Office for Health management

Learning from the NHS in Change

A study on the management of major structural change in the NHS

prepared by

OPM

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Mission Statement

We contribute to a better health service by

- supporting people development
- stimulating change in the way things are done
- helping the whole system to improve

Contents

Executive Summary

This report, compiled by OPM, explores how learning from the UK experience can assist strategic planning and organisational development in the Irish health services as they move into a period of unprecedented structural change.

In detailing the nature of organisational change in the NHS over the last 15 years, we (at OPM) have included an analysis of the change management approaches used. This analysis has been drawn from the experience of a number of senior health professionals whom we consulted, in combination with our own understanding of this history of change.

A number of conclusions emerge. And, while some do relate specifically to structural change, the concept of change used is a broad and encompassing one, reflecting a whole systems approach with the focus firmly on people, patients, members of the public and frontline staff.

First, and fundamentally, is the importance of considering how the complex dynamics of change are handled, and how the human consequences of these actions are managed. The importance of engaging people – to develop the awareness, understanding and support that is required to receive the benefits of significant transformation – cannot be overestimated. Nowhere is this clearer than in relation to the involvement of clinicians and others on the frontline: their active engagement in the process of reform has been shown to be a vital element in transforming services.

Second, related learning tells us that effective change management requires clearly enunciated values and a shared purpose. Specific, realistic timeframes, with identifiable milestones along the way, are also required so that people can see the evidence of emerging benefits and feel confident about the direction of travel.

Third, a clear HR strategy, with a realistic investment in leadership and management development, must be regarded an essential tool for delivering major organisational change in health services.

Fourth, it is important to focus on getting the infrastructure right; this includes building the workforce capacity, encouraging organisational agility and flexibility, and developing the technology and information systems required to support service improvement.

Fifth, people recognised the value of having an agency dedicated to promoting reform and modernisation through a range of leadership and service improvement programmes, firmly linked to change objectives. However, as many of those interviewed were keen to stress, central leadership and direction must be balanced with a healthy recognition of the need to encourage local ownership and innovation, and to focus service improvement and performance management interventions on outcomes which have meaning both across the system and within local health economies.

Of course this brief synopsis belies the complexity of the issues at hand and the need for further detailed consideration of questions we have identified in this report. As a starting point – for shaping a range of interventions to nurture and sustain change – we suggest a focus on three questions:

1. How can the strategic change process best be supported?
2. How can capacity and capability be developed in the health economy to support change?
3. How can the infrastructure be put into place to support change most effectively?

Some partial answers to these questions, based on the NHS experience, are as follows:

Supporting strategic change

- Provide a strategic approach to leadership development, management training and capacity building.
- Provide a systematic focus on health outcomes though practice improvements in joined-up working, modernisation and performance improvement.
- Ensure that learning and development takes place locally, and is available nationally.
- Develop a 'continuous loop' of engagement in service improvement, involving patients, the public, clinicians and other frontline staff; support this with effective communications.
- Shift old cultural patterns and promote desired norms and behaviours, whilst controlling or removing unacceptable patterns.
- In the service culture and in ways of working, reflect general policies on:
  - patients' rights and responsibilities,
  - standards of conduct and performance for managers and clinical staff
  - wider behavioural standards, including those relating to equalities.
- Develop review processes which generate useful evidence informed by local perspectives rather than being overly influenced by 'fads' or inappropriate, imported ideas.
- Balance local and central roles, i.e. ensure the right balance of uniform expectations and support for local innovation.

- Develop a meaningful and effective enabling role – 'a skilled and critical friend, close to the center but not of it', who can support local innovation, share learning and support managers though demanding transitions.

Developing the capacity in the health economy to support change

- Put effort into the development of emerging and future managerial and clinical leaders.
- Support the development of change facilitators, acceptable and trusted by people in the field.
- Locate technical specialists with service providers/commissioners.
- Facilitate learning initiatives such as collaboratives, peer reviews and learning groups, and the involvement of local people in them.
- Develop multi-disciplinary and multi-agency team working and networking
- Disseminate examples of good and 'illustrative' practice.

3. Developing the infrastructure to support change

- Develop and disseminate learning tools and resources.
- Facilitate and promote the use of key strategies, including an explicit HR strategy at both national and local levels
- Promote National Service Frameworks to 'embed' basic standards in service delivery models and in performance review and service scrutiny processes.
- Develop approaches to using such standards, which facilitate local innovation
- Develop commissioning tools, including quality control frameworks
- Develop system-wide regulatory, governance and scrutiny frameworks which provide adequate checks and balances to ensure service improvements while still enabling performance expectations to be shaped locally.

1. Our Brief

The Irish health services are about to commence a period of structural change, which is likely to be wide-ranging. Given that the existing organisational arrangements of the Irish health and social care system have remained largely unchanged for over thirty years, there is little direct experience within it on how to implement system-wide structural change. By contrast, the UK's NHS has undergone a number of quite fundamental reorganisations over the last fifteen years. The Office for Health Management (OHM) felt, therefore, that lessons could fruitfully be learned from the UK experience.

OPM was invited to prepare a report detailing the nature of organisational change in the NHS over the last 15 years, including an analysis of the change management approaches that have been used, and to make any observations that we felt would be useful for the Irish health and social care system.

2. Our Approach

To explore the nature of the experience of change within the NHS over the last 15 years, we interviewed a cross-section of senior leaders who had either been responsible for policy development and implementation throughout the service or who had been close observers of change over time. And to gain a range of perspectives on the lessons that might help to identify learning relevant to the proposed changes for the Irish health and social care system, we contacted a number of managers, clinicians and change specialists. The list of those contacts is at Appendix 1.

To help to 'trigger' responses from these people, we prepared a briefing document that identified the main strands of change in the NHS over the last decade and a half. It follows immediately after this introduction (page 2) while the full document from which this briefing was developed is at Appendix 2. It, in its turn, was based on a number of primary and secondary sources located through a literature review.

The interviews were designed to help people explore a number of issues:

- their role in the change processes occurring during the past 15 years
- their assessment of the outcomes of major changes
- what they had learned from this period of change that they felt was significant, and
- the potential lessons they saw for the Irish system.

We also asked specifically about the human consequences of change and about how the processes of performance development and capability building had been used to support policy implementation and structural change. We explored in some detail the current role of the Modernisation Agency in facilitating and disseminating service improvements.

We hope that this report will encourage discussion, especially on a number of themes raised by the discussions we held and by our analysis of people's responses.

3. The Context

In order to set the context for this discussion of change and help relate the experience of change to improvements in health outcomes we used the briefing paper below as the background to all our discussions. It provides an overview of the structural and purposive changes made to the NHS over the last fifteen to twenty years. It is divided into five main sections: 'Who's in Charge?', 'Choice and Competition', 'Targeting Health Gain', 'Shifting the Balance to Primary Care', and 'The Modernisation Agenda'.

A briefing paper summarising change in the NHS

Who's in charge?

The 1980s saw central government make a concerted effort to achieve greater managerial control over the NHS. The major changes of this period were:

The Griffiths-inspired reforms of 1985, which were based upon the finding that the NHS had no coherent system of management at a local level. These reforms included:

- The 'consensus' style of management was rejected and replaced with general managers in health authorities, hospitals and units. The aim was to strengthen strategic direction and responsibility by putting in place a clear structure of line management and devolved budgets.
- Policy and strategy were separated from management within the NHS. The Health Service Supervisory Board advised on the strategic direction of the NHS, while the NHS Management Board was concerned with management, such as performance review of regional health authorities and finance.
- Management budgets were introduced into hospitals.
- The first package of national performance indicators was introduced to provide information on clinical activity, finance, staffing, support services and estate management. A second set appeared in 1985.
- The NHS Training Authority was established to improve management training and education.

The White Paper, *Working for Patients,* which led to:

- The creation of the NHS Policy Board and the NHS Management Executive (the NHSME). The intention was to sharpen further the split between responsibilities for policy, on the one hand, and management or implementation on the other.
- The composition of health authorities was changed to resemble company boards made up of health authority senior managers and non-executive directors. Representatives of the health professions and members nominated by local authorities were removed.
- Local managers were given the power to negotiate and monitor contracts with consultants, a power previously held at regional level. They were also included in the membership of the committees that made distinction awards to consultants, the criteria for which now included the need for consultants to demonstrate a commitment to the management and development of the service.

This period also saw the introduction of **the GP Contract** and **Performance Related Pay** (PRP).

It is difficult to evaluate the 'success' of these reforms, but it is possible to point to improved efficiency, productivity, and outputs on the one hand, and higher waiting lists, public dissatisfaction, and increased uptake of private insurance on the other.

Choice and competition

The beginning of the 1990s saw a push for greater consumer choice and improved quality of services in the NHS.

The 1991 Patient's Charter set out a number of consumer standards and rights against which the performance of the NHS could be judged. It was intended to make the NHS more responsive and thus act to raise quality.

The 1990 *NHS and Community Care Act* introduced a number of important changes

- The financing and purchasing of care was separated from its provision to create a form of internal market.
- The providers of services – acute hospitals, mental health services, ambulance services, and so on – formed self-governing NHS trusts.
- GPs with larger practices (set at 11,000 patients or more, but later reduced to 5,000) were allowed to apply to become fundholders.

Looking at the impact of these changes:

- The evidence suggests that choice did not increase through fundholding.
- Competition among providers was limited and their freedoms were severely constrained by the Department of Health.
- The Department of Health did not spend enough time preparing for the internal market.

Within a very short time, the government began to soften its market rhetoric. 'Commissioning' replaced 'purchasing' as the market became more regulated. Policy began to be focused on other areas, such as improving the health of the population, giving greater priority to primary care, raising standards through the Patient's Charter, and ensuring that medical decisions were evidence-based.

Targeting health gain

Alongside the organisational changes in the NHS, there was a growing interest in what is called 'targeting health gain': improving clinical quality, such as through medical and clinical audit, evidence-based medicine and guidelines; and focusing on outcomes, particularly in public health.

For most of the 1980s, the government still considered that responsibility for the quality of clinical care lay with healthcare professionals themselves. Once trained, they could be relied upon to deliver care of a high standard. This 'hands off' approach began to change with the 1989 White Paper *Working for Patients*, which set out a definition of medical audit, a key component of clinical quality. Though it emphasised that medical audit should be professionally led, the Paper stated that management involvement was necessary to ensure that an effective system of medical audit was set up, and protected funding was made available to regional health authorities to support this. In 1992 the multi-professional Clinical Outcomes Group was established to promote a multi-professional approach to *clinical* audit – covering all aspects of care, including that provided by nursing and paramedical staff.

