PRIME MINISTER

10 January 1986

VALUE FOR MONEY SEMINAR: HEALTH

The admirable note by the Efficiency Unit makes it clear that it is all very well to develop 450 performance indicators but you then need to get people to act on them. The DHSS will use them in the annual reviews of the performance of regional health authorities. That is all well and good, but is hardly exciting.

Ask Victor Paige to choose the ten most important performance indicators. Identify the ten least efficient district health authorities under each indicator. Send Victor Paige to visit the five health authorities which score worst to find out what is going wrong and tell them to buck their ideas up. One or two District Chairmen might even wish to resign.

Conduct exactly the same operation at the top end of the scale. Victor Paige and Barney Hayhoe should visit the best five districts and praise them publicly. Maybe one or two of the key individuals could be honoured. In due course, you might be free to visit the health authority scoring best over all.

High profile decisive action like this is what is needed to galvanise the Health Service.

DAVID WILLETTS David Willetts

JS10/RI5

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PRIME MINISTER

VALUE FOR MONEY SEMINAR 10 00 AM WEDNESDAY 15 JANUARY - THE NHS

The purpose of this seminar is for Victor Paige and his team to display to you the means by which the efficiency of the NHS is being improved, the results achieved, the future strategy, and the performance indicators by which progress will be measured. It will provide an opportunity for you to compare this approach with that of John Banham of the Audit Commission. You will recall asking if the Commission's approach could be applied to the NHS.

About a dozen people will attend. They are listed in Annex A. The principal speakers will be Michael Fairey and Ian Mills. Michael Fairey is a Deputy Secretary board member of the NHS recruited from the North West Thames Regional Health Authority. He will demonstrate how a general manager could use the performance indicators in a specific district (in this instance Basildon and Thurrock). Ian Mills is the board member for finance and was recruited from Price Waterhouse Associates. He will talk about financial management in the NHS.

Financial resources for the NHS are growing slowly in real terms while the demand - especially from the over-75s - is rising fast. The need is for improved productivity and cost savings. Up to now effort has been concentrated on administration and support services. There is still good mileage there as the NHS scrutinies (Annex B) show; but the NHS cannot neglect the area of big money: medical and nursing manpower. It needs to improve unit costs per patient.

I suggest you take both presentations before opening up discussion. My impression is that after a slow start the NHS board is making good progress. It would be helpful if the tone of discussion were encouraging but firmly directed to delivering better results. Specific points are:

(1) Do the performance indicators go to the heart of the matter? For example, do they enable a general manager to focus on the right issues in the Barnet District Health Authority? How will they be used to give the people of Barnet a better deal?

(2) What do the indicators show about the success of treatment? Are they mainly for accountants or can they be used by doctors to appreciate and improve performance in the NHS?

(3) When will it be possible to use the indicators to set targets for improving performance?

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(4) How can the indicators be used to get some good publicity for value for money in the NHS?

(5) Will clinicians be given budgets for patient care and how will they be encouraged to make the most of those budgets?

(6) Derek Rayner introduced scrutinies into the NHS in 1982. They found great scope for improvement (listed in Annex B). Where has the NHS got to in implementing the improvements? Can the pointers from scrutinies be used to generate improvements on a much wider scale (eg surplus land and buildings, energy conservation, working practices of hospital ancillaries, use of consultants' time)?

(7) Is there too much interference from DHSS? There are 500-600 formal circulars to the NHS each year, 3,400 written and 6,600 telephone communciations on personnel matters alone. There must be great scope for simplification and savings.

ROBIN IBBS
10 January 1986

(Copy to Sir Robert Armstrong)

JS10RI17

ANNEX A

PROBABLE PARTICIPANTS

Secretary of State for Social Services
Minister for Health

Sir Kennth Stowe

Victor Paige)
Ian Mills) NHS Management Board
Michael Fairey)

Sir Robin Ibbs
Sir Robert Armstrong
Nigel Wicks

JS10/RI6

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ANNEX B

NHS SCRUTINIES

FIRST ROUND (1982-1984)		Savings identified (£m) Annual	One-off
1.	Use of non-ambulance transport	15	20
2.	The non-emergency ambulance service	9	-
3.	Central stores	"substantial"	-
4.	Residential accommodation	10	up to 700
5.	Recruitment advertising	4	-
6.	Collection of income due to Health Authorities	½	-
7.	The cost of catering	15-20	-
8.	Road Traffic Act charges	-	-
9.	Use of forms	4	4
		more than 60	up to 724

