

4.3 Current performance management arrangements in Northern Ireland

Performance management systems are, in reality (and despite the simplified three-stage process described in figure 4.1) rather complex, and invariably difficult to describe. However, at a very broad level of description, the current performance management system in Northern Ireland could be characterised as centrally-driven within a hierarchically-managed organisation. However, the system lacks appropriate performance structures, information and clear and effective incentives - rewards and sanctions - at individual, local and national organisational levels to encourage innovation and change.

These criticisms emerged from our consultations with key stakeholders. It was clear, for example, that the current performance management system was adjudged to require further development, with an absence of accountability in the system. In particular, none of the individuals and groups we met were able to provide a clear description of the incentives and sanctions in place to ensure that the targets set by the Minister were achieved.

The general view was the system would benefit from less centralisation of control whilst it was unclear whether the Department or the Boards were in control of the Trusts. The view of DHSSPS officials was that the 'hard line' approach to performance management in England over the last few years had led to disruption, uncertainty and a lack of confidence amongst management and hence would be inappropriate in Northern Ireland. Nevertheless, an internal DHSSPS/HPSS review of the current performance management system completed in January 2005 was critical of the system and has recommended various changes¹¹³ (see Box 4.2). However, none of its recommendations address the key issue of *how* performance is to be improved.

Box 4.2: DHSSPS/HPSS review of current performance management system

A review of the performance management arrangements for the HPSS was concluded in January 2005 and concluded that the current system:

- is complex, unwieldy and very bureaucratic;
- not comprehensive in terms of being able to measure HPSS performance as a whole, often focusing on new initiatives rather than the totality of resources;
- lacks linkage between annual and strategic plans. As a result, there is a lack of continuity between the two and often a focus on short-term gains at the expense of longer-term achievements;

And that,

- targets do not always reflect the real priorities, particularly in terms of the outcomes for people who use the health and social services;
- data is often collected which is not put to any useful purpose; and
- equally, appropriate information is often not available to support the monitoring process.

The review recommended various changes - chiefly, a new set of performance indicators to capture the totality of the work carried out by the HPSS.

However, the review contained no criticisms or recommendations about the *effectiveness* of the current system to actually improve performance - in particular, no reference was made as to the process or mechanics by which performance is to be improved.

¹¹³ HPSS Performance Assessment and Reporting Framework, Report and Proposals from Working Group, DHSSPS).

Below we examine this particular issue and other key elements of a performance management system - structures and processes, information and analysis, and standard/target setting.

4.3.1 Performance structures and processes

By performance structures we mean leadership, management and accountability arrangements in the health and social care system. In this respect, the Review of Public Administration (RPA)¹¹⁴ has tackled a different aspect of performance structures and has made proposals for changing the number of health and social care organisations. However, the RPA's recommendations - drafted by the DHSSPS - also suggest a mode of working and interaction between health and social care organisations which touches on the way performance management systems might develop. In particular, the RPA rejects a competitive model in health and social care, and instead proposes an integrated commissioner/provider model. We pick up this issue in the conclusions to this section.

Pace the current recommendations of the RPA, the health and social care performance management system, as noted above, is centralised and hierarchical in nature; over 1,000 staff at the DHSSPS¹¹⁵ and a further 800 staff in the four Boards control the flow of funding to service providers, develop and promulgate planning and strategy guidance and set performance goals - primarily through the annual Priorities for Action (PfA) document.

The DHSSPS develop the annual PfA based on their Public Service Agreement (PSA). Boards then respond with Health and Wellbeing Investment Plans (HWIPs) which set out how they will meet the PSA goals. Finally, individual trusts then have to produce Trust Delivery Plans (TDPs) which in turn set out how they will use their resources in pursuit of these goals.

In terms of monitoring and accountability for meeting PfA plans, as the 2004/5 PfA states,

'HWIPs and TDPs will continue to provide the focus for rigorous [Health and Personal Social Services] monitoring and accountability arrangements throughout the year. These arrangements include quarterly reporting to the Department by Boards and Trusts, meetings between Boards and Trust officials and the Department¹¹⁶ and accountability review meetings involving Board chairs and the Minister.¹¹⁷

In effect, the Department runs the health and social care services in Northern Ireland along fairly traditional management lines and with accountability flowing upwards from trusts, to Boards, and finally to the Department. As is clear from descriptions of the performance management system supplied by DHSPSS to the review (see

¹¹⁴ An interim report is currently (May 2005) out for consultation

¹¹⁵ DHSSPS have indicated that over 400 of these officials are providing direct operational services.