Other developments at this time that were related to quality include:

- The setting up of the NHS Research and Development programme in 1990.
- A national hospital accreditation scheme, developed from a pilot started by the King's Fund, which examined hospital organisation and assessed the extent to which standards were being met, and allowed action to be taken when they were not.
- The Clinical Standards Advisory Group (CSAG) established in 1991, which advised ministers on clinical standards within the NHS.
- The internal market saw the rise of contracts between purchasers and providers that specified quality requirements: initially waiting times but then clinical quality indicators requiring specific audits and regular reports.

The development of all the various mechanisms for assessing and improving quality was, however, haphazard. Each developed along separate lines and without coordination. The result was that the roles and responsibilities of the various organisations involved were not well defined.

Alongside the push for quality, public health was a subject for increasing discussion in the late 1980s. In 1988 an inquiry team under the chairmanship of the Chief Medical Officer, Sir Donald Acheson, published a report on the future of the public health role. This was followed by *The Health of the Nation*, which represented, for the first time, a clear strategy to tackle public ill-health and identified five priority areas.

Shifting the balance to primary care

The 1990s saw a significant growth in primary care. It was seen as playing a vital role in public health and health prevention work and, thereby, acting to keep costs down in the expensive secondary care sector. In addition, it was, and still is, seen as a means of offering healthcare that better suits users' needs. By placing more care in the community, access is improved.

- The 1990 GP contract used a range of tools to increase the role of GPs and other primary healthcare professionals in the area of public health. These included financial incentives for achieving immunisation and disease-screening targets and performance related payments for health promotion and chronic disease programmes.

- The GP fundholding reforms saw a big expansion in primary care-based purchasing. More GPs were involved than ever before in such activities and, as the decade progressed, different kinds of fundholding developed, such as multi-practice consortia and Total Purchasing Pilots.

Improvements in primary care services during this period were noted. One study found that many practices had invested heavily in equipment and services; there was a wider range of services available, and a substantial increase in nursing and other staff. Many services that were previously only available in hospital settings were increasingly transferred to primary care settings.

The election of a Labour government in 1997 only strengthened the role of primary care as a gateway to health services. Fundholding was replaced by primary care groups (PCGs), though GPs retained their status as independent contractors. Today, PCGS have developed into primary care trusts (PCTs) and the traditional GP practice is now being increasingly supplemented by a new range of primary and intermediate services, such as walk in primary care centres, NHS Direct, minor injury units, diagnostic and treatment centres and healthy living centres.

As these changes have progressed, however, there have been some doubts expressed over the ability of PCTs to manage effectively the roles and responsibilities they have been given. Attention has focused on how some PCTs can deliver to meet local needs in the face of high priority national targets and a lack of capacity, both financial and human.

The modernisation agenda

The pace of change within the NHS under Labour, particularly from the time Alan Milburn was appointed as Secretary of State for Health in 1999, has been astonishing. Alongside the commitment of massive new public funding, a multi-themed agenda of modernisation has been developed, including greater patient and public involvement; opening up the NHS to alternative providers; new frameworks for raising performance, standards of clinical care and levels of accountability; training and development for staff; and shifting power closer to the front-line. All this has been underpinned by a fundamental restructuring of the NHS and the establishment of a number of new agencies.

To support the implementation of the NHS reforms, a human resources strategy has been put in place for the entire workforce. Technological change, new government priorities focusing on widening access and life-long learning, the development of new health roles and the expansion of existing ones, the growth of multi-disciplinary working, and the need to make the NHS a more attractive place to work, have all contributed to the government taking a fresh look at how it trains and develops NHS staff. For example, the new NHS University (NHSU), first mentioned in the Labour 2001 election manifesto, will be officially launched in October - November 2003. Workforce Development Confederations have replaced the Regional Education Development Groups and a number of other agencies to bring together local NHS and non-NHS employers to plan and develop the whole healthcare workforce.

The government has recognised that, if the 'modernisation agenda' is to be successfully delivered, the way NHS is managed needs to strengthened and developed. A strategy *Managing for Excellence in the NHS* has been introduced. An important player in this strategy will be the Modernisation Agency. Its role is to promote reform and services for patients by working with NHS staff and their partner organisations. It aims to complement local initiatives through a range of leadership development and service improvement programmes for both clinicians and managers.

Concurrent with the delivery of this modernisation agenda has been the restructuring of the NHS. The government has stated that the Department of Health will be slimmed down as power and resources are devolved from Whitehall to regional and local levels. Day-to-day management of the NHS is being passed to strategic health authorities (SHAs), while healthcare resources are to being shifted to PCTs.

Looking at the whole Labour reform agenda for the NHS, some commentators have argued that the Government has tried to do too much and has relied too heavily on structural change. For all the talk of local empowerment and the decentralisation of control, a frequent complaint found among clinicians and managers of PCTs, NHS trusts, SHAs and other organisations is that they have to deal with too many organisational changes, inspections, reviews, targets and demands for performance information from an enormous number of government agencies.

4. Our Findings

a) Overview

Throughout the NHS, wherever there are experiences of major change initiatives, strong feelings are generated, both for and against. Many people to whom we have spoken as part of this project believe the present government is really making positive inroads into improving the activity of the health services. Many others, however, feel that the changes are coming too fast with too little planning, and are delivered within a highly critical context. This pressure, they judge, does not bode well for long-term sustainable change.

This report is thus limited in its objectivity, being the sum of many subjective experiences. However, we believe there is much to be gained from carefully considering these experiences and assessing the extent to which the more obvious dangers can be reduced.

- A number of common strands exist in people's responses and, although there were many different assessments of the degree of success of the different policies introduced over the period, people clearly believed that the service as a whole is now producing more effective health services and achieving improved health outcomes in line with the real growth of investment and strengthened controls over activity and priorities. These gains were described in terms of:
  - improved access,
  - greater use of evidence-led investment in service development,
  - a stronger focus on patients' requirements,
  - more reliable data on activity and performance, and,
  - a strengthened regulatory system for both organisations and individuals.
- The policy context has also been strengthened with a system-wide framework of outcome goals and performance targets. Such improvements, however, have not been achieved simply through the interventions of the modernising agenda. The gains have also been made through the innovation and performance of local leaders, managers and clinical staff

over an extended period, working in the context of system-wide influences and a gradual growth in capacity. Change builds on change; the evolution of general management and the experiments with markets have set the context for strengthening clinical governance and the effective use of enhanced regulation and inspection. The current intense debates about the opportunities and challenges presented by foundation hospitals have to be seen in the light of these previous changes.

- Many argue that, although such changes have been achieved, this has been at the considerable cost of creating a driven, top-down, and 'control-centred' system. This is a system that is under considerable pressure to meet political targets, but is not creating sufficient local ownership or real innovation to enable it to continue to perform at this level.

- There is general agreement that many individual changes – such as the introduction of general management or the creation of the health market – were effective in their own terms. In structural terms, they achieved what they set out to do. But they were less effective in leading to improved health outcomes, as they were focused strongly on process rather than outcomes.

- The last five or six years have seen the introduction of a much broader approach, led by the current government. This approach to change has focused on a modernising plan to include all public services. The plan has created a more systemic policy framework, where the approaches from one part of the public sector influence and fuel developments in others. The underlying features of this framework include 'joined-up services', 'outcome-focused investment', 'modernisation of working practices', and 'target-led performance review'. In the responses we received to our questions, there was little fundamental dispute with these values; however, there was considerable disquiet about the means by which the current changes are being 'driven' into the health system.

- Many of the people we spoke to were strongly in favour of active, strongly-led changes, delivered speedily. They also recognised the need for individual and local interpretation, within an agreed range. They commented strongly on the need for practical support during the change process, coupled with an honest recognition of the financial and human consequences of change. Many of the more recent changes have been introduced only at the cost of considerable personal effort, and there is a strong feeling that this is not recognised at the policy level. Successful implementation is rewarded with more pressure to change further and faster, greater levels of regulation and control, and more public scrutiny. Innovation will only appear if people are allowed to take some risks but many people felt that the pressures for control, particularly from the centre, were driving out managed risk.

- Much is still dependent upon reasonable levels of funding. A considerable gap exists between the political version of increased expenditure and the realities of local budgets. Much of the current additional investment is lost in paying interest and loan charges, and meeting uncontrollable inflationary pressures. For example, from the average uplift in the NHS of around 10% for local health economies in 2003/4, after unavoidable uplifts, debt repayments and including annual efficiencies, less than 2 % is commonly left for new developments. This gap between the political rhetoric and local reality undermines many of the positive opportunities for change.

- Many people felt that development support was a key to successful change. It was important, too, that the support was provided as part of a local implementation process. There were a number of examples of the national contribution to such processes; in particular, the Modernisation Agency was discussed at some length. Some people felt that this organisation does provide local help and support: its 'Leadership Programme', for example, was quoted extensively as a very helpful source of ideas, contacts and direct services. However, there were also a number of people who had experience of teams being 'parachuted in' but adding little of benefit to local initiatives.
- We discussed the impact of change on individuals. There was considerable concern that, in order to demonstrate rapid progress, politicians and civil servants were under-estimating the de-motivating effect of criticising current and past performance. There was broad agreement that better ways have to be found to showcase success and limit failure. 'Naming and shaming' may pay some dividends occasionally but, as a long-term strategy, it is doomed to failure.

b) Changing and developing individuals

Many of the people we spoke with or received comments from were keen to stress the critical importance of the 'people issues' and the essential need to work with 'hearts and minds' in pursuing service reforms. Tapping the public service ethos, which for many health workers is very important, was seen as a key to developing effective service leadership. People recognised, however, that reinforcing these values was difficult in a culture that is often characterised by weariness with change and a sense of powerlessness in effecting visible and lasting service improvement.

An important point made to us – which underscores all our observations in regard to changing and developing people – is that the advocates of major system changes often greatly underestimate the lead time needed. For this reason the human resource strategies necessary to facilitate service level change have to be made a management priority. The recent commitment to a national strategy for HR was seen as a useful framework to support and contain local action.

The key features of change in the NHS

The key changes that people identified, in relation to human resources, were an increased focus on building effective leadership, engaging people in action-oriented approaches to learning, working in multi-disciplinary and multi-agency teams, building an explicit HR strategy for the service and a strong emphasis on clinical and public/patient engagement in management and service development activity.

