G. Best
1991.

THE FOLLOWING PAPER IS AN ATTEMPT TO COMMUNICATE THE ESSENCE OF A SERIES OF VERY INTERESTING AND COMPLICATED DISCUSSIONS ABOUT THE FUTURE OF THE NHS REFORMS INVOLVING MYSELF, JO IVEY BOUFFORD, ANDREW FOSTER, PETER GRIFFITHS, RON KERR, CHARLES MARSHALL, JOHN MITCHELL AND GEOFF SCAIFE. AS SUCH, THIS IS A VERY AMBITIOUS PAPER WHICH FAILS TO LIVE UP TO ITS TERMS OF REFERENCE. HAVING SAID THAT, THE ISSUES WHICH THE PAPER ATTEMPTS TO ADDRESS NEED URGENTLY TO BE ADDRESSED. THE PAPER IS VERY MUCH A DRAFT WHICH NEEDS TO BE THOUGHT ABOUT, INTERFERED WITH, RE-CONCEPTUALISED, AND WHATEVER ELSE PEOPLE DO TO GENUINE DRAFTS.

MOVING ON FROM STEADY STATE - WHERE NEXT?

This paper is being written on the 16th of June 1991: it addresses the question of what the NHS managerial agenda should be between now and the next general election. I take as a starting point the following 'imperatives':

i The reforms are in place and, like it not, the cat is now out of the bag. There is no going back between now and the election (or, for that matter, after the election). 'Steady state' is already slipping into the past: developments over the next 6-12 months need managing.

ii Many of the best managers and others within the service now feel in a state of limbo. Although most senior managers and many others feel that the reforms should be taken forward, it is not at all clear how best to do this between now and the election. There is therefore an urgent need for some positive leadership from the top. In other words, managers and others need to be convinced a) that significant, positive things can be achieved between now and the election; and b) there is a reasonably clear path forward over this period.

iii This lead to the service must however take on board three crucial realities. First, it must be recognised that although people need to be motivated and encouraged, many NHS managers are now simply out of their depth. It is imperative therefore that any lead can be 'cascaded' downward in a way that provides firm guidance for moving beyond steady state. Secondly, although positive, confident leadership is necessary, risk needs to be minimised. In other words, although considerable change is certain to occur between now and the election, it is important that this change is managed, not simply 'discovered'. Thirdly, the lead given to the service must recognise that a change of Government is a distinct possibility. People are simply not going to be motivated if they believe that all of their efforts will be in vain if a Labour Government is elected.

The remainder of this paper sketches out a framework for beginning to manage the reforms over the next 6-12 months. The approach put forward still begs a number of questions and needs further development. Arguably however, something like this needs to be developed - and quickly.

Performance management:

Conceptually, there is no problem with managing the reforms. The recent paper from the Management Executive (ME) on the development of Performance Management is clear enough. It proposes that:

i NHS performance is managed through a line of general management running from the ME, down through regions, to purchasers;

ii purchasers' contracts with providers become the principal means for bringing about change;

iii population 'health gain' becomes the end to which all change is directed; and

iv providers become increasingly independent so as to maximise their ability to respond to what purchasers want for their populations.

It would be difficult in principle to argue with this. And if we were at the beginning of an electoral cycle, it would no doubt be possible to devise ways of translating this into an exciting, feasible managerial agenda. But this isn't the beginning of an electoral cycle, and so the following ideas need to be thought through.

The purchasing agenda:

The purchasing side of the NHS reforms is in a bit of a mess. At one extreme, purchasers have been encouraged to negotiate block contracts designed to minimise change. Simultaneously, the rhetoric has been about radical change - 'managing the community's health', health gain, and the like. In addition, mergers have been mooted, sometimes put into practice, and sometimes put into practice but only for specific purposes. In parallel, GPs have been more or less doing their own thing. The result has been that the purchasing function remains underdeveloped and that with one or two notable exceptions, the vast majority of purchasers display a hesitancy of purpose.

