Prime Minister
An interesting note from Howard Davies on the NHS reforms. He is relatively confident on the contracting system – but is worried about bed information flows and management control.
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FROM THE CONTROLLER

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PERSONAL AND CONFIDENTIAL

A Turnbull
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Dear Andrew

You asked if I had any thoughts on the progress being made around the country on implementation of contracting in the NHS and the likely impact of the shift to capitation-based funding on the patterns of referral next year.

As you know, our formal responsibilities in the NHS do not take effect until October, so my impressions are inevitably anecdotal. I have been spending time in the Oxfordshire DHA and the John Radcliffe Hospital, and have discussed the prospect with GMs and others from four other regions.

Progress on Contracting

Though a lot of constructive work has been done, few HAs will have a solid basis of financial information on which to build prices for individual procedures or patient stays. Only in the early Resource Management sites can this be done with any accuracy.

But this absence of information is generating less anxiety than might be expected. The managers and clinicians I have talked to do not expect it to be a major problem in practice, in the short term at least. This is so for three reasons:

- many believe that the early focus should and will be on service agreements based on needs assessments rather than on detailed pricing arrangments. They see this as central to the success of the purchaser/provider split, and as something which is achievable next year;

- the lack of information affects both sides of any bargain. Providers do not know what to charge. Purchasers do not know whether prices quoted are high or low;

- as a result, they expect relatively little change in the pattern of referrals in year one.

These expectations may be unrealistic. But it is apparent that many authorities are implicitly treating year one of the contract regime as something of a "shadow" exercise. In other words, they will seek to **describe** the present pattern of referrals in contractual terms, rather than seeking to use the contracting process as a lever to engineer change in that pattern. As a result, even "importing" authorities like Oxfordshire expect to see roughly the same volume of business come their way next year as this.

This would suggest that the contracting process might safely be left to proceed next year, and that few disruptive changes will occur. But there are two other aspects to consider:

- the impact of GP practice budget holders and

- the special position of London.

Risk Areas

GP fundholder referrals are less easy to predict and control than those of purchaser districts. But there is evidence to suggest that in the short run they will not be very volatile. Some hospitals, self-governing candidates in particular, have surveyed GPs in their area to assess their intentions. Most have, I think, found that they do not plan major shifts. This is in part because they like to argue that they already refer in the way they think best for their patients. It may take a little time for the implications of greater choice to make themselves felt.

The London acute care problem - too many expensive teaching hospitals - remains to be resolved. One hopes that the dynamics of the reforms will make it more capable of resolution in due course. Certainly I am told that the medical barons are now prepared to admit that there is a problem and to discuss the way forward with NHS managers.

One might expect that the suburbs and shires around the capital would take the earliest opportunity to take some of their business away. But I have to report that the London Regional General Managers do not expect that to happen. This is partly because they know the suburbs and shires are short of capacity themselves, but also, I think, because they are determined to avoid disruptive change at a sensitive time by using the financial levers they still hold to oblige districts to refer in to the centre. I have no doubt that this will create strains within the system, indeed some are already apparent (the Guy's general manager's resignation). But they may be manifest in the form of managerial arguments, rather than ward closures.

Could I offer a couple of supplementary observations?

Style

First, there is some irritation among managers at district and hospital level about the style of communications they get from the centre. They think there is too much focus on details and "ticking boxes" to record progress, and too little on the underlying purpose of the reforms. They think this is both tiresome and counterproductive - because it will inevitably be apparent that many of the details are not in place in April. This will be presented by some as a sign of failure, even though almost all the people I meet believe that much of what is happening is beneficial to the NHS and, furthermore, that clinicians attitudes are changing fast.

Management Control

Second, press speculation on the speed of the reforms of course generates comments in the NHS. Most of the managers I have spoken to take a slightly cynical, world-weary line: "Of course change will not go quite as fast, or be implemented in quite as pure a way, as Ministers might like. We are practical men. We know in which direction we are supposed to move. But we also know we must not take too many risks, particularly in the next couple of years".

The question comes down, then, to how much trust one has in the ability of management to control the system, particularly in the face of groups who may have an interest in destabilising it.

I cannot answer that question with any confidence. What I would say is that the managerial grip is going to have to be very tight in the next 18 months. It will be vital to ensure that information flows up the system, about what is happening on the ground, in time to influence it. My impression is that the information flows in the NHS are weaker in that direction. The periphery picks up hints from the centre quite fast; the centre does not always seem to know what is happening, or about to happen, at the periphery. It monitors progress against its own agenda, but does not always pick up the local dynamics of change.

Paradoxically, perhaps, it may be that it will be easier to maintain a tight grip if the reform process is seen to be proceeding and according to plan. But managers need to be given some discretion to steer around obstsacles and selectively to pull back from fences at which individual horses look likely to fall.

Yours sincerely

PP Howard Davies