The period in question has seen a number of notable developments in leadership training and development.

In the mid 1980s there was still a nationally-led training programme, delivered through a number of regional training centres. The focus was on the graduate entry programme for

managers and financial specialists. This was supplemented by a series of targeted programmes for specific groups including nurses, doctors and PAMs, to introduce them to the basics of management. Continuing development for senior managers and clinicians was left to their professional associations, some universities and the royal colleges.

With the introduction of general management came considerable additional investment in training, the creation of a more open market for educational providers, and a range of new training agencies and academic bodies entering the market. The national lead agency, the NHS Training Authority, became the NHS Training Directorate and was later remodelled into a series of independent organisations. Active competition developed between old and new providers, with increasingly regional and local purchasing arrangements complementing national programmes. The national framework still existed through the 1990s, but local providers offered many different approaches and learning models.

Individual NHS trusts were beginning to purchase development services, both external programmes and internal training. This further encouraged a growing range of new providers. Some trusts created their own commercially available development services that continue to grow to this day.

Some top-level leadership programmes were available, such as the Corporate Manager Programme/Top Manager Programme, but there was no national, strategic commitment to investing in today's leaders as well as tomorrow's. The first major indication of this strategy in action was the creation, at the end of this decade, of the Chief Executive Development Programme, later renamed the NHS Leadership Programme. This service for top-level managers was recently brought within the Modernisation Agency. Many of the chief executives we spoke to, particularly those recently appointed to their roles, indicated their strong approval and support for the service that they have received here. These developments coincided with a shift in emphasis from 'transactional leaders' to' transformational leaders'. There was also an increasing recognition of the need to focus on developing 'emotional intelligence' alongside technical skills.

The NHS Confederation, the independent representative body for the health services, provides a substantial programme of development around policy implementation and offers a wide range of briefings to all key staff. All clinical staff are also required to engage in post-professional development programmes that include clinical, technical and managerial content.

The major shifts in investment have been from nationally prescribed 'sheep dip' approaches, to targeted learning outputs, tied to personal development programmes and universal appraisal arrangements. National agencies have seen a shift in their role from control of the development agenda – commissioning from a small number of approved suppliers and, in some cases, direct delivery – to the production of development priorities, controlling the direction of investment and setting the regulatory framework to ensure compliance. Delivery is far more localised and diverse. There are also some trends that indicate the return of a national approach to development. The Management Training Scheme is now back as a single integrated programme after some years of being led at regional level.

There is also now a much clearer separation between management development & training and leadership development. There is the clear recognition that both are needed and that

different groups of people need different opportunities for skills training, personal support and task-focused facilitation. The growth in the emphasis on clinical governance in the last five years has also been mirrored in clinical leadership development.

A recently introduced Competence Framework for CEOs provides a focus for the development and performance assessment of leaders throughout the service. This has been complemented by the introduction of a 360-degree review tool, e-based and available nationally, to be used at board level to assess performance more openly.

Recent emphasis has been on extending learning opportunities beyond the NHS to encourage both multi-disciplinary and multi-agency approaches to learning. This affects people throughout the service, from chief executives to frontline staff.

HR strategy

The NHS Plan has two central objectives that affect human resources: an increase in the number of staff and a redesign of jobs. The HR strategy, *HR in the NHS Plan*, supports these objectives through work in four areas:

The first is aimed at making the NHS a model employer by offering better working conditions, model employment practices, the ability to balance life in and outside work, job security, lifelong learning, fair pay, staff involvement and good communication. In addition, management style is meant to be facilitative and involving, not hierarchical and controlling, and should seek to help each individual to make the most of him- or herself through coaching, mentoring and development and through devolving authority to small, integrated teams.

The second is the attempt to ensure that the NHS provides a model career: this is done through the concept of the 'skills escalator'. Staff are to be encouraged to renew and extend their skills and knowledge through a process of lifelong learning so they can move up the escalator. At the same time, roles and workload pass down where appropriate, giving greater job satisfaction and generating efficiency gains.

Third is an emphasis on improving staff morale. The strategy states that staff attitudes to their work have a direct effect on patient care. Steps to improve morale include those mentioned above, but also commissioning research into how the NHS can learn from other employers about model employment practices and morale; and developing a national communications strategy to present a more positive image of the NHS.

The fourth area is focused on building people management skills. *HR in the NHS Plan* states that effective human resources management sustains efficient organisations by supporting their objectives and ensuring the effective recruitment, retention and development of highly competent people with the skills required, while developing a supportive culture which promotes partnerships, communication and staff involvement and improves morale and individual performance.

The government has recognised that if the modernisation agenda is to be delivered successfully, it is necessary to strengthen and develop the way the NHS is managed.

Managing for Excellence in the NHS outlines the strategy here:

- instituting a *Code of Conduct for NHS Managers* that sets out shared values
- supporting managers and leaders by investing in development, particularly via the Modernisation Agency
- driving to create an experienced and diverse leadership by recruiting black and minority ethnic managers and young managers, supporting clinicians making the move to management, and enhancing training for in-house specialists
- developing senior management and succession planning through a senior management network.

The main points of learning that emerged from our discussions in respect of individuals involved in change were identified as:

- To create the conditions for change, it is necessary to 'destabilise' the system; but don't create continuing uncertainty or high levels of stress.
- Create a vision with and for people.
- Develop the leadership capacity of the system by investing in all levels.
- Maintain a national framework with room for local approaches.
- Set clear strong messages and clarify the 'five must-dos'. Use images, metaphors and 'word pictures' to get the message across.
- Manage the HR aspects of change. Ensure that staff understand the processes that will be used to support change and that these are transparent, fair and well communicated. Don't just move people aside or let them leave the system badly.
- Encourage, motivate and create pressure for change, but don't undermine people.
- Focus on helping people understand the outcomes to be achieved, not just the processes to be undertaken.
- Recognise that strategic change is built through local action and innovation, set within a wider framework. This will not be risk-free and so some failure must be accepted as a necessary part of the process.
- Support the managers; provide them with time out for learning and networking and think about how to give them effective support when the going gets tough.
- Change can require differing levels of HR support over time. Initially, very focused and intensive HR support may be needed, phasing down into a more general level of help or support, as it is needed.

- Build capability and competence in line with a change plan.
- Keep people informed.

The following selection of comments represent many of the thoughts people expressed to us.

'Learning sets, having a mentor, and bouncing ideas around with peers are all very useful.'

'Chief executives are critical in achieving change, not just because of their lead roles but because they have such an influence on how an organisation 'feels'.'

'Match management capacity with the needs of the reform. For example, have a dedicated project director and a public involvement facilitator. Particularly helpful is support with project management techniques to maintain momentum and keep all stakeholders on board.'

'Open and honest communication, including sharing uncertainty.'

'People assume the worst; the rumour mill / water-cooler discussion goes into overdrive.'

'Communicate, communicate, communicate and if you don't know, say so. Always be honest, address concerns head on and listen to what you're being told. Understand the frame from which it's being expressed as this is often more important than the words themselves.'

'Recognise the personal investment people make in their work. Encourage change without threatening the motivation of highly committed people.'

'The impact of rapid and constant change in the NHS has had a number of effects on staff – it has been de-stabilising, has increased sickness through stress and has increased uncertainty. This should be a major concern for all organisations going through or planning change.'

'Provide support for staff involved in change – mentoring, coaching, time out to learn and time away from the coalface.'

Implications

In respect of these developments, the implications for Ireland appear to be to:

- Ensure that there is an overarching strategic approach to leadership development, management training and capability building that relates directly to the health delivery strategy.
- Encourage a range of development providers at both national and local levels and develop quality control frameworks to help local users to commission effectively.
- Create strong links between the regulatory process, performance appraisal and individual development, ensuring that innovative approaches are used.
- Facilitate the continuing development of managerial and clinical leaders, as well as developing leadership skills for the next generation.

- Pay attention to the needs of the front line; link learning and development activities to the culture change objectives.
- Link modernising approaches in terms of service development to opportunities for personal learning, using action-based approaches and collaborative learning models.
- Find opportunities to connect professional bodies and royal colleges actively into these processes.

c) Changing services

Respondents told us of the importance they placed on the complementary role of national frameworks and regulation, coupled with flexibility and encouragement of innovation at the local level. A second major point that many people made was how important it was to engage clinicians in the design and delivery of service improvements.

Key features of change in the NHS

Comments about the key features of change tended to focus on learning and development, HR and organisational change initiatives which are covered elsewhere. This is perhaps not surprising given that many of the initiatives in the NHS in this area have been quite recent.

The introduction of Care Pathways in the 1990s encouraged a focus on integrated service delivery across health economies. Managing change around agreed pathways of care proved a powerful methodology and one which is still being built upon, most recently with the release of 'Keeping the NHS Local' which gives insights into the best models for reconfiguration.

The majority of people we spoke to thought that this whole-system, patient-centered approach was very important. Some, however, noted that infrastructure reform had not been given the same amount of attention and that, as a consequence, workforce capacity and flexibility have become inadequate, and hospital infrastructure, technology and information systems actually hinder the development of learning networks between different trusts.

The main points of learning that emerged from our discussions in respect of services in change were as follows:

- National frameworks, regulation and guidance are important for those things that need to be consistent across the whole of the system. National guidelines, regional support and additional funding all help to create positive messages in support of change. However, too tight a hold on what has to be done, or very specific targets, can actually get in the way of change. This is particularly the case when short-term targets act against the long-term changes that will really deliver what is required.
- Exchange good practice, but also share what has not worked so well. As one respondent put it, '(We need) *access to where others have tried and succeeded – or failed.*' Ensure that information is shared between local leads and national or regional leads.

- Clinicians are very good at identifying good practice in their area, and they can implement change very quickly. However, they often do not look outside of their area and don't see the impact that what they have changed may be having on other parts of the system. That is why it is vital to look at the whole of the care pathway.

- There was strong consensus that clinical support is a key to success when implementing service changes. In the words of one respondent, *'A powerful ally … is a clinical leader with vision and ideas, who is sufficiently charismatic to persuade colleagues and peers and who can maintain momentum and enthusiasm.'* People believed that regular and honest communication with clinicians was one way to ensure strong clinical engagement.

- More general champions for change should also be identified at an early stage. These people have very specific skills – more facilitators than managers, although they also need good project management skills. There are not enough of these people in the NHS and their posts are often only funded for a 12 or 24 month period.