If the potential benefits of the reforms are ever to be realised, this now has to stop. It must be remembered that purchasers are supposed to be implementing ME priorities by managing the performance of the service through their contracts. To do this, purchasers therefore need to know:

i what ME priorities are and therefore, what constitutes 'performance';

ii how they are to be held accountable for improving (or otherwise) this performance; and,

iii how they are supposed to cope with all of this when their DMUs are in financial difficulty, GPs keep behaving in unpredictable ways, Trusts keep trying to create 'competitive advantage', their own financial position is unclear, and so on.

To address these three problems, it is necessary to a) provide a clear definition of the 'performance' which purchasers are supposed to be managing; b) be crystal clear about how they are to be held accountable for this; and c) ensure that this evolving line of general management (from ME to RHA to purchaser) is clearly delineated and, as far as is practical, kept seperate from the line which tries to manage the transitional problems associated with moving from the old system to the new. In particular, if the purchasing function is to develop at all over the next 6-12 months, RHAs need to be held rigorously to account for managing transitional problems such as those set out in iii) above while, at the same time, purchasers are provided with some basic tools for getting on with the job of purchasing.

Practical purchasing:

Purchasers cannot be expected to bring about significant change in the allocation of resources nor in provider behaviour in the short term. Instead, they require an approach to resource allocation which will allow them to develop and learn how to be effective purchasers. One such approach incorporates the following key features:

i Purchaser's performance needs to be judged against a small number of clear, simple measures that relate clearly to what people want and need from the NHS. For example:

* Maintaining or increasing appropriate volume of service.

* Maintaining or improving access to services.

* Maintaining or improving the choice available to patients by a) engendering appropriate competition between providers and b) ensuring that wherever possible, there is an

appropriate choice of mode of care (e.g. inpatient, outpatient, home care, etc.).

* Maintaining or improving the continuity of care across organisational boundaries.

* Maintaining or improving service quality in the sense of reducing cancelled appointments and complaints; improving waiting and response times; ensuring that where needed, patients or clients have access to an informed 'advocate'; and so on.

* Being able to explain how much different services cost, and not overspending the purchasing budget.

These six aspects of a purchaser's performance have three important characteristics: first, they can be readily understood; second, they can be measured now; and thirdly, it would be extremely difficult to improve them without, at the same time, improving the services available to patients.

ii Purchasers now need to be held to account for this performance. For this purpose, they should be obliged to earmark a manageable but not insignificant proportion of their budget for year-on-year re-investment. The purpose of this re-investment programme would be to move away from steady state in a managed way while, simultaneously, bringing about improvements in one or more of the aspects of performance set out above. For example, a typical purchaser might be told to identify (say) 3% of their budget which is at present invested in activity which, when measured against the above criteria, looks like a less than ideal investment. Having identified these activities, the purchaser would then be held to account to free up those resources and then to re-invest them in activity which improves (say) three or more aspects of performance.

iii Regions would become responsible for ensuring that all purchasers were engaged actively in such re-investment programmes and for checking that this re-investment was having a measurable impact on service performance. This would then become a key aspect of performance management - ie. the ME would have defined how performance was to be judged, and RHAs would be held to account for seeing to it that resources were being shifted in a way that improved this performance.

This is only one piece of the jigsaw needed to move purposefully on from steady state. It is however an important piece because it is

central to overcoming a number of the problems set out at the beginning of this paper: ie.,

* it provides clear guidance to purchasers for moving beyond steady state;

* it is a managed approach which begins to establish the managerial line from ME down through RHAs, to purchasers;

* it provides a means of promoting essential dialogue between purchasers, GPs and providers (see below);

* it provides a feasible way for purchasers to learn how to purchase effectively; and

* some purchasers are already engaged in this kind of work and there is therefore a certain ammount of experience to draw upon;

* it is likely to survive a change of government in the sense that a Labour Government - whatever their proposals - is unlikely to interfere with investment programmes that can demonstrately be shown to be improving aspects of performance such as access, service quality or appropriate volume.

In passing, it should also be noted that this kind of approach has the potential to reconcile an incremental, managed move away from steady state, with the more radical (but utterly unrealistic) 'public health' rhetoric so far associated with most discussions of purchasing. That is to say, if a purchasing authority is seen to be re-investing 3% of its budget year-on-year in ways that sustain or improve volume, access, choice and so on, it is extremely unlikely that they could persist in this for (say) five years, without their population experiencing some health gain. Health gain is therefore achieved by concentrating on better management, not by focusing on the 'holy grail' of better health.