Not enough information is yet available to us to assess implementation

SECOND ROUND (1985-1986)

1. Marketing of private beds in NHS hospitals
2. Creditor payment arrangements
3. Alternative sources of income
4. Publications and stationery
5. Medical aids and appliances in the community
6. Liaison with the private sector
7. Telephone services
8. Equipment maintenance contracts
9. Inventory management of medical gas.

P.R.

MR WICKS I have told DHSS that Mr Alderson Mr Willetts should come when the meeting is rescheduled, PM will chair. MDA 13/1 N.W. 10.1

VALUE FOR MONEY SEMINAR ON THE HEALTH SERVICE: WEDNESDAY 15 JANUARY

You will find on this file the brief which DHSS has already provided (the meeting was shifted from 9 December). Ian Beesley of the Efficiency Unit will also be supplying a short note.

Down to come are the Secretary of State, Minister of State, Mr. Paige, Mr. Fairey, Mr. Mills, Sir Kenneth Stowe, Sir Robin Ibbs, Sir Robert Armstrong, Mr. Battle (DHSS - to operate the technology) and you.

DHSS have now asked if their Chief Medical Officer can come. I have said yes only on the condition that one of their other people drop out.

There is also a question about attendance by the Policy Unit (David Willetts). He would very much like to be there. Ian Beesley sees no real objection to this, but takes the point that the Policy Unit have not in the past attended these Value for Money seminars. DHSS, predictably, would prefer them not to be there.

We kept the Treasury out of the meeting on the basis that this is simply one more in the series of VFM sessions which enable the Prime Minister to discuss directly with the accounting officers and Secretaries of State cost effective management of their departments. On that basis, David Willetts should not come. On the other hand, this meeting is rather different, certainly larger, than the others. The Treasury would in any case probably welcome David's attendance at the meeting rather than see it as inconsistent.

You will wish to decide whether David should be present, and let me know. DHSS would also like to be kept in the picture.

MEA

MEA

10 January 1985

VC4ADW

The Chief Secretary made a bid to attend.

6/1

MR. NORGROVE

ATTENDANCE AT THE VALUE FOR MONEY SEMINAR ON THE HEALTH SERVICE: 15 JANUARY 1986

I have spoken to Ian Beesley in the Efficiency Unit. Through him, Sir Robin Ibbs has confirmed his view that the rule for these seminars should be to keep the numbers as low as possible. The Treasury have not been invited to earlier seminars. Part at least of the reason for this is to discourage discussions from becoming another element in the public expenditure round.

I have passed this on to the Chief Secretary's Office. It is true, of course, that this particular seminar is in a slightly different category from the rest. Numbers are already on the high side; Sir Robin Ibbs thinks, in fact, we might seek to reduce them anyway and you will wish to consider this. I note, incidentally, that we do not have Sir Ken Stowe down to attend - I will remedy this today.

done.

Mark Addison

6 January 1986

DG2ASO

Life

SL2 ADF

10 DOWNING STREET

From the Principal Private Secretary

12 December 1985

I should have written before now to say how sorry the Prime Minister was to have to postpone at such short notice the Seminar which was arranged for last Monday. The Prime Minister is well aware of all the work which participants have devoted to the preparation of these Seminars, but an absolutely unavoidable piece of Government business arose which made it impossible to have the Seminar on the planned date.

I am glad to say that a new date has already been arranged. This is on Wednesday 15 January.

I am sending a copy of this letter to Sir Robin Ibbs and to Michael Stark (Cabinet Office).

N L WICKS

Tony Laurance, Esq.,
Department of Health and Social Security

cc BS ✓ cc B/YP

CF. For seminar when it is reinstated

N L 15.1.86.

