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PRIME MINISTER

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NHS REFORMS

IS THE PACE OF CHANGE MANAGEABLE?

Over the last few weeks, the Royal Colleges have been lobbying heavily behind the scenes in the House of Lords, arguing for a slow-down in the timetable for NHS reform. The impact has been significant. During the Second Reading debate last week, most of the speakers argued for a slower pace. David Wolfson supports this view based upon his recent experience of overseeing two information technology projects in Camberwell and Nottingham.

This note looks at the main reforms; the timetable up to implementation; the degree of preparedness of the necessary information systems; the Royal Colleges' case for slowing down the reforms; and the possible options for the Government (page 10).

MAIN REFORMS

Most of the concerns relate to the introduction in April 1991 of self-governing hospital trusts, general practitioner fund holders and operating contracts. Hospital trusts and fund holding are options open to willing volunteers who can demonstrate their ability to proceed. Each group will cover about 10 per cent of the total. Whilst operating contracts will affect all hospitals and health authorities next April.

1. Self-Governing Hospital Trusts

Some 50 Self-Governing Hospital Trusts (SGHT) will be created in England next April out of a total of 580 spread geographically around England.

There will be three main differences between self-governing hospitals and directly managed hospitals.

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- A self-governing board will have the freedom, within limits, to run a hospital more flexibly, free from the direct control of the District Health Authority.

- The board will be able to employ staff and set their pay levels and conditions free from nationally negotiated rates, although in practice, pay rates will be close to the national norm.

- And they will be free to manage their own capital assets and borrow or invest money within limits.

There will be other changes in common with all NHS hospitals whether they are self-governing or not. For example, a system of capital charging is being introduced across the board, to improve value for money, in the use of capital. This has been viewed as a free commodity in the past. And all NHS hospitals will start earning their entire income through operating contracts with District Health Authorities or GP fund holders (considered in more detail below).

Self-governing hospitals should not become too much of a headache for management because they are among the most dynamic; they are the best prepared for the reforms; and their consultants are the most supportive of the changes.

2. **General Practitioner Fund Holders**

There will be around 400 fund holders representing about 2,500 GPs out of a total of 30,000 in England.

Large general practices with at least 9,000 patients on their list are eligible for this scheme. Regional Health Authorities are carefully sifting through candidates to ensure they have the capacity to proceed. Adequate computer systems are an essential prerequisite.

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These large GP practices will be given a budget of around one million pounds each to arrange contracts for their patient list covering elective surgery, outpatient consultations and the related diagnostic services. Savings left over at the end of the year will be reinvested in the practice to improve patient care.

Since these GP practices are among the most professional, health service managers are not envisaging any serious financial breakdowns within these GP practices. Regions are more concerned with the impact of GP fund holders on the buying power of District Health Authorities. From the planners perspective, if local GP practices are given fund holding status the District Health Authority will lose some of its own funding. So there is a risk that money could be diverted by the GPs to hospitals in other districts, which could lead to more bed closures locally.

While this may be the best solution in the long run for a poorly performing hospital, a sudden jolt could have political consequences. In the words of Julia Cumberlege, Chairman of the South West Thames "GP fund holders are the wild card". Her suggestion to limit the number of fund holders to two per district is an excellent one, at least in the first year (there are 191 districts). This could be increased over time. Duncan Nichol supports this view.

3. **Operating Contracts**

An internal market will be introduced across the health service next April.

After the NHS White Paper was published, it soon became apparent that it was preferable not to introduce contracting for GP fund holders and self-governing hospitals only, without at the same time introducing an across-the-board contractual framework.

For example, if there are two hospitals in a district, one

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being a district managed hospital in which all the salaries and medical costs are paid by the district, and one being a self-governing trust relying on contracts to cover its costs, the former would always be able to charge a lower price to a GP fund holder for additional work. The fixed costs of running the hospital are already covered.

So in April next year, all expenditure in the NHS will be covered by pre-agreed contracts between District Health Authorities (**purchasers**) on the one hand and one or more hospitals and community health units (**providers**) on the other. The contracts will specify the required quality, quantity and cost of the services. A high percentage of the new operating contracts will be locally based especially for accident and emergency work and maternity services. But for some procedures such as elective surgery (hips, cataracts and hernias) or specialist services such as kidney dialysis, some contracts are likely to cross the district boundaries, especially in and around larger cities.

