

## 4. Performance management

### 4.1 Introduction

The previous section has shown that on broad efficiency measures, and in particular in terms of waiting times, there is room to improve the performance of Northern Ireland's health and social care system.

Northern Ireland is not alone. As the OECD have noted<sup>111</sup>, almost regardless of funding levels or sources, health and social care systems around the world face common issues and problems when it comes to improving their performance. Despite high levels of commitment and professionalism from health and social care staff, best efforts to provide appropriate care in the most efficient way can be frustrated by the way systems are structured and organised. Poorly designed (or, indeed, the complete absence of) incentives and systems to promote improvements in performance at national, local and individual levels can significantly affect the way the health and social care system responds - to patients' needs, to the dynamic nature of medical technology and to changes in attitudes and values.

How health and social care systems are managed, the incentives and sanctions in place and the type and availability of performance information are critical to improving performance.

In order to set some context for the situation in Northern Ireland with respect to performance management this section first details some of the reform efforts being pursued in OECD countries. It then describes the current performance management system in Northern Ireland and recent suggestions for changes (mainly in structures) aimed in part at improving performance.

The key question this section addresses is whether current reforms and modernisation in Northern Ireland will be adequate to tackle the performance issues previously identified.

### Section Conclusions

Current performance management arrangements lack the performance structures, information and clear and effective incentives - rewards and sanctions - at individual, local and national organisational levels - required to encourage innovation and change.

These criticisms were confirmed in our consultations with key stakeholders. It was clear, for example, that the current performance management system was adjudged to require further development, to deal with an absence of accountability in the system. This review does not feel that recommendations of the Review of Public Administration adequately addresses the weaknesses with the performance management system. And contrary to the RPA, this Review would suggest that some form of separation between the providers of services

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<sup>111</sup> OECD (2004) Towards high performing health systems. OECD, Paris.

and the funders/commissioners of services would be an important factor in sharpening up incentives in the system.

Overall, the system needs to be reformed to take on serious, long term central target setting coupled with rewards and sanctions at organisational and individual levels and greater devolution to providers to give them the scope to respond. In turn, providers themselves need to consider how to devolve functions within their organisations, in particular, ways in which to engage frontline staff with the incentives faced by the organisation as a whole - through, for example, devolution of budgets and associated responsibilities.

The nature of the rewards and sanctions need careful thought. For example, mainly for reasons of scale (and efficiency), the competitive economic environment currently being developed in England is unlikely to be appropriate in Northern Ireland. However, this does not rule out, for example, the introduction of an activity-based prospective reimbursement system for providers (similar to Payment by Results) with tariff setting (not necessarily fixed at average costs) used to drive improvements in efficiency and selective increases in activity to meet pan-service goals. Nor does it rule out the promotion of greater public and patient awareness of variations in performance in the system.

Moreover, it does not rule out careful expansion of patient choice. While in England choice is being rolled out mainly with a policy emphasis on the leverage it may have over providers (crudely, losing business will stimulate cost and quality improvements), from the patient's point of view, a more formalised and embedded process of choice (not just of hospital, but over the myriad of decisions that are taken throughout the system which affect a patient's care) can improve patient satisfaction and service responsiveness. This may be a weaker incentive than that being introduced in England, but the limits to what could realistically be offered by way of choice need to be recognised in what is a relatively small system. Nevertheless, there may be certain services, specialties, operations etc where options do exist for real patient choice and where patients would like to exercise greater choice.

In addition, and despite the previous rejection of GP fundholding, to both strengthen the involvement of general practitioners in the system and as part of a devolution strategy for commissioning secondary care services, thought should be given to the practical involvement of GPs in the purchasing of care. Again, Northern Ireland has an opportunity to develop its own approach to this form of devolved commissioning.

Finally, no system relies on just one or two performance levers. In England, for example, the new payment system and (managed) patient choice are going to run alongside continued use of targets (renamed 'standards') and, importantly, an evolving regulatory system at arms length from government which aims to promote the ultimate goals of the system - better quality of care, more efficient and cost effective use of resources. NICE, the National Patients Safety Agency, the Healthcare Commission etc, are important organisations which aim to promote better care. Much of these organisations' work and output are public goods available for any system to use and from which Northern Ireland could benefit and could inform development of the new HPSS Regulation and Improvement Authority.