- Be open about the timescales being set for the changes. Milestones along the way help to maintain momentum as well as people's commitment and belief that change can happen.

- While some people saw the Modernisation Agency as being very helpful, particularly because of its independence, others viewed it as *'a series of multiple, unconnected projects'*. One criticism that a number of people levelled at the Modernisation Agency was the perceived lack of coordination between different MA programmes. *'A trust can have 20 or 30 MA people working with it, using the same tools, but without sharing the learning. This lack of coherence is being recognised now by the MA.'*

The following selection of comments represent many of the thoughts people expressed to us.

'Ensure there is a clear statement of the expected outcomes at the start of the process. There is a sense of making things up as you go along about the reforms in the NHS. For lasting change to work, there needs to be much more clarity about the aims and the implementation'.

'There needs to be a very robust implementation plan for change to work'.

'Staff need to be truly involved right from the beginning – e.g. developing service changes – and throughout the implementation process. Within parameters, they need to choose how to move forward and be allowed to experiment, with incentives and support. Incentives can be honest appreciation, which would go a long way. When staff and patient needs do not coincide, be honest about it.'

'Engage directly with the public.' A good example is a review of hospital services in Surrey and Sussex that one respondent was involved in. *'All meetings were open to the public; the steering group included lay people and local councillors; and all minutes and papers were published. When local politicians made it clear that, whatever, the evidence, they would only support a decision to keep hospital services local, some of the public were outraged. The public, therefore, can be more powerful allies than local politicians if they are engaged directly and are shown the evidence.'*

'Don't underestimate the impact of a common change culture.'

Implications

In respect of services in change, some of the implications for Ireland's health services are:

- Reconfiguration needs to start with the strategic vision for change and modelling the infrastructure requirements as soon as possible. This requires new methodologies, particularly for workforce modelling, away from the 'silo' professional culture, and into mapping networks of care – with tasks rather than particular professions. This however, requires early 'buy in' from the professional associations or colleges and training establishments.

- A drive to engage the clinician around professional – and therefore accountable – practice is needed to inform and integrate change.

- Exploit the potential of team working to capture and share learning and drive local change.

- Work with whole systems approaches, such as the care pathways, which involve multi-professional teams and cross-organisational working.

- Should the Irish system remain a mixed economy of providers, it is vital to get right the issue of healthcare governance (clinical and corporate) across one system; the risk of small and unrelated scrutiny and governance units should be minimised.

d) Changing organisations

Participants offered a very rich history of involvement in reforms, with some going back to the 1970s and many at least to the introduction of general management in the mid 1980s. Some contrasted the change process of the mid-1980s to that embodied by 'Shifting the Balance': they saw the former as having been well planned and the latter as being overwhelming in its ambition and demands.

People consistently emphasised the need for clear purpose, structured implementation planning and a focus on outcomes.

Key features of change in the NHS

Discussion turned to the establishment of primary care groups and trusts. As one person described it, the creation of the corporate governance framework for a new model of organisation was *'really exciting, but it did feel like that was done in isolation. The most successful of these have been where sufficient resources have been made available to them.'*

Asked to comment on specific examples of change in the NHS, some felt that the best reorganisation was *'the 1984 general management changes'*. These were well conceived, with a clear purpose to them, and they were well implemented. The changes brought about by the 1990 NHS and Community Care Act, however, happened without clear aims or adequate

resources. Initially the focus was on trusts, but then on the health authorities as commissioners. The result was a service out of balance.

A number of technical approaches or change models have been used to help implement change in the NHS. There is considerable evidence that there is a tendency to be 'fashionable' rather than careful in choosing these approaches. The effectiveness of a number of these models is described in a recent review commissioned by the NHS Service Delivery and Organisation (SDO) National R & D Programme, *Managing Change in the NHS.*[1] This review looks at the literature on change management and describes some of the main tools, models and approaches used, along with the available evidence about their effectiveness.

Examples include:

Content, Context and Process Model

This model suggests that successful change is a result of the interaction between the content and what of change (objectives, purpose and goals); the process or how of change (implementation); and the organisational context of change (the internal and external environment). One study[2] shows that healthcare organisations were found to be more or less able to manage strategic change depending on the context in which they were operating. Eight interlinked factors served to differentiate the higher from the lower performers:

1. Quality and coherence of local policy
2. Key people leading change
3. Cooperative inter-organisational networks.
4. Supportive organisational culture
5. Environmental pressure, moderate, predictable and long-term
6. Simplicity and clarity of goals and priorities
7. Positive pattern of managerial and clinical relations
8. Fit between the change agenda and the locale

There was a pattern of association between the eight factors but there were no simple cause-and-effect relationships.

Total Quality Management (TQM)

An evaluation by Joss and Kogan[3] of TQM in the NHS found little evidence of staff empowerment or changes in health status. They concluded that implementation was piecemeal and concentrated on peripheral and administrative activities rather than clinical

1 Valerie Iles and Kim Sutherland (2001) *Managing Change in the NHS: Organisational Change, A review for healthcare managers, professionals and researchers*, NHS Service Delivery and Organisation (SDO) National R & D Programme

2 A Pettigrew, E Ferlie, and L McKee (1992) *Shaping Strategic Change*, Sage Publications

3 R Joss and M Kogan (1995) Advancing Quality: Total Quality Management in the NHS, Open University Press

practice. Iles and Sutherland suggest these findings may reflect the reluctance of medical staff to engage in TQM efforts.

Business Process Reengineering (BPR)

The main concepts that underpin the BPR approach include the following:

- Organisations should be organised around key processes rather than specialist functions.
- Narrow specialists should be replaced by multi-skilled workers, often working in self-managed teams.
- BPR involves total disassociation from current practices and radical rethinking.
- The direction for the requisite radical rethinking comes unequivocally from top management.

Managing Change in the NHS cites a number of studies that have found that two of the central principles of BPR – the radical approach to change and the erasing of historical context – are fundamentally incompatible with the traditions, culture and politics of the NHS. It suggests there is direct conflict between the revolutionary approach and the widely held belief that consideration of context is important in securing organisational change. The NHS evaluations found that BPR projects were implemented in an evolutionary way and struggled to identify core or generic processes.

Managing Change in the NHS argues that the purely top-down, imposed approach of reengineering has not proved successful in the NHS. Both bottom-up commitment, including the initiative of clinicians, and senior leadership are key to ensuring smaller improvements are consistent with overall direction. It is also vital for ensuring that redesign initiatives are integrated with mainstream organisational processes and objectives. While it is felt to be extremely helpful to have a dedicated change team who can maintain momentum and provide a pool of expertise, it is important that they are not isolated (and dismissed) as a 'special project'. There is consensus that redesign takes time, and that hopes of 'overnight' transformation are misplaced, although identifying some early successes helps gain interest and acceptance. Individuals and organisations need time to learn new ways of thinking, to reflect and to implement, and both clinical and managerial staff need dedicated time set aside.

Securing individual behaviour change

The Effective Health Care[4] bulletin *Getting evidence into action* provides a review of published accounts of methods and approaches that have sought to secure change in the behaviour of healthcare professionals. Its main conclusions are:

- Most interventions are effective under some circumstances; none is effective under all circumstances.
- A diagnostic analysis of the individual and the context must be performed before selecting a method for altering individual practitioner behaviour.

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4 Effective Health Care (February 1999) *Getting evidence into practice*, NHS Centre for Reviews and Dissemination, University of York

- Interventions based on assessment of potential barriers are more likely to be effective.
- Multifaceted interventions targeting different barriers to change are more likely to be effective than single interventions.
- Educational outreach is generally effective in changing prescribing behaviour in North American settings. Ongoing trials will provide rigorous evidence about the effectiveness of this approach in UK settings.
- Reminder systems are generally effective for a range of behaviours.
- Audit and feedback, opinion leaders and other interventions have mixed effects and should be used selectively.
- Passive dissemination when used alone is unlikely to result in behaviour change. However, this approach may be useful for raising awareness of research messages.

Managing Change in the NHS argues that the quality of implementation, the sensitivity to different points of view and the degree of support from influential members of the organisation are all vital to successful change. Managers need to respond to the fact that people in a system see things differently and therefore must work towards mutual trust and understanding based on transparency and honesty.

Key learning points that emerged in respect of services in change

Many of the learning points identified by respondents echoed the points made above.

Comments here represent many of the thoughts we heard expressed.

'Don't worry about structure, but focus on accountabilities, relationships and responsibilities. Let form follow function, as structure should change when change is needed. Otherwise there is a terrible waste of resource and the creation of cynicism'

'Change in the NHS has often involved mixed political messages; too many priorities or constant changes /additions to priorities; and constant detailed monitoring, especially if duplicated by different levels in the hierarchy'

'A clear statement of the expected outcomes at the start of the process and the timescales for the changes'

'Much more support in the year when we were actually setting up the organisation –there are loads of issues around staff transfer, transfer of property, creating the corporate governance framework for a new model of organisation was really exciting, but it did feel like that was done in isolation'

'If it is big bang, then do it quickly'

'Deal with the political issues'

'Project management skills - dedicated - to maintain momentum and keep all on board'

'Milestones along the way to maintain commitment, momentum and believe change can happen.'

Implications

In respect of these developments, the implications for Ireland appear to be:

- Consider whether the scale of service delivery operations offers opportunities to initiate and manage change in an engaged and highly supported way less possible in a larger system.
- Locate service infrastructure as close as possible to delivery and, wherever possible, support delivery through local or regionalised resourcing.
- Ensure clarity of purpose exists and is communicated effectively at each step in the organisational change process
- Concentrate on getting the 'ways of working' right; avoid a preoccupation with structure. Recognise the potential for restructuring to destabilise and focus on rebuilding processes, systems, relationships. The recovery costs are likely to be higher than anticipated.
- Use the learning from the general management experience documented here to focus in on clarifying responsibilities and accountabilities in service delivery i.e. an unambiguous 'line of sight' from decision to delivery at the front line.
- Avoid trying to create uniform geographical or organisational structures across the service; instead recognise local variation and tailor structures to encourage innovation.
- Build ways of working through local engagement and creativity rather than imposition.