The contracts are not meant to be legalistic or adversarial. They are seen as an opportunity to discuss and agree how improvements to patient care can be secured. Any disputes between NHS parties will be resolved within the NHS. The degree and speed of changes can only be determined locally and will take into account present service levels, GP referral patterns and the need to maintain financial controls. The Regional Health Authorities are closely overseeing the transition.

There will be three types of contracts in existence:

(1) **Block Contracts**

In essence, these contracts will mirror the existing system. Under this contract, a hospital would agree to provide a full or partial service to any person living in the DHA catchment area. This is the simplest contract to set up

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and should cover accident and emergency services as a minimum.

(2) **Cost and Volume Contracts**

In this case, a hospital would agree to provide a maximum number of surgical procedures for a fixed amount of funds within preagreed quality parameters. Here, the obligation on the hospital for delivering a fixed level of service is more apparent.

(3) **Cost per Case Contracts**

In the first year, it is highly unlikely that either hospitals or districts would wish to negotiate for bespoke contracts covering the cost of treatment for specific individuals. Regional Health Authorities are actively discouraging these contracts until the reforms are bedded down.

On the surface, an all embracing contractual system would seem to be difficult to achieve in such a short space of time, in the absence of well established information technology and accounting systems. But in the first year of the contracting system, most contracts will be represented by the more straightforward 'block contract' variety.

4. **Other changes**

(1) Indicative drug budgets will be introduced in April 1991 for all GPs. No major transitionary problems are anticipated here. Information technology is largely in place; the budgets are not cash limited; and they are viewed only as a slight tightening of the existing system.

(2) Medical audit will be phased in over a period. No timetable problems are anticipated.

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(3) In April 1991, the family practioner services will report to the Regional Health Authorities rather than directly to the Department of Health. This change will actually help the region to manage the transition.

TIMETABLE

Detailed reports are currently being prepared by each of the 14 Regions, under the supervision of the NHS Chief Executive and his number two. These will show the steps that are being taken over the next 12 months to introduce the new changes as smoothly as possible. The chart prepared by South West Thames Region is a helpful guide to the planning process (**Annex 1**).

The Merseyside region's timetable is also a good illustration of the careful management of change. (**Annex 2**). The most interesting points to note are:

- Mersey is not expecting a free for all. In the words of the Regional General Manager they are "seeking to ensure that contract funding will be simple to introduce, simple to operate and will not result in increased and unnecessary bureaucracy. The ten District Health Authorities in Mersey Region are being grouped into four purchasing groups in order to minimise the workload associated with contract funding for both purchasers and providers. We do not anticipate that in the first year of the operation of contract funding, there will be significant changes in the volume or range of activities undertaken."

- Draft applications for self-governing status have been produced by all seven front-runners. Two other major acute hospitals are pressing vigorously to join the group. So far, secret ballots among consultants in two of the front runners have resulted in clear mandates in favour of pressing ahead with the reforms. The impact on management style has already been felt. In the words

of the manager, "There is a concentration of standards, quality and service to a degree previously unparalleled".

- Twenty strong candidates for GP fund holding have been selected out of 72 expressions of interest.

Over the last week, I have contacted six regions to discuss their timetable for change: Merseyside, Northern East Anglia, South West Thames, South East Thames and Wessex. They are all emphasising the use of block contracts which obviate the need for detailed information on each clinical procedure. All the regions I spoke to expect to see the contracts in place in 'shadow' form by October/December this year. The six months leeway will help managers to tackle problem areas. This timetable is only the start of a longer-term evolutionary process. Over time, contracts will become more sophisticated and flexible and the numbers of self-governing hospitals and GP fund holders should continue to grow annually.

INFORMATION SYSTEMS

Information systems will play a crucial supportive role in the future of the NHS, not simply to provide the necessary information for a contractual framework but perhaps most importantly to help improve the quality of patient care. The Royal Winchester Hospital, one of the first seven sites chosen for implementation of the Resource Management Initiative, has demonstrated this principle ably. And the new nurse management system introduced by the nurses in Greenwich hospital, has already improved the management of nursing care considerably.