¹¹⁶ Extracts from annual DHSPSS/Board accountability reviews are noted in Annex I.

¹¹⁷ It is worth mentioning in passing that while it is fairly easy for members of the public to locate publications setting out DHSSPS, Board and Trust plans, priorities and targets for the following year, it is much harder to locate any publications succinctly summarising what targets had been achieved in previous years.

annex H), there is little account of how failure to meet targets or plans is dealt with and little on positive mechanisms and processes to encourage improvements in performance.

From our consultations, it was clear - as noted above - that this system is generally considered to be too centralised, too bureaucratic, and with a lack of clarity as to whom should be held responsible for performance improvement.

From our survey of chief executives of trusts and in relation specifically to the DHSPSS waiting time performance management arrangements and the role of incentives to meet targets, there was a split between those that felt current DHSPSS waiting time performance management arrangements were effective, and those that felt that they were either not very effective or ineffective (see table 4.1).

Table 4.1: Trust chief executive survey: 'How effective are the Department's external waiting time performance management arrangements?'

| The Department's waiting time performance management arrangements are... | Number of responses |
|--|---------------------|
| Very effective | 0 |
| Effective | 10 |
| Not very effective | 3 |
| Ineffective | 3 |
| It is too soon to comment | 2 |

While there seems to be some contentment among chief executives regarding the effectiveness of a system that is meant to improve the performance of organisations they manage, we would observe that the outcome of this system with respect to waiting times does not appear to have produced significant improvements (see section 3.6 on waiting times).

We therefore suggest that serious consideration be given to ways to improve the structures governing the performance management system and the processes used to lever up performance.

4.3.2 Performance information and analysis

Any performance management system, whether hierarchical and management driven, or decentralised and driven through downwardly accountable mechanisms, requires timely and appropriate performance information on which to base future decisions and monitor the outcomes of past decisions.

The experience of this Review in its own attempts to draw together and analyse performance information confirms the DHSSPS/HPSS' s own review of the performance management system that the right information does not always exist or that information systems sometimes lack the ability to provide answers to basic performance questions. Asking, for example, a straightforward question such as whether or not waiting times targets had been met from year to year proved more difficult for this Review to clearly establish than should be the case¹¹⁸. And while the

¹¹⁸ With current information systems, as the NI Audit Office have noted (*Waiting for Treatment in Hospitals*, NIAO, November 2004), it is impossible to know how long individual patients wait from GP

Review has presented various perspectives on tracking funds through the system, this was by no means easy or, indeed, directly addressed key performance questions concerning the benefits derived from recent spending increases.

But more than the collection of the right sort of information, there is the question of engaging in the right (or indeed, any) analysis of data to address performance problems and issues. For example, as far as this Review has been able to ascertain there has been little or no thorough analysis in or outside the DHSSPS of reasons why A&E attendance rates in Northern Ireland are so high (around 31%¹¹⁹ higher than in England for example). Similarly, there is little or no analysis of the equally high rate of GP consultations, whether these are appropriate or indeed desirable from a clinical point of view (or indeed whether best use is being made of a valuable and expensive health care resource).

Finally, information on performance is not given the public prominence it deserves. As already noted elsewhere in this Review, performance information has been seen as part of the remit of the statistics section of the DHSSPS and by implication (and in practice) separate from the performance analysis/management system and somewhat buried from public view.

4.3.3 Standard/target setting

While the annual Priorities for Action documents have nominally set out goals and targets each year, as this Review noted with respect to waiting lists and times, the PfAs appear somewhat short term, with little connection across years or clear long term goals and appropriate targets. There is an overwhelming case in Northern Ireland for a new look at systematically setting short, medium and long term objectives and quantifiable standards/targets for the health and social care system.

There are clear dangers inherent in an over-reliance on targets as part of a performance management system, but in the (desirable) absence of a market-driven process, targets can act as the 'signals' to providers, helping to direct their priorities and energies into those areas, services and outcomes deemed desirable.

This, however, begs the question of what *is* desirable. The use of targets places a significant onus and responsibility on those setting the targets to balance, for example, the needs of individual patients or clients against those of the community as a whole; or to reach a balance in the often inevitable trade offs between desirable goals such as efficiency and equity. On this, there is a clear need for each 'level' in the system to be clear as to its role and responsibility with regard to the generality or specificity of targets. Overall strategy and priorities need to be set by government, with the DHSSPS translating these into more detailed targets.