Appendix 1

People we talked to

Listed below are the names of the people who took part in our discussions

Alan Carpenter	Somerset Coast PCT	Chief Executive
Anne Walker	Bedford and Hertfordshire Ambulance Service	Chief Executive
Caroline Wigley	Birmingham Women's Healthcare NHS Trust	Chief Executive
Caroline Taylor	Croydon PCT	Chief Executive
David Hill	James Paget Hospital NHS Trust	Chief Executive
David Peat	Primary Care Trust	Chief Executive
Gail Wannell	West Middlesex University Hospital NHS Trust	Chief Executive
Gerry McSorely	Nottingham City Hospital	Chief Executive
Gillian Duncan	North Hampshire PCT	Chief Executive
Graeme Betts	Hillingdon PCT	Chief Executive
Hilary Daniel	West Norfolk Primary Care Trust	Chief Executive
Jo Whitehead	South Gloucestershire PCT	Chief Executive
Louise Newcombe	Bassetlaw PCT	Chief Executive
Moira Britton	Tees and North East Yorkshire NHS Trust	Chief Executive
Paul Unsworth	Tendring PCT	Chief Executive
Peter Bradley	London Ambulance Service NHS Trust	Acting Chief Executive
Sheena Cuminsky	Wigan and Leigh NHS Trust	
Simon Pleydell	York Health Service	Chief Executive
Andrew Reed	Bedford and Luton Community NHS Trust	Chief Executive
Audrey Bradford	Fenland Primary Care Trust	Chief Executive
David Crawley	Isle of Wight PCT	Chief Executive
Graham English	Central Derby Primary Care Trust	Chief Executive
Ian Piper	Portsmouth Primary Care Trust	Chief Executive
Jeffery Worrall	Sherwood Forest Hospitals NHS Trust	Chief Executive
John Newbury-Helps	Barnet, Enfield and Haringey Mental Health	Trust Chief Executive
Paul Haigh	Kensington & Chelsea PCT	Chief Executive
Rhona MacDonald	Bath and North Somerset PCT	Chief Executive
Sandy Taylor	Durham County Priority Services NHS trust	Chief Executive
Sophia Christie	East Birmingham PCT	Chief Executive

Steve Shrubb	Northumberland Mental Health Trust	Chief Executive
Stuart Hatton	North West Anglia Healthcare NHS Trust	Chief Executive
Tony Gardener	Cornwall Healthcare NHS Trust	Chief Executive
Vince McCabe	South East Hertfordshire PCT	Chief Executive
Jan Sobieraj	Barnsley District General Hospital NHS Trust	Chief Executive
Rennie Fritchie (Dame)		Independent commentator
Dick Stockford	DOH	Director Development
Hilary Rowland	HAS	Chief Executive
Ron Kerr	National care standards commission	Chief Executive
Sue Rubenstein	Modernisation Agency	Development Specialist
Henie Lustgarten	Modernisation Agency	Development Specialist
Graham Arnell	Ex OPM: Private sector	
Peter Houghton	Norfolk, Suffolk and Cambridgeshire SHA	Chief Executive
Robert Creighton	Ealing PCT	Chief Executive
Alasdair Liddle	IM Power	Non-Executive Director
Paul Corrigan	Department of Health	Special Advisor
Andrew Foster (Sir)	Audit Commission	
Alan Langlands	University of Dundee	Principal & Vice Chanclr.
Nick Timmins	Financial Times	Public Policy Editor
Penny Humphris	Modernising Agency	Dir. Leadership prog.
Linda Brooks	Modernising Agency	Programme Lead
Karen Lynas	Modernising Agency	
Ken Sharpe	Ex NHS Manager,	Indpndnt. Fincl. Consltnt.
Sue Gallagher	Ex NHS Manager,	
Adrienne Fresko	Deputy Chair Audit Commission and former Chair of Croydon Health Authority	
Ken Jarrold	Strategic Health Authority	Chief Executive
Terry Hanafin	Essex Health Authority	Chief Executive
Candy Morris	Kent & Medway SHA	Chief Executive
John Allcock	Mental Health & Community Care Division, NHS Executive Senior Policy Manager	
Alan Burns	Trent Strategic Health Authority	Chief Executive
Jocelyn Cornwell	Commission for Health Improvement	Director
Jude Williams	Teenage Pregnancy Unit	Director
Alison Kitson	RCN	Prof. of Nursing & Director of the RCNI
Paul Beard	RCN	Director

Appendix 2

NHS Reform: Mapping the Nature of Change in the NHS over the last 15 years

Preface

This report aimed to identify the main strands of change in the NHS over the last decade and a half. It is based on a number of primary and secondary sources generated through a literature review.

Who's in Charge?

The mid-1980s was a difficult period for the NHS. Though government spending on health grew in real terms, resources were pushed to the limit as an ageing population, changing technology and increased user expectations all placed heavy demands on the NHS. There was much debate in the media and among policy think tanks over the solution to these problems and whether the NHS in its current form could effectively continue.

The Thatcher government was reluctant to commit significantly more resources to the NHS without first looking at options for fundamental reform. Across the public sector more generally, the government had embraced a style of management that stressed a number of key themes - value for money, efficiency, performance measurement, a focus on results, and a willingness to, both, learn from and use the private sector in delivering public services.

Against this backdrop, an inquiry into the management of the NHS was initiated in 1983 by the then Secretary of State for Health and Social Security. Led by Roy Griffiths (later Sir),

managing director of the Sainsbury's chain of supermarkets, the inquiry team presented its report in October. It found that the NHS had no coherent system of management at a local level. There was a lack of accountability and willingness to take responsibility for decision-making. Compared to management in the private sector, the NHS lacked any real continuous evaluation of its performance against criteria such as quality, operating within budgets, cost improvement, productivity, and motivating and rewarding staff. There was little measurement of health outcomes and little evaluation of clinical practice or the effectiveness of clinical interventions.[5]

The government argued that this lack of managerial control promoted inefficiency and that existing budgets had to be used more efficiently before there could be any talk of increased funding. Following the publication of the Griffiths report, a number of reforms were implemented intended to strengthen managerial control. These included:

- The 'consensus' style of management was rejected and replaced with general managers in health authorities, hospitals and units. The aim was to strengthen strategic direction and responsibility by putting in place a clear structure of line management and devolved budgets;
- Policy and strategy were separated from management within the NHS. The Health Service Supervisory Board advised on the strategic direction of the NHS, while the NHS Management Board was concerned with management, such as performance review of regional health authorities and finance;
- Management budgets were introduced into hospitals;
- The first package of national performance indicators was introduced to provide information on clinical activity, finance, staffing, support services and estate management. A second set appeared in 1985;[6]
- The NHS Training Authority was established to improve management training and education.

The newly established NHS Training Authority published "Better Management, Better Health" in 1986, which was a comprehensive review of management education, training and development in the NHS. From the 1960s to the mid-80s, managers in the NHS had had access to a number of local and national programmes, the former provided by health authority specialists or colleges, and the latter sponsored by the DHSS. With the NHS Training Authority, management development increasingly became a central concern of management generally, rather than a preoccupation of management development specialists.[7] For example, health authorities had to identify a local person with responsibility for implementing management development strategies and new national programmes were introduced, such as

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5 Bristol Royal Infirmary Inquiry (2001) *Final Report*: *Learning from Bristol: the report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984 –1995, Chapter 4, The Changing NHS 1984-1995*, Command Paper: CM 5207. London, HM Stationery Office

6 May, Annabelle (1993) Thatcherism, the New Public Management, and the NHS, in Light, Donald and May, Annabelle (ed) *Britain's Health System: From Welfare State to Managed Markets*, Faulkner & Gray, p. 24

7 Thompson, David (1997) Developing Managers for the Late 1990s, in Spurgeon, Peter (ed) *The New Face of the NHS*, Royal Society of Medicine Press Ltd, p.177

the National Accelerated Development Programme, Individual Performance Review and The Management Education Syllabus and Open Learning (MESOL) project, which offered learning programmes to new managers through a network of learning centres and delivered by open or distance learning.

By mid-1994, some six and a half thousand managers had been through the MESOL programme. Thompson argues that it was a success because it offered the market something it wanted. Many other development programmes, however, were less successful. Thompson points to a fundamental tension. The government's strategy on management development encouraged, both, management development providers to compete with each other for contracts and health authorities to buy development training that they felt was appropriate for them. This was a natural extension of the market philosophy apparent in other NHS reforms. At the same time, however, the government wanted greater national consistency and coordination of management development and tried to introduce an accreditation / recognition scheme for management centres and health authorities who had met appropriate standards, but this failed because neither purchasers nor suppliers of management development - the market - wanted it. The overall result of these tensions was fragmented management development programmes of varying quality and a 'supply-led'[8] system that saw too many programmes that lacked appeal to managers in the field.

In April 1991, the Training Authority was abolished and replaced by a NHS Training Directorate under the control of the NHS Director of Personnel. However, there was confusion and ambiguity around the role of this Directorate in that it combined a policy and strategic role with the function of commissioner and supplier of training products [9]. To tackle this problem, in April 1996 the NHS Training Directorate was abolished and its main functions split into two parts: a development unit, based in Leeds, responsible for overall policy and strategy; and an Institute of Health and Care Development in Bristol. Regional Education Development Groups, made up of purchasers and providers of health services, were also set up to make workforce planning and development a main responsibility of employers, rather than specialists or policy makers in the centre, which can be seen as a move to a more demand-led approach to management development.[10]

Overall, the Griffiths inspired reforms were part of a process that, in the eyes of some commentators, saw the, '*balance between managerial and professional authority began to shift toward the former.*'[11] This shift was a far from welcoming development for many clinicians, who argued that a chronic lack of funding was the real reason behind the perceived crisis in the NHS. In 1987, for example, the presidents of the Royal Colleges issued a public statement warning that the NHS was facing ruin. The late 1980s and 1990s were marked by very stiff and acrimonious opposition from many healthcare professionals as the government continued to push for greater managerial control. In 1989, it published the White Paper *Working for Patients*, which introduced a number of further reforms:

8 Thompson (1997), p.180

9 Ibid, p. 179

10 Ibid, p.180

11 Patricia Day and Rudolf Klein (1991) *Britain's Health Care Experiment*, Health Affairs 10 (3), p.6

- The NHS Policy Board replaced the Health Service Supervisory Board, with the Secretary of State as the Chairman, and the NHS Management Executive (the NHSME) was also created in the place of the former NHS Management Board. The intention was to further sharpen and focus the split between responsibilities for policy, on the one hand, and management or implementation on the other;[12]

- The composition of health authorities was changed to resemble company boards made up of health authority senior managers and non-executive directors. Representatives of the health professions and members nominated by local authorities were removed;

- Local managers were given the power to negotiate and monitor contracts with consultants, a power previously held at regional level. They were also included in the membership of the committees that made the distinction awards to consultants, the criteria for which now included the need for consultants to demonstrate a commitment to the management and development of the service.