The longer-term vision may well be to develop more up-to-date systems in hospitals, districts and GP practices throughout the Health Service. But the shorter term plans for April 1991 are to build on the existing systems. Michael Fairey, the NHS director of information, has prepared an action plan to ensure the necessary changes will be in place by April 1991.

When I spoke to him the other day, he confidently predicted that our timetable is achievable provided we keep the new contracting system as straightforward as possible.

The main pre-April 1991 objectives are:

- To improve the quality of information in every hospital about the source of patient flows between districts. Patients' postcodes will be the source of the data.

- To improve the quality of the so called "Korner" cost system, where necessary, to develop crude prices for the block contracts.

- To adapt financial systems for setting prices, generating invoices and enhancing the accounting systems.

- To ensure that all GP fund holders are fully computerised with a tailored software package to manage the contract.

This approach seems sensible.

THE ROYAL COLLEGES' CASE FOR SLOWING DOWN

The Royal Colleges are taking the lead in presenting the case for pilot studies in one or two regions outside London. They argue that chaos will ensue if this course is not followed because the necessary infrastructure will not be in place in time. Is this a reasonable assessment?

Their main argument is that self-governing hospitals will attract all the best clinicians at higher pay, leaving some district hospitals to whither on the vine. And if patients are unable to travel, they may then receive a raw deal. Of course, this analysis fails to grasp the potential for raising the quality of services right across the NHS. But there may well be a hidden agenda here. The Royal Colleges and the BMA are eager to retain national control.

David Wolfson accepts the main principles of the reform but he agrees with the Royal Colleges that we are moving too fast. His two main concerns are:

(1) **There is a dearth of information technology in the health service**. He believes this could lead to failures in the contracting system. He would rather see our information systems developed extensively in two regions only, rather than spread thinly across the 14 regions. In a private company, this strategy may well be right. But our main aim is to change the culture of the NHS. For example, when the White Paper was launched in January last year, self-governance was treated with derision by my local hospital, North Middlesex. Now there is a new sense of confidence. Around 8 out of 10 consultants support self-governance. It is this change in culture which is driving their desire to improve information systems, not the other way around.

(2) **He is also concerned that there are substantial financial deficits in some health authorities which could undermine the reforms**. There is much truth in this argument, especially in some areas of London. If these shortfalls are not addressed, there is a danger that deficits will lead to more bed closures and longer waiting lists. This point is more convincing than the first. We will need to lubricate the changes by ensuring that pay awards are fully met and that cost improvements are not expected in the transitional period.

NHS management are already instigating the following procedures to minimise the risks.

- Regions are devoting their best managers to take on the task.

- Hospitals are being encouraged to use the more straightforward block contract wherever possible, to reflect current expenditure and current patient flows. Change will only be encouraged at the margin in the first year.

- Districts will hold a reserve budget to help fight any fires. For example, Clive Froggatt mentioned that the Cheltenham Health Authority will retain 15% of its budget to be spent throughout the year in addition to the pre-agreed annual contracts.

- In view of the simplicity of the contracts in the first few years, it is not necessary to revamp the entire information systems in the NHS. Hospitals, districts and GPs are building up their capacity to monitor patient flows; to determine the approximate costs of care and to introduce accounting systems.

Yet if we hope to minimise the dangers any further especially in London - where the problems are most acute - and go some way towards addressing the concerns of the medical colleges, are there any compromises?

POSSIBLE OPTIONS

Medical audit and indicative drug budgets can be introduced nationally without any major disruption. Therefore the new options relate only to contracting, self-governing hospitals and GP fund holding.

(1) **Pilot Schemes in Two Regions**

The other 12 regions would remain unchanged.

Benefits

- Less risky managerially.

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- The Royal Colleges would withdraw their opposition. Our relationship with the medical profession would become less confrontational.

- The House of Lords would be appeased.

Weaknesses

- Politically, this would be seen as a major climbdown. The momentum would slow down dramatically.

- We would demoralise many of the 80 strong candidates for self-governance and hundreds of potential GP fund holders. And we would have little to show in 85% of the country at the general election.

- There is a danger that The Royal Colleges, BMA and other unions would still remain obstructive. And they would direct their firepower to ensure the pilots failed.