4.3.4 Incentives: Rewards and sanctions

referral to inpatient admission. Moreover, the lack of a patient record-based information system (such as the Hospital Episode Statistics system in operation in England for over a decade) at NI level also makes it virtually impossible to know waiting times for specific procedures.

¹¹⁹ Provisional figures for 2004/05 indicate that the gap has fallen to 28%.

Targets are necessary, but not sufficient for improving performance, however. Of absolutely crucial importance is the system of incentives and sanctions associated with targets. The 2002 Wanless Review made some important observations about the role of incentives and sanctions in driving up performance in health and social care.

In particular, the review noted that:

'Appropriate processes must be in place to ensure that the nationally-set standards are delivered by the health service. There are many cases where this has not happened and standards of care delivered have fallen short. The vision of the health service in 20 years' time set out in this Report cannot permit this, so the processes of objective setting, incentivisation and targeting have to be sensitively designed to ensure they achieve the required results rather than distort resource allocation.'

There are a number of aspects to such 'processes'. They particularly relate to the way in which resources and information flow around the system and in which incentives and targets are used to direct the delivery of efficient and effective levels of care. The flows are vertical, between those setting standards nationally and those delivering them locally, and horizontal, between the different health and social care providers locally.

There is a fine balance to be struck in deciding on the most appropriate way to ensure that central standards are achieved across the service. The setting and auditing of targets is one means which can be used. Financial incentives are another.' (Para's 6.23-6.25 *Securing our Future Health: Taking a Long-Term View*, HMT 2002)

This Review agrees with these observations, and in particular with the need to design open and explicit incentive systems which reward success and penalise failure. A survey this Review conducted among trust chief executives to explore issues concerning waiting times performance revealed - at best - some ambivalence towards the current performance management system.

For example, just over half of chief executives stated that current performance management arrangements provided little or no incentives for their trusts to meet waiting times targets and just five out of sixteen that it provided sanctions if trusts fail to meet targets (see table 4.2). There was agreement that to some extent performance management arrangements would be more effective if they included stronger incentives and sanctions. The very fact that there appears to be disagreement between chief executives over whether the current system contains any incentives or sanctions at all is problematic, and suggests greater clarity and a shared understanding of the performance management system is needed.

Table 4.2: Trust chief executive survey: 'To what extent are there incentive for your trust to meet waiting times targets, and sanctions if you miss them?'

| | Performance management arrangements provide incentives for the Trust to meet its waiting time targets... | Performance management arrangements provide sanctions if the Trust fails to meet its waiting time targets... | Performance management arrangements would be more effective if they included stronger incentives and sanctions for achieving waiting time targets |
|-------------------|---|---|--|
| To a large extent | 2 | 1 | 2 |
| To some extent | 6 | 4 | 8 |
| To a small extent | 5 | 6 | 4 |
| Not at all | 4 | 5 | 1 |

And for those chief executives who believed more incentives and sanctions were needed table 4.3 outlines their responses.

Table 4.3: Trust chief executive survey: 'What incentives and sanctions would be most effective in improving waiting time performance?'

| Rewards | Sanctions |
|--|--|
| Rewards of investment funds to divisions | No service development for poor performing departments |
| Improved flexibility in being able to reward key individuals not covered by performance related bonus system | No staff development for poorly performing departments |
| Transfer services to departments which have good performance records and have genuine competition | Increased organisational and individual accountability for failure |
| Increase funding available for exceeding target | Money follows the patient reimbursement |
| Productivity payments for staff | 'P45s' for failing managers and practitioners |
| Small amounts of funding to purchase equipment | League tables. Funding related to performance. |
| First priority for additional operating sessions | |
| Money follows the patient reimbursement | |
| Investment linked to performance | |
| League tables. Funding related to performance. | |

These suggestions prompt a number of possible ways forward for addressing some of the deficits in the current performance management system identified above and noted by many of those we consulted during this Review.

Tariff-based provider budget setting/payment system

Healthcare Resource Group (HRG)-based reference costs form the basis for the reform of hospital reimbursement system (Payment by Results, PbR) in England. Although linked with patient choice (and money following the patient), a key independent aspect of PbR and one which embodies a powerful financial incentive to reduce variations in costs (and, over time, to drive down the mean) is the fact that individual HRG 'prices' are fixed. In England, and for the time being, HRG tariffs are fixed at the national average HRG cost. The implication of this is that hospitals providing HRGs at above-tariff cost will need to examine ways of reducing their costs.