In 1990, the introduction of the new GP Contract saw the first substantial move to define the role of GPs. Effectively imposed on the profession after the rank and file rejected it, the contract was motivated by government desire to keep down costs and focus on prevention in primary care, and to make GPs more accountable. It used a number of explicit contractual tasks and financial incentives and levers to influence the way doctors worked. GPs became more accountable to Family Health Service Authorities (FHSAs) and were required to produce annual reports and meet targets for various health screening and preventative services.[13]

Performance related pay (PRP) was also introduced into the NHS at this time when providers were given the power to introduce their own terms and conditions, but with the obligation that employees could remain on existing pay structures. A study by Arrowsmith *et al*[14] suggests that take up of PRP has been quite limited, but that senior managers in organisations where it has been tried see real merit in it. Senior managers believe that PRP can raise employee performance and deliver a clear message about the importance of organisational performance. Employees appear more sceptical, however, and believe that it has no effect or threatens traditional patterns of support. Arrowsmith *et al* conclude that the evidence, though not at all conclusive, suggests PRP has had only a very modest beneficial impact.[15]

The 1980s and early 1990's saw, then, a large number of managerial reforms, but it is worth remembering two important points. Firstly, throughout the period up to 1991, the NHS

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12 Bristol Royal Infirmary Inquiry (2001) *Annex A, Chapter 2 - A Historical Background to the NHS, Main events, 1984-1996*

13 European Observatory on Health Care Systems (1999) *Health Care Systems in Transition - United Kingdom*, WHO Regional Office for Europe

14 Jim Arrowsmith *et al* (2001) *Performance-related Pay in Health Care*, Journal of Health Services Research Policy, 6(2) (April 2001)

15 Ibid, p.118

remained largely unchanged in terms of the ways it was funded and structured. The Ministerial Review of 1987, prompted by intense media coverage of failures in the NHS and the outspoken criticisms of many within the medical professions, had initially looked at alternative methods of funding, but these were rejected. Secondly, though managerial control over the NHS was increased in many ways, there were still very large gaps, not least in regard to the management of clinicians. So, while medical audit became compulsory, managers had greater power for calling the medical profession to account for their use of public funds, and contracts were more explicit in what they expected from the jobholder[16], GPs and Consultants continued to have considerable independence in the way they worked. Testimony given on behalf of the DoH at the Bristol inquiry suggested that the Department still had a '*hands-off approach so far as individual clinical care was concerned.*'[17]

Evaluating the 'successes' of the 1980s push for managerial control is obviously quite problematic. Day and Klein state that, '*there is no doubt that throughout the 1980s the NHS did improve efficiency, productivity, and outputs. Lengths-of-stay were cut; costs per acute case fell. The number of patients treated in hospitals rose by more than 20 percent over the decade, a far higher figure than would have been expected from either spending trends or demographic changes.*'[18] They go on to say, however, that waiting lists continued to climb, which though a poor indicator in itself, contributed to widespread public opinion that the NHS was failing. The British Social Attitudes Survey on the NHS showed that dissatisfaction with NHS rose during the 1980s, from 25% in 1983 to 47% in 1990[19].

The uptake of private insurance also increased. As possible evidence of frustrated demand[20], the number of people covered by private insurance rose from 3.5 million at the start of the 1980s to almost 6 million by the end.

On the other hand, Chris Ham argues that the 1987 Review's rejection of alternative forms of funding shows the government felt the NHS was actually performing quite well compared to many foreign health systems. There were problems with long waiting lists, poor quality of care and a lack of user responsiveness, but total expenditure was relatively low - an important factor in the eyes of the government - and services were, overall, comprehensive and of a high standard[21].

According to the government, then, what was needed was not more fundamental reform, such as a move to system of private health insurance, but the rigour of the market to further increase efficiency and quality and to provide greater choice. These changes are outlined in the next section of this paper.

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16 Patricia Day and Rudolf Klein (1991), p.8

17 Bristol Royal Infirmary Inquiry (2001) *Annex A, Chapter 4 - National Accountabilities and Roles, The National Framework: responsibilities for healthcare, Perceptions of responsibility*

18 Day and Klein (1991), p.5

19 Julian Le Grand et al (1998) *Learning from the NHS Internal Market – A Review of the Evidence*, King's Fund, p.25

20 Day and Klein (1991), p.5

21 Chris Ham (1997) *Management and Competition in the NHS*, Radcliffe Medical Press, p.6

Choice and Competition

At the start of the 1990s there were two main developments intended to improve choice and quality of services. Firstly, the publication of The Patient's Charter, and secondly, and more significantly, the structural reforms contained in the *NHS and Community Care Act*.

The 1991 Patient's Charter set out a number of consumer standards and rights against which the performance of the NHS could be judged. In 1989, the White Paper *Working for Patients*[22], which formed the basis of the 1990 *NHS and Community Care Act*, had stated as an aim 'to give patients, wherever they live, better healthcare and greater choice amongst the services available.' It was part of an approach to putting patients first that had seen them increasingly referred to as consumers. The Griffiths inquiry, for example, which had been led and staffed by members drawn from the private sector, recommended that NHS managers should try to find out what consumers thought of their health services and use the information to modify them.[23]

The Charter was intended to make the NHS more responsive and thus act to raise quality. Ten new rights were established, including the rights to detailed information about local health services, including quality standards and waiting lists; guaranteed admission to hospital within two years of being put on a waiting list; and full investigation of any complaint about the service. These rights, however, were not legally enforceable. The Charter made more information available to the public, but this did little to directly change the practice of clinicians.

The second and more significant reform was the introduction of the internal or quasi market to the NHS. Influenced by the work of thinkers such as Alain Einthoven and the changes the government had itself brought about in the schools sector, the belief was that competition would benefit users by offering greater choice and raising the quality of services. As Klein puts it, *'by mimicking market forces, the new arrangements would force providers to be both more efficient and more responsive; if they failed to improve their performance, they would lose income as purchasers switched their contracts.'*[24]

The 1990 *NHS and Community Care Act* introduced a number of important changes to the NHS. First, the financing and purchasing of care was separated from its provision to create a form of internal market, with district health authorities acting as purchasers of services. They were given responsibility for assessing the healthcare needs of their populations and commissioning the services that would best met these needs. This separation aimed to challenge provider dominance by breaking the links that had formed between DHAs and their local providers. This would encourage, on the one hand, DHAs to shop around and, on the other, providers to improve the quality of their services in order to compete. In this way, the benefits of competition - better services - would be passed on to users.[25]

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22 Department of Health (1989) *Working for Patients*, Cm 555. London, HMSO

23 Michael Calnan and Jonathan Gabe (2001) *From Consumerism to Partnership? Britain's National Health Service at the Turn of the Century*, International Journal of Health Services, 31 (1), p. 122

24 Rudolf Klein (1998) *Why Britain Is Reorganizing Its National Health Service—Yet Again*, Health Affairs 17 (4), p.3

25 Chris Ham (1997), p.16

The second important change was that the providers of services - acute hospitals, mental health services, and ambulance services, and so on - formed self-governing NHS trusts. Fifty-seven (57) trusts came into being in April 1991 and by 1994 nearly all services had achieved trust status. As self-governing entities, they were given a number of financial, HR and managerial freedoms.

The third change involved GPs with larger practices (set at 11,000 patients or more, but later reduced to 5,000), who were allowed to apply to become fundholders. Initially, 306 practices covering 7% pf the population were involved, but by 1996 there were 3,735 practices covering over 50% of the population.[26] The programme originally allowed GPs to purchase a set range of range of diagnostic and elective services from any provider, but this range was increased over time. To help with the transition to fundholder status, practices received additional funding for that year. Once they had become fundholders, GPs received an annual management allowance used to employ fund managers and other staff.[27]

Much has been written about the effect of these changes on the NHS; in particular whether they increased choice for patients, improved the quality of services available, or affected the equity of services. There is room here to only briefly touch upon the main points.[28]

The evidence suggests that choice did not increase through fundholding. It was taken up by many GPs and they appear to have had more success than other purchasers in obtaining a responsive service – shorter waiting times and quicker test results, for example. They did not increase choice, however, in terms of where, when or how patients were treated. Patients did not shop around for alternative fundholding GPs and so there was little pressure on them to compete for patients.

Competition among providers was also limited. In many parts of the county there were few if any alternative providers for purchasers, the DHAs, to choose from. DHAs were not free to keep or invest any surplus they generated through savings and they were under pressure from the centre not to destabilise their local health systems. In 1994, the regional health authorities were converted into regional offices of the NHS, which further acted to strengthen management control over the DHAs. The upshot was that instead of shopping around for services, the health authorities increasingly moved toward negotiating long-term agreements with their local providers.

The freedoms of trusts were also severely constrained by the Department of Health. Trusts were not permitted to behave as true profit-seeking firms, but were required to break even and prices were strongly regulated. As with DHAs, this limited the incentive to act as true agents of a free market. In sum, as one commentator puts it, '*the incentives were too weak and the constraints were too strong.*'[29]

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26 Ibid, p.25

27 Ibid, pp.26-27

28 The following passages are based on Le Grand et al (1998), Calnan and Gabe (2001), Day and Klein (1991), European Observatory on Health Care Systems (1999), Ham (1997), Chris Ham (1996) *Contestability: a middle path for health care,* BMJ 312: 70-71, 13th January

29 Le Grand et al (1998), p. 130

It has also been argued that too little time was spent by the Department of Health preparing for the internal market. The reforms needed a strong supporting framework in place, but the reality was that, for example, managers lacked both the skills for purchasing and the information systems to provide up to date and comprehensive information on costs, money flows, clinical activity, and so on.[30] There was a lack of detail in the proposals and rather than use pilots to test them, the reforms were implemented in one go.

Within a very short time of implementation, however, the government began to soften its market rhetoric. 'Commissioning' replaced 'purchasing' as the market became more regulated. The policy agenda focused on other areas, such as improving the health of the population, giving greater priority to primary care, raising standards through the patient's charter, and ensuring that medical decisions were evidence based - policies that depend on effective planning and coordination in the NHS.[31] Fundamentally, then, government was caught between its faith in the power of the market to deliver choice and raise quality, and fear that a true market would lead to strong health inequalities and fractured planning.