- Pilots would not be taken as seriously.

- The management culture in the NHS would not change in most areas.

There is little to commend this option.

(2) **Status Quo**

Benefits

- The momentum of the reforms would continue as before.

- Tangible evidence of successes should be visible at the next election.

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Weaknesses

- More risky, managerially.

- The relationship with the medical profession would continue to deteriorate.

- We are likely to be forced to reverse the House of Lords amendments in the Commons.

This option is still preferable.

(3) **Extend the responsibility of the proposed new Clinical Standards Advisory Group**

As you may know, the Department of Health is exploring the possibility of setting up a 'Clincial Standards Advisory Group', represented by the Royal Colleges, to monitor standards of care in hospitals as well as standards of training. The remit of this group could be extended to monitor the impact of the reforms on medical care. Such a move would be conciliatory.

Benefits

- The Royal Colleges may grasp this olive branch and become less obstructive.

Weakness

- In the longer-run, this group could emerge as a powerful new lobbyist for more funding.

- It is unlikely to tackle the professions' real concern.

(4) **Partial Contracting**

Contracting would be limited to certain procedures such as

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elective surgery. (15-20% of hospital costs). This would mean ring-fencing all other medical departments such as accident and emergency, maternity and community health services. Hospitals would have to finance their elective surgery costs by arranging contracts with the local district and nearby districts.

Self-governing hospitals and GP budget holders would be left to proceed as before.

Benefits

- the new contractual system would be introduced more slowly, reducing margin for error.

Weaknesses

- the hospitals would still need to set up a contracting department.
- the Royal Colleges and the House of Lords are unlikely to accept this option.
- the management implications of partial contracting look horrendous.

Again there is little to commend this option.

(5) **A Compromise Solution**

(a) Increase the number of pilots to cover the most capable three or four regions outside the Thames area. Within the pilot areas, operating contracts would be introduced across-the-board as would self-governing hospitals and GP fund holders.

The selection would have to satisfy a number of characteristics:

- geographically spread;

- characteristically diverse where possible;
- strongest management;
- areas where there is the greatest enthusiasm for the reforms;
- we would need to avoid the Thames areas because of the significant cross boundary flows in London. Contracting would not be possible in one area of London.

Possible candidates would be:

(My analysis excludes the relative support for GP budget holding, but this is fairly evenly spread.)

South Western RHA

14 hospitals and community units are on the shortlist, more than any other region. Much of the area is rural outside Bristol. It is self-contained. An advantage is the absence of large cross boundary flows to other regions.

Northern RHA

5 hospitals and community units including one hospital covered by the Resource Management Initiative (Freeman). Management is strong.

Mersey RHA

6 strong candidates near a major conurbation. Strong support from consultants.

Trent RHA

9 candidates in a central area of the country. Good management team which in innovative.

East Anglia RHA

Only 4 candidates for self-governance. But management has already developed pilot projects in contracting between district health authorities.

(b) In non-pilot areas there would be no contracting between District Health Authorities and hospitals. However, self-governing hospitals and GP fund holders would still go ahead with one proviso. Clinicians would be paid at national rates to appease the Royal Colleges.

Duncan Nichol could be asked to try and work out a doable scheme. In our meeting earlier this evening, he said he would think through this possibility.

Benefits

- The Royal Colleges may well support this approach.

Weaknesses

- Same as (1) above.

- For the reasons outlined earlier (see top of page 4) it may not be possible to introduce self-governing hospitals and GP fund holders outside the internal market.

- There is no doubt that the pace of change in the non-pilot areas would still be reduced considerably.

Summary and Conclusion

The cultural change in the NHS has been enormous over the last twelve months. But managerially we may be running a little ahead of ourselves. This may be a good thing in most areas of the country but there are greater risks in the Thames regions.

A pilot scheme in two regions only is not a realistic option. Yet if it is possible to develop a compromise option based on three or four regions, and involving the candidates for self-governance and GP funding throughout the country, perhaps with fewer freedoms as a first step, this may be workable. If this option is not possible managerially I believe we should stand our ground on our present timetable.

Kenneth Clarke could be asked to develop the compromise option further to see if it is workable.

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