Providers and steady-state:

One important aim of the reforms is to give NHS providers much greater independence and managerial autonomy so that they will be free to adapt to the priorities and preferences of purchasers. In the short-term however progress toward this objective is likely to be modest. There are two principal reasons for this. The first is that despite their best efforts, purchasers are not yet in a position to put forward clear priorities and preferences, and

then to use their financial 'leverage' to persuade providers to change. The second reason is that the great majority of providers lack the necessary managerial experience, infrastructure and capability required to take advantage of the new freedoms in a purposeful and prudent manner. Instead, both purchasers and providers are going to take a number of years to build up the expertise necessary to exploit these freedoms in a way that will benefit patients.

In the meantime, the majority of providers are behaving in ways that ought to give cause for concern. In particular, most providers seem at present to fall into one of the following three categories:

i There are providers which the reforms are passing by. Unfortunately, many of these tend to be non-acute DMUs and 'backwater' acute units which have always been, and continue to be, grossly undermanaged. These providers are clearly in no position to move beyond steady-state: rather, they are likely to be swept along by whatever trends post-steady state sets in train.

ii There are providers which have adopted the rhetoric of the reforms, and have sometimes introduced 'structural' change consistent with the reforms (e.g. clinical directorates), and have convinced themselves and others that they are now in a position to use the new freedoms in a purposeful and prudent manner. Many acute DMUs including a significant number of first and second wave trusts, would appear to come into this category. More often than not, the reality is that while many of these providers are adept at deploying the rhetoric of the reforms, few have yet to grasp the nettle of proactive clinical services management and the reappraisal and re-definition of 'clinical freedom' that is so central to the reforms. Left to their own devices, it is these providers that will almost certainly be the source of most 'surprises' over coming months. This is because they will either a) find that they are unable to deliver on clinical activity targets they have agreed to; or b) be unable to maintain a viable relationship between activity levels and revenue; or c) both. Indeed, this is already happening in a number of circumstances.

iii Finally, there are those providers which have to a greater or lesser extent grasped the nettle of the reforms and are making real progress. In most cases these would seem to be first or second wave Trusts which, for whatever reasons, have a 'critical mass' of better-than-average managers (including clinician-managers); a better-than-average management

information 'infrastructure'; and, more often than not, a track record of better-than-average management. Although this group of providers is best placed to cope successfully with a post-steady state NHS, they are in almost all cases, running well ahead of their purchasers. This means that many of them are engaging in what might be termed 'pre-emptive' or 'predatory' behaviour in order to position themselves favourably in anticipation of the post-steady state phase. This behaviour includes such developments as 'clinician poaching' (often to create a regional monopoly in a particular speciality); 'differential pricing' (to encourage difficult-to-reverse changes in referral patterns); and 'capitation blackmail' (whereby providers in 'gaining' districts negotiate deals of convenience with providers in 'losing' districts). Left to their own devices, these providers will also produce some 'surprises' over coming months.

In so far as this analysis is a realistic one, it is clear that performance management cannot be restricted to the purchasing side in the short-to-medium term. On the contrary, providers are likely to present at least as many post-steady state problems as are purchasers.

As a way into this problem, reconsider briefly the purchasing authority seeking to reinvest 3% of its budget in services that improve performance. Clearly, if the purchasing authority is required to make this reinvestment, it will be looking to each of its providers to cooperate in finding ways to do this. Each provider in turn, will have an incentive to cooperate lest it lose its share of the 3%. Providers therefore will need to develop the capacity to respond to and engage with, this re-investment process. In other words, if performance management is really going to come down through the purchasing side in a way that demonstrately improves the service to patients, it will be necessary to ensure that - in the short term at least - providers are motivated to and capable of playing an active role in this process.

Fortunately, some providers are already attempting to do just this. One of the better known examples of this is the work presently being undertaken within the Guy's and Lewisham NHS Trust. This has involved the Trust in undertaking a major review of the services it presently provides in order to determine how these measure up to the changing demands likely to emerge over coming months and years. More specifically, the review is intended to provide a clear picture of:

i the present strengths and weaknesses of the Trust in terms of the quality, relevance and appropriateness of its services;

ii the trust's relative 'competitive' position in relation to other providers as well as the preferences and plans of purchasers including GPs; and

iii the kinds of changes in services it is desirable to bring about, and how quickly these can be achieved.