30 Day and Klein (1991), p.12

31 Chris Ham (1996)

Targeting Health Gain

The late 1980s and 1990s saw a growth in interest by the NHS in what is called here 'targeting health gain'- improving clinical quality, such as through medical and clinical audit, evidence-based medicine and guidelines; and focusing on outcomes, particularly in public health. Alongside the medical professions and academic institutions, the NHS established research centres and programmes, encouraged the dissemination of best practice, laid down guidelines and protocols, and set targets.

Though the NHS always had an interest in effective and quality clinical care, guidelines had historically derived from consensus conferences or expert opinion[32]. For most of the 1980s, the government still considered that responsibility for the quality of clinical care lay with healthcare professionals themselves. Once trained, they could be relied upon to deliver care of a high standard. Medical audit did become more widespread during this period as the professional associations took greater interest. The Griffiths reforms (see above, *Who's in Charge?)*, too, acted as a spur for quality in a number of ways - the introduction into the NHS of private sectors various notions of quality, such as Total Quality Management; the establishment of regional and local quality assurance positions and programmes; and the emergence of clinical directors with a responsibility for the quality of their services.

Unlike the commercial world, however, the growing managerial focus on quality in the NHS did not encompass the whole organisation and all staff. Rather, medical quality and quality management were largely kept separate[33], with the former still in the hands of the professions. This 'hands off' approach began to change with the 1989 White Paper *Working for Patients*, which set out a definition of medical audit, a key component of clinical quality. Though it emphasised that medical audit should be professionally led, the Paper stated that management involvement was necessary to ensure that an effective system of medical audit was set up[34] and protected funding was made available to regional health authorities to support it. Audit was now to be included in all consultants' job descriptions and time for audit reflected in locally agreed job plans. In 1992 the multi-professional Clinical Outcomes Group was established to promote a multi-professional approach to *clinical* audit – covering all aspects of care, including that provided by nursing and paramedical staff. The group placed an emphasis on linking clinical audit to other programmes such as resource or risk management, quality assurance, research, development and education.[35]

There were also a number of other developments at this time related to quality:

- The setting up of the NHS Research and Development programme in 1990. In 1991 a research and development strategy was launched with the aim of basing clinical, managerial and policy decisions on robust information;[36]

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32 Steven H Woolf *et al* (1999) *Potential benefits, limitations, and harms of clinical guidelines*, BMJ 1999, 318: 527-530 (20 February)

33 BRI Inquiry Secretariat (1999) *BRI inquiry paper on medical and clinical audit in the NHS*, p.8

34 Ibid, p.13

35 Bristol Royal Infirmary Inquiry (2001) *Annex A, Chapter 2 - Main events, 1984-1996*

36 Geoffrey Rivett (2002) *From Cradle to Grave: fifty years of the NHS*, [Internet Version] http://www.cripplegate.com/index.html

- A national hospital accreditation scheme was developed from a pilot started by the Kings Fund, which examined hospital organisation and assessed the extent to which standards were being met, and action was taken when they were not. The pilot became a national scheme and by 1995 a third of the country's hospitals had submitted themselves voluntarily to the procedure;[37]
- The Clinical Standards Advisory Group (CSAG) established in 1991, advised ministers on clinical standards within the NHS. It began with neonatal intensive care, childhood leukaemia, cystic fibrosis, coronary artery bypass grafts, emergency and urgent admissions to hospital, the management of normal labour and services for people with diabetes. Studies noted significant differences in patterns of care and a clear gap between demand and the resources provided;[38]
- The internal market saw the rise of contracts between purchasers and providers that specified quality requirements, initially waiting times but then clinical quality indicators requiring specific audits and regular reports.[39]

The development of all the various mechanisms for assessing and improving quality was, however, haphazard.[40] Each developed along separate lines and without coordination. The result was that the roles and responsibilities of the various organisations involved were not well defined. This led to confusion as to who was responsible for what between the various parties - the DoH, the regional and district health authorities, the trusts and the various bodies outside the NHS, such as the Royal Colleges, and healthcare professionals themselves.[41]

Alongside the push for quality, public health was a subject for increasing discussion in the late 1980s. In 1988 an inquiry team under the chairmanship of the Chief Medical Officer, Sir Donald Acheson, published a report on the future of the public health role. It identified a number of problems, including: lack of information about the health of the population; lack of emphasis on health promotion and disease prevention; confusion about the roles and responsibilities of public health doctors; confusion about the responsibility for communicable disease control; and lack of information about outcomes on which to make informed choices.[42]

This was followed by *The Health of the Nation*, issued as a consultation paper in June 1991 and then as a White Paper the following year. It represented, for the first time, a clear strategy to tackle public ill-health and identified five priority areas for action - heart disease and strokes, cancers, mental illness, sexual health, and accidents – with a set of targets for the year 2000. The strategy was welcomed, though critics pointed to its emphasis on an individual's contribution to their poor health through behaviour, rather than referring to the socio-economic determinants of ill-health.[43]

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37 Rivett (2002)

38 Ibid

39 John Øvretveit (1997) Proving and Improving the Quality of National Health Services: post, present and future, in Spurgeon, Peter (eds) *The New Face of the NHS*, Royal Society of Medicine Press Ltd, p.126

40 Bristol Royal Infirmary Inquiry (2001) *Final Report, Chapter 6: Quality, Standards and Information, Other initiatives concerned with quality, Poor co-ordination of systems for assuring quality*

41 Ibid

42 European Observatory on Health Care Systems (1999), *Health Care Systems in Transition - United Kingdom*, p.18

43 Ibid, p.11

Shifting the Balance to Primary Care

The 1990s saw a significant growth in primary care. Between 1985 and 1995, the number of GPs in England rose by 10 per cent and average list sizes fell.[44] Primary care was seen as playing a vital role in public health and health prevention work and, thereby, acting to keep costs down in the expensive secondary care sector. In addition, it was, and still is, seen as a means of offering healthcare that better suits users' needs. By placing more care in the community, access is improved. From the 1990 GP contract to the creation of primary care trusts, there has been a real shift in emphasis so that by 2004 primary care is intended to manage 75% of the total NHS budget.

The 1990 GP contract used a range of tools to increase the role of GPs and other primary healthcare professionals in the area of public health. These included financial incentives for achieving immunisation and disease-screening targets and performance related payments for health promotion and chronic disease programmes. These latter involved registration, data collection and the provision of advice and included maintaining registers of patients with hypertension, coronary heart disease and stroke; maintaining registers of patients' smoking habits; monitoring diet and physical activity; carrying out annual health checks on people over 75 years of age; and carrying out cervical and breast cancer screening.[45]

The GP fundholding reforms, touched upon earlier in this paper, saw a big expansion in primary care-based purchasing. More GPs were involved than ever before in such activities and as the decade progressed, different kinds of fundholding developed, such as multi-practice consortia and Total Purchasing Pilots. The latter provided fundholders budgets for purchasing the complete range of secondary and community health services for their patients. An evaluation study on the ability of total purchasers to achieve their own objectives found that, '*The pilots with the highest direct management costs per head were the most likely schemes to meet their objectives.*'[46] Looking forward to the proposed establishment of PCGs (see below), the study concluded that, '*to be effective commissioners, these care groups will need to invest heavily in their organisational development.*'

Improvements in primary care services during this period were noted. One study found that many practices had invested heavily in equipment and services; there was a wider range of services available, and a substantial increase in nursing and other staff.[47] Many services that were previously only available in hospital settings were increasingly transferred to primary care settings.

The government's increasing attraction to the idea of a 'primary care led NHS' fed into the 1995 *Health Authorities Act*, which led to closer integration of primary and secondary care through the merger of district health authorities and family health service authorities. In

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44 Geoffrey Rivett (2002)

45 European Observatory on Health Care Systems (1999), p.59

46 Goodwin, Nicholas *et al* (1998) *Evaluation of total purchasing pilots in England and Scotland and implications for primary care groups in England: personal interviews and analysis of routine data*, BMJ, 317:256-259 (25 July)

47 Rivett (2002)

1996, this was followed up with a consultation on the future of primary care in the NHS. The resultant White Paper, *Choice and Opportunity: Primary Care: the Future* set out a number of new models of primary care that the government intended to pilot.

The election of a Labour government in 1997 only strengthened the role of primary care as a gateway to health services. Fundholding was replaced by Primary Care Groups (PCGs), though GPs retained their status as independent contractors. Today, PCGS have developed into primary care trusts and the traditional GP practice is now being increasingly supplemented by a new range of primary and intermediate services, such as walk in primary care centres, NHS Direct, Minor Injury Units, Diagnostic and Treatment Centres and healthy living centres.

As these changes have progressed, however, there have been some doubts expressed over the ability of PCTs to effectively manage the roles and responsibilities they have been given.[48] Attention has focused on how some PCTs can deliver on local needs in the face of high priority national targets and a lack of capacity, both financial and human. The change to PCT is not just organisational, but cultural, too, as GPs, are being encouraged to take a more corporate approach. This is presents a difficult management challenge.[49] Help for PCTs has come from the Modernisation Agency, the internal development agency for the NHS set up in April 2001. The National Primary Care Development Team (NPDT) is managing a number of initiatives, including The National Primary Care Collaborative, which has been judged by an Audit Commission report to have been very successful in improving access and in changing practice culture to do this.[50]

The same Audit Commission report notes, however, that there is considerable variation in the range and quality of services available to patients. Primary care has historically been neglected in favour of spending on hospitals and much of the new money will have to be spent on basic improvements. Nearly one in ten GP premises fail basic standards, such as having sinks in treatment rooms, with a higher proportion in deprived and inner city areas.

There are also huge pressures on staff working within primary care. There is a shortage of both experienced managers and a range of clinicians, particularly GPs. The same Audit Commission report showed that the overall vacancy rate for GPs is less than 3%, but in some areas one in five GP posts is vacant. One in three GPs and practice nurses are aged over 50, but in some areas this proportion is even higher – a demographic 'time-bomb'. Furthermore, the number of those joining general practice is only slightly higher than the number of those leaving. More staff are also working part-time (one in five GPs and more than four in five practice nurses) and this is likely to increase.