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY

Telephone 01-407 5522

From the Secretary of State for Social Services

N L Wicks Esq CBE
Principal Private Secretary
10 Downing Street

6 December 1985

Dear Nigel

VALUE FOR MONEY IN THE HEALTH SERVICE

The presentation to the Prime Minister on NHS performance indicators, about which David Norgrove wrote to me on 3 September, is taking place on Monday 9 December. As background for this, you may find it helpful to have the attached note about performance indicators and their use in the NHS.

Those attending from here will be the Secretary of State, the Minister for Health, Mr Victor Paige, Mr Mike Fairey (Director of Planning and Information Technology) and Mr Ian Mills (Director of Financial Management) - the last three will be involved in giving the presentation. The presentation will last thirty minutes and will be illustrated by computer graphics: Tim Battle will also be coming across to operate these.

I am sending a copy of this letter and attachment to Sir Robin Ibbs and to Michael Stark.

Yours sincerely

Tony

A Laurance
Private Secretary

JS

NHS PERFORMANCE INDICATORS

What are PIs

1. Performance Indicators (PIs) are ratios describing hospital and community health services. They cover several aspects of performance:

- economy (eg energy use in hospitals)
- efficiency (eg cost per patient treated)
- effectiveness (eg mortality rates for new born babies)
- access (eg waiting lists per thousand population)
- achievement of care policies (eg percentage of child in-patients nursed in child wards rather than adult ones).

2. Because of the complexity of health services and the difficulties of measuring quality of care and severity of illness the PIs do not provide complete measures of performance. You cannot judge performance on the basis of PIs alone. Rather the PIs are indicators; they help managers to identify the scope for improving performance and they point up high performers from which others can learn.

Whose performance is indicated and how?

3. Most PIs describe the performance of District Health Authorities (191 in England). Some of these are broken down by hospitals within Districts.

4. A District PI shows how a District performs, and where it lies in relation to all other Districts. Extreme values (eg in the top or bottom 10 per cent of English Districts) are highlighted. Comparisons with selected Districts can be made.

5. PI data will be issued annually; this will show how a District's performance is changing over time.

What is new?

6. The PIs have pulled together data from a variety of NHS data sources which previously were difficult for managers to use in combination. Some PIs have been adjusted for factors such as differences in hospital case-mix which have distorted comparisons in the past. The PIs are arranged in a hierarchy. Questions stimulated by the first line of PIs can be followed up by examining relevant branches in the lower parts of the hierarchy where clues for management action may be found; thus the PI data may be searched purposefully and efficiently.

7. This year for the first time the PIs are on a microcomputer. The Computer programme is easy to use, it permits a NHS manager with no previous computer experience or training conveniently to explore the large PI database. It exploits colour graphics to display the data attractively and strikingly. The PIs are also issued on paper for the benefit of those few Districts without access to a microcomputer.

Who developed the PIs?

8. Most of the development has been carried out by the Department's Operational Research branch but involving leading NHS personnel (Authority Chairmen, doctors, nurses, general managers etc). Involving these "performers" in the design process has been crucial to establishing the credibility of the indicators in the NHS, especially with doctors.

Who uses the PIs?

9. The DHSS sends the PI package to the General Managers of all Regional and District Health Authorities. The District General Manager is expected to use the PIs to identify ways of improving the performance of his services. Relevant parts can be copied and sent to other managers in the District (eg PIs on patient throughput to doctors, PIs on catering costs to hospital and catering managers). The Region is expected to monitor its Districts' performance, using PIs in annual reviews. The NHS Management Board will conduct annual performance reviews of regions to check that they are taking appropriate action.

How will this help managers?

10. The PIs reveal strikingly wide ranges in performance, eg.

- Sixfold variation in duration of stay in hospital for orthopaedic patients;
- Eightfold variation in unit costs for cleaning hospitals;
- Threefold variation in hospital catering costs per patient-day.

In many cases of poor performance managers will not have been aware previously how far down the national list they are. The new awareness will help to convince them, and the staff who may be affected, that something should be done and, by referring to the high performing districts, that something can be done.

11. Managers with average PI scores need not be complacent. They can aim to lift their performance to the high levels currently being achieved by the better performers. This type of approach has already yielded results. For example, Mersey Region negotiated with doctors targets for improvements in patient throughput PIs. The process has been valuable in identifying obstacles to improve performance: and as a result more patients have been treated.