Such a payment system could be used as a budget setting system for trusts, one which directly links reimbursement to activity and which, through the tariff setting process, embodies a direct incentive to address cost variations.

'Earned autonomy'

The reward from earned autonomy can be a combination of greater freedom from central control and diktat (earned on the basis of achieving goals set centrally) and access to financial rewards - for example, specific performance-related funding.

Patient choice

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. Moreover, choice based on more explicit information on performance - for example, waiting times - can help reduce performance variations.

GP commissioning

Although previously rejected, the idea of devolving the purchasing or commissioning of patient secondary care to general practice could provide an additional stimulus for secondary care providers to more actively respond to the concerns GPs have about the care their patients receive. The survey of GPs conducted by this Review to explore views on waiting lists and times produced some strong responses from GPs who often felt that the secondary care system was not always doing all it could to meet the access needs of their patients (see Annex G).

GP commissioning does not have to follow the model of fundholding in terms of, for example, the volume of services GPs commission. Commissioning could, for example, be based around specific services, specialties or even interventions.

The objective or focus would be to sharpen the incentives on the secondary care provider side to respond appropriately to the signals GPs would send as a result of the pattern of their commissioning.

Publishing performance information

The publication of performance information is not only a necessary aspect of public accountability, but can also provide information to inform patients' choices within the health and social care systems, make a public link between spending and outcomes, and highlight progress towards targets. Wide and prominent dissemination of performance information can also improve the quality and timeliness of information¹²⁰.

An independent inspectorate (see below) may consider publishing an annual overview performance report on the health and social care system which would collate all targets and associated information and reach an overall judgement on progress. Such assessments need to be seen to be independent and not feel obliged to pull their punches: It needs to be recognised that publishing performance information is not (and should not be) a comfortable thing for the health and social care system.

External support and advice

Support from an external source or agency can often help individual organisations successfully tackle performance problems and can act as a way to disseminate learning and new ways of doing things across the health and social care system. Support may be delivered in a formal way via some specific organisation (such as the Modernisation Agency) and as the result of a specific trigger (failure to meet a target or satisfy a regulatory inspection) or could be informally arranged and provided by another trust.

Independent inspection/regulation

Ensuring that the health and social care system not only reaches minimum standards of quality of care and minimises risk to patients, but also strives for improvements in quality can be enhanced through independent inspection and regulation. The newly established HPSS Regulation and Improvement Authority in Northern Ireland is currently developing ideas for its role and activities, but it could usefully examine the development of similar organisations (such as the former Commission for Health Improvement, now the Healthcare Commission in England). It could also explore the possibility of more formal connections to exploit economies of scale.

This Review has not had the time to work up how any or all of these options for injecting a greater sense of urgency and 'bite' into the performance management system might be developed in the context of Northern Ireland. By way of comparison, and to some extent evidence of what works and what does not, Box 4.3

¹²⁰ Currently, performance information is not only buried in the Statistics and Research section of the DHSSPS website, but is limited in scope and extremely user-unfriendly.

summarises the recent experience of developments in the English NHS performance management system.

Box 4.3: Recent experience of developments in the English NHS performance management system: there is no 'magic bullet'.

Over the last five years or so the English NHS has been subject to a barrage of changes in its performance management system in attempts to lever up performance and, in particular, to ensure that Ministerial and government commitments were met.

Between 1997 and 1999, the main focus of health policy was to explore alternative arrangements to the internal market which, in their 1997 manifesto, new Labour had promised to abolish. In place of fundholding, for example, GPs were offered influence via newly reformed health authorities - Primary Care Groups. Importantly, targets - and one target in particular, Labour's manifesto pledge to reduce waiting lists by 100,000 - emerged as a tool of performance management.

Ministerial changes, a commitment to large increases in funding and a perception that the new arrangements were not delivering change fast enough, lead to the drawing up of the NHS Plan in 2000 and a tougher, more centralist system and experiments in rewards and sanctions in relation to an expanded set of longer term targets. Franchising of top management, national performance funds, greater public dissemination of performance ratings ('naming and shaming') and star ratings emerged to increase pressure on the system to deliver.

And overall, the period from 2000 to 2004 was a time which saw remarkable reductions in waiting times and the achievement of other targets set by government. There were also costs. Complaints about micro management by Ministers, the distortion in clinical priorities arising from tactics to meet stringent targets and some evidence of managerial manipulation of performance data became more common. In part (although the NHS Plan flagged this next stage in the development of the performance system) this led to greater emphasis on 'earned autonomy' - that is, less central interference earned by meeting targets. The creation of Foundation Trusts status embodied this devolutionary shift.