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48 Anna Coote and John Appleby (eds) (2002) *Five-year Health Check (5): A Review of Government health policy 1997-2002*, King's Fund, p.7

49 David J Hunter (2001) *Managing the NHS*, Health Care UK - Winter 2000, Kings Fund, p.72

50 Audit Commission (July 2002), *A Focus on General Practice in England*, p.30

The Modernisation Agenda

The pace of change within the NHS under Labour, particularly from the time Alan Milburn was appointed as Secretary of State for Health in 1999, has been astonishing. Some of this change can be see as a continuation of the reforms begun under the Conservatives, such as the focus on quality and patient choice, but one obvious and significant difference has been the commitment of massive new public funding, which dwarfs the increases seen in the 1990s. Following on from the Wanless Report, which looked at the long term funding needs of the UK NHS, the NHS budget is now more than £25bn higher than it was in 1999-2000. From 2003-04, spending will rise by an average 7.5% annually, making it the largest ever sustained increase in NHS funding.

The government believes, however, that increased investment in itself will not deliver the targets it has set for the NHS. A multi-themed agenda of modernisation has been developed, including greater patient and public involvement; opening up the NHS to alternative providers; new frameworks for raising performance, standards of clinical care and levels of accountability; training and development for staff; and shifting power closer to the front-line. All this has been underpinned by a fundamental restructuring of the NHS and the establishment of a number of new agencies. This section of the report provides a brief overview of these reforms (some of which have been touched upon earlier in this paper).

Placing the user or citizen at the heart of public service delivery is a Labour modernisation theme that runs through the whole of the public sector. Within the NHS, the NHS Plan states that, 'care has to be shaped around the convenience and concerns of patients.'[51] This takes a number of forms:

- Offering users choice in their care so that it is as convenient and suitable for them as possible. The government has stated that, 'patients in the NHS will have a choice over when they are treated and where they are treated…Hospitals will no longer choose patients. Patients will choose hospitals;[52]

- Providing users with good quality information so that they are able to make informed decisions about their care or that of family members. Current examples include the star ratings for acute, specialist, mental health and ambulance trusts (primary care trusts will receive theirs in 2003), and the Commission for Health Improvement's inspection reports;

- Involving patients and the wider community in the design, delivery and regulation of NHS services so that they reflect their needs and can be seen to operate in a transparent and accountable manner. Patient / user involvement will be increased through new organisational structures, such as Patient Forums, and greater representation in regulatory bodies – for example, the Nursing and Midwifery Council has increased the number of lay members from four to eleven.

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51 Department of Health (2000) *The NHS Plan: A plan for investment, A plan for reform*. London, HMSO, p.88

52 Department of Health (2002) *Delivering the NHS Plan - next steps on investment, next steps on reform*. London, HMSO, p.22

In order for patient choice to really work and to deliver on the targets set by the government for the NHS, capacity in the system has to be increased. This is to come from working with alternative providers – principally private sector healthcare companies. Instead of a single monopoly provider of services, there will be a greater plurality of providers, but inspected and regulated according to set standards. The NHS has begun to and will increasingly see public private partnerships to support the rapid development of Diagnostic and Treatment Centres (DTCs); use of spare private sector hospital capacity backed by a new framework of prices based on healthcare resource groups (HRGs); and the bringing in of overseas providers of healthcare with their own clinical teams.

Underpinning this plurality of provision has been the introduction of a broad regulatory framework that looks at clinical quality, performance and accountability. The 1998 White Paper *A First Class Service: Quality in the New NHS*[53] set up a number of agencies and systems, some of which have again been reformed more recently:

- The National Institute for Clinical Excellence (NICE) issues guidance for clinicians about new and existing interventions on their clinical and cost-effectiveness;
- National Service Frameworks (NSFs) set out 'care blueprints' to define how services are best provided and to what standards;
- Clinical governance, the statutory duty of quality, aims to introduce a system of continuous improvement into the NHS. To help make clinical excellence and quality improvement central features of the NHS, the Modernisation Agency offers support by providing direct support through development programmes; by providing information about the experiences from local development work; and by providing a forum for discussion;
- The Commission for Health Improvement (CHI) assesses local action to improve quality. An Office for Information on Health Care Performance is to be established within it to collect and analyse data, and publish independent information on NHS performance, including the NHS performance ratings. CHI will also publish a new, independent annual report on the quality of services for NHS patients. In 2004, CHI will bring together the health value for money work of the Audit Commission and the private healthcare role of the National Care Standards Commission to become the Commission for Healthcare Audit and Inspection.

In addition, new special health authorities have also been established, such as The National Clinical Assessment Authority (NCAA), which provides a support service to the NHS when concerns over the performance of an individual doctor are raised; and The National Patient Safety Agency, which co-ordinates the efforts of the entire country to report, and more importantly to learn from, adverse events occurring in the NHS.

A programme of reform has also targeted the regulation of the healthcare professions. The aim has been that the various professional bodies should be streamlined, have faster and more transparent processes, have much greater patient and public involvement and thus strengthen public confidence in professionally led regulation. For example, the new Nursing

53 Department of Health (1998) *A First Class Service: Quality in the new NHS.* London, HSMO

and Midwifery Council has reduced its members from 60 to 35, but increased the number of lay members from four to eleven. In addition to reforming the individual regulatory bodies, the regulatory system as a whole is being changed. A new overarching body, the Council for the Regulation of Healthcare Professionals, is being established so that the regulatory bodies are held properly and explicitly to account for their performance as competent public authorities.

Star ratings now exist for NHS trusts, with plans for primary care trusts to follow. The ratings measurements include quality of experience for patients, how efficiently resources are used, and fairness of access. More autonomy will be given to the best performing and increasing intervention in the poorest.

To support the implementation of the NHS reforms, a human resources strategy[54] has been put in place for the entire workforce. Technological change, new government priorities focusing on widening access and life-long learning, the development of new health roles and the expansion of existing ones, the growth of multi-disciplinary working, and the need to make the NHS a more attractive place to work, have all contributed to the government taking a fresh look at how it trains and develops NHS staff. The new NHS University (NHSU), first mentioned in the Labour 2001 election manifesto, will be officially launched in October - November 2003. It is intended that the NHSU will work in partnership with existing education providers to offer nationally recognised learning programmes to all staff, as well as to patients, volunteers and carers. A consultation exercise is currently engaged in helping to develop initial plans, but it will offer learning opportunities for all from literacy and numeracy courses to vocational qualifications, postgraduate education and management and leadership development.

Workforce development confederations have replaced the regional education development groups and a number of other agencies to bring together local NHS and non-NHS employers to plan and develop the whole healthcare workforce. Newly established, they will work with strategic health authorities, postgraduate deaneries, government offices for the regions and regional development agencies, among others, to deliver on workforce issues in the context of the NHS Plan and local priorities. Specific roles include developing and leading an integrated approach to workforce planning for health and social care communities; taking the lead in developing a shared approach to HR policy and practice; negotiating, managing and monitoring the performance of contracts with education and training providers; and promoting patient, carer and student input into the development and delivery of healthcare education and training.[55]

At a management level, the government has recognised that there is a need to strengthen and develop the way NHS is managed if the modernisation agenda is to be successfully delivered. *Managing for Excellence in the NHS* [56] outlines the strategy:

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54 Department of Health (2002) *HR in the NHS Plan: More staff working differently*

55 Department of Health (2002) *Workforce Development Confederations Guidance*, http://www.doh.gov.uk/workdevcon/guidance.htm

56 Department of Health (2002) *Managing for Excellence in the NHS*

- A Code of Conduct for NHS Managers that sets out shared values;
- Supporting managers and leaders through investing in development, particularly via the Modernisation Agency;
- Driving to create an experienced and diverse leadership by recruiting black and minority ethnic managers, young managers, supporting clinicians making the move to management, and enhanced training for in-house specialists;
- Developing senior management and succession planning through a senior management network.

An important player in this strategy will be the Modernisation Agency (*also see above, p.14*), an internal NHS organisational development agency established in April 2001. Its role is to promote reform and services for patients by working with NHS staff and their partner organisations. It aims to complement local initiatives through a range of leadership development and service improvement programmes for both clinicians and managers. The Agency's Leadership Centre runs programmes such as the RCN Clinical Leadership Programme, Clinical and Medical Directors Leadership Programme, programmes on leadership for nurse and allied health professions consultants, and for executive directors and chief executives, and on public health leadership, and team leadership development in clinical services. Service improvement programme areas include clinical governance, demand management and primary care.

Concurrent with the delivery of this modernisation agenda has been the restructuring of the NHS. The government has stated that the Department of Health will be slimmed down as power and resources are devolved from Whitehall to regional and local levels.[57] Day-to-day management of the NHS is being passed to strategic health authorities (SHAs), while healthcare resources are being shifted to primary care trusts. New NHS foundation trusts will not be line managed by the Department, but held accountable through their governance arrangements, a licence issued by an independent regulator, CHAI inspections against national healthcare standards and contracts with commissioners. They will have the freedom to develop their board, governance and stakeholder structures within defined parameters and retain all revenue as surpluses. However, they will be under a statutory obligation to manage their assets for public benefit, such as reinvesting revenue into local services.

Looking at the whole Labour reform agenda for the NHS, some commentators have argued that, *'The Government has tried to do too much, too soon, and has relied too heavily on structural change to restore a service suffering from decades of under investment.'*[58] A number of achievements are noted - closer integration of health and social care, a new system for transparent, evidence-based rationing in NICE and a more standardised perspective on healthcare. However, the government's desire to 'knock the system into shape' has necessitated a huge number of interventions and thus strong central control.

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57 Department of Health (2002) *Delivering the NHS Plan*, p.28

58 Anna Coote and John Appleby (2002), pp. 6-7

For all the talk of local empowerment and the decentralisation of control, a frequent complaint found among clinicians and managers of PCTs, NHS trusts, SHAs and other organisations is that they have to deal with too many organisational changes, inspections, reviews, targets and demands for performance information from an enormous number of government agencies. In the view of Calman et al, [59] only front-line management can undertake detailed redesign of services, but instead of improving frontline services, senior management time is taken up with demands from government. The result is that, according to David Hunter, '*the climate surrounding the Government's style of managing is one of fear and distrust.*'[60] With such a strong centre, managers increasingly look to the DoH rather than local communities for guidance, which is in danger of creating a 'managerial infantilism'[61] that cannot deliver the Modernisation Agenda.

59 Kenneth Calman *et al* (2002) *Make or Break Time? A commentary on Labour's health policy two years into the NHS Plan*, School for Health, University of Durham

60 David J Hunter (2001) p.71

61 Ibid. p.75

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