This work - which is now well advanced - has involved the Trust in working closely with both purchasers and GPs in order to build up a picture of their preferences and priorities as well as of the changes the Trust may need to introduce in order to better reflect these. Interestingly also, in the context of this paper, the criteria used to assess the quality, relevance and appropriateness of clinical services have much in common with the criteria for judging improved service performance suggested above (see attachment A).

Clearly, if all providers were to be obliged to engage in a review of this kind, a second piece of the post-steady state jigsaw would then be in place. That is to say, if at the same time as purchasers were seeking to reinvest (say) 3% of their annual budgets in more appropriate services, providers were simultaneously reviewing the services they provided, these two sets of activities would clearly give rise to a series of bi-lateral (and in some cases, multi-lateral) dialogues which would be central to managing the process of moving beyond steady state. Such dialogues would moreover have a number of features consistent both with the 'spirit' of the reforms as well as with the need for positive management of the move away from steady state: ie.,

* they would involve purchasers and providers in planning a reinvestment programme that would be built around a shared perception of what constitutes improved service performance;

* they would give rise to a series of incremental yet tangible changes which would a) require providers to adapt their behaviour to purchaser's investment priorities and, in so doing, b) lead to improvements in service performance;

* because the desire to reinvestment would 'drive' the process, it would contain incentives for all parties - purchasers, providers and GPs;

Having said this, the success or otherwise of such a strategy would

depend crucially upon the ME devising a form of guidance which on the one hand, ensured that all purchasers and providers were strongly motivated and/or obliged to engage in such dialogues but which, on the other hand, was non-prescriptive enough to allow for idiosyncratic 'deals' and trade-offs appropriate to local circumstances.

Managing the market:

The overall objective of this paper is to sketch in a managed approach to moving beyond steady state. The suggested approach is built upon a foundation consisting of:

i a simple, clear, measurable and shared definition of service performance which in the first instance might consist of six dimensions: appropriate volume; access; choice; continuity; service quality; and cost;

ii an obligation laid upon purchasers to reinvest (say) 3% of their budgets year-on-year, in ways that demonstrately sustain or improve service performance so defined;

iii an assumption that, because they will want to ensure that they benefit (or at least not lose) from their purchasers' reinvestment plans, providers will want to review their own priorities and services;

iv the availability of guidance and support to ensure that all providers have the minimum necessary capacity to undertake such a review and that, broadly speaking, the reviews cover roughly the same ground (it is assumed that because providers will want to engage with purchasers' investment priorities, they will utilise the same or very similiar definitions of performance in undertaking their reviews);

v an assumption that because purchasers will be engaged in investment planning and providers in service reviews, these activities will give rise to a series of bi-lateral and multi-lateral dialogues built around shared perceptions of service performance and a desire to identify programmes of incremental change intended to bring about improvements in performance.

It is further assumed that components i, ii and iv above would constitute key elements in the ME's approach to Performance Management. That is to say, although change would be driven 'down through' the purchasing side via purchasers' reinvestment

priorities, the provider side will require considerable guidance and support if these priorities are to be translated into tangible changes that improve the service to patients in the short term.

Even if all five of these foundation stones are put in place however, there are still compelling reasons for supposing that the evolving internal market will require further, active management. If all or most purchasers and providers up and down the country, are engaged in a series of bi-lateral and multi-lateral negotiations built around a shared understanding of performance, there is little doubt that many of these would give rise to iniatives and changes that would be welcome and would contribute to an improved service for patients. The same changes would also however give rise to developments that would be unwelcome and, at least in the short-to medium term, result in a poorer deal for patients. Some examples might be:

* an apparently incremental (3%?) change in one institution's budget jeopardising the viability of one or a small number of services which, in turn, could threaten the viability of the entire institution (even though this might be desirable in the longer term);

* incremental, managed change in providers running significantly behind 'capitation drift' leading to a major financial and/or viability crisis (even though again, the shift in resources might be desirable in the medium-to-long term);

* a focus on service performance as defined earlier, 'squeezing out' developmental work which could lead to major clinical advances and/or service improvements at a later date;

* pressure on providers to phase out or reduce certain services leading to interim volume levels that threaten clinical quality;

* pressures to move services out of institutional settings leading to the provision of services in the community before a supporting infrastructure of local services is in place;

* and so on - there are many other examples.