From 2004, the system entered a new phase - greater devolution, but also increased independent monitoring and regulation and the start of experiments in patient choice. Importantly, a new reimbursement system for hospitals began its phased implementation - Payment by Results. This system will not only enable money to follow the choices made by patients, but due to its fixed tariff, provides a very strong financial incentive on above-tariff trusts to reduce their costs. Despite this search for more 'automatic' or devolved mechanisms for levering up performance, the system still retains some tough targets - notably the goal of reducing maximum waiting times from GP referral to hospital admission to 18 weeks.

The current focus of policy is now on purchasing. Primary Care Trusts (formerly Primary Care Groups) have generally been felt not to have performed well, and experiments are now taking place with a form of GP fundholding - GP commissioning - as a possible way of sharpening the purchasing function.

Much in the system is still evolving and drawing hard conclusions about what works and what does not - or rather, what works, but at what cost - is difficult. However, the health system overall has probably learnt the habit of change and has gained a greater confidence in experimenting with new ways of doing things. Importantly, it has also learned the benefits of clinical engagement in the process of change (through, for example, the development of the national service frameworks, and clinical networks).

Given the record on recent and current progress on improving system performance in Northern Ireland, doing nothing would not appear to be an option and ways need to be explored for introducing some 'constructive discomfort' into the system

alongside greater devolution of responsibility and increased independence from government of some functions such as inspection and performance monitoring and reporting to government and the public in general.

Noted earlier was the fact that current recommendations from the Review of Public Administration explicitly rule out one option for sharpening the current performance management system - namely, competition. The RPA consultation document states that *'...the development of new structures will embrace the principle that the commissioning and delivery of services need not be separated organisationally.'* It then goes on to note that *'These principles point clearly to the development of structures characterised, not by the need to generate competition, but by the creation of partnerships between commissioning and delivery...'* (Para 5.10 *The Review of Public Administration Further Consultation*, March 2005)

The RPA's recommendations for reconfiguring health and social care organisations - in particular, the creation of around five Health and Personal Social Services agencies - in effect reinvent a pre-1990 English NHS model in which health authorities received weighted capitation allocations, planned services and directly managed (and set budgets for) the hospital providers in their area. However, despite acknowledging that there *'must be clear lines of accountability to the Department and the Minister for expenditure, quality and performance'* (Para 5.24 vii), and while noting that performance management remains the remit of the Department, it is not clear in this model how performance improvements are actually to be achieved. In particular, it remains to be seen how providers are to be held to account for their performance. While 'partnership and integration' can generate good things for patients and users, there is a distinct danger that the performance model implied by the RPA's structural reform could fail to provide the necessary incentives and sanctions - or 'bite' - to encourage providers of services to continually seek out new ways to improve their performance.

Overall, from the point of view of performance management, it is hard to see any difference between the RPA's recommendations and the way the current system operates.

Nevertheless, if the RPA's reconfiguration recommendations go ahead, *and* it is accepted that a more robust performance management system, with, for example, more explicit rewards and sanctions, needs to be developed, then serious and urgent thought needs to be given to methods for holding providers to account within these new, more integrated structures.

Overall, however, this Review would suggest that some form of separation between the providers of services and the funders/commissioners of services would be an important factor in sharpening up incentives in the system. Given the particular circumstances in Northern Ireland, its population size and distribution, the political governance structures etc, there needs to be further investigation of the most appropriate form of separation, however. While the four health boards have, in theory, acted as commissioner/purchasers, it is not clear that the full benefits of this arrangement have been achieved. It may be that a single pan-Northern Ireland commissioner would be more appropriate. This arrangement would not preclude some devolution of commissioning to GPs (see below). A crucial aspect of such arrangements however is the design of the rules of engagement and the framework

in which commissioners are required to operate. In particular, commissioners would need clear objectives/targets in order to drive performance through their commissioning decisions. The regional level performance management system therefore needs to be reformed to take on serious, long term target setting

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 and strength 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 the creative tensions that a separation of purchasing and providing can bring, and nor, 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 to the separation of the tasks of provision and commissioning, ways of both strengthening 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 which could build on the Local Health and Social Care Groups.

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.

Recommendation 23: There is a need to develop an explicit performance management system with rewards and sanctions which provide enough 'bite' to encourage change and innovation in the health and social care system. There are many options for the types of incentives that could be introduced and their design for Northern Ireland. There should however be a commitment to such reform coupled with further investