided an outline framework for change in the NHS. Filling in that framework will be an extraordinarily demanding task, as the contributions to this volume make clear. It will provide a challenge both to the NHS Executive to flesh out and implement the proposals and to bodies like the King's Fund to provide the analysis, evaluation and training that will be needed. And, as with the 1991 reforms, the NHS that eventually emerges may well be different from the Government's new blueprint.

Chapter 1

Primary care groups in England

Nicholas Mays & Nick Goodwin

The aim of primary care groups

From April 1999, the introduction of primary care groups (PCGs) in England will represent a fundamental reform of the NHS since, in their most radical form, PCGs could develop into organisations akin to North American managed care organisations or New Zealand independent practice associations (IPAs). As outlined in the White Paper, *The New NHS,*[1] PCGs represent an important component of the Government's plans to move from a supposedly competitive internal market towards a more collaborative, integrated system, while retaining the basic feature of the internal market, namely, the separation between commissioning and providing services.

The Government's aim in introducing PCGs is to build on the experience of previous approaches involving general practitioners in the process of shaping and negotiating local patterns of service provision, such as standard fundholding (SFH), multi-funds, fundholding consortia, locality commissioning groups, general practitioner commissioning, extended fundholding pilots (EFHs) and total purchasing pilot projects (TPPs).[2] Thus there are strong elements of continuity in what is proposed, especially the continuing elevation of the role of primary care professionals. At the same time, the Labour administration wishes to remedy what it regards as three principal drawbacks of previous commissioning models:

- the perceived fragmentation and potential incoherence of decision making produced by the 'plurality' of different types, scope and sizes of commissioning bodies in the NHS;
- the perceived institutionalised inequity between fundholding and non-fundholding practices under the previous arrangements, commonly referred to as 'two-tierism';
- the additional transaction costs generated by the large number of local commissioning agencies, particularly the costs at practice and provider levels of single-practice budget-holding.

In order to retain the advantages of devolved, primary care-led commissioning, while overcoming the inequity, fragmentation and cost of the previous arrangements, the Government proposes far larger bodies at local level, involving *all* general practices in an area and responsible for commissioning a wider range of services than any of the previous models, particularly fundholding. As a result, nearly 4,000 existing commissioning organisations will be replaced by about 500 PCGs in England.

Continuity versus change

The plans for PCGs (Box 1) and their relationships with health authorities, trusts and social services exhibit features of both continuity and change. In many respects, the Government is doing no more than recognising innovations which have already occurred. However, the features of Level 3 and 4 PCGs promise major change to the ways in which primary care is delivered and secondary care commissioned.

The elements of continuity with the previous Government's approach are as follows:

- the purchaser-provider separation remains, although, as in fundholding, the strict separation apparent in the distinctive roles of the health authority (HA) and trusts is blurred since general practitioners are also providers of care (albeit not of hospital and community health services). PCGs, especially at Level 4, erode the separation still further since community nurses will also be involved in the running of PCGs for the first time;
- HAs will retain a strong commissioning role and, particularly in the early years, will play a key part in developing and supporting the new PCGs, as well as holding them to account for their commissioning and providing. HAs will not wither away, the new system will depend on their expertise at local level;
- the Government, like its predecessor and the Liberal Democrats, continues to place great faith in primary care professionals to make sensible decisions about the specialist services needed by their patients and to put in place alternatives to the acute hospital, thereby promoting more cost-effective use of overall resources;
- as under fundholding, primary care-based commissioners will be allocated real budgets (at Level 2 onwards) from which they will be allowed to make 'savings' to re-invest for the benefit of their patients, encouraging them to consider substitution of less costly care for more costly care;
- the allocation of budgets to PCGs continues the observed trend towards breaking down the distinction between budget-holding and non-budget-holding forms of local commissioning since, increasingly, groups of non-fundholding practices have been allocated budgets with some autonomy as to their use.

Box 1 The structure, organisation and role of primary care groups

Structure of PCGs

- Groups of general practices of around 100,000 patients based on 'natural communities'
- Managed jointly by GPs and community nurses with representation from social services
- Funded by a national capitation formula
- Budget savings used to purchase additional patient care, virement between budget headings
- Cash-limited budgets with all general practitioners operating under a cash-limited drug budget

Levels of PCGs

LEVEL 1	Advisory to HA on its commissioning while managing own collective budget for prescribing costs and cash-limited part of general medical services
LEVEL 2	A sub-committee of the HA deploying a devolved budget to commission a range of hospital and community health services (HCHS). Budget the ultimate responsibility of the HA
LEVEL 3	A free-standing commissioning organisation with own delegated budget. Accountable to HA for commissioning a range of HCHS for registered population
LEVEL 4	A 'primary care trust' holding a fully integrated, capitated budget covering the whole of HCHS and GMS with additional responsibility for community health services previously provided by community trusts. Also responsible for managing all GMS activity and payments previously made under the national GP contract

Key roles of PCGs

- Control a budget, provide GMS, 'gatekeep' access to secondary care
- Commission up to 85 per cent of total NHS services via service agreements with providers
- Contribute to the development of local HA's health improvement programme
- Promote health of patient population
- Monitor local service developments
- Develop primary care provision
- Integrate primary care and community care services

However, there are a number of other aspects of what is proposed for PCGs which are distinctively different from the situation in the immediate past:

- in theory, the advent of PCGs means the end of individual practices holding their own budgets independently as of right and marks a shift towards collective forms of budgetary management;
- for the first time, community nurses, and possibly other primary care professionals, together with representatives of the local social services, will be involved in local commissioning of health services alongside general practitioners;
- it will be compulsory for *all* general practitioners to be involved in PCGs, thus removing the volunteer status of previous initiatives;
- PCGs will be groupings of practices, but they will be organised geographically, with all the practices within a particular area forming the PCG. In theory, in order to encourage equity between PCGs and to facilitate resource allocation using needs-weighted capitation, there will be no provision for practices and practitioners to choose the practices with which they work in the PCG. This is very different from the arrangements in fundholding multi-funds and consortia;
- whereas in the past large parts of the GMS budget were not cash-limited at local level, in the future all allocations to PCGs will be cash-limited, irrespective of the level at which the PCG operates;
- PCGs will have a far wider set of responsibilities than fundholders or TPPs, including broad requirements to promote the health of their populations and to monitor local health services;
- finally, the Level 4 PCG will have a unique capacity to incorporate all the community hospital services (CHS), including the whole of community nursing and the professions allied to medicine (PAMs), thereby creating a single body responsible for the delivery of the full spectrum of primary and community care in the NHS on contract to the local HA. While energetic former fundholders and TPP lead general practitioners may see PCG Level 4 as an opportunity to lead a properly integrated primary and community care provider organisation with access to a full secondary care budget for commissioning services, there is nothing, in principle, to prevent managers from a former community trust leading the new primary care trust.

Potential problems in establishing and running PCGs

Inevitably with any new policy, it is easier to identify potential problems in implementation than to predict the advantages of the innovation over previous arrangements. PCGs are no exception. Most of the obvious, early-stage difficulties appear to be related to the organisational development challenge posed by the requirement to put in place groupings of independent practices which are larger than many fundholding groups, yet smaller than current HAs.

Organisational development

PCGs will require previously independent general practices to work together in groupings larger than most of the collectives which came into being under fundholding and without the immediate focus on the delivery of a service of mutual benefit, which occurs through the increasingly popular out-of-hours general practitioner co-operatives. For example, the evaluation of the progress of the first-wave TPPs in their first 'live' year (1996/97) showed the need for pilots to develop robust organisations and forms of corporate working between practices before progress could be made.[3] In particular, those among the larger TPPs which had achieved most had spent considerable time (up to two years) developing mature and effective organisations. That the average TPP has a population of around 30–40,000, far smaller than that proposed for PCGs, suggests that organisational development problems will take time to overcome.

Unlike TPPs and multi-funds, PCGs will be compulsory and practices will not be allowed practices to choose their allies. Fundholders and non-fundholders, together with doctors who believe in taking fiscal responsibility on behalf of the NHS and those who reject this role, will be required to make common cause in their local PCG. The fundholders will have to cope with the sense of loss brought about by the removal of their practice level budgets, while learning to work with practices which may have very little experience of either collaboration or commissioning services and managing budgets. Moreover, while guidance on the establishment of PCGs suggests that existing innovative pilot schemes, such as primary medical services (PMS) pilots, will 'provide an important opportunity to learn and develop practices that will be necessary to ... the development of primary care groups',[4] there is likely to be substantial difficulty in integrating such pilots with less innovative practices, combined with reluctance on behalf of the pilots to integrate their schemes with practices perceived to be less able. In areas with few fundholders, and where locality commissioning groups have remained advisory, there may be little experience of managing budgets and commissioning services and antagonism towards the budget-driven mechanisms inherent in PCGs.

Seen in this light, what incentives will there be for general practitioners to take an active part in PCGs? Will all general practitioners wish to take on the complex task of commissioning or take an interest in the management of the budget? There are few obvious incentives for active participation, particularly in the Level 1 and 2 PCGs in which the general practitioners' income from the national contract is largely unaffected by the operation of the PCG. Yet active involvement by all, or the vast majority, of practitioners is important if the Government's aim of producing an equitable form of commissioning organisation in which no groups of patients are disadvantaged is to be realised. Unfortunately, even among the highly selected, experienced fundholding practices involved in the volunteer TPPs, there were frequent examples of practices and/or doctors who took no active part in the pilot and who were unwilling to alter their behaviour to correspond to corporate goals. Yet the evaluation of the TPPs showed that pilots in which the general practitioners left problems of financial management to lead partners and attempted to insulate their actions from budgetary considerations found it considerably more difficult to control their expenditure in-year than those in which there was more general involvement in budgetary management.[5]

In addition to the difficulty of bringing practices together on a large scale, the proposed PCGs will have to involve community nurses and other professionals in a leadership capacity. While the logic behind this is clear, given the fact that primary care is far more than general practice and the clinical contribution of individual general practitioners, neither the White Paper nor subsequent NHS Executive guidance[4] gives details on the terms by which this is to occur. General practitioners are independent contractors in partnerships, while community nurses are employees of community trusts, yet both will need to be brought together to manage a single budget. However, only at Level 4 will the PCG budget include all the resources covered by the activities of each set of professionals. The proposals for Level 1 PCGs merely suggest that community nurse representatives will be involved in decisions related to the prescribing behaviour and costs of general practitioners, while their own activities remain outside the control of the PCG – hardly a recipe for harmony! The requirement to involve the local social services, though logical given the inter-dependent nature of health and social care, particularly of elderly people at practice level, will add further complexity to the management of the PCGs.

Agreeing boundaries

The indication in the White Paper that PCGs should have populations of approximately 100,000 appears to be related to a concern for equity and to realise economies of scale from having fewer, larger commissioning bodies (see below, this chapter) and to a desire to align NHS and local government boundaries at local level. Quite apart from whether a population of 100,000 is either too big or too small, depending on which of the PCGs' roles is under discussion, the goal of coterminosity is undermined by the fact that general practitioners' lists do not relate to either HA or local authority boundaries or sub-divisions. There is an uneasiness between setting the boundaries of a PCG on the basis of, for example, community trust and social services areas, as against recognising PCGs as aggregates of practice lists and reorganising CHS and social services accordingly.

The White Paper also talks of organising PCGs around the concept of 'natural communities'. However, a critical tension emerges at this point since 'natural communities' do not equate to a prescribed population size. Indeed, these two elements in the configuration of PCGs are most likely to pull in opposite directions. For example, in rural areas, PCGs based on 'natural communities' may need to be much smaller than the proposed 100,000 population, while in conurbations, by contrast, 'natural communities' with a strong spatial character may be hard to find if areas are highly heterogeneous in population terms. Guidance on the content of 'natural geographical communities'[4] further highlights the spurious nature of the term, since it requests PCGs to be 'congruent with the distribution of minority groups', 'reflect transport links, consider habits, language [and] culture', as well as 'meet the needs of the mobile (homeless, travellers and refugee population)'. It is highly unrealistic to suggest that any PCG will be able to establish a 'natural community' covering all these characteristics and virtually impossible at the population size proposed. Consequently, one can predict considerable flexibility in both the size and composition of PCGs in different settings.

Improving primary care and clinical governance

Fundamental to the rationale for involving primary care professionals in the commissioning of health care is the opportunity it offers to bring clinical decision making and resource management decisions together at the level of the individual clinician and at the same point in the health system. At the heart of the PCG concept is the idea that practices and doctors must act collectively, rather than individually, in managing a common budget. For this to work in multi-practice settings, not only do practitioners and medical managers have to have good information on activity (referrals and prescribing), cost and patient morbidity, but also general practitioners have to accept collective responsibility for staying within budget and agree to be bound by the decisions of the collective. In addition, PCGs need to be able to exert some direct control over their practitioners' behaviour since most groups will contain general practitioners antagonistic to, for example, prescribing and referral protocols, since they imply a reduction in traditional decision-making autonomy and a greater emphasis on rationing. While information feedback and regular, well-structured peer review may do a great deal to align the performance of professional colleagues, there may need to be sanctions where more extreme differences exist. However, apart from at Level 4, the mechanism by which PCGs could intervene in the working of individual practices is unclear. For example, will a PCG be able to replace a poorly performing doctor? Equally, will a general practitioner be able to transfer (with or without his/her patients) to a better run PCG? The White Paper and NHS Executive guidance are silent on all this, although it is well known that the range and quality of care within general practice varies widely throughout the country, particularly in inner cities, suggesting that the challenge of creating collective responsibility within PCGs will be great.

Management costs

In implementing the proposals in the White Paper, the Government has announced that it will set a cap on total management costs at local level to cover HA, PCG and trust activities. The aim is to reduce the current levels of management spending by abolishing fundholding, replacing annual contracts with three-year service agreements, ending the system of extra-contractual referrals (ECRs) and eliminating the overlap of functions between HAs and sub-district bodies such as fundholders, locality commissioning groups and TPPs. This is to release resources for new ventures such as *NHS Direct* and the computer networking of all NHS general practices into a single system.

The expected management and transaction costs associated with universal primary care-based commissioning in the form of PCGs, while retaining HAs, are very difficult to predict, since they are likely to depend on a large number of factors, such as the size and scope of PCGs. While the 'minimalist', advisory model of PCG (Level 1) may be capable of being managed relatively cheaply, it is difficult to see how it can contribute to the wider requirement to manage services efficiently within a budget. Yet the more ambitious model of PCG, which takes collective responsibility for managing a budget, is likely to require relatively high management costs. Indeed, there may need to be increases in overall management spending in the short term, as new PCGs are set up with the help of HAs whose role will be fundamental as PCGs assume budgetary and commissioning responsibilities. The evidence to date from the national evaluation of the TPPs suggests, crudely, that the more effective models of PCG will tend to cost more to run.[6]

There is an assumption behind the White Paper plan that, by making PCGs the size of small districts, their management costs per capita can be reduced through economies of scale and the elimination of duplication of functions throughout the local health system. Together with the abolition of fundholding and the simplification of the working of the internal market, it is assumed that total management costs can be reduced significantly. The evidence from the TPPs indicates that the reality is likely to be more complex since there was no significant reduction in per capita management costs in the larger projects. This was because, while there were some management functions where straightforward economies of scale could be realised, there were other organisational costs which increased. These costs were typically associated with communication and co-ordination between practices and with paying general practitioners for their time spent on TPP work.[7] Moreover, since TPPs comprise 'leading-edge', volunteer SFH practices, they have been able to count on a high proportion of uncosted additional time given by key participants, particularly from lead general practitioners. The implication is that the costs of co-ordinating general practitioners across more, and non-volunteer, practices under PCGs are unlikely to be less than they are for TPPs.

However, changes in the costs of HAs, savings from the abolition of fundholding and the potential impact on trusts must also be taken into account. For HAs, the effect is likely to be cost-neutral in that the functions required to support fundholders will be replaced by requirements to support and hold accountable the new PCGs. Thus, HA responsibilities will relocate rather than alter total system costs.[7] The cost consequences of abolishing fundholding are complicated, but there should be economies realised from managing integrated and collective budgets. Assuming that all the current management costs of fundholding are removed, this would yield £2.50 per capita averaged across the whole population of fundholding and non-fundholding patients.[8] Yet rough estimates of the costs of managing PCGs beyond Level 1 produce figures in the region of £3.50 to £4.00 per capita, based on the experience of the larger TPPs.[3] This suggests that any savings will be small. The picture for trusts is similarly complex and hard to predict with any confidence. While one might predict a reduction in transaction costs incurred by providers through a reduction in the number of contracts negotiated with commissioning bodies, the costs of providing disaggregated information to PCGs on expenditure and activity by general practitioner, by practice, or by locality may be onerous, particularly for mental health and community trusts.

In conclusion, direct management costs and other transaction costs associated with PCGs are unlikely to be appreciably lower overall than current arrangements. If management investment is cut, the result is likely to be slow progress towards PCGs at Levels 2 to 4, resulting in modest achievements by PCGs.

Autonomy and a **raison d'être**

Lurking behind the previous discussion of management costs is uncertainty as to the extent to which the Government wishes to see PCGs as robust, autonomous (but accountable), not-for-profit (but able to re-invest a surplus) commissioning and primary care development agencies *or* as sub-units of the HA advising on the local health improvement programme, but working closely within its limits and those of the national service frameworks. There is a tension in the White Paper, familiar in much NHS policy in the last 30 years, between the idea of passing an ever-growing proportion of the NHS budget to primary care-based organisations in the hope that they will use their increasingly integrated budgets to make creative decisions locally and the idea of strengthening central control over the quality of, and access to, different clinical services. If the latter tendency prevails, then it is arguable that the PCGs will have little to do as service commissioners except follow the National Institute for Clinical Excellence (NICE) instruction manual and the health improvement programme (HIP). The HIP will already have determined the range and location of local health services together with the investment strategy needed to improve them. The PCG will be left with managing a budget while the priorities and changes of use of elements within that budget have already been determined elsewhere. This hardly seems to be an attractive role for former fundholders and total purchasers.

