Improving performance in the English National Health Service

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Performance improvement in the English NHS since 1997 has resulted mainly from targets and terror. The Coalition Government elected in May 2010 is committed to reducing the use of process oriented targets, and instead will seek to bring about further improvements in performance through patient choice and provider competition. The adversarial political system in Britain contains the risk that newly elected governments will throw the baby out with the bathwater. Health policy makers should resist the temptation to reject policies inherited from their opponents and should seek to provide direction from the top and empower frontline teams in taking forward reform.

Key words: targets, performance management, choice and competition

What is the evidence from 1997–2010?

A recent review by the King’s Fund found that considerable progress has been made in improving the performance of the National Health Service (NHS) in England under the Labour Government first elected in 1997. Notable achievements include major and sustained reductions in waiting times for treatment, reductions in rates of health care associated infections, improvements in areas of clinical priority such as cancer and cardiac care and progress in reducing rates of cigarette smoking. These achievements have resulted from substantially increased spending on the NHS linked to an ongoing programme of reform.

The Labour Government’s reform programme focused initially on the use of government targets and national standards to bring about improvements. Examples included targets to cut the length of time patients have to wait for an appointment and standards set out in national service frameworks to improve clinical services. Subsequently, steps were taken to increase patient choice and stimulate provider competition, alongside measures to strengthen inspection and regulation. The most recent phase of reform has sought to place greater emphasis on the role of clinicians in improving the quality and safety of health care in recognition of the limits of targets as a means of achieving sustainable improvements in care.

Political devolution to the four countries that make up the United Kingdom since 1999 has resulted in different approaches to health care reform as well as different results. An analysis carried out by the Nuffield Trust compared the experiences of England with what has been achieved in Northern Ireland, Scotland and Wales in the last decade. The analysis concluded that England had made greater progress than the other three countries over this period and it argued that the main reason for this was the greater emphasis placed in England on targets and standards as a means of reform.

This conclusion is echoed in other studies that have drawn attention to the role of ‘targets and terror’ in contributing to waiting time reductions in England. Specifically, the strengthening of performance management, and the holding to account of NHS organisations for the delivery of the government’s health policy objectives, has focused the attention of leaders at a local level on the implementation of high priority targets. The boards of NHS

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organisations, and particularly chief executives and their senior colleagues, know that their jobs are at risk if they fail to meet these targets, and this has had the effect of concentrating management effort on those targets seen as being of greatest importance.

Also significant has been the growing influence of the regulators, such as the Healthcare Commission, the body that oversees the quality of care, and Monitor, the organisation that regulates NHS Foundation Trusts, in reinforcing the focus on national targets and standards. Not only this, but also the regulators have intervened when NHS organisations have experienced financial difficulties or the quality of care they provide has come into question. I can speak from experience as a non-executive director of an NHS Foundation Trust about the large amount of time and effort local leaders spend ensuring that they meet the requirements of the regulators and keeping them at arm’s length.

By comparison, patient choice and provider competition appear to have had a limited impact on performance to date. This was the view of a joint review carried out by the Audit Commission and the Healthcare Commission in 2008 and has been confirmed by recent research by the King’s Fund into the way in which policy has been confirmed by recent research by the Health Service Research Centre.

The role of choice and competition in improving performance remains an issue of debate. In organisations like Jonkoping County Council competition works mainly through transparent reporting of information and comparing what is achieved in relation to other county councils in Sweden. Much the same applies in the Veterans’ Health Administration (VA) where the use of comparative information on the performance of regional networks is used to stimulate improvement. In the VA and in Intermountain Health Care, there is a clear and consistent focus on the quality of care, underpinned by a culture of measurement and reporting. This includes investment in information systems and deep engagement by clinicians. By contrast, it has been argued that the ability of patients to choose another health plan and the threat posed by competing providers are important factors in enabling Kaiser Permanente to leverage the benefits of being an integrated system to achieve high levels of performance.

One of the conclusions from research into high performing health care organisations is that skills in execution and implementation may have a bigger influence on quality improvement than the particular methods of improvement (for example, lean, total quality management and quality collaboratives) that are adopted. This reinforces the need to invest in internal capabilities for improvement to make a reality of change being driven bottom up instead of top down. If clinicians are expected to play an increasing role in performance improvement, then giving priority to the development of clinical leaders and providing them with the appropriate skills is likely to be necessary. This has obvious implications for the success of policies like commissioning in future.

The pendulum effect in health policy

As policy on the NHS in England migrates from targets and terror to empowered clinical teams as the main means of improving performance, together with a greater emphasis on patient choice and provider competition, there is the perennial risk that the pendulum will swing too far and too fast in the opposite direction. Studies of high performing companies have drawn attention to the need to work across a series of dualities in seeking to improve performance. These dualities include:

- providing direction from the top and empowering front line teams to make change happen

Implications for the new government

The election of a Coalition Government made up of Conservative and Liberal Democrat politicians in the May 2010 general election heralds a new approach to performance improvement in the English NHS. The government has already made it clear that less reliance will be placed on process oriented targets in future and more attention will be given to improving health outcomes, such as cancer survival rates. Patient choice and provider competition will also be given priority and renewed efforts will be made to empower clinicians to bring about improvements in care. Particular emphasis is being placed on the role of general practitioners who will be expected to take control over budgets with which to commission most care for their patients in a radical development of the practice based commissioning policy promoted by the previous government.

The question that arises is whether these policies will be sufficient to build on the progress made in England since 1997 and to enable areas of under achievement, such as improving productivity and focusing much more on quality and safety, to be addressed? In addressing this question, the results of recent research into high performing health care organisations around the world hold some pointers. This research indicates that in many of these organisations performance improvement derives more from building internal capabilities for improvement than responding to external pressures such as targets, national standards and regulators. To borrow a phrase from Kaiser Permanente, performance improvement results from ‘commitment rather than compliance’, and depends critically on engaging clinicians in the work that needs to be done.

Evidence from Kaiser Permanente, as well as other high performing organisations such as Jonkoping County Council in Sweden, the Veterans’ Health Administration and Intermountain Health Care in the US, also indicates that performance improvement requires a consistency of purpose over time and much greater stability in leadership than is usually the case in the NHS. Raising standards of care is not amenable to quick fixes, and patience is needed before the results of improvement efforts become apparent. Particularly important is investment in training and development for staff and building the leadership and change management capabilities to implement and sustain improvements over time. This includes setting goals for improvement, measuring progress towards their attainment and publishing the results.
promoting competition where it offers the greatest potential and supporting collaboration where organisations need to work together to improve performance

working through the hierarchy as well as building relationships through networks

emphasising the importance of clinical engagement and leadership while valuing the role of managers

managing the present and planning for the future

The adversarial political system in Britain contains the ever present danger that newly elected governments will, in colloquial terms, ‘throw the baby out with the bathwater’ and reject policies they inherit because they were developed by their opponents. At some future date these policies are refreshed when the preferred approaches of the politicians in power do not have the desired effects. This is precisely what happened on the election of the Labour Government in 1997 with the ending of the internal market experiment promulgated under the Thatcher and Major governments followed by its reinvention in a much more radical form by Tony Blair in 2002.

In the current context, there is a real risk that the contribution that targets and standards have made to performance improvement has not been sufficiently acknowledged by the Coalition Government and that some of the progress made since 1997 will be lost as a consequence. To make this point is not to argue for the new government to simply continue the approach taken by its predecessor. Rather, it is to make the case for policy learning in which governments build on what has worked rather than always returning to the drawing board.

REFERENCES


HiTs now included in MEDLINE

The Observatory is delighted to announce that its HiT country profiles will now be included in MEDLINE, the US National Library of Medicine’s premier bibliographic database. This will increase dissemination and ensure health system information is available to all those who need and want it most. It will also reinforce the Observatory’s commitment to supporting and promoting evidence-based policy-making in health.

MEDLINE is available at: http://www.nlm.nih.gov/databases/databases_medline.html

Launch of new HiT Template

The European Observatory on Health Systems and Policies is excited to announce the launch of a new and improved template for the Health system profile (HiT) series. HiTs are country-based reports that provide a detailed description of a health system and of policy initiatives in progress or under development. They are produced by country experts in collaboration with the Observatory staff. The HiT template is designed to guide the writing of HiTs by setting out key questions, definitions and examples needed to compile a country profile of the health system.

This new edition of the template is a revised version of the 2007 template and incorporates the many useful comments and suggestions from users and contributors. New features include: clear sign posting for ‘essential’ versus ‘discretionary’ sections; summary paragraphs for all chapters; a revised and extended chapter on performance assessment; and increased focus on public health and intersectorality.

The new template is available to download at: http://www.euro.who.int/__data/assets/pdf_file/0003/127497/E94479.pdf