Most if not all of these kinds of problems arise in whole or in part because purchasers and providers lack what the economist would refer

to as 'perfect information'. All markets experience 'failures' - and therefore produce surprises - because buyers and sellers lack perfect information. The NHS internal market will be no exception to this rule. For example all five of the problems above could be averted or at least significantly ameliorated if all of the purchasers negotiating with the same provider knew what the other purchasers were up to. Indeed, most of the interim problems and potential surprises associated with the move away from steady state are going to arise in situations where relatively large providers are trying to respond to a variety of purchasers who have failed to negotiate shared priorities. Even where this is not the case however, there will still be problems: no player, be they purchaser or provider, is always going to have all of the information they need to anticipate the 'interim' impact of all of their decisions - even when these decisions make longer term sense.

There is therefore a strong case for a 'higher' authority to be taking an overview of the market to help to ensure that these interim problems (which might involve a relatively large number of role players) are detected as early as possible and then managed. Many purchasers argue of course that, were they to become large enough (covering a 'natural catchment' of say, 1 - 1.5 million?), they would then be be in a position to act in such a capacity. Perhaps in theory, but for the immediate future, there seems little alternative but to see this task as one of the key roles of RHAs. If this is accepted, then the analyses underlying this paper suggests that Regions would have three key roles to play in managing the internal market:

i Performance management: if an approach such as that sketched in earlier is adopted to move beyond steady state, Regions are likely to have a key role in ensuring that the key elements are in place. They would for example have a key role to play in ensuring that all purchasers had the necessary capacity to devise investment programmes which reflected the shared dimensions of service performance; that in devising these programmes, purchasers consulted widely and appropriately; and that, where appropriate, purchasers formed consortia which enhanced their capacity to devise effective, year-on-year investment strategies. In short, for the next five years or so, Regions are going to have a key role to play in developing and managing the 'purchasing side' of the internal market.

ii Change management: although it must be purchasers' investment strategies which drive and determine the direction of change, the inevitablility of 'market failures' require that Regions have a role in overseeing change - particularly in the early

years while purchasers are developing their capacities to devise coherent and purposeful investment strategies. There is likely to be three aspects to this role: first, overseeing the pace of change (because many market failures of the kind listed above, can be averted soley by determining an appropriate rate at which change can feasibly occur); second, overseeing the scale of change (e.g., checking to ensure that if the next 3% is the one that triggers the demise of a service or institution, this is what is intended); and third, establishing what might be called 'investment principles' within which purchasers and providers will be able to agree the direction of longer-term change (ie. providing a set of 'design principles' or 'best practices' against which purchasers can assess the longer term implications of their year-on-year reinvestments. (Although there is clearly much more to be said about this regional role, a rough and ready assessment suggests that were a Region to do these three things well, purchasers would still be in a position to drive change while, at the same time, many of the most serious forms of market failure would be averted.)

iii Research and development: although the above two roles might encourage a purposeful and managed approach to change while averting the worse surprises, they would do little to ensure that valuable clinical and other developmental activities would not be 'squeezed out' in a change process driven essentially be the desire to effect short-term improvements in service delivery. For this reason, a 'higher' authority (perhaps if not Regions, then the DoH) needs to be in a position to ensure that there is a purchaser primarily interested in fostering and protecting appropriate developmental activity. This is because the contribution of many of these activities to improved performance can often only be appraised over the medium-to-longer term. By contrast, markets almost always function in a way that assigns greatest value to short-term gain.

This vision of the role of Regions in a post-steady state world is both imperfect and incomplete. What seems clear however is that for an interim period at least, the market will need to be managed to overcome the problems of imperfect information, lack of management capacity on the parts of many purchasers and providers, and the consequent certainty of market failure. Carefully designed work in the field is needed now to see how this all fits together.