Uncertainty about PCG autonomy is further revealed in the ambiguous passage in the White Paper which discusses whether the PCGs will have the right to shift resources between trusts in the new collaborative NHS. The inference seems to be that *in extremis* this could occur, though Government would prefer it if PCGs guaranteed trusts as much of their past income as possible and did as little as possible to create uncertainty over provider funding. It is hard to see how the Government could entirely remove the right for the PCG to move resources unless the financial incentive to retain surpluses were to be eliminated altogether, but it is clear that there will be very significant constraints on how PCGs commission services. If this analysis is correct, it raises serious questions as to whether it would have been preferable to establish PCGs exclusively as *provider* organisations dedicated to developing new ways of organising and paying for primary care with a single budget for primary care services (GMS plus CHS). If the pattern of secondary and specialist services is effectively to be determined by others, then it appears to be illogical and potentially wasteful to involve PCGs as well.

Leadership and sustainability

There will be approximately 500 PCGs in England expected, over time, to assume responsibility for commissioning services, with up to 85–90 per cent of the NHS total budget. This contrasts with 90 or so HAs at present. The pool of expertise in service commissioning is finite and, in specific service areas, already regarded as inadequate at HA level.[9] There are signs from fundholding, locality commissioning and total purchasing that the enthusiasts among the general practitioners are beginning to express an interest in standing down, but that succession planning is not proving easy. NHS clinical professionals are accustomed to predictable and well-ordered career paths, training and remuneration, but there is no recognised employment option at present for the general practitioner who chooses to lead a commissioning organisation or act as the primary care equivalent of the hospital clinical director. This is unsurprising given that such roles are less than five years old, but it highlights a potential problem in setting up effective, durable PCGs. Where will the clinical leadership come from and how will general practitioners and others be attracted to the role? Are there enough such people with the knowledge and skills to run PCGs? Will the Service be prepared to pay for the true costs of the clinical leadership of PCGs? The enthusiasts were prepared to spend more time than they were paid for on schemes which were seen as innovative and which they had considerable freedom to shape from the very beginning. The same may not apply to PCGs, which are to become the standard organisational form across the NHS in England.

User involvement and choice

The internal market reforms of the first half of the 1990s did little to alter the traditional position of patients and the public both in terms of their involvement in decision making ('voice') and in terms of their ability to choose between providers ('exit'). The 1997 White Paper will do little to strengthen this 'downward' accountability, although 'upward' accountability will be considerably strengthened.

PCGs will be accountable to HAs, who will have the power to withdraw some or all of the devolved responsibility from PCGs. There will be 'accountability agreements' against which the performance of PCGs can be measured by health authorities so that national standards can be assured throughout the Service. Thus 'upward' accountability is clear.

For 'downward' accountability, it is assumed that the general practitioners and community nurses who run PCGs will represent the interests of local patients as fundholders do currently, since they understand patients' needs and they deliver most local services. PCGs will also be required to involve the public in their decision making, but how this will be brought about is not spelled out. Again, this is little different from the requirements placed on HAs which they find difficult to fulfil. Thus, the PCG proposals have effectively stifled potential individual patient choice since, in order to tackle perceived equity problems, the ability to choose between practices offering different primary care services or better rates of access to secondary care (as in fundholding) has been removed. Instead, the balance has been shifted to the greater collective involvement of patients and public in decision making, yet the evidence from previous attempts to increase the 'voice' of patients suggests very limited success in GP-led organisations.[10]

Conflicts of interest

The development of devolved organisations in the NHS is a matter of constantly having to balance contradictory requirements, such as central accountability and local control; professional autonomy and public regulation. The proposal for PCGs further erodes the purchaser-provider separation, which offered a crude protection against providers acting with self-interest, and it gives general practitioners potentially more control over NHS resources and over aspects of care which were previously outside their control, including the capacity to invest more resources in primary care, thereby perhaps reducing their own workloads or providing services for which they can then be remunerated. Examples of this have occurred in TPPs and indicate that there are *a priori* reasons for being concerned about possible conflicts of interest if general practitioners as providers are granted increased budgetary responsibility and increased scope for deciding whether to commission a service from elsewhere or provide it in house.

Whether such arrangements call for external regulation depends on an understanding of the personal objectives of general practitioners in the NHS. Unfortunately, little is known about how general practitioners faced with different sets of incentives will behave, whether altruistically to maximise their patients' welfare, or through self-interest to maximise their income; ensure reasonable leisure time for themselves; shift undesirable work onto other members of the primary health care team; and develop new, more satisfying career options.[11] The evidence from the experience of fundholding suggests that the extent of both service improvements and undesirable opportunistic behaviour has been modest.[12,13]

Nonetheless, unless one assumes that all general practitioners are wholly altruistic, PCGs will require some form of regulatory or performance management arrangements. Indeed, the White Paper discusses the requirement for HAs to hold PCGs to account for financial performance and securing health improvements. The precise specification of the regulatory system will be important since it will need to allow PCGs sufficient freedom to have a *raison d'être* and to make efficient commissioning decisions, while holding general practitioners, who will still remain independent contractors, to account for their clinical performance (see section above on *clinical governance*). The fact that general practitioners will remain independent contractors (except perhaps in certain Level 4 PCGs) poses major internal clinical governance problems and external regulatory problems for PCGs.

Potential advantages of PCGs

Despite the potential problems in the implementation of PCGs, and their possible disadvantages in the longer term, there are features of the White Paper proposals which may prove advantageous. The allowance for flexibility of progress from a Level 1 to a Level 4 PCG, over a long-term period (five to ten years), suggests that the Department of Health has learned from experience and recognised that radical and speedy reform tends to back-fire. The incremental nature of PCG development is to be welcomed since it will have the advantage of taking local contexts into account, particularly the different skills and experience of individuals at practice level. Another benefit of the proposals is that they greatly clarify the 'upward' accountability arrangements of primary care-based commissioning bodies compared with the former TPPs. Whatever the limitations of tighter upward accountability (see above), PCGs will have a strategic framework on which they can rely in a way in which total purchasers never had.

Budgetary leverage

The decision to give all PCGs, at a minimum, a budget for general practitioner prescribing and practice infrastructure will provide a focus for the PCG and an incentive for general practitioners to take some part in the organisation, if only for the negative reason of preventing other practices assuming too great a share of the infrastructure payments. Real budgets with some scope for independent service agreements will also give the PCGs the potential to make their own service development decisions, albeit within the framework of the health improvement programme and in broad accordance with the national service frameworks. This should allow some element of contestability to enter the new collaborative NHS. The experience of the TPPs showed that a budget and independent contracts were strongly associated with a higher level of achievement in the first 'live' year.[3]

Scale and strategic change

PCGs will be considerably larger organisations, in both population and resource terms, than all but a very few of the existing range of commissioning schemes. As a consequence, there is a possibility that they may be better able to engage in the strategic reconfiguration of local services, including acute hospitals than their predecessors, and be able to command the attention of trusts by their larger budgets. This view is inevitably speculative and is not shared by all commentators. Boyce and Lamont[14] argue that PCGs of 100,000 will 'lack the flexibility that individual fundholders had to move contracts between trusts. But neither will they have the leverage of health authorities, which have often been sole purchaser for local trusts. Primary care groups risk being neither "small enough to walk" nor "big enough to hurt".' Similarly, Light[15] argues that PCGs of 100,000 remain too small since '*purchasers need to be large and strong, not small, local, and weak*', while PCGs are also criticised for the establishment of cumbersome and costly management systems. Nevertheless, PCGs are at least moving primary care-led commissioning in the right direction in terms of scale with the added benefit of reduced transaction costs in the contracting process, especially for acute trusts.

Potential for integrated budgets

Commentators on North American managed care organisations, such as health maintenance organisations, maintain that efficiency gains are best made when the commissioner accepts responsibility for all services from an integrated budget.[16] One incentive for PCGs to progress to higher levels is the capacity to integrate GMS, SFH, TPP and the remainder of HCHS into a single funding stream derived from a fair capitation formula sensitive to population needs. In theory, the integrated budget should allow reductions in accounting and other administrative costs (see above) while encouraging the PCGs to develop new forms of care spanning different sectors. The PCGs should therefore be able to substitute more cost-effective for less cost-effective forms of service. For example, the Level 4 PCG will allow far closer integration of GMS and CHS staff and resources into a fully functioning primary health care team, breaking down the divide between primary care controlled by general practitioners through their national contract and primary care delivered alongside by the staff of community trusts. It is not yet clear where staff from mental health trusts would fit into the Level 4 PCG primary care trust, if at all.

Potential for greater local legitimacy

One of the consequences of fundholding was that general practitioners were effectively undertaking health care rationing decisions for prescribing and elective care on behalf of the state since clinical and resource management decisions were brought together. PCGs will greatly extend this responsibility to all general practitioners for 85–90 per cent of NHS resources. PCGs will be identified with, led by, and managed by, general practitioners and community nurses rather than general managers. Since people know, and generally trust, their general practitioners (whereas neither proposition holds for the staff of their local HA), there is at least a possibility that the PCG will be granted greater legitimacy when it has to take tough decisions than the local HA could ever aspire to. If this is the case, PCGs may be able to bring about radical changes, which HAs cannot, because their changes could so easily be interpreted as cost-saving 'cuts'.

Appropriate scope and scale of commissioning

Although the appropriate scope (i.e. the range of services to be commissioned) of commissioning from regional to practice scale is not discussed in detail in the White Paper, there is a tendency to assume that the vast majority of services can be commissioned at PCG scale. However, there is an opportunity to arrange some commissioning at practice level, if desired (e.g. for certain CHS), some at the level of small groups of practices within the PCG, some at PCG level and some at HA and regional levels. Rather than the unsystematic dispersal of commissioning responsibilities which currently exists between the 'plurality' of different organisations involved, it would be possible to develop an appropriate and evidence-based pattern of commissioning for different services at different scales of population and expertise. Retaining some commissioning (and, thereby, budgetary management) at practice level would reassure former fundholders and ensure that all practices took some responsibility for managing resources, although it would plainly have management cost consequences.

Implications of the introduction of PCGs

For general practice and primary care, the principal implications of the advent of PCGs concern a potential shift towards more collective forms of primary care delivery as the barriers between individual practices and practitioners dissolve. If the previous 30 years in the NHS have been marked by the gradual demise of the single-handed general practitioner working without support staff (except in a few parts of inner London), the next period will feature new forms of primary care organisation between practices. The process is already well advanced from the bottom up with the evolution of general practitioner out-of-hours co-operatives. The White Paper gives it an additional top-down push, as all general practitioners are increasingly brought into the 'mainstream' of NHS budgetary management. PCGs will be accountable to the HA initially for their HCHS commissioning and for the management of a restricted sub-set of GMS and prescribing resources. However, at Level 4, PCGs have considerable power, but in return, for the first time, a primary care organisation (the primary care trust) will be directly accountable to the local HA both for its HCHS *and* for its GMS provision since it will have a fully integrated health care budget.

The progressive movement of PCGs from Level 1 to Level 4 will bring about the gradual merging of GMS and HCHS funding streams which, hitherto, in the history of the NHS have been separate. At a minimum, all PCGs will be responsible for a merged budget covering general practitioner prescribing and the cash-limited part of GMS, but at higher levels, there will be both an opportunity and a requirement to merge HCHS, prescribing and GMS. This last will include the elements in GMS which relate to the pay of individual general practitioners and which are currently determined by the working of the national general practitioner contract.

The implication of all this for the future is that, increasingly, groups of general practices will become responsible for managing each other's remuneration. The White Paper does not spell out how this will work in practice since it repeats the assurance that any general practitioner who so wishes can remain on the current national contract, thereby avoiding direct accountability to the HA for GMS. On the other hand, the national general practitioner contract is likely to be not so much abolished following a set-piece confrontation with the General Medical Services Committee of the British Medical Association, as to become increasingly inappropriate and irrelevant. For example, it is hard to see a well-managed Level 4 PCG operating with some general practitioners on the old national contract and others in new sub-contractual relations with the PCG alongside other CHS professionals. The White Paper does not resolve fully the question of who commissions GMS and to whom general practitioners are accountable at local level, but it does strengthen the hand of those who wish to replace the national contract with something negotiated more locally.

The second broad implication of the development of PCGs is that it represents yet another attempt to square the circle of devolved, locally sensitive, patient-responsive commissioning of services and strategic, population-focused, health gain-oriented commissioning at HA and/or regional level. Whereas under the Conservative system the bulk of the commissioning action took place either at practice level or at the level of populations of 300,000 and upwards, under the Labour model, commissioning responsibilities have been drawn both upward from practices and downwards from HAs to a new intermediate tier of 100,000 population, but this time led by primary care professionals. At the same time, as more and more commissioning resources are being devolved to intermediate level PCGs, the Labour scheme puts in place an increasing range of central controls over the *content* of the services to be procured with the introduction of health improvement programmes and national service frameworks.

The third and final major implication of the PCG proposals is that their establishment will be a long-term process. It is likely to take several years before effective PCGs are present across the whole of England, not only because the development capacity of most HAs will be stretched, but because the expertise required to make the transition will vary widely. This is one reason why variations in the powers and capacities of PCGs at different levels have been built into the process. Ultimately, however, there is an expectation that all PCGs should move towards Level 4, yet it is difficult to assess how PCGs in different circumstances will be able to make the transition. Moreover, there is likely to be mounting pressure within PCGs from innovative and like-minded practices to progress through the various levels in a way which will not, or cannot, be shared by other practices within the same PCG. Consequently, PCGs may suffer from internal fragmentation. It should be interesting to observe how long the Government will be prepared to tolerate the potential inequity within fragmented PCGs and between PCGs, operating at very different levels, within the same HA.

Conclusions

PCGs are a rough-and-ready solution to Labour's main criticism of fundholding. Their size and inclusiveness based on 'natural geographic communities' attempts to remove at a stroke the most obvious inequity in the previous arrangements, namely, the institutionalised 'two-tierism' between fundholding and non-fundholding practices. The plans for more central control over the content of what is commissioned at PCG level respond to the vaguer concern of Labour at the so called 'fragmentation' produced by the large number of small and large purchasers in the former internal market.

However, it is harder to see the PCG approach meeting Labour's other goal of reducing the transaction costs generated by persisting with a purchaser-provider separation and devolved commissioning led by primary care professionals. Although there are many unknowns, it is unlikely that what is proposed will do more than shave a little off the overall costs of managing the NHS at HA, PCG and trust levels.

Finally, the proposals continue the process, which was begun with fundholding, of attempting to integrate clinical and financial responsibilities within the same organisation.

Under fundholding, the budget only applied to a part of GMS and only to volunteer practices, so the question remained: who commissions general practitioners' services? Under PCGs, all general practitioners will be obliged to join larger budget-holding bodies. However, general practitioners will be permitted to remain independent contractors, not to the PCG, but to the Secretary of State. As a result, integration will remain incomplete, posing problems both for the internal management of the PCGs and for their external regulation. The question of who commissions the services of general practitioners will not be fully answered.

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Chapter 2

The health authority's new roles

Michaela Benzeval & Angela Coulter

Introduction

Leading and shaping

The revised allocation of responsibilities outlined in *The New NHS* leaves health authorities (HAs) with the most difficult task of all. Not only do they have a pivotal role in implementing the Government's new agenda for the health service – the White Paper dubs this 'leading and shaping' – but they are expected to do all this at no extra cost and with the threat of downsizing and mergers hanging over them. HAs will have new statutory responsibilities for improving the health of the population with clearer lines of accountability from NHS trusts and primary care groups (PCGs). They will be expected to set the strategic direction for health service commissioning, to ensure fair allocation of resources, to lead the development of integrated care, to create, support and supervise the new PCGs, to monitor health needs, disease trends, costs, utilisation, expenditure, health outcomes and quality of care, to encourage public involvement, and to promote public health by fostering partnerships with a wide range of agencies. The three main responsibilities of the HA – developing primary care, leading commissioning, and promoting public health – pre-date this White Paper, but the new plans will have many ramifications for the way in which these roles are carried out.

Leaner and fewer?

The threat to the existing configuration of HAs comes from plans to devolve their commissioning responsibilities to PCGs, together with a proportion of their management costs. The White Paper makes much of the high transaction costs and fragmentation of responsibilities which it attributes to the internal market introduced by the Conservative Government in 1991. The new Government intends to reduce the number of bodies involved in commissioning, to cap management costs and to develop a more integrated system of care. Smaller HAs can see the writing on the wall. HAs vary considerably in geographical coverage and population size – ranging from less than 300,000 to more than 900,000 – but if the majority of commissioning is to be devolved to 500 PCGs covering populations of about 100,000, some HAs will be too small to carry out the strategic role that remains once they have handed over their direct responsibility for purchasing health services.

This chapter looks at each of the HA's three main roles and considers the problems HAs are likely to face in carrying them out.

- Will they be adequately resourced to deliver the Government's ambitious agenda?
- What levers will they have at their disposal to ensure that other actors comply with the strategy laid out in the health improvement programmes?
- How will they cope with the reality gap between the 'top down' elements in the system, for example the national service frameworks and guidelines issued by the National Institute for Clinical Effectiveness, and the exhortations to allow the system to develop from the bottom up, encouraging local responsiveness and public participation?
- Will the new system allow them to keep the public health agenda at the centre of their priorities, or will they become so embroiled in the complexities of PCG development that wider public health issues are sidelined?
- Will they have access to the necessary skills and human resources and will HA staff be up to the job?

The three roles

Developing primary care

In announcing its plans to give primary care control over budgets for specialist services, the Government is following the lead of its predecessors who hoped to strengthen primary care and enhance its capacity to manage the demand for expensive hospital resources. The HA's role in this strategy is to facilitate service developments in primary care and to lead the strategy for primary care commissioning.

The need to develop the service provider role in primary care has been recognised in a number of official reports. Despite the strong position of general practice in the British health system relative to other countries and high standards of primary care provision in many parts of the country, a review carried out by the previous Government revealed wide variations in quality with inequitable distribution of resources, weak teamworking, co-ordination failures between agencies, low staff morale and recruitment difficulties.[1] Standards were known to be particularly poor in inner cities. For example, the King's Fund London Commission reported that 26 per cent of practice premises in inner London were below the minimum standard as against only 2 per cent in the rest of the country, and childhood immunisation, child health surveillance and cervical screening coverage lagged way behind the national average.[2]

Levers for change

In trying to tackle these problems HAs had few levers at their disposal. GPs were bound by a national contract which offered little scope for local flexibility or negotiation by the HA. Most HAs struggled to contain their spending within budget limits and there were few resources available for investment in primary care development. Fundholding had succeeded in stimulating some new developments in primary care, but most fundholders were well organised practices providing relatively good services. The poorer quality practices were not fundholding and therefore not in a position to benefit from the scheme. Under the previous regime HAs found themselves unable to stem the widening inequalities in access to high quality care.