12. PIs do not improve performance on their own. PIs are an aid for managers to diagnose problems. The manager then needs to examine the problems on the "shop floor" and talk to the staff concerned. Only then should he decide what action to take, coupling his judgement with the PIs and other data.

What is the benefit to the patient?

13. Patients benefit from improved efficiency by getting quicker access to more care. But quality of patient care, though not measured quantitatively, has not been neglected. The PI package includes checklists of questions about quality which managers are asked to use alongside the PIs. For example, for hospitals for long-stay elderly patients the checklist includes:

- Are there menu choices for each meal? How is choice exercised?

- Are there individual patient care plans?

- Are there written nursing policies?

When a manager asks these questions in a hospital he is able to access the quality of care more generally and identify ways of improving it.

NAT HEALTH : Expenditure : PES

PRIME MINISTER 4 December 1985

THE HEALTH SERVICE WAITING LIST

Your meeting on Monday to look at value for money and performance in the Health Service is a good opportunity to push for progress on the performance indicator that people care about most - waiting lists and waiting times.

The waiting list varies enormously from place to place, and from specialty to specialty. It does not correlate with expenditure in a District. Instead, it seems to depend on the energy of the local surgeons and the purposefulness of the managers. The way forward is to break the waiting list down into manageable parts so that effective practical measures can then be taken locally.

Identifying the Problem

The first stage is to focus on the really serious delays which no-one can possibly defend. The total waiting list in England and Wales stands at about 670,000. Of these, approximately 131,000 people have been waiting for more than a year for operations in the 5 main specialties. Of these 131,000 people, about 33,000 (25%) are concentrated in just 13 of the 201 Districts in England and Wales. And 26,000 (20%) are in only 30 individual specialty waiting lists - involving, at most, a few hundred doctors.

Send in the Scrutiny Team

You could set up a Rayner-type scrutiny team to visit the places and specialties with these particularly bad waiting lists, and propose practical remedies. They should dig down into the detailed hospital activity analyses, which the DHSS do not incorporate into their performance indicators, and press for improvements. Great care would be needed to select the right people.

What can they do?

The team would not have dictatorial powers. They could shame local Districts, encourage them to be better, and show how to improve their way of working. They could work with Victor Paige's Management Board, and could achieve the following:

i. Simply telling a District that a scrutiny team will be looking at their waiting list can concentrate minds wonderfully. The problem might start disappearing before the scrutineers have arrived.

ii. Spread best management practice in intensive use of operating theatres; rapid turnover of beds; staggering consultants' private work, etc.

iii. Encourage Districts to buy operations from outside - either from other Districts or the private sector. It would be very good to put some impetus into creating an internal market into the Health Service.

iv. Discover impropriety, or even illegality, amongst doctors. Some of them who are contracted to work full-time for the Health Service do extraordinarily few operations because too much of their time goes into private work.

Objectives and Publicity

The review team should be set a clear objective of halving the number of people waiting for over a year for operations in each District which they visit.

This could be made into a public objective for the NHS as a whole. There are risks in adopting such a high profile - we do not want to repeat the mistake of the Labour Government which in 1975 announced that nobody should wait for more than a year, but had no means of implementing this. On the other hand, a public objective would send out a clear signal to everyone in the Health Service that this was something to which the Government attached top priority. It would also be politically attractive.

Will the problem always be bad management?

In some cases, the problem will be that:

- A specialty is under-funded. We clearly do not want this exercise to push up expenditure. I don't believe it would do so, as the areas with long waiting lists are not particularly short of money. Moreover, if funding is the problem, it is likely to involve distribution within a District - too much money going to the consultant doing exotic transplants; and not enough to his weaker colleague replacing hips.

- The figures are unreliable. Waiting list figures are pretty reliable, but occasionally they may be misleading. (In some hospitals, women waiting to give birth are counted on the waiting list: after all, they are waiting!) But it would be very useful simply to have improved the statistics to reduce the appearance of the problem.

Next Steps

I recommend that this idea be put on the agenda for next Monday's meeting on the Health Service. I have tried it out experimentally on the Ibbs Unit, who would like to take it further.

David Willetts

DAVID WILLETTS

10 DOWNING STREET

Set up for
Monday 9th
December at
16.30.

CR
6/9.