The previous Government's 1996 White Paper, *Choice and Opportunity*,[3] was an attempt to focus attention on the need to improve the quality of primary care provision which had been relatively neglected while attention was fixed on primary care-led purchasing. The NHS (Primary Care) Act, which became statute just before the change of government in 1997, at last gave HAs the levers they needed to make an impact on the quality of primary care. The Act allowed for deregulation and new contractual flexibilities to enable HAs to raise standards by facilitating organisational developments in primary care, but they were slow to seize the initiative. The scheme was introduced on a voluntary basis and a number of GP-led schemes and a few trust-led schemes 'went live' in April 1998. The primary care act pilots (PCAPs) are experimenting with practice-based contracts for personal medical services, salaried GPs and nurse-led primary care services. For the most part HAs simply 'nodded through' initiatives that came from primary care providers, making little attempt to stimulate developments in the most needy areas. Once again there were signs that the benefits would go to the more innovative general practices, with inner city areas and nurse-led initiatives being squeezed out. If so, it would be unfair to lay all the blame on the HAs. Much of the initial momentum had been lost in the confusion about objectives following the General Election and mixed messages about the relative importance of primary care development in the new Government's agenda.

Raising standards

In once again placing more emphasis on primary care as commissioner of services rather than as a provider, *The New NHS* fails to provide guidance on how HAs might tackle poor quality primary care. This is a serious omission. Ninety per cent of patient contacts take place outside hospital and good quality primary care can have a major impact on the burden of disease. For example, it has been estimated that early detection, appropriate advice, effective prescribing and monitoring could reduce hospital admissions for asthma by 30 per cent, achieve 35 per cent reduction in rates of hypertension and halve the number of hip fractures among older people.[4] Primary care development should be a central plank in the HAs' strategy for improving the health of the population, yet the proposed national framework for assessing performance includes only four out of a total of 37 indicators which can be used to assess the quality of primary care delivery.[5]

In one short paragraph on primary care development the White Paper hints that peer pressure within PCGs will lead to quality improvements through skill sharing and redeployment of resources.[6](p.34) Shared budgetary responsibility could indeed lead to greater sharing of clinical responsibility and involvement in PCGs could do much to counter the isolation that is a feature of general practice, but the group dynamics will need skilful facilitation if conflict is to be avoided and beneficial results achieved. This will require considerable sensitivity and experience in primary care development. But many senior staff in HAs gained their experience in hospital management and secondary care planning. In the mergers between district health authorities and family health services authorities which took place between 1994 and 1996, few of the top jobs went to people with primary care experience. There are real concerns that many HAs lack the skills that will be needed to nurture improvements in primary care.

Leading commissioning

Developing PCGs

The organisational development task facing HAs may prove to be even more demanding than their service development responsibilities. They are expected to encourage the formation of PCGs, to engage them in the development of health improvement programmes (HIPs) and to steer their commissioning plans. In insisting that PCGs are to be organised on a geographical basis covering 'natural communities' and in removing the freedom to opt out, the plans mark a radical departure from previous voluntary arrangements involving GPs. Health authorities will have the task of persuading and, if necessary, coercing groups of about 50 GPs to work together, some of whom will have had no previous experience of involvement with commissioning or of close working with other primary care professionals. Engaging with self-selected groupings of like-minded professionals is very different from creating organisations which include all primary care staff in a locality, some of whom are reluctant to join. In some areas GPs who have been at the leading edge of fundholding and practice development will find themselves sharing budgetary responsibility with practices which they consider disorganised and inefficient. The potential for tensions and conflict will be considerable.

In areas where relationships between general practices, community trusts and HA staff are good, establishing PCGs will be relatively straightforward, but good relationships between these groups are by no means universal. Poor communication between groups of professionals can result in poorly co-ordinated care for patients. Bringing these groups together to pool resources and share decisions is a welcome development which could transform the cottage industry of primary care into larger, more streamlined and efficient organisations, much better equipped to co-ordinate patient care, but it is a high risk strategy. If HAs cannot persuade PCGs to agree on priorities or conform with plans set out in the HIPs, the resulting disputes could consume considerable management time and distract attention from effective ways of meeting local health needs. The competitive tension between HAs and fundholders, fostered by the previous Government's strategy, has in some cases left an uncomfortable legacy of mutual suspicion which will have to be overcome. The Conservative Government's enthusiasm for fundholding led them to encourage GPs to think that they could act independently of HAs in developing their purchasing plans.[7] GPs were seen as 'better' purchasers than HAs, an unfair comparison since the fundholders had the far easier task of purchasing only a selected range of elective services. HAs now have the difficult job of persuading those GPs who cut their teeth in fundholding that it is in their interests to collaborate with their PCG colleagues and the HA.

Carrots and sticks

At the heart of the Government's new strategy is the aim of aligning clinical and financial responsibility. This means putting clinicians in the driving seat, in particular GPs and community nurses who the White Paper considers 'are best placed to understand their patients' needs as a whole and to identify ways of making local services more responsive'.[6](p.12) This is an implicit recognition that HA-led commissioning lacked teeth because individual clinicians were not signed up to the plans and HAs were not given the means to hold them to account. HA staff will now have to negotiate the transfer of responsibility for commissioning to doctors and nurses working in primary care. If clinical and financial responsibility are to be truly aligned, clinicians will have to be persuaded to get actively involved in shaping the HIP and in complying with its implementation, but the carrots to persuade them to do so seem weak and the sticks, in the form of 'reserve powers',[6](p.30) and 'withdrawal of devolved responsibility',[6](p.39) are alarmingly vague at present.

While some GPs relish the opportunity to get involved in non-clinical activities such as contract negotiations and budget monitoring, a substantial majority do not.[8] Health authorities may find that GPs expect additional payment to engage in these tasks. Alternatively some PCGs may prefer to leave the administrative responsibilities in the hands of HAs, in which case they will need to retain sufficient staff to carry them out. The total purchasing pilot schemes (TPPs) have been reluctant to take on responsibility for the full range of services and co-ordination between multi-practice groups and the HA has not always been easy (see Chapter 1). It will be interesting to see whether primary care professionals are keen to seize the leading role in commissioning by travelling up the White Paper's stairway to become Level 4 primary care trusts or whether they will be content to languish at levels 1 and 2.[6](p.35) If the latter, the result could be essentially cosmetic with the bulk of commissioning left in the hands of HA staff and alignment of clinical and financial responsibility remaining an elusive goal.

Resourcing commissioning

There are other reasons for thinking that HAs may need to retain staff rather than slim down. Effective commissioning requires a wide range of skills, including needs assessment and planning, contracting, monitoring and performance management, accounting and budget management. A population approach to health commissioning requires some knowledge of epidemiology and access to data on the distribution of disease. In addition to understanding the processes of commissioning, some specialist clinical knowledge is required to make strategically coherent purchasing decisions. This knowledge may not be vested in general practice or community trusts. Few primary care staff are trained in epidemiology or population sciences and few have experience of manipulating data. PCGs will have a choice of buying in the necessary expertise or asking HA staff to perform these tasks on their behalf.

It has been argued that PCGs will be too small to achieve sufficient leverage over providers.[9] In absolute terms the appropriate population size for commissioning depends on what services are to be commissioned. One argument, based on theories of 'epidemiological stability', is that community nursing and other community health services, elective surgery and outpatient facilities are logically purchased at practice level, while most other secondary care services, including accident and emergency and maternity services, may be better purchased under block contracts by organisations covering populations of around 300,000, leaving tertiary and more highly specialised services to be covered at a 'regional' level (roughly 1 million population).[10] The Government's intention is for PCGs to purchase all but a small number of specialist services, but if the above estimates are correct the future commissioning role of HAs may need to be greater than currently envisaged.

For all these reasons it may not prove possible to reduce HA staff numbers very substantially. The Government expects them to 'streamline their administrative functions, including the sharing of functions between authorities',[6](p.30) and predicts the emergence of fewer authorities covering larger areas. Larger authorities may be better placed to provide efficient and effective support for commissioning, but this may be detrimental to their other responsibilities for service development and public participation, which require small local agencies. Either way, it seems most unlikely that the new system for commissioning will be less costly than the one it replaces.

Promoting public health

The New NHS makes it clear that 'the lead responsibility for improving health and reducing heath inequalities will be at the heart of the new health authority role'.[6](p.25) To this end, it is imposing two new duties on HAs:

- to improve the health of their local population;
- to work in partnership with other NHS agencies and local authorities 'for the common good'.

The Green Paper *Our Healthier Nation* makes it clear that within this, HAs should set out 'a range of locally-determined priorities and targets ... with particular emphasis on addressing areas of major health inequality in the local community'.[11](p.40) In both the Green and White Papers the Government places considerable emphasis on the contribution that HAs, in partnership with others can make to its public health agenda, stating that:

> *Taken together, the health improvement programmes across the country, combined with the Government's role ... will form a concerted national programme to improve health and tackle health inequalities.*[11](p. 40)

The key question therefore is whether HAs have the necessary experience, skills and capacity to lead this strategy at the local level. A number of issues are relevant.

- What resources will HAs have at their disposal to promote health and tackle health inequalities?
- How can HAs develop effective partnerships with local authorities and other agencies to tackle the local causes of ill health?
- Do HA staff have the appropriate skills and experiences to develop effective partnerships to address the broader determinants of health at the local level?
- What leverage will HAs have over PCGs to ensure their contribution to the public health agenda?

Resources

The New NHS gives little information on how HAs will be funded to tackle the broader public health agenda. While the intention to cap management costs is clear, the Green Paper emphasises that resources for public health will not be subject to this limitation. However, no information is given in either document on the level of resourcing that HAs will receive for this purpose nor what resource allocation system will be used to distribute such monies. Will HAs be given a specific budget for this purpose or will they have to top slice money from the general allocation for the area? If the latter there is a danger that health service pressures will swallow up the bulk of the resources, as they have in the past, leaving little money to invest in improving the public's health. Without adequate resources either in terms of joint finance for public health initiatives or for HAs to pump-prime public heath strategies, action in this area will be limited.

Effective partnerships

The New NHS places a duty of partnership on HAs to work with local authorities and other agencies to improve the public's health. The White Paper promises that this will be reflected in the duties of partner organisations, and more importantly, that local authorities will be given 'a duty to promote the economic, social and environmental well-being of their areas'.[6](p.26) The Green Paper *Our Healthier Nation* does not expand on this duty nor does it develop any accountability mechanisms or performance management criteria to ensure that local authorities contribute to the public health agenda.

While many local authorities are enthusiastic about this new emphasis on improving health, the Green Paper is very unclear about their role and the focus on disease-orientated targets makes it difficult to engage local authorities' interest in this agenda.[12] Moreover, local authorities are currently facing a plethora of Green and White Papers on a wide range of topics with no guidance on how they should be integrated at the local level or where public health fits into their priorities.[13] Local authorities are crucial to the new responsibility of the HA to improve public health because they control many of the local services that might influence it. Without clearer guidance and accountability mechanisms for local authorities, the ability of HAs to make inroads into tackling the root causes of ill health will be severely limited.

The Chief Medical Officer's review to strengthen the public health function[14] makes it clear that at the local level coterminosity of boundaries between HAs and local authorities is important for joint working. Unfortunately this is an increasingly rare occurrence, with many health authorities having to relate not only to several local authorities but also different layers of local government responsibility. This is likely to be exacerbated by the possibility raised in the White Paper of HAs merging in the future. Health and local authorities must have a shared population focus if they are to work effectively together to improve health.

Little guidance is given in either the White or Green Papers or the CMO's review of the public health function on what mechanisms are appropriate for developing effective joint working nor who within each agency will lead the partnerships. This is particularly problematic in local authorities since it can be difficult to get different departments to work together. A strategy for leading public health across local authorities and other local agencies is required. Studies of existing intersectoral collaborations [15,16,17,18] suggest that important factors include:

- clarity of purpose and benefit for each partner, a shared vision of values and objectives;
- dedicated project leadership and senior commitment from all organisations;
- the development of mutual respect through interagency team-building balanced with achieving tangible benefits in the short term to maintain enthusiasm;
- clear management structures and delineation of responsibilities;
- dedicated resources.

It will take considerable time and commitment to develop effective partnerships that enable HAs and local authorities to work together to tackle the root causes of ill health. It is currently questionable whether either agency will have sufficient space, given other commitments, to make a real difference to the public's health in the near future.

Skills

To deliver the public health agenda the skills and experiences of staff in HAs and other partner agencies need strengthening. The CMO's review begins to identify ways in which this should be done, but much more concrete proposals are required. In particular, there needs to be a new approach to training and development that ensures that different kinds of professionals both from within the NHS and from partner organisations develop a much better understanding of:

- the broader determinants of health and how they can influence them within their own roles;
- the wide range of organisations that influence the public's health, their different cultures and how they operate;
- the skills necessary for the multi-agency, multidisciplinary team working that is required to address the complex determinants of health.

Since incorporating such dimensions into general medical and other professional training programmes will take considerable time, efforts need to be made now to ensure that current professionals begin to develop the skills and understanding necessary to help them play their part in the public health strategy.

PCGs

Finally, PCGs will be crucial to local attempts to promote health and tackle inequalities in health for two reasons. First, they will control most of the health resources in the area. Decisions therefore about the relative importance of expenditure on health promotion or other specific activities to develop local alliances or promote access to health care will be taken by PCGs. Second, while action at HA level will be required to develop a strategic approach to promote health and tackle health inequalities, the Green Paper makes it clear that efforts should be targeted at the most needy areas. The role of PCGs in developing partnerships at the local level for health will be very important, but traditionally GPs have shown little interest in public health. It seems likely that PCGs' agendas will be dominated by medical perspectives and health *care* issues. Much clearer guidance is required to ensure that PCGs adequately address and prioritise the public health agenda.

Integrating mechanisms

The three roles that HAs will have under *The New NHS* will be developed, integrated and priorities balanced through two new phenomena – HIPs and health action zones (HAZs). At the same time HAs will be held to account for all of their activities through the performance management framework.

Health improvement programmes

The White Paper establishes HIPs as the key integrating device at the local level to bring the public health and health care agendas together. The HIPs will cover a three-year period and set out how national targets and priorities will be addressed, what additional local targets will be set and how the needs of the most disadvantaged sections of the community will be targeted. They must be produced in consultation with other NHS agencies, local authorities and involve the public. They will also have to take account of the new national service frameworks and clinical guidelines issued by the National Institute for Clinical Excellence. HIPs should be quite different from current purchasing plans, which, with a few notable exceptions, focus almost exclusively on acute sector issues.

HAs are supposed to secure public participation in the development of HIPs. Many HAs have made strenuous efforts to involve their publics in the past but with little real success. Mechanisms for stimulating public participation are weak and the White Paper provides only rhetorical support for this goal.[19] It is unfortunate that guidance on HIPs is still to be issued, despite the fact that drafts will need to be produced this autumn so that they can be consulted on in time for implementation in April 1999. Such guidance is urgently required to ensure that HAs really involve other agencies and the public in developing priorities and plans across the range of their responsibilities.

Health action zones

In eleven specific areas the Government has established HAZs as 'trailblazers, leading the way in modernising services and tackling inequalities'.[20] The eleven areas cover some of the most deprived parts of the country including large metropolitan cities, small urban towns and rural areas. A second group of HAZs will be established in April 1999. The foundation stones of each HAZ are partnerships across a range of organisations to tackle key problems both in terms of the determinants of ill health and poor services. The HAZ will share some additional resources – £5.3 million in 1998/99 and £30 million 1999/2000 between them – but more importantly they will be able to remove various bureaucratic hurdles that currently inhibit intersectoral action and service provision. How successful they are will crucially depend on whether the reality will match the rhetoric in this respect. Current plans for HAZs are highly ambitious and the links between actions proposed and intended outcomes are not always well founded in evidence.

Performance management framework

To ensure that local action covers all of the Government's priorities *The New NHS* establishes a performance management framework that incorporates six dimensions:

- health improvement;
- fair access;
- effective delivery of appropriate health care;
- efficiency;
- patient and care experience of the NHS;
- health outcomes of care.

The consultation document on the framework for assessing performance[5] was issued in January 1998. It sets out a wide range of indicators under the above headings that will replace the Purchaser Efficiency Index, which was felt to have been too narrow and created perverse incentives for HAs in the past. An indicator set will be developed, in the first instance from existing routine data sources, 'to give a balanced view of NHS performance at the health authority level' in order to 'raise questions, highlight areas where further investigation may be required and drive improvements in performance.'[5](p. 13) The indicators will be supplemented by measurements of progress against targets set out in *Our Healthier Nation*. Some of the indicators currently proposed are crude representations of the principles they purport to be attempting to monitor. The indicators for fair access, for example, which are to be based on utilisation rates, make no attempt to take into account need nor to assess whether access is the same for different demographic or social groups. As such it will be impossible to judge from them whether the NHS is upholding its commitment to 'fair access to health services in relation to people's needs irrespective of geography, class, ethnicity, age or sex'.[6](p.64).

System issues

Achievement of the Government's plans will depend heavily on the capacity of HAs to deliver the new agendas in relation to *The New NHS* and *Our Healthier Nation*. Will the new 'leaner' HAs be able simultaneously to promote new relationships with local authorities and other agencies to tackle the broader determinants of ill health, to support the evolution of PCGs, to continue to commission services where necessary and to ensure the continued development of primary care? What relative priority will HAs attach to each of these agendas? Will attempts to address issues in one area conflict or detract from efforts in the others?

Skills and staff

The skills and experience required for each of the HA's roles are likely to be different and not necessarily those of existing staff. To lead the wider agenda to promote health, HAs will need strong multidisciplinary public health skills, senior staff will also need to be able to develop, motivate and maintain the broad range of networks necessary to address public health issues. While the CMO's review of the public health function[14] recognises some of these requirements, a considerable amount of work is required to put them into practice. In terms of developing primary care and PCGs, HAs will need strong negotiation and facilitation skills. Supporting the PCGs in their commissioning role will require considerable data collection and analysis to monitor their progress against agreed targets. Staff time will be severely stretched trying to address all of these issues at the same time.

In addition to the need to develop this broader range of skills, HAs are expected to become smaller and operate within a tight management cost envelope to be set by the Department. There will be a single management cost allocation of about £3 per head of population to be shared between PCGs and HAs, although public health will be excluded from this. Unless PCGs decide to leave most of the detailed work to support commissioning in the hands of the HA, there will be a substantial transfer of resources from the HA to PCGs. Moreover, the White Paper makes it clear that in the medium to long term it expects HAs to merge to cover larger populations. It will not be surprising if staff are demoralised and demotivated by the threat of a further round of mergers and downsizing. On top of this, many HAs face serious difficulties in meeting their financial targets for the current year. Smaller budgets, the prospect of continuing organisational change and hence possible redundancy in the future, may cause key staff to leave for other jobs. Many potential PCGs are already recruiting commissioning staff from their associated HAs.

Relative priorities

Given that HAs will face considerable restraints on their capacity to deliver this broad agenda, it is highly likely that some responsibilities will take precedence over others. For example, as HAs work with PCGs to develop their commissioning role, it may become harder for them to simultaneously negotiate improvements in primary care. More explicitly the public health agenda is lagging far behind the health service one. The publication of *The New NHS* White Paper first, before *Our Healthier Nation,* has meant that energies have been focused on how this will be implemented rather than the public health agenda. Moreover, the current timetable suggests that the White Paper on public health will not be published until the autumn,[21] which will be after the first HIPs have been produced.

The continuing focus on old chestnuts like waiting lists as the main target for new funding will reinforce the dominance of acute service issues in HAs' and the public's mind. All of this suggests that public health and primary care development will continue to have low priority in the NHS's agenda. A considerable communications effort is required to rebalance the agenda so that the public and professionals recognise the importance of these issues alongside the focus on hospitals.

Conclusion

HAs face a formidable new management agenda in leading the implementation of *The New NHS* and *Our Healthier Nation.* Their three roles – developing primary care, leading commissioning and promoting public health – are of equal importance for achievement of the Government's goal of creating:

> *'a national health service which offers people prompt high quality treatment and care when and where they need it ... and works with others to improve health and reduce health inequalities'.*[6](p.4)

There are serious grounds for doubt about whether HAs are up to the task and whether the timetable can be achieved without the expenditure of additional resources. The promise to shift '£1 billion from red tape into patient care'[6](p.4) may be electorally popular, but it risks undermining the Government's longer-term objectives.

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Chapter 3

National service frameworks

Anthony Harrison

The White Paper proposes that a series of national service frameworks should be developed – see Box 1 – for what it terms major care and disease groups. This approach fits well with a 'new' NHS more explicitly committed to equity than the NHS under the Conservatives. The intention is that they should be based on the best evidence of clinical and cost-effectiveness and that they should also take into account user views. The NHS has, since its origins, paid little attention to the design of services, as opposed to the proper execution of particular procedures, either at national or local level. At first sight therefore, the proposal that there should be an annual programme for the development of such frameworks seems attractive.

Box 1 National service frameworks[1]

The Government will work with the professions and representatives of users and carers to establish clearer, evidence-based *national service frameworks* for major care areas and disease groups. That way patients will get greater consistency in the availability and quality of services, right across the NHS. The Government will use them as a way of being clear with patients about what they can expect from the health service. (para 7.8)

The new approach to developing cancer services in the Calman-Hine Report, and recent action to ensure all centres providing children's intensive care meet agreed national standards, point the direction. In each case, the best evidence of clinical and cost-effectiveness is taken together with the view of users to establish principles for the pattern and level of services required. These then establish a clear set of priorities against which local action can be framed. The NHS Executive, working with the professions and others, will develop a similar approach to other services where national consistency is desirable. There will be an annual programme for the development of such frameworks starting in 1998. (para 7.9)

The White Paper does not give a detailed explanation of why national service framework are thought to be necessary nor does it indicate the kind of service which it was appropriate to deal with in this way. By way of examples however it refers to two very different services, for which a national approach has recently been adopted. One is cancer care, which deals with large numbers of people of all ages and which is provided by a vast range of professionals right across the NHS many of whom also care for people who do not have cancer. The other is paediatric intensive care which is a very small service to be found in only a few hospitals and provided by specialists, but which might be seen as part of a broader paediatric service.

As these examples indicate, what exactly should count as a service is not straightforward. The NHS uses the term indiscriminately as in hospital service, pathology service, geriatric service, stroke service and so on. Other 'services' rarely get that name: for example, the term emergency medical service is rarely used in the UK (though common in the USA) perhaps because those who provide the elements of it – A&E, out of hours, etc. – do not see themselves as part of a coherent whole called an emergency service.

What a service should cover may be contentious. Recently a number of clinicians have argued for the creation of stroke as a separate specialty.[2] The debate prompted by this proposal indicated a range of views as to 'what should go with what': whether for example, in respect of prevention, stroke was sensibly grouped with coronary artery disease as the risk factors are similar, or, whether in respect of acute management, it should be grouped with other sources of brain damage. This debate suggests that it is not self-evident what should count as a service. Different principles of association, disease, patient type, treatment method, may be used to define 'what goes with what'. These points suggest that the definition of *a* service requires careful analysis in its own right and that this would be true at local or national level.

As the origins of this discussion suggest, the notion of a service is linked to that of a specialty. But its more important feature perhaps is that it involves integrating the contributions of a large number of different professionals in different organisations into one entity. That entity may be a free-standing organisation, such as the National Blood Authority, it may be based on a contract such as those which in some parts of the country cover maternity care as a whole (though not the GP contribution): or it may be based on agreed clinical arrangements for the routing of patients between different professionals such a clinical pathway.

The case for service integration across organisational boundaries has been recognised since the early days of the NHS. Experience suggests that it is hard to achieve. Perhaps the main reason for failure lies in the way health services in general work. Some professionals may define themselves in terms of their speciality: others in terms of a broad function – district nursing or general practice. A service has to combine the contributions both of those whose vision is narrower and those whose vision is wider than the service itself. That is inherently difficult to do since tribal professional loyalties are strong and often reinforced by organisational and financial boundaries. Moreover, there is a risk, if the service-level vision is achieved, that there will be an offsetting reduction in shared vision in other services.

Whatever the formal arrangements the aim, in the words of *The New NHS* and also, curiously, the previous Government's White Paper, *A Service with Ambitions,* is to ensure that patients are not passed from 'pillar to post' but clearly directed or routed to the next link in the care chain. This is obviously desirable for any service, however defined. We begin therefore by considering what are the characteristics which might make it appropriate to adopt a *national* framework for a set of clinical activities which are related in some way which might justify them being designated as a service.

At several points the White Paper refers to the expert report[3] – known as Calman-Hine – as a model of how service development should proceed. The Calman-Hine report, published in April 1995, was subsequently adopted by the Conservative Government and is currently being implemented. In the second part of this chapter we consider whether this is a good model or not. Finally, we consider some general issues which arise from the development of service frameworks.

There are three main reasons for basing service development on the notion of a *national* service framework:

- the appropriate scale of provision is greater in scale than any one purchasing or providing unit;
- the quality of service is variable as between different parts of the country;
- if the 'right' way of providing a service can be ascertained, then it should be implemented nationally.

We take these in turn.

Scale

Ever since the first steps were taken to ensure that the whole country had access to the full range of hospital services, it has been recognised that some services could not be efficiently provided at a local level. Subsequently, the funding of such services became either a national or a regional responsibility.

Even after the implementation of the 1990 reforms, the previous Government recognised that the appropriate way of providing some services meant that they had to be commissioned on a wider scale than any one purchaser. But it was left to district purchasers to organise themselves into appropriate groupings or to agree on lead purchasers.

As the Audit Commission has shown[4] and as the White Paper recognises, these arrangements typically have not worked. District purchasers did not always work well together and they often did not have sufficient information to make effective use of the specialists services that were available to them.

The White Paper accepts this analysis:

> *Although health authorities have begun to work together voluntarily to plan and fund these services, the results are patchy. A more systematic approach is needed if fair access is to be guaranteed and if clinical staff are to be supported in developing the most suitable and effective care. The Government will therefore introduce new arrangements for planning and commissioning specialist services.*(p 61)

Guidance for the commissioning of specialist services was subsequently issued: most of those listed were of a type to be found in only a few parts of the country, e.g. haemophilia service, bone marrow transplants and genetic services. Services such as these may form part of more broadly defined services such as paediatric or cancer care, the rest of which may be available at local level. But whether they are or not, there is clearly a case for some national role in relation to them.

Reducing variation

The Secretary of State announcing the first two services for which national service frameworks are to be developed, coronary heart disease and mental health stated his objective as being to ensure that

> *everyone, wherever they live, and whatever their circumstances – has access to services of uniformly high quality.* [5]

Given the Government's overall approach to the NHS, an equity objective is clearly appropriate but questions remain about the form the objective might take and whether it is in practice attainable. As far as the form of objective is concerned, the two main candidates would be outcome of care and equality of access (i.e. similar intervention rates for similar populations). However as the consultation paper on the proposed national framework for performance assessment[6] indicates, it will not as a general rule prove easy to find measures which both fully allow for variations in need as between populations, the circumstances which might influence access in practice and which can be made readily available. The more broadly defined a service is, the greater the range of measures required.

As for differences in the quality of delivery, including the role of primary care in identifying properly and promptly those who need referral to secondary care, it is inevitable in a large service such as the NHS, that variations in quality will emerge. The question therefore is how the actual delivery of care of services for which a national framework exists will be monitored, acceptable and unacceptable variation identified and poor performance put right. These are large questions which will take time to answer but only to raise them is enough to indicate that the aim of a uniformly high standard is, to say the least, challenging.

Implementing the 'right' way

If care is to be evidence-based then once the 'right' way of dealing with a particular condition is identified, it would seem to follow that it should be generally adopted. In principle, the logic is the same for a specific intervention or treatment as it is for a whole system of care. But the evidence to demonstrate that one system of care is better than another system is different from that required for a single intervention:

- the attributes of a system of care are numerous and diverse, and hence it is inherently difficult to find evidence bearing on all of them singly or in combination;
- the bulk of the research effort devoted to health services has a narrow rather than a broad focus, i.e. a specific drug or surgical procedure. As a result it is typically not possible to base a comparison of two ways of delivering a whole service, as opposed to particular elements within each.

It follows that in general it will be more difficult to demonstrate that a whole system of care is better than the alternatives than it is to demonstrate the superiority of a particular intervention. On this basis it would seem unwise to assume automatically that the best way of providing a broadly defined service can be identified with confidence on the basis of existing evidence.

Furthermore, medical technology changes as do supporting technologies such as information management and transfer. There may therefore be a case, depending on just how strong the evidence is, for maintaining different ways of providing a service precisely in order to compare their merits at the overall level. There may also be a case for not making investments in human and physical as well as organisational change, which may have to be reversed.

An example: cancer care

The New NHS cites, on more then one occasion, the Calman-Hine report on cancer as being a good example of them approach it is aiming for. We consider next whether it does point the way forward.

The starting point of Calman-Hine was that British cancer care was not as effective as that in other countries. But while that comparison suggested change was required it did not in itself indicate exactly what changes were required. In fact, the Calman-Hine report did not offer a substantial body of evidence in favour of its proposals: instead it relied heavily on the assumed benefits of greater specialisation and of greater organisational integration between the various skills required.

Although increasing specialisation has typified the development of health services all over the world, the benefits of specialisation remain, over the broad span of clinical work, unproven. As far as medical specialties are concerned, a recent report from the Royal College of Physicians[7] concluded:

> *The question arises as to whether patients' desires are best met by a service consisting of pure specialists, a combination of specialists and generalists, or of specialists who also undertake general duties. Patients dislike being cared for by several different specialists if they have more than one condition and would prefer their care to be the prime responsibility of a single physician whom they know and trust, but who also has access to advice from other specialists as necessary. This is as true for secondary specialist care as for primary care. There is little firm evidence about whether they have a better outcome when they are treated by a specialist physician or a generalist. Apart from acute asthma, it is unclear whether outcomes are any different when patients are managed by specialists or general physicians in collaboration with the specialists. In this context it is worth noting that there is a rapid retreat from multiple specialist care in the United States where the need to contain costs is driving care in the direction of the general internist.*(p 23)

A review by the University of York[8] also came to a sceptical position about the scale of the benefits of specialisation, as the following conclusion of their analysis indicates:

> *Overall, the literature on links between volume of activity and clinical outcomes suggests that for some procedures or specialties there may be some quality gains as hospital or clinician volume increases. In other areas the research suggests an absence of significant volume gains. However, any association found may be confounded by other variables such as differences in patient case-mix between high and low-volume hospitals (or clinicians). The bulk of the research, because it does not sufficiently take into account case-mix differences, probably overestimates the size of the impact of volume on the quality of care. In the few cases where volume-quality links have been suggested by more reliable studies, the thresholds indicated in some studies are relatively low and could be reached through specialisation of tasks within a hospital rather than through an increase in the size of the provider. However, where volume is associated with quality, the direction of causation is not established. It is difficult to use findings of a positive relationship between volume and outcome across hospitals or clinicians to infer what would happen to health care outcomes if existing low-volume units expanded.* (pp 19–20)

Within cancer care itself, a survey[9] published subsequent to Calman-Hine concluded that while there was a body of evidence which supported the case for specialised care (and no study shows a worse outcome), the evidence was weak for some cancers. Moreover, the study also quotes evidence that in some circumstances a network of units in general hospitals can deliver an equivalent level to specialised centres. But very little such comparative evidence exists, so had the committee wished to make a systematic comparison of the alternatives they could not have done so.

The Calman-Hine report set out a broad vision of how cancer care should be provided but it was far from being a blueprint even for the clinical aspects of care. The response to the report can be considered under the following heads:

- professional critiques;
- other obstacles to implementation.

Professional critiques

In general, the expert report was well received. Nevertheless, it was criticised by clinical groups that were not well represented on it. Those representing the interests of haematology for example have argued that their part of the service was already organised in a clinical and cost effective way. The Medical Royal Colleges pointed to the lack of any consideration of psychiatry.

Another key gap was primary care. The report states that primary care is the focus of care, but, in practice, the bulk of it is about the acute sector. It suggests that the relationship between primary and secondary care should be a partnership rather than a permanent or temporary transfer of responsibility, but it gives no indication how this should be achieved. More significant, it does not deal in any detail with the crucial relationship between initial presentation with symptoms and the initiation of appropriate diagnostic procedures – not to mention the scope for improving patient awareness and hence bringing forward the presentation of symptoms. Nor does it deal substantively with prevention and the case for extended screening.

Thus, as these examples indicate, Calman-Hine was not in fact a study of a whole system of care, despite the broad ranging nature of the principles upon which it was based. It did not attempt to define the patient pathway (and the many different pathways) from awareness of something being wrong through to effective treatment. It did not attempt to identify where the critical failures in existing arrangements were and hence provided no indication of where benefits were most likely to accrue. Moreover, it appears that the implementation of the Calman-Hine proposals has to be some degree been at the expense of screening services.[10]

Obstacles to implementation

By their nature the Calman-Hine proposals were broad brush, leaving a great deal to be worked out on the ground. Not surprisingly therefore, the process of putting it into practice did not prove entirely straightforward. When things moved to the stage of detailed implementation, a large number of issues emerged which have meant in practice that the Calman-Hine proposals will not be implemented for the country as whole within the foreseeable future, in particular:

- finance and resources;
- training;
- patient information.

A number of these issues were analysed in *The Workforce and Training Implications of the Calman-Hine Cancer Report,*[11] which points out that:

The National Cancer Alliance produced a map indicating the number of comprehensive cancer centres with the facilities and staffing that meet the requirements of the Calman-Hine Report. There are currently 15 in the UK. It is not realistic to assume that we will ever have 40 such cancer centres and 150 cancer units, even by the year 2001. The resource and training implications are too great. (p. 17)

It goes on to identify the training requirements of the proposals. These are extensive – covering all the professionals involved- but their precise extent has proved hard to establish, not least because the current staff commitment to cancer care is not known with precision.

The issue of patient information is fundamental to the creation of an effective service, but on the basis of extensive experience of helping clinicians and managers implement Calman-Hine proposals, John McClenahan and Peter Mumford[12] found that:

Detailed information needed to plan and manage individual patients' treatment is fragmented and disconnected. Different specialties and even more, different organisations, collect similar information in different ways, using different definitions, format and content even of similar data items, and different computer systems or paper-only records. Notes of different professions are often filed separately inaccessibly to other members of the clinical team.

Even in aggregating data for service planning, management, and contractual purposes there are conceptual and practical difficulties with no commonly agreed solutions. Progress will be possible if (at least locally) organisations and their departments can agree on a common framework for:

- *describing the elements of cancer and related services. This needs to be done in a way which allows them to be progressively disaggregated from the current block contracts for surgical and medical services;*
- *separate the description and counting of activity in different processes of diagnosis and treatment from the locations at which they are currently performed – so that, for example, outpatient clinics run by cancer centre staff in surrounding DGHs are clearly accounted for in activity and financial terms;*
- *clarifying boundaries between cancer services and other services – especially in the early stages of screening and diagnosis.* (pp. 3–4)

As these points indicate, the creation of a service, all the parts of which work effectively together is a long and slow process involving a great deal of groundwork.

Broad implications

We have argued that in principle there is a case for service frameworks where the needs of patients require the process of care to be agreed, provided and audited over a large number of different organisations and professions. If this pattern of care delivery is to become the norm, then some general issues arise, as follows.

Service and contractual structures and accountability

The essence of a cancer care service is that it requires people in different organisation to work within the same clinical, organisational and financial framework. How these cross-boundary interfaces should be handled in financial and contractual terms is far from clear.

Various models are available ranging from lead hospitals (the hub and spoke model) to complete contractual separation into an independent cancer service. The latter form has not been seriously considered, but in some cases, e.g. for paediatric or geriatric care, contracts already run across community and hospital trusts. The merger of finance for general medical and hospital services opens the way for contracts running across primary and secondary care.

Whatever the institutional framework, a key question is what the lines of accountability should be. Experience with the breast cancer screening service,[13] a relatively narrowly defined service demonstrates how serious failures can arise when neither local nor central management is properly engaged. The tighter central control, the greater the case for a direct, national line of accountability cutting across existing reporting arrangements.

Audit

In general, the current organisation of clinical and external audit mirrors the form organisation of the health service. It follows that it typically does not bear on flows of patients between organisations. This is a critical weakness in a system of care which aims to integrate services between providers. A form of audit is require which is patient, rather than provider based.

Knowledge base

As this chapter has already pointed out, the knowledge base for the Calman proposals was limited even within the clinical field. This shortfall stems from a general weakness in clinical and health services research, that they both tend to focus on the individual intervention rather than the context within which it is to be applied, and ignore economic and organisational aspects. It follows that the same will be true for other similar proposals.

Linking frameworks

The Calman-Hine proposals did not consider the impact of a cancer care system on other services but its proposals for greater specialisation would impinge on the way other hospital services are provided through its impact on the work of the remaining generalists. Obviously, if more frameworks are developed, the implications for organisation of hospitals become more significant particularly for those functions, of which the reception of emergency patients is the most significant, which require contributions from across the range of specialities.

Furthermore, there is no reason to expect that all national frameworks would point to the same pattern of provision, i.e. the same balance between less specialised and highly specialised institutions. If the national framework programme is developed therefore, an eye will have to be kept open for the implications for the rest of the hospital system.

The same is true for primary care. As the Cancer Collaboration report points out, the implication for primary care is that there will be some degree of specialisation among GPs. A series of national frameworks might require each primary care group for example to have its own series of framework specialists. There may be a case for this, but it needs to be made in its own right. It would be a major change and not one which could be regarded simply as an incidental consequence of a change in the organisation of hospital-based care

Conclusion

The notion of a service framework appears to offer a route to a better and more uniform standard of care, both desirable objectives. In practice, that route may be difficult to negotiate because of the wide range of practical obstacles we have identified in this chapter. It would therefore be wise for the Government not to attempt to implement as large a programme as the White Paper appears to envisage. Calman-Hine does not provide a model for service framework development. In fact, looked at as a bid for a major development of a particular service, the report is woefully inadequate.

Whatever scale of programme the Government does enter into, it should place much more emphasis on implementation than Calman-Hine. In particular it should:

- identify training requirements;
- identify cost implications;
- identify the full range of tasks which must be tackled, e.g. the design of information systems;
- identify the impact on other services;

and finally and more important, demonstrate the links between the proposals for change and the benefits expected.

The Health Service Circular[14] announcing the first stages of implementing the programme describes the process as follows:

> *To set national standards and define service models, each national service framework will include an assessment of the health and social care needs to be addressed; the evidence on effective and efficient interventions and organisational arrangements; the present position and the issues to be tackled; resource implications and timetable for change.*(para 10)

It goes on to acknowledge that while the work will draw on existing research it may be necessary to commission further work. That dose of realism serves to underline the central argument of this chapter, that progress is likely to be slow, however desirable the goal.

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Chapter 4

Accountability and performance

Bill New

The White Paper represents one more step on the road to greater visibility and openness in the way the NHS conducts its business. The relevant proposals centre on a significantly modified approach to measuring activity and outcome, with performance indicators broadened to include clinical measures and a new emphasis on national – i.e. central – action. Much of this is not, at first sight, particularly controversial. For example, there have long been calls for measures of performance to move away from a narrow focus on 'activity' to include clinical 'outcome' – after all, the NHS should improve health, not just increase the numbers treated. But in doing so the proposals raise uncomfortable questions about the limits to ministerial accountability, and indeed the limits to understanding such a large, complex institution as the NHS. How much can we hope to know about how public institutions work? Does accountability always require us to publish and publicise data, even if we have doubts about their accuracy? Is there, indeed, a limit to what we can demand in the name of democracy?

The White Paper sets out the Government's ambition (see Box 1) by emphasising a shift from the previous administration's concern with efficiency – in particular the purchaser efficiency index. It makes clear that its approach to assessing the performance of the NHS will be more 'holistic', and that it is appropriate to include measures of health outcome – in other words, that 'clinical governance' should form part of new accountability arrangements.

In a follow-up consultation document, *A National Framework for Assessing Performance,*[1] the Government set out their approach in more detail. It re-emphasises the 'six important principles' from the White Paper, including 'to renew the NHS as a genuinely national service' and 'to shift the focus onto quality of care', as well as noting that it wished to move away from measures of performance which simply counted activity or financial performance (see Box 2).

This review of the White Paper will first consider the relationship between accountability and the NHS' objectives, before moving on to consider the particular issues raised by performance indicators and the new NHS Charter. Finally, a short concluding section will return to some of the wider questions of information 'overload' in modern democracies.

Box 1

The White Paper states that:

The Government will bring [quality and efficiency] together in a new approach to measuring the performance of the NHS and holding it to account. Experience shows that the way in which performance is measured directly affects how the NHS acts: the wrong measures produce the wrong results. New arrangements will concentrate on measuring what really counts for patients through a new Performance Framework. It will focus on more rounded measures – health improvement, better quality and outcomes of care and the views of patients – as well as real efficiency gains. (p.20)

Box 2 The new performance indicator framework

Six areas are identified by the new Government within which a modified set of performance indicators will measure how the NHS is operating along various dimensions. They are:

• health improvement	– the overall health status of populations, reflecting social and environmental factors and individual behaviour as well as care provided by the NHS and other agencies
• fair access	– access to elective surgery – access to family planning services – access to dentists – access to health promotion – access to community services
• effective delivery of appropriate health care	– health promotion/disease prevention – appropriateness of surgery – primary care management – compliance with standards
• efficiency	– maximising use of resources
• patient/carer experience	– accessibility – co–ordination and communication – waiting times
• health outcomes of NHS care	– NHS success in reducing levels of risk – NHS success in reducing levels of disease, impairment and complication of treatment – NHS success in optimising function and improving quality of life for patients and carers – NHS success in reducing premature death

NHS objectives

Any system of performance assessment must have some idea of the objectives the 'performance' is supposed to achieve. The indicators and their subject areas (see Box 2) imply certain objectives (such as fair access and improving health), but these are not set out specifically. The consultation document merely states that

> *the small set of indicators is not intended to be comprehensive in covering all aspects of NHS activities. However, so far as data availability allows, the indicators have been chosen to throw light* ***on particularly important health service objectives and activities***[1] (p. 16, emphasis added)

Why something counts as 'particularly important' was not enlarged upon. Certainly, many recent government documents, including those of the previous administration, outline a general commitment to the NHS principles. For example, the Conservative's *A Service with Ambitions*[2] states that these 'principles ... require the NHS to be':

- universal in reach
- high-quality
- available on the basis of clinical need, without regard to ability to pay.

Similarly the current White Paper states the 'historic principle' of the NHS is:

> *that if you are ill or injured there will be a national health service there to help; and access to it will be based on need and need alone – not on your ability to pay or on who your GP happens to be or on where you live.* (p. 5)

The difficulty lies in translating such broad brush statements into practice. Concepts such as 'need' and being 'there to help' are vague – they invite support by avoiding specificity. Whereas it is easy to say what the NHS should not do (discriminate according to ability to pay or where you live) it is much harder to decide precisely what it should do.

The fact is that public institutions are prone to adopting numerous objectives, and typically they are in competition with each other. For example, we may agree that one objective of the NHS is to extend life expectancy (under 'health improvement') while another is to reduce levels of disease and impairment (under 'health outcomes'). If resources were unlimited, it would be possible to pursue both these 'objectives' simultaneously and without ever needing to question priorities. But if the NHS devotes increasing quantities of its resources to interventions which extend life, such as drugs which slow the progression of cancer, it will have fewer opportunities to provide treatments which improve quality of life, such as hip replacements. These are choices, involving trade-offs *between* indicators, which the White Paper avoids.

As new indicators are introduced, new tensions may emerge. Waiting times are already suspected of diverting attention away from issues of clinical urgency. More generally, objectives which are of immediate and salient value to patients and users may not be compatible with those which place an emphasis on fairness. The typical patient has experience of their GP and the acute sector – it may be here rather than in areas of long term or mental health care where the 'objectives' of patient satisfaction become concentrated. Fairness may pull in other directions.

Such tensions lie behind the indicators, nagging away at those who have to establish what the NHS will and will not be able to do. What is the range of appropriate NHS objectives and what trade-offs are necessary and acceptable between them? These questions will need to be tackled sooner or later.

Performance indicators: tin-openers or dials?

Assuming that objectives of some kind are identifiable, it is not surprising that measurement tools have been devised to assess progress toward them. Accountability, after all, involves giving an account of how well one is doing and in order to do this successfully one must have information about what is actually happening. This is particularly true for a large complex agencies such as the NHS where there is ample scope for different parts of the organisation to do things differently, perhaps doing more or less well in achieving objectives.

Performance indicators, and other measures of success, are a relatively recent innovation.[3] Their origins lie in the rational budgeting models developed during the 1960s, as central government became concerned that it was losing 'grip' on what its departments were doing with the large and increasing budgets which Parliament voted them.

Interest in these developments waned during the 1970s as fiscal crises focused minds on the more pressing concerns of reducing global expenditure, but resurfaced during the 1980s as the Thatcherite concern with efficiency and value for money again concentrated attention on what the public was getting for its money. First published in 1983, performance indicators in the NHS as elsewhere during this period were concerned with 'squeezing' more out of the system. Their central role was to reveal *relative* performance and thereby provide an incentive for under-performers to do better. They were much criticised for focusing on input and process measures – including financial performance – at the expense of outcome measures relating to the clinical performance of the NHS. The indicators proposed in the consultation document attempt to address these criticisms, and represent a welcome change of emphasis. But there remain difficulties, both specifically and more generally in the use of these kind of measures.

Specific issues

Some of the indicators are hard to interpret. For example, the indicator for access to community service – district nurse contacts – is awkward to interpret as the length and content of a contact is highly variable. The inclusion of an element of the indicator to cover contacts over 1/2 hour is an attempt to counter the first point, but the second remains. Furthermore the average figure for a district may hide significant variations within it – for example, between the areas covered by different primary care groups. In the case of some of the indicators – conceptions rate for girls aged 13–15 or decayed, missing and filled teeth in five-year-olds – the critical question is whether or not change in the indicator can be attributed to action on the part of the NHS. In the case of the indicators of fair access, it is curious to omit any indicator relating to general practice, particular as that is the part of the service people use most and one in which there are known to be variations in quality. In fact, the White Paper acknowledges that there are important omissions, announcing that the 'new NHS Charter is likely to include new standards for assessing the quality of treatment and care'.[1](p.11)

In the case of experience of the service, one may question why admissions within three months should be the measure rather than one of four, five or six months. Equally, there are variations in focus: one part of the set contains an average measure – admissions within three months – while other parts propose measures for particular procedures (see Box 3 for examples of specific indicators).

Box 3 Specific indicators proposed: a selection

Health improvement	Deaths from all causes (for people aged 15–64) Cancer registrations
Fair access	Conceptions rate for girls aged 13–15 People registered with an NHS dentist District nurse contacts
Effective delivery of appropriate health care	Early detection of cancer Inappropriately used surgery Cost-effective prescribing
Efficiency	Day case rate Length of stay in hospital Generic prescribing
Patient/carer experience of the NHS	Patients who wait more than two hours for emergency admission Delayed discharge from hospital for people aged over 75 Inpatients admitted within three months of a decision to admit
Health outcomes of NHS care	Decayed, missing and filled teeth in five-year-olds Emergency psychiatric re-admission rate Survival rates for breast and cervical cancer Avoidable deaths

General problems

Criticism of performance indicators can also be made at a more general level. For example, they are commonly accused of displaying or encouraging:

- tunnel vision (narrowly focused; ignore the objectives behind the indicator);
- measure fixation (concentrate only on what can be measured, at the expense of qualitative outcomes);
- myopia (encourage short-term rather than long-term strategies);
- convergence (encourage league tables and convergence toward the mean – performers at the 'tail' of a distribution move in, rather than those at the mean 'moving out');
- ossification (rigidity caused by old measures);

- gaming (such as underperforming so as not to get harder targets, recoding data, or avoiding 'difficult' cases);
- proliferation (increase in number of performance indicators to counter-act preceding problems).

This catalogue of weaknesses is certainly not encouraging. Essentially, the various difficulties can be boiled down to one of measurement and quantification. This is more or less a prerequisite of any system of performance assessment: if Government wishes to find out how well an agency is doing in relation to an objective, or how various parts of an organisation are faring relative to each other, then it is necessary to make some kind of numerical judgement. Otherwise, rigorous and systematic comparison is difficult – it is not possible to judge whether health authority A is doing better than health authority B without quantifying *something.*

But here the problems start. It is clearly awkward to put a number against something as nebulous as a health improvement, and as a result performance indicators (PIs) have tended to focus on easily measurable process measures and to some extent still do – patients with operations cancelled, day case rate, etc. 'Output' measures which do form a part of the current set – survival rates, avoidable deaths – have been chosen on the basis that data is relatively easily available. The danger, then, is that the attention of providers and policy-makers will become unduly focused on those aspects of the NHS activity which are more easily measurable, at the expense of possibly more important elements which are harder to measure – such as a patient's satisfaction with the experience of care as the ultimate outcome, for example. In recognition of this danger, a 'national survey to provide comparable information on patient and user experience' is promised.[1]

Another difficulty emerges when the purpose of the PI is to allow comparison of various parts of the system. Thus, in the consultation document an example is given of performance in relation to care of the elderly. Most of the examples presented show how various health authorities 'rate' according to a PI in each of the broad categories – for example on 'meeting the need for hip replacements for over-65s'. It is virtually impossible to look at the graphics without coming to the conclusion that some are doing worse than others – that some are at the top or bottom of a 'league table'.

But 'league table' comparisons are controversial, principally because of the operation of confounding factors – circumstances more or less beyond the control of those working in the NHS. Thus, we need to be sure that case-mix, severity, environmental factors and so on are all accounted for.[4] There is also the question of chance: one's position in the league may simply be down to luck, and once appropriate statistical confidence limits are built in, apparent variations in performance become rather less significant.[5] But presenting data so that comparisons are possible without the potential for constructing a league is almost impossible. Thus there will always be a need for these tables to be accompanied by statistical health warnings.

Dilemmas for democracy

Much of the data on which the indicators are based has been in existence for many years. The difference now is that they have a formal status as *performance* indicators, they are presented in a readable format and disseminated more widely. But given all the difficulties of interpretation outlined above, what are we to make of the PI strategy? There is a tension here. On the one hand, a Government concerned with public accountability and openness will argue that, even if data are imperfect, there is a duty on them to do everything possible to understand how public money is spent, particularly when the NHS consumes 'more than £1000 every second' (White Paper, p.68). Information, warts and all, must be in the public domain. On the other hand, the danger is clear enough that more information, if poor or misleading, may lead to worse decision-making than continued reliance on existing methods. The unbridled desire for more data, in the name of democracy or for any other reason, can be overplayed.

Furthermore, there are uncertainties about who is supposed to use the indicators, and how. Clearly the public, and patients, have an interest and even if they cannot use them directly to obtain improved service, the media are likely to publicise stories of poor practice with reference to the league tables discussed above. However, users have their own 'indicators' in the form of the *Patient's* (soon to be 'NHS') *Charter*, discussed below, and so they are probably not expected to be the principal clients. Purchasers – or primary care groups – may be able to use indicators to 'lever' change from providers; similarly central government may use the new agencies, such as the Commission for Health Improvement, to intervene where indications of lax standards persist, although it is not clear what sanctions are a vailable to make change happen. Indeed, it will not be easy for any of these groups to make a convincing case for change when the information relates to performance long since passed, and possibly already rectified, and when there is limitless opportunity for arguing that 'circumstances' are to blame.

Perhaps, then, the crucial factor is how they are used. As long as the purpose is to indicate where further study may be required, then the problems outlined above are not insuperable. Indicators may be valuable means of establishing where truly bad practices persist, or where consistently good performers can offer lessons for others. If a poor performer puts its own house in order, it may have been the fear of investigation which spurred the improvement. In short, performance indicators should be 'tin-openers' (to cans of worms) not 'dials' of performance.[3](p.115) The question remains whether such caution will be exercised when the desire is for quick answers and immediate improvement.

Patient's Charter, NHS Charter

What relationship exists between the *Patient's Charter* – or the forthcoming NHS Charter – and other performance indicators? It seems reasonable to assume that all these measures are ultimately supposed to benefit patients. But by referring to a set of indicators as 'patient's' the implication was that they had more relevance to the users of the service. Even though the name is to change, there is no indication that this objective will not remain. In other ways, however, the *Patient's Charter* standards were similar to the process PI measures used by the previous Government, including various waiting time measures, and numerous standards relating to hospital catering and cleanliness. It was never clear precisely where these standards had come from, beyond those, like being registered with a GP, which were already enshrined in legislation. The fact that the old Charter emphasised 'standards' was, in fact, one of its principal distinguishing features. Performance indicators do not, as a rule, specify targets which agencies or individuals have to achieve. Instead they emphasis *relativity* – how various parts of an organisation measure up to one another, but without specifying whether the average is itself good enough. The *Patient's Charter*, on the other hand, set targets which were expected to be met, regardless of relative performance.

The Government committed itself to reviewing the existing Charter, and as part of that process commissioned the King's Fund to look at what a future NHS Charter might contain.[6] The research included a literature review, as well as interview and focus group work with patient and professional groups, clinicians and mangers. One of the positive findings of this research, for the previous Government at least, was that many of the elements of the Charter turned out to reflect the 'genuine' concerns of the patients themselves, and had helped to set some useful standards and priorities for action. More generally, and more importantly, there was a widespread belief among NHS staff that it precipitated a change in culture toward patient, rather than professional, needs. However, on closer inspection of how precisely patient's needs were defined – why certain 'standards' and not others were set, for example – and how they were specified, that weaknesses appeared. In fact, many of the problems with the Charter echoed those associated with performance indicators more generally: it lacked a statement of overall objectives, created perverse incentives (for example, on waiting times, rather than urgency), ignored clinical outcomes, data collection and monitoring was difficult, and patient expectations were raised too high. The King's Fund report argued that, among other things, a future Charter should have a clear purpose, should pay equal attention to primary and community care services, and should concentrate on qualitative as well as quantitative outcomes.

Perhaps it is in the Charter's purpose where the real uncertainty lies. If it is in fact a management tool, a means for the NHS' masters to change service culture, then it could be argued to have been reasonably effective. Certainly, such an outcome should not be undervalued. But it does lead one to ask exactly where the patient/user fits in, particularly where they feel a standard is valuable and in their interests, but where professional opinion differs. Many of the Charter standards were thought misguided by commentators, but might well be popular among patients – particularly those on waiting times. Should a charter simply contain things which patients think important? Or should this be limited by 'professional' concerns – on cost-effectiveness measures, for example? In short, should the service lead or follow the wishes of patients? As with performance indicators, the question is whether these indicators can or should be used as sticks with which to beat the service, or merely warning signals of where further investigation is necessary. If the latter, and that is the conclusion implied by the analysis above, then there would seem to be limits to the role of rigid 'standards', even where these are explicitly for the use of patients.

Concluding comments

The new set of performance indicators is not the only change with relevance for the NHS. The reformed administrative structure – reviewed elsewhere – also has implications for accountability. Being funded principally out of general taxation, the service must be accountable 'upwards', at least in part. Any public institution which derives most of its funding through a vote of Parliament, must answer to Parliament for how that money is spent. This is the origin of Nye Bevan's famous 'bedpan doctrine' – that he wished to know of everything that went on in the service, including the sound of bedpans dropping. Answering for all parts of an immensely complicated organisation has always been difficult, but with ever increasing torrents of information pouring into the centre, the danger is of 'overload'[7] – that the Secretary of State is now, in a practical sense, overwhelmed by the duties inherent in his position.

Nevertheless, the Government has, to a limited degree, acknowledged the constitutional reality of central accountability with its strengthened commitments to a *national* service, and the creation of new agencies to help the centre make this happen. Furthermore, the creation of primary care groups clarifies and strengthens the accountability of GPs, particularly the old fundholders, with direct links to health authorities and then to the NHS Executive (White Paper, p. 21). So, a desire for more geographical fairness and consistency, which requires more central action, has reinforced traditional notions of accountability. No doubt there will continue to be calls for more local accountability, even for local authorities to take over the commissioning function. But such a reform may entrench further the very variations the Government are committed to eradicating.[7]

If the White Paper's proposals are logical in relation to geographical fairness (more centralist monitoring and control), while at the same time making improvements to the tools for achieving it (a more rounded set of performance indicators), the strategy remains open to criticism. Concerns persist about misleading and inaccurate league tables, creating perverse incentives. The Government will counter that 'people' have a right to such information, that we have to know more about how our money is being spent, that any information is better than none.

These are uncomfortable questions for democracies: how much information is good for us, when it is so complex and hard to interpret? Is bad information better than none? Is there ever a case for withholding information, when we are really unsure about what it is telling us? After all, if it is so hard for the 'experts' to agree on what the data means, what hope for the rest of us?

Perhaps we should accept that improving accountability will be slow and painful. Performance indicators should be 'tin-openers', indicating where things might be going wrong, but not 'dials'. Finding out about how we might make the system better should not seduce us into thinking we will ever make it perfect. In fact, one key lesson may be that the Government should now resist the temptation to acquire ever increasing quantities of information, and instead invest in the capability to make better sense of it – in particular how to communicate complex and ambiguous evidence to the general public.

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Chapter 5

Health and social care partnerships

Janice Robinson and Richard Poxton

> *'... the internal market will be replaced by a system we have called integrated care, based on partnership and driven by performance. ...*
>
> *By breaking down barriers and forging stronger links with local authorities, the needs of the patient will be put at the centre of the care process. Now, there will be common goals so that each part of the local health service works in concert with one another and in partnership with local government and others. ...*
>
> *To give substance to the co-operation necessary to bring about improvements in health there will be a new statutory duty of partnership placed on local NHS bodies to work together for the common good. This will extend to local authorities, strengthening the existing requirements under the 1977 NHS Act.'*

Partnership is one of six key principles underlying proposed changes in *The New NHS*. The White Paper is littered with references to collaboration, interdependence, co-operation and working together and this language signals an important change in the way NHS bodies will be expected to work with each other and with other agencies like local authorities. This emphasis on partnership clearly reflects the Government's determination to bring down the 'Berlin Walls' which have so bedevilled services required by people who have both health and social care needs. By promoting a more collaborative approach across organisations and sectors, the Government is hoping to bring about greater coherence and co-ordination in the design and delivery of local care services – an achievement that has so far eluded previous administrations.

Action to improve collaboration between the NHS and local government is by no means new. Throughout the history of community care, successive Governments have exhorted health and social services to work together, introducing formal mechanisms such as joint consultative committees, joint planning and joint finance to facilitate such collaboration. However, the desire to foster partnership has undoubtedly intensified in recent years.

The previous Government's NHS and Community Care Act aimed to secure more integrated care but in practice exacerbated long established problems in the organisation of care for people with long-term illness or disability. The emphasis on competition in an internal market (for the NHS) and in a mixed economy of welfare (for social services) led to services becoming more fragmented – making the task of co-ordinating care for individuals and developing services for local populations more difficult. Furthermore, NHS withdrawal from long-term care and a lack of clarity about NHS responsibility for the care of people with 'continuing health needs', led to conflicts about cost-shunting, and an increase in legal challenges by members of the public who wished to contest decisions that denied them access to free NHS care and compelled them to seek means-tested social services. Despite efforts made to resolve these difficulties, a succession of problems on the boundary between health and social care continued to emerge, related to hospital discharge arrangements, increasing emergency care admissions and controversies about rehabilitation and recuperation services.

Over the last year or so, there have been signs of an emerging consensus that more concerted action is needed to achieve better integrated care. In many parts of the country, NHS bodies, including those in primary care, have been demonstrating a greater willingness to work with local authority social service departments and to engage in jointly commissioning and providing services.[1] Serious consideration has also been given to options that go beyond partnership, with calls for the Government to create integrated health and social care agencies responsible either for commissioning services or for co-ordinating services for groups of people (such as those with serious mental illness).[2] We have also seen pressure building up for new partnerships to be formed around public health and urban regeneration – an agenda that goes way beyond health and social services and that presents new challenges and opportunities for working across organisational boundaries.

While there is a good deal of evidence to suggest that a new climate of co-operation between the NHS and local government has already broken out, studies of collaborative working in total purchasing pilots and in joint commissioning initiatives suggest that we cannot rely on public agencies to work together voluntarily nor is good will on the part of individuals working within those agencies sufficient by itself to achieve collaboration. [3,4]

Furthermore, even when strong collaboration exists between health and social services, progress towards better integrated care has been generally slow. Sometimes it appears that the greater the effort to clarify responsibilities in community care the harder the task becomes. This is because there are a number of structural barriers that stand in the way of effective partnership.

First health and social care systems are different; they have different origins and a variety of different organisational, administrative and professional cultures. Some of these differences are fundamental to the way services have developed on either side of the health and social care divide and those differences will need to be overcome in order to make any significant progress towards better care. Thus, partnerships have to be forged between a national health service that is free at the point of delivery, that has central accountability, and universal access, and social care services that have local accountability, wide local variations and restrict access through eligibility criteria.

In addition, there are practical difficulties to be overcome, given that the respective partners are not allowed by law to pool their resources, that they have difficulties in linking information systems, that they have different (and sometimes unclear) decision-making systems and that they have different ways of defining success and measuring outcomes. This is not to forget that the most significant barrier to partnership can be attitudinal, characterised by a lack of trust and either passive or active resistance to change.

The question arises whether clear and loud proclamation by Government on the need for collaboration, combined with measures designed to foster partnership can overcome these historic barriers.

There is a clear recognition in the White Paper that more formal arrangements are needed to strengthen partnership working, making use of critical levers for change. In this respect, the proposals are an advance on previous White Papers that have also urged collaboration between the NHS and local government. They are also much more ambitious than earlier attempts to compel or enable co-operation, ranging as they do across the ‘mainstream’ affairs and finances of both agencies rather than focusing solely on a narrow band of issues around the boundary between health and social services.

The White Paper envisages a range of partnerships between practitioners, commissioners, monitors and policy makers. To this end, partnership arrangements will be built into key points in the organisation of the NHS at national, regional and local levels. Thus, at local level, social services will be represented on the governing bodies of primary care groups that are expected to plan and deliver services for local communities. At a more strategic level, health and local authorities will be required to work together on local health improvement programmes, creating a framework for improving the health and well-being of local populations. All local NHS bodies will be expected to work within that framework. Arrangements at regional and national levels will reflect the focus on partnership at local levels, with regional chairs playing a part in ensuring that local partnerships are developed between the NHS and local authorities and the Department of Health taking a lead in integrating national health and social care policies – thus creating a context in which partnerships can operate.

The building blocks for partnership rely heavily on a mix of legislative change, including a new statutory duty of partnership placed on both health and local authorities, and of financial and other incentives designed to reward authorities seen to be making progress against specific targets and objectives. The White Paper admits that financial rewards for good performance are likely to be 'modest and non-recurring' and there is an explicit expectation that these sums would be available for local 'projects'. The other incentives appear to be psychological in nature, relating to the pride or shame that can stem from benchmarking exercises that reveal performance to be either good or poor when compared with that of other areas. Sanctions for poor performance are also envisaged, where regional offices will be able 'to intervene directly to strengthen existing management'.

By opting for partnership rather than organisational integration, the Government is backing an approach that certainly has the potential for delivering better integrated care but which also has inherent weaknesses and may in the end fail to deliver. The test will be the extent to which the proposed formal arrangements for partnership relate to shared decision-making (as opposed to information sharing and liaison); ensure that respective partners have equal power and authority to influence decisions about plans, service developments and day to day practice; and show an understanding of what it takes to develop a collaborative culture, with a shared vision of future services and a shared commitment to shaping a new future.

Without more detail about implementation, it is difficult to judge what might happen but a preliminary analysis suggests that the new partnerships may be very fragile and may need strengthening in order to make it worthwhile for different players to enter into partnerships and to make it more likely that worthwhile outcomes will be achieved for service users. This becomes apparent when examining the White Paper's proposed arrangements for partnership at different levels in the NHS.

Partnership at primary care level

Primary care groups are expected to develop around natural communities, taking account of coterminosity with social services. PCGs will be expected to work closely with social services on both planning and delivering better integrated care. Social services representatives will be members of their governing bodies.

On one level, it makes sense to involve social services in PCGs. This is already happening on a voluntary basis in GP commissioning groups in many parts of the country.

Experience of current partnership working shows that many family doctors, community nurses and social care staff share an interest in provision for people with continuing health and social care needs. They are readily able to identify strengths and shortcomings in current provision and often have useful ideas about ways of improving local services. While this might be seen to augur well for successful partnership in locality commissioning, it is not clear whether enthusiasm among practitioners will be translated to committed and involved commissioning in PCGs. In addition, there must be some uncertainty about the extent to which social care issues will feature on the very full agenda of primary care groups.

The role, function and powers of governing bodies have not been spelt out in the White Paper. Enthusiasm about participation in governing bodies is likely to depend upon the extent to which such bodies are seen to have any real clout. Furthermore, health interests will inevitably dominate primary care groups, both in terms of the scope of business to be attended to and, probably, the composition of governing bodies. Social services will, after all, be invited to join a committee or a sub-committee of the health authority. In addition, it is not clear what role social services personnel are expected to play as members of those governing bodies. If they are expected to be advisory or even just to observe, there would be little incentive for social services to get involved. Real partnership will require social services to take part fully, alongside their health colleagues, in decisions made by the governing body.

Much will also depend upon the knowledge, skills and attributes of the social services personnel who will be co-opted on to these governing bodies. Recent guidance has suggested that local authorities will be asked to nominate 'an officer at operational level'. No doubt some assistant directors of social services will be nominated, but it is more likely to be area managers or principal officers, many of whom will have limited experience of the planning process.

Social service members of governing bodies will also require relative autonomy to participate in shared decision-making within a framework set by health improvement programmes agreed by local and health authorities. Without this authority, delays will be caused by the need to refer upwards to senior officers or members of the local authority. Such delay would only serve to reinforce prejudices widely held in the health service.

If better integrated care is to be achieved through partnership at this level in the system, it will be important to find ways in which health and social services can deploy their respective resources to improve provision for local communities. Further thought needs to be given to this issue, in order to help health and social services move beyond merely aligning their resources – a goal that has proved frustratingly difficult to achieve in joint commissioning pilots, largely because of the complexity involved in identifying which resources should be aligned, where the relevant budgets are held and how decision making at different levels without two separate public bodies can be co-ordinated. Greater clarity and further simplification of local finances will be required for effective partnership, even if legislation is enacted to enable pooled budgets.

Strategic partnerships between health and local authorities

Health authorities will be required to develop partnerships with local authorities and other agencies that have a contribution to make to a 'new strategic approach to the planning and delivery of health care'. The link with local authorities is seen as crucial in the task of 'identifying how local action on social, environmental and economic issues will make most impact on the health of local people.' It is seen as equally important in the development of local strategies for improving health and health care, which are to form the basis of health improvement programmes.

At this level in the system, the emphasis will very definitely be on partnership with local authorities, rather than with social service departments. For, although health authorities will be expected to work more closely with local social services on planning care for patients, it will be chief executives of local authorities who will 'participate in meetings of the health authority' and not directors of social services. This makes sense given the desire to connect the local NHS with the broader corporate responsibilities of local authorities, including housing, transport, education, leisure and so forth , a link that may very well open up new opportunities to create a more comprehensive and integrated system of community care that goes well beyond health and social services.

However, these broader strategic partnerships will inevitably be more complex, particularly in health action zones, where they are likely to encompass new partnerships with income support and employment agencies and with private sector interests. This complexity may result in the partnership between health and social services being further marginalised, to the detriment of some of the most disadvantaged sections of the community as attention is focused on the politically sensitive hospital agenda and the new opportunities presented by the public health and regeneration agenda.

For most local authority chief executives, the personal learning curve will be a steep one. Some will be able to draw on corporate local authority expertise developed through health sub-committees and central policy units. Most will require briefings and continuing support from social services staff. In this sense, local authorities will need to work hard to engage effectively in collaboration with their health counterparts.

Whether the costs, in terms of time and effort, will be justified remains to be seen. Certainly many local authorities have long wanted to have a greater influence on decisions being made about local health services – decisions that so often have a knock on effect on demand for their own services like supported housing, care homes, day and home care services. Formal recognition of their interests and of their potential contribution to health service planning will be welcomed by most. However, there are still many uncertainties, given that local authority elected members will apparently have no part to play in these partnerships and that authority devolved to chief executives to make decisions on behalf of his/her local authority is not clear.

In the 'New NHS', health authorities will have a role in 'stimulating primary care partnerships'. There is clear recognition here that partnerships between primary and social care agencies will not grow by themselves and that proactive development, including financial inducements, will be required to get the 'partnership show' on the road. Whether the new slimmed down health authorities will have sufficient resources, in terms of money and people with the skills required to foster those partnerships, remains to be seen.

Partnerships at regional level

The White Paper envisages that regional offices of the NHS Executive will work with their counterparts in the Social Services Inspectorate, monitoring local action to strengthen partnerships across health and social services and reviewing progress in controversial boundary issues such as continuing care and mental health. No doubt this watching brief is helpful, at least in as much as it provides a clear message from the centre that partnership is a valued way of working. The fact that regional chairs will take 'a stronger role in ensuring local partnerships are developed between the NHS and local authorities' is a further indication of the importance being attached to collaboration.

This message from the centre can also be expected to bolster those Regional Offices who, in recent years, have played a very proactive role in fostering partnership between health and local services, and have intervened to mend fences when relationships have turned hostile or broken down. But, while it is important not to underestimate the influence that regional offices have on local services, it is equally important to recognise that their primary function will continue to be one of performance management. There is no indication that regional offices will have any developmental function, proactively working to build partnerships and to support the development of a collaborative culture that will not come about overnight. Intervention of this kind will, it seems, only come into play when authorities are seen to be failing in some way, at which point, 'targeted management support' will be offered. If this fails to do the trick, regional offices will be able to 'intervene directly to strengthen existing management.' If all of this means that outside expertise will be drafted in to augment or take over positions in health authorities, trusts and primary care groups, this is a sanction that most local NHS bodies will want to avoid. However, such intervention will clearly be a last resort when working relationships have broken down or when agencies simply refuse to engage in any collaboration at all. Even then it is unlikely that still-born or aborted partnerships will be the fault of any one individual and any direct intervention by regions will still have to address complex factors in the local environment that are preventing collaboration.

Partnership at national level

In the 'New NHS', the Department of Health, and within it, the NHS Executive, will be made responsible for 'integrating health and social care policy'. This is seen as essential for providing a national lead which others can follow locally. Certainly, integrated policy development would provide the necessary context for developing better integrated care on the ground. At the very least, it should avoid some of the most glaring conflicts and contradictions in health and social care policy that over the last decade or more have soured working relations at local level and fractured all attempts at achieving continuity and co-ordination of care for individuals. Proactive efforts to 'join up' health and social care policy are already evident in the Department of Health but for greater integration, further strides will be needed to co-ordinate policies across departments, most notably with the Department of Social Security, the Department of Transport, Environment and the Regions (which allocates central grants to local government), and the Department for Education and Employment.

At the same time, serious consideration has to be given to what is involved in better integrating health and social care policies. No details are given in the White Paper, but it should be evident that no Government will be recognised as giving a national lead on partnership if it continues to allocate central funding to local agencies in a way that leads directly or indirectly to cuts in expenditure which disproportionately affect social services, and which 'bail out' overspending health services. Nor can partnership at local level flourish when policies regarding the long-term care of older people continue to create real tensions in relationships between the NHS, local government and wider community interests.

It is perhaps too early to be able to give a clear verdict on the partnership approach proposed in the White Paper. Further guidance has been promised which will provide greater detail on the arrangements proposed. A White Paper on social services is also being prepared and that will probably have more to say about partnership with the NHS. In advance of these documents, we have adopted a positive but cautious view of the proposals to boost partnership working in the 'New NHS'.

The partnership approach is worth trying. However, partnerships can be expected to be fragile given that the NHS and local authorities are separate organisations, with different funding streams and lines of accountability. No doubt, partnerships will work in many different circumstances but they can also be expected to be stretched to breaking point by different pressures affecting the different partners. The imperative to get hospital waiting lists down and to achieve ever faster through puts in hospital admissions intensifies pressures on social services. Cuts of millions of pounds in social service expenditure due to changes in resource allocation formulas strain relationships with health partners, most especially when some of those health partners publicly criticise social service departments for 'blocking beds'.

The arrangements proposed to foster more effective collaboration between the NHS and local government represent an admirable effort to find a way forward that minimises organisational disruption and builds on good practice that already exists. In the current climate, partnership is probably the best hope there is for the future planning and delivery of more integrated health and social care services – despite its inherent weaknesses. It is undoubtedly the most politically acceptable option at the present time, given the widespread reluctance to consider linking control of health and social services in unified and elected bodies.

It would nevertheless be wise not to expect too much of the partnership approach. In the absence of other policy developments around the financing of long-term care, and around differential charging for health and social services, even the strongest partnerships are unlikely to be able to pull down the principal barrier to integrated care, namely the incentive for the NHS to direct patients towards means-tested social care and for people with continuing health and social care needs to opt for free NHS care if they can. Issues such as these need a policy response that is not about agencies working together but is about equalising service charging on both sides of the health and social care divide.

In the final analysis, if the partnership approach fails to deliver better integrated care for vulnerable people, this will only strengthen calls for more fundamental changes in the organisation of the NHS and local government.

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Chapter 6

Clinical governance

Steve Gillam

New wine?

One of the main themes of *The New NHS* White Paper – quality – was cleverly encapsulated in a single phrase last December. NHS trusts and primary care groups are asked to embrace the concept of clinical governance. The White Paper describes characteristics of the 'quality organisation' where processes such as clinical audit are integrated within a quality programme for the organisation as a whole (Box 1). Good practice, ideas and innovations are systematically disseminated within and outside the organisation. Practice is as far as possible evidence-based. Clinical risk reduction programmes are in place. Adverse events are openly investigated and the lessons shared. Complaints are used constructively to draw lessons for clinical practice. A National Institute of Clinical Excellence and the Commission for Health Improvement are to be established in support of this initiative.

At first sight, the processes described are not new. What will clinical governance mean in practice? What are the barriers to implementation of these proposals and how can they be minimised?

Old bottles

Many public sector bodies have sought over the last ten years to import the organisation-wide quality improvement strategies perceived as successful in manufacturing and service industries. The advent of clinical governance heralds the latest of many attempts in the NHS to exercise greater managerial control over clinical activities. Variations in the quality of health care and in the outcomes achieved by different providers are well established. Previous attempts to address these variations have met with limited success.

The 1989 White Paper *Working for Patients* extolled the virtues of audit.[1] In some disciplines, 'the critical analysis of the quality of health care' was already established as best practice. What was new was an attempt to generalise audit activity. Over £400 million has been spent on audit in the hospital and community sectors to mixed effect. The audit movement has fallen short of expectations in various ways.[2] First, audit topics have reflected the priorities of doctors with little non-medical involvement (*pace* the shift

Box 1 Clinical governance

'A quality organisation will ensure that:

- Quality improvement processes (e.g. clinical audit) are in place and integrated with the quality programme for the organisation as a whole.
- Leadership skills are developed at clinical team level.
- Evidence-based practice is in day-to-day use with the infrastructure to support it.
- Good practice, ideas and innovations (which have been evaluated) are systematically disseminated within and outside the organisation.
- Clinical risk reduction programmes of a high standard are in place.
- Adverse events are detected, and openly investigated; and the lessons promptly applied.
- Lessons for clinical practice are systematically learned from complaints made by patients.
- Problems of poor clinical performance are recognised at an early stage and dealt with to prevent harm to patients.
- All professional development programmes reflect the principles of clinical governance.
- The quality of data collected to monitor clinical care is itself of a high standard.'

from medical to clinical audit). Second, it has proved difficult to routinise audit activity. *Working for Patients* did not free resources for health professionals to dedicate time to audit. Finally, involvement remains patchy. Clinical audit has not engaged the traditionally 'hard to reach'. Participation remains voluntary and is not a contractual obligation upon general practitioners.

The internal market refocused attention on the primary/secondary care interface, value-for-money and health care's evidence base. The early emphasis of the effectiveness initiative was on contracting as a means to effect change. Priorities were centrally directed and already familiar (use of steroids in premature labour, curettage in women under 45 years, thrombolysis, grommet insertion, etc.). This was alienating for clinicians and counter-productive. Contracting proved a blunt instrument. Latterly, the NHSE has adopted a more facilitative approach encouraging the development of local effectiveness strategies and acknowledging the professional development implied. However, accountability for clinical effectiveness has hovered between purchaser and provider – never properly defined.

The challenge for trusts

The new language is therefore to be reflected in the management of NHS trusts. They will have new statutory duties for the quality of care. Chief executives will carry ultimate responsibility for assuring the quality of their services just as they are now accountable for the public use of resources. They will be expected to secure appropriate local arrangements – possibly through the creation of sub-committees (led by senior consultants, nurses or other professionals) with responsibilities for ensuring internal clinical governance. Trusts will receive monthly reports on quality in the same way as they now receive financial reports and will be expected to publish an annual report on what they are doing to assure it. As well as strengthening existing systems of professional self-regulation the White Paper purports to offer a framework for extending this more systematically into the local clinical community.

Before rushing in to establish new committees and supportive structures, trusts need to look critically at the plethora of existing networks and groups pushing in the same direction. They will find drug and therapeutics committees, audit groups, effectiveness initiatives beavering away to improve clinical standards. Mapping the extent of these cross links – and quietly terminating some of the less productive – may be a useful first step.

The clinician/manager interface

Chief executives may feel pressured to flex these new powers. They will need to tread carefully if health professionals are not to be alienated. Clumsy intrusions into their clinical domains are too easily dismissed as cost containment. Clinician-managers will be crucial to successful implementation if clinical governance is to be professionally owned. The authority of these hybrids is easily undermined. Their ability to ensure compliance delicately derives from continuing identification with the rank-and-file.[3] They will need more grooming than clinical directors currently receive for their new roles.

The new breed of audit or effectiveness facilitator is another hybrid with a contribution to make. Unfortunately, career progression for this cadre remains unstructured. In some regions, much has been done to develop their skills but opportunities to progress in the field are few. Turnover is high and expertise is easily squandered. It will be important to identify these individuals and properly plot their development needs.

Clinical information

Faith in purely technical solutions to the problems of data quality remains widespread (perhaps because no one likes to acknowledge how little the investment has yielded thus far). The technology exists that should render much of the requisite data collection routine but progress in developing an essential building block – the electronic patient record – is painfully slow. Where the quality of data collected to monitor clinical care is of a high standard, information systems remain poorly developed.[4]

A greater challenge is to convince health professionals of the potential benefits for patient care in routine use of new information systems. They know that the easily measurable is rarely useful. Performance indicator packages are at an early stage of development. Technical obstacles such as the difficulties of controlling for casemix are not easily resolved. Progress in validating outcome measures has been disappointing. Most indicators are influenced by factors outside the control of health systems. Thorough audit requires completeness of data entry and consistency of data coding but complaints about the quality of data provide a convenient smokescreen. For measures of the quality of care will always be partial or imperfect. The challenge is to present comparative data in ways that encourage self-scrutiny. Fears that managers will misuse such information are only likely to be realised where clinicians disengage from the debate.

Medicine-based evidence

There is a dearth of evidence to underpin the setting of standards in many areas of clinical endeavour. The national R&D initiative will only slowly fill the gaps. It is fashionable to deride the tyrannies of evidence-based medicine (EBM) but the reductionist ideology of the randomised control trial is under assault. Many aspects of quality that patients appear to prize most highly – empathic communication, the nature of personal relations that derive from continuity of care – will always elude simple quantification. This has generated much sterile, epistemological debate between sociologists and natural scientists.

The 'solution' lies in flexibly tailoring evidence and method to question and context. Promoters of clinical governance need to acknowledge the way these disputes provide a language for surfacing tribal rivalries (the caring qualitative nurse versus the scientistic medical interventionist).

The evidence-based health care movement has helped to highlight the complexity of behavioural change. We have little evidence upon which to base change management strategies though the Cochrane Collaboration (EPOCH) should improve matters.[5] Ironically, local opinion leaders (not necessarily bearing evidence based opinions) can be an influential intervention (Box 2).[6] Pharmaceutical companies know the power of one-to-one 'academic detailing'. Personal contacts need to be supplemented by financial incentives and educational approaches using audit. Unfortunately, the most effective strategies are also the most resource intensive.

Box 2 Interventions

- Academic detailing
- Audit
- Peer review
- Opinion leaders
- Study groups
- Rounds
- Mass media techniques
- Feedback
- Guidelines
- Financial and other incentives
- Computerised decision support
- Targeted education/training

Trusts and PCGs will have to become more sophisticated about 'knowledge management'.[7] They need to be able to scan and filter the overwhelming volume of new knowledge with which they are bombarded. NHS organisations are unsystematic about the distribution of key documents (*Effectiveness Bulletins*, *Bandolier*, etc.) to those who should act on them. The King's Fund's PACE programme has illustrated the importance of an organisation-wide approach to aligning the systems underpinning evidence-based health care: audit, guidelines production, R&D, library functions, IT, training and education.[8]

NICE CHIMP

Little detail is yet available concerning the role of the National Institute of Clinical Excellence (NICE) or the Commission for Health Improvement (CHI). NICE is to promote cost-effective care by producing research based guidelines. National service frameworks will set out the patterns and levels of service which should be provided for major care areas and disease groups along the lines of the Calman-Hine proposals for cancer services (see Chapter 3). These will establish performance measures and the CHI will monitor progress through a series of service reviews. Work is beginning in the areas of mental health and coronary heart disease. NICE should help ensure consistency in decision making across health authorities, for example, with regard to the purchase of new technologies. New interventions and pharmaceuticals need to have demonstrated their cost effectiveness prior to their introduction. However, the recommendations of this new body will need statutory force if they are to be more influential than the blithe recommendations emanating from existing R&D institutions.

The emphasis on clinical excellence needs to be tempered with an understanding of clinical realities. Behavioural change and the implementation of evidence is a messy business. The language of quality improvement has a short half life. Audit is disparaged and EBM fatigue is well established in some parts of the system. The experience of recent years, nay 'evidence', suggests that an organisation seen to be carpet-bombing the NHS with clinical directives and centrally elaborated models of care will not win professional co-operation. The difficulty of cost-effectively reconciling rigour and local ownership is most stark in relation to guidelines.

The role of the CHI is regarded with more suspicion. This statutory body, at 'arm's length from Government', will publish information on how trusts compare with one another in terms of their effectiveness (health outcomes), equity (access to their services), and humanity (patients' and carers' views). In addition, the CHI has a troubleshooting role to send teams to trusts where problems are identified. A cross between Ofsted and the Audit Commission is too easily dismissed as political gimmickry. Clinicians have been quick to spot the ambiguity of its remit. A health service inspectorate, monitoring and improving quality across the NHS, suggests evolution towards a centrally sponsored programme of health services accreditation. Responding to major clinical disasters (as what Kieran Walshe has called an 'official locker of stable doors') requires the teeth to remove or redeploy individuals failing to address serious deficiencies in clinical or managerial performance.[9] Such an organisation must have a developmental, educational and preventive remit. Both NICE and the CHI will require resourcing but no new money is pledged.

Primary care groups

PCGs too will be required to assure the quality of services they commission and provide. They are required to appoint a lead professional with responsibility for clinical governance to work with a contact person in each practice.[10] General practitioners have experience of the same audit tools and processes but never before have they been required to be their brothers' or sisters' keeper. They have not routinely shared much information within let alone between practices. Even referrals and prescribing data are still seen as confidential. The autonomy and individualism of general practitioners more than any other group of health professionals make the development, sharing and dissemination of guidelines problematic. Evidence-based medicine is widely regarded as the preoccupation of geeks in anoraks. Careful education and facilitation will be required allowing time for the requisite trust to develop. The processes of clinical governance will sorely test inter-practice relations. It will be important to ensure that nursing staff are included in discussions. Practice managers' vital contribution to marshalling the inputs of different health professionals should not be overlooked.

The nature of professionalism

Professional and statutory bodies have a vital role in setting and promoting standards but the Government requires practitioners to accept responsibility for developing these standards within their local NHS organisations. Professional development programmes will be required to reflect the principles of clinical governance. Failing clinical performance is seldom recognised early. The GMC has been attempting to tackle this for some years in the face of rising public disquiet. Poor performance must be handled through processes that are professionally led but the regulatory machinery will need to be increasingly transparent. Recent events in Bristol have grimly highlighted the issues at stake. They will hasten the development of rigorous monitoring procedures. The duties of clinical governance can be seen as redefining the nature of accountability for those working in the NHS.

Why should the new emphasis on collective responsibility be more effective at reining in those health professionals who have ever remained ‘outside the loop’? Personal relations will be tested and the dangers of scapegoating already isolated doctors are evident. Doctors are traditionally reluctant to interfere with their colleagues’ clinical practice. Respect for their colleagues’ independence is easily dismissed as collusive. Clinical governance will therefore place testing ethical obligations upon health professionals.

Leadership skills are required at clinical team level. But corporate commitment to NHS organisations as a whole is acquired over years. Many shortcomings may derive from junior staff who turn over rapidly without forming such affiliations. Early induction in the arts of management is an increasingly important element of training. Processes to improve quality must be accessible to many professional groups. Well known barriers to interprofessional collaboration – differences in culture, language and status – will continue to present an educational challenge.[11] Few trusts or practices have made progress in widely involving users/carers in audit or effectiveness initiatives. The mechanisms of clinical governance are likely to alter health professionals’ notions of what it means to be publicly accountable.

Conclusion

In summary, clinical governance is about holding health care organisations more formally accountable for the quality of services they provide or commission and requiring them to demonstrate the effectiveness of their quality assurance mechanisms. The extension of corporate governance from financial to clinical matters has been hailed as one of the most radical of the Government’s proposals. While we have some evidence to guide approaches to professional development, we know little about the organisational development required to get research evidence into practice. Mechanisms for monitoring and managing clinical performance will prove controversial. In the short term, their success will hinge on new structures and systems, properly resourced. Timetables are tight with legislative change required to extend the statutory responsibilities of trust chief executives, to establish primary care groups and the new bodies supporting clinical governance. In the medium term, success will hinge on the sensitivity with which lead managers and health professionals work together to effect change. In the longer term, we may look back on clinical governance as marking the last rout of traditional notions of clinical freedom. But don't bet on it.

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Chapter 7

A new style of leadership

David Knowles

Implications for managers

From a managerial perspective, three elements in the White Paper are striking:

- The internal market has been abolished, but the separation of purchaser (now commissioner) and provider functions remains. If the Government finds in due course that this apparent contradiction reflects the requirements of policy rhetoric, rather than the reality of managing the business, then that is not NHS managers' concern. The White Paper does have some elements of reorganisation, notably of primary care services. But the commitment is to an evolutionary process, with space and opportunity to experiment and, critically, for organisational learning and development. All of that, combined with an absence in England (in contrast to Scotland and Wales) of any explicit or even implicit encouragement to play the 'merger' game, whether trusts or health authorities, ought to constitute an agenda that managers can see as positive and encouraging.
- The White Paper ups the stake on performance management, especially clinical governance. At one level that ought not to be too threatening. Progressive managers have always seen themselves as having a legitimate role in this area. Managers will be anxious however about the perhaps unrealistic expectations of Ministers that these mechanisms will ensure consistent clinical performance standards and the suspicion that Ministers will deal out rough justice to the unfortunate manager of the next, and subsequent, Kent and Canterbury.
- The new agenda is characterised by the buzz words of the White Paper – collaboration and partnership. It constitutes the equivalent of sliced bread – virtuous in its utility, but desperately in need of filling to offer sustenance. With few exceptions, managers in the NHS have been there, done that – and, for the most part, have failed! There is an elusive quality about genuine partnership, even across the social/health boundaries, though no one doubts that it is a wholly legitimate and worthy aspiration.

There is relief that the Government's proposals are couched in a new, relatively sophisticated language of organisational development and that the direction set out in the White Paper is an eminently sensible response to what, in the light of experience, has been the excesses and rough edges of the internal market. But they also leave managers potentially as hostages to failure – exposed and vulnerable. Managers in the NHS are, for the most part, well paid, but they are not generally valued and there is little evidence this has changed, other than for the worse, under the Labour Government.

Yet even Mr Dobson can be under no illusion that his vision for the NHS can be realised without the commitment and energy of leaders within the NHS. If he and his successors are to succeed, they must generate confidence in and valuing of leaders in the NHS. This chapter provides an analysis of the leadership role and outlines some of the challenges and constraints which are likely to present. The assumption is that implementation of the quiet evolution of the White Paper's proposals will be dependent on the quality of leaders in the NHS. But it will be a style of leadership which will, in many respects be different from what has previously been required.

The 1991 NHS reforms

In 1991 when the Conservative NHS reforms were introduced I was the chief executive of Riverside Health Authority in West London. At that time, it had over 9,000 staff and the second largest revenue budget in the English health districts. It was also on the brink of completing a major reorganisation of its services, including the closure of six hospitals and the building of the Chelsea and Westminster Hospital. The closure agenda involved substantial service rationalisation and the reduction of the labour force by a third.

Leadership in that organisation, as in many of the other health authorities, required a distinctive mix of operational and strategic capacities. They were demanding and complex roles. Leadership involved moving resources between the different sectors of health care and seeking to generate collaborative working between sectors, and with social services in the usually coterminous local authorities.

But the organisational framework of the NHS was fundamentally flawed. While the political controversies raged around the Governments restructuring proposals, what was not in doubt was the need for radical change to address the generally acknowledged weaknesses of the system. These included the penalisation of clinical productivity, wide variations in levels of efficiency, unmeasured effectiveness, under-investment in capital, low overall level of investment in health care, a centralist public bureaucracy administratively focused, and long (and getting longer) waiting times and lists for elective surgery.

The 1991 reforms constituted radical change well beyond anything previously experienced in the history of the NHS. The internal market produced a new language, new disciplines and a new style of leadership geared to the needs of the new organisations. District health authorities phased out their operational service provider roles as they focused on their prime purchasing/commissioning functions. NHS trusts emerged, usually from the directly managed units within the old district health authorities, and new leadership styles evolved.

With 500 plus trusts in England and Wales, the focus of leadership was on the needs of the organisation, as distinct from the needs of the community. Chief executives existed to defend the interests of their organisations, to make them financially stable while undertaking the basic function of delivering health services. The underlying assumption was that the combination of health authorities seeking to maximise, through effective commissioning the health services for their communities, and the existence of competing trusts, would ensure that the trusts would become low cost, high productivity and customer focused organisations.

That may have been an entirely legitimate response to the chronic problems of the NHS in the late 1980s, but it was scarcely an environment for the exercise of collaboration and partnership, which are the words which resonate through the White Paper *The New NHS.* While these were words which did begin to become fashionable again well before Labour was elected, they were representative of a leadership and managerial style which had been consciously jettisoned in favour of something altogether tougher and harsher. It may not always have been entirely politically correct to articulate it, but successful leaders in the NHS trusts and chief executives in particular were those who played the game to ensure organisational advantage.

Ironically, these chief executive tsarist figures had more than a touch in common with some of the high profile NHS leaders of a previous generation – the House Governors of the major teaching hospitals in the first 26 years of the NHS' existence. They defended their organisations with a certainty that their privileges should be sustained and enhanced as the means of ensuring 'centres of excellence' and the supporting panoply of medical teaching and research.

The distribution of power since 1991 between the commissioning health authorities and the provider trusts has been weighted in favour of trusts. The commissioning role has not been easily understood by the general public nor even by the politicians. Effecting change, other than by incremental growth, has not been valued or supported, especially if it has involved closure or significant change in the use of hospitals.

The notion that a hospital is a kind of parking lot, in which particular services are located for periods of time which may vary from the relatively permanent to the short term, as distinct from a focus of continuing institutional loyalty, does not command much sympathy. So leadership of the trusts became synonymous with sustaining the existence of the organisation within the semi- competitive environment of the internal market. Collaboration and partnership were the stuff of King's Fund management development programmes and wholly admirable statements as long as they did not bring into question the viability of the trust as a discrete organisation!

New leadership for the 'New NHS'

The White Paper seeks evolutionary cultural change and has, wisely in the eyes of most commentators, avoided wholescale organisational change. Indeed it offers a degree of sophistication unprecedented in the history of the NHS through the notion of a stepped approach to primary care trusts.

Accepting that primary care can be delivered within an initially wide spectrum of organisational options, it will allow for pilots, for experimentation and, more significantly, for organisations to develop at a pace which is consistent with their leadership capacity. Primary care organisations in differing stages of development will mean that community trusts and health authorities will have to adjust their roles and functions to reflect the particular local organisational shape of primary care. The inevitable reconfiguration of trusts and health authorities will not, as with previous NHS reorganisations, fit within a pre-determined schedule and will be connected to the pace of primary care organisational development.

Providing leadership to this process of change will require a higher degree of sophistication. The big addition to the standard requirements of effective operational management (dominantly in the trusts) and long sighted strategic management (dominantly in the health authorities), will be the need for imaginative organisational development which enables the shape and purpose of existing trusts and health authorities to change flexibly, as new primary care focused organisations evolve.

This is leadership which is not institutionally based and which values collaborative partnership, rather than competitive behaviour. It is leadership which can engage organisational development strategies and which can constantly adapt to changes in the social economic and political environment.

That will require courage and self awareness, just as much as an enhanced portfolio of predetermined skills and competencies. My colleague Judith Riley[1] distinguishes between management development as a process of filling jugs (the manager/leader as a jug which needs to be topped up periodically with taught skills and competencies) and growing plants (the manager/leader as a plant needing variable amounts of sun, moisture, perhaps fertiliser and certainly nurturing). Developing leadership capacity to meet the demands of the new NHS will, on this analogy, be more the province of the horticulturist then the barman.

The new challenge

'Performance management' has become a new and essential element of the governance process within the NHS. Before the 1991 reforms, managerial accountability was held within organisations. Sometimes, but not very often, sanctions against a health authority were applied and in extreme cases, direct action was enforced against a chairman or general manager. But it was the exception, rather than the rule. Despite the emergence of general management in the 1980s, the NHS as a whole still mainly operated through administrative control systems and only rarely engaged in effective performance management.

As far back as Enoch Powell's period as Minister of Health in the early 1960s, Ministers and Secretaries of State found that the NHS could be strangely reluctant to move in the policy direction they determined. Richard Crossman the Secretary of State for Health and Social Security from 1968 to 1970 records in his diaries[2] the frustration of getting the NHS to accept his sense of mission to do something about the unacceptable condition of most of the large institutions for the mentally ill and mentally handicapped. He reflected that the problem was probably related to the size of the NHS. The sheer enormity of it meant that great pressure had to be applied to begin to get it to move in a predetermined direction. He argued that when it did finally start to move it would generate momentum and the pace of change would gradually increase. His solution, therefore, was to apply the weight of his office and personal political power to get this elephantine organisation to move. He departed office convinced that with a little more time he would have had the desired effect. Despite his intellectual authority and experience, he failed to appreciate that the levers of power at the levels at which these services were provided, were largely disconnected from central government, at least in relation to the reality of the processes of service development and change.

Griffiths and general management began to change all of that in the 1980s, so that by 1991 there was an experienced core of key leaders in the NHS (notably in the NHS Management Executive and in the RHAs) who understood that ensuring a leadership capacity to implement legitimate government policy was crucial to the success of the reforms. From an early stage in the process, the systems of performance management were given high priority. The notion of tight/loose was developed, with 'tight' targets in respect of which compliance was a required element of successful performance by accountable leaders – the chief executives primarily. Meanwhile the volume of guidance relating to issues which were genuinely believed to be better dealt with at a local level was drastically reduced. The annual priorities and guideline documents from the NHSE constituted the basis for a system of performance management which has substantially changed the culture of leadership within the NHS. It is a measure of the effectiveness and, in the jargon of the mid nineties, the robustness of this essentially bureaucratic mechanism, that it can now be easily adapted to serve the new political masters.

Leadership within the NHS, requires the capacity to work within the policy framework determined nationally and to manage performance, along with the exercise of substantial discretion around local agendas, which will be becoming more pronounced as primary care organisations evolve.

Burke and Lewin[3] draw a distinction between transactional and transformational management and argue that leaders within organisations are those who concern themselves dominantly with the processes of transformation. They suggest that transformational activity includes a constant concern with the condition of the external environment, mission and strategy, organisational culture, and individual and organisational performance. Judy Rosener[4] draws a different distinction. For her transactional management is a process of enabling others to do their work well and therefore seeking to create environments within which staff respond constructively and productively.

From this literature it can be suggested that leaders in the new NHS should be challenged to generate capacities to be the means of transformation, both of the organisation and the individual staff within it. Such a notion of the challenge for leaders in the NHS is relatively uncontroversial. Most leaders in the NHS would readily sign up to that agenda, although the translation from theory to practise on the evidence of current leadership presents difficulties. It may be that the problem is in the translation, or that the helter-skelter of life in a still undermanaged NHS, means that the urgent always seems to take precedence over the important.

However, the next element of the challenge for leaders in the NHS presents a more obvious risk of political and organisational dislocation. Rittel and Webber[5] introduced the idea of 'wicked' problems and this has been subsequently developed by a number of significant management gurus, including Henry Mintzberg.[6] Wicked problems are complex and do not lend themselves to conventional solutions. They comprise interconnected elements which often mean that a course of action designed to achieve progress, produces negative side effects. Wicked problems are set in the context of constantly changing social, economic, technological, environmental and political environments, which are largely unpredictable. They often are viewed quite differently, but equally legitimately, by multiple stakeholders. They challenge the sense of a rational world, in which leaders exist to produce solutions. Fact or fiction, Mrs Thatcher's alleged demand for Ministers who would bring solutions, not problems, speaks for politicians in all parties, and in the community more widely, who expect the NHS to deliver comprehensive health care services, particularly, as in the early and mid-1990s, when it was demonstrated that extra revenue resources had been provided. They conclude that the failure of the NHS to deliver the basic objective of comprehensive service, as promised in the original Act and all subsequent NHS Acts, must reflect a failure of leadership.

Leaders in the new NHS have to cope with the inevitability of wicked problems and the unrealistic expectations which are the product of the failure to understand, or perhaps in the case of some politicians a convenient pretence not to understand, the essential wickedness of the environment of health care, within which leaders in the NHS have to operate.

Intractability

As a student at LSE in the 1960s, I had an early introduction to the sociological and economic data which demonstrated the inequity of provision of health and social services within the UK from Peter Townsend and Brian Abel Smith,[7] influential writers and inspired teachers. Coming from industrial Wigan, it was inevitable that this material would fuel a sense of injustice, and my early experience in the NHS easily confirmed it.

Both on the basis of anecdotal and more considered evidence, the people of Wigan did seem to be getting a poorer deal from their NHS than the people of West London where, in the 1970s I became one of the leaders in a health district. The people of Scotland had more health resources (and poorer health) than the people of England. For the most part a universal truth was that the sectors of mental health and learning disabilities demonstrably had a less than fair share of the total resources of the NHS. Inequality was everywhere apparent and the evidence was re-enforced by the Black Report in 1980[8] and *Health of the Nation* in 1992.[9] If GP fundholding became the 1990s example of two tiered service, to anyone with a memory and/or informed judgement, it would be apparent that this was merely the latest of many examples of two-tiered service operating within the NHS.

At the heart of leadership in the NHS is the intractable problem which derives from a conflict of priorities and the fact that, for all practical purposes, there is a continuing and permanent excess of demand over supply for health care. Politicians may promise 'comprehensive' services and may indeed believe that it is in the mission of the NHS to provide them, but leaders within the NHS have to come to terms with a different reality. They have to provide leadership to organisations that have to cope with the need to make choices which create both advantage and disadvantage for the communities they serve. Most significantly, the inherent problem will never be solved and to compound the nature of the challenge, it is almost inconceivable that attempts of leaders in the NHS to do the best possible in the particular circumstances in order to maximise health gain for their communities, will not be recognised publicly as such and will be a source of continual conflict and controversy.

That constitutes a tough environment in which to be a leader, but it is precisely this context of a complex societal and economic environment which most calls for imaginative and principled leadership. To be effective in that environment requires leaders who are first and foremost, self aware and clear about their personal values, but also skilled in operating in complex, 'wicked' situations and can practice the concepts of emergent strategy and opportunistic management. They will be leaders who have a clear sense of how to enable staff to be self fulfilled and creative in their work, and will have an instinct for the means of generating collaboration and partnership.

If the consequences of the 'infinite demand/finite resource' dilemma is at the heart of the intractable problems which NHS leaders face, it is not the only example. The constant tension between the health needs of the individual and the needs of whole communities is not capable of resolution. It is a tension that leaders have to reflect in the direction of travel that they initiate within their NHS organisations. It is a tension which, to some degree, is reflected in the differing ethical bases which underpin the activities of the separate groups of people within the NHS. For the providers of health care the dominant ethic is rights-based – the right of the individual who presents for care to have the optimum level of service, within the limitations of available human and physical resources. That contrasts with the utilitarianism of managers, including the Secretary of State and the NHSE, who inform their judgements with a notion of the greatest good for the greatest number. The tensions which result from this underpin much of the personal conflict that is experienced daily within the NHS and which constitutes a clear example of intractability. It cannot be resolved. It has to be lived with, as a fact of life in a complex world, where the separate constituent parts do not always come together with convenient connections.

There are other examples of intractability. No one knows what is the right level of management costs as a proportion of total turnover. The White Paper, in its least convincing and most obviously politically corrupted section, requires an arbitrary reduction of £1 billion in those costs. There is little rational explanation of why that is judged to be appropriate and certainly no justification for the particular figure selected. But we can be confident that in the run up to the next General Election (and the one thereafter) 'management' costs in the NHS will be an issue declared by the opposition parties, with the premise that if elected they will reduce them – just as Labour wishes to do now. Intractability at its most perverse – no logic and certainly no answers.

Although the White Paper sets its sights on an evolutionary approach to the realisation of its objectives, it is only a matter of time before the standard constraints of political life re-emerge; a credible Opposition fighting its corner and probing for weakness in government strategy and delivery performance, along with government ministers looking to sustain their own career progression by examples of personal drive and effectiveness. All of this is both inevitable and necessary in a parliamentary democracy, but it is another element of intractability which challenges leadership in the NHS.

The role of doctors

In the Government's urgent search for a sensible alternative to the GP fundholding scheme, to which new Labour had boxed themselves into a corner of total opposition, it is not surprising that they should come up with proposals for different ways of organising primary care, but which keep the doctors in the driving seat. This is sensible on two counts; first that the positive momentum of change which has been experienced as a result of GP fundholding needed to be sustained, and second, because doctors, whatever the anxieties that might be felt about it by nurses and other health care workers are, as a profession and by virtue of their education and status, already in *de facto* leadership roles. That is not to suggest that all doctors are natural leaders or are comfortable in leadership roles. Nor is it to suggest that leaders within the NHS will not be drawn from other health care professional groups or from the ranks of 'generalist' managers. It is merely a recognition that the nature of the doctor's clinical role, whether in primary, secondary or tertiary care, does contribute an element of leadership which is generally acknowledged, not least by patients and the wider community.

But investing in doctors as leaders comes with a potential downside. Doctors, not unreasonably, draw on the sum of their micro experiences in the delivery of clinical services, for a coherent view of the macro issues that confront them when they are in leadership and senior managerial roles. Doing the best for one's patient is very different from trying to maximise the health of the population.

It is not uncommon for doctors who have that conceptual view of the health service to struggle to come to terms with the intractable problems. Conspiracy theories tend to abound. The 'problem' could, it is often reasoned, be solved if 'x', in higher authority behaved appropriately, usually by providing more money! – the denial of an inherently wicked problem. If a more sophisticated analysis of the wider macro policy issues in health care is not facilitated, then doctors in major leadership roles (for example, in charge of PCGs or primary care trusts) will be potentially dangerous and become disconnected from the NHS corporate agenda.

Two years ago I was visiting the leader of one of the large GP 'superfunds' and asked for his reaction to the publication the previous week of the latest annual priorities document by the NHSE. He remembered the document but confessed that after reading a few pages he binned it and observed that he didn't need the NHSE telling him what should be the priorities. He knew what the priorities were for his patients and that was all he needed to know!

That story reminds me of an experience in a central London health district in the late 1970s, when I was trying to argue the case for a direct transfer of revenue resources from the main teaching hospital, The Middlesex, to two notably cash starved major mental illness hospitals in Surrey (Horton and Banstead) for which the district had managerial responsibility. The response of the still all-powerful Medical Committee (its active membership, almost exclusively consultants from The Middlesex), was to express sympathy for the condition of Horton and Banstead, but to deny that it was reasonable or ethical 'to rob Peter to pay Paul'. In taking that stance they were not acting in an unprincipled way. They were sustaining the quality and quantity of the services for which they had a direct personal responsibility, along with the well-being of the institution to which they committed their loyalty.

The point of both anecdotes is that doctors do construct their development and change agendas, as a reflection of their own, dominantly micro focused experience, rather than the Government's priorities. In addition, doctors functioning in organisational leadership roles are significantly more willing to challenge, to complain, to criticise and, if the opportunity presents, to go public. They sense, correctly, that they have less to lose because they can always revert back to full-time clinical practice.

In the first thirty years of the NHS there is good evidence that hospital consultants in the major acute hospitals, particularly the teaching hospitals, were able to use their considerable power base to ensure that resources available for service development were directed to the clinical services for which they had responsibility. It was this failure to understand how the levers of power operated within the NHS that was at the heart of Crossman's failure to get the NHS to move in the direction he desired.

The significant transfer of leadership responsibility within the NHS to GPs, who are not currently directly employed, constitutes a significant change, which will bring many of the advantages spelled out in the White Paper. It may also bring some problems which the Government might not have anticipated. It will be hard to make them accountable and they may contribute by their priority decisions to the further disintegration of the concept of a *national* health service.

Conclusion

My contention is that for this White Paper and the unusual processes of change that it encompasses, to have any chance of successful implementation will be dependent on the development of new leadership styles within the NHS.

Many of the new leaders will be clinicians. In the initial conception that will be doctors, especially GPs, but my expectation is that other professional groups, notably nurses, will increasingly assume the leadership roles. The emphasis will be less on the steady accumulation of perceived management skills and competencies through a succession of relatively conventional management jobs, and more on innate leadership qualities – the capacity to enable others to be fulfilled in their work; the ability to scan the horizon and respond to the changing social, economic political and technological environment; the flexibility to think and act both strategically and opportunistically; the self-confidence to live with permanent uncertainty and the inevitability of intractable problems; the commitment to principled, transparent managerial processes. Personal, as much as management development will be critical to sustaining the energy and creativity of existing leaders and preparing the next generation of leaders.

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A King's Fund analysis of Labour's plans for the NHS

The Government's eagerly awaited White Paper on health aroused no great passions when it was launched at the end of last year.

Unlike its predecessor, the 1989 Conservative White Paper, *Working for Patients*, Labour's *The New NHS* has prompted no battle of words or major health debate.

Yet in this, warn the authors of *Implementing the White Paper*, lies a danger. For as with the 1991 reforms, the NHS that eventually emerges may well be different from the Government's latest blueprint.

This review of the White Paper draws on the collective experience and work of the King's Fund. The common theme of all the contributions is that while the aims of the White Paper are to be applauded, translating aspirations into achievement is going to be difficult.

With a series of complex changes in the pipeline, this policy paper from the King's Fund identifies the issues involved and the problems that will have to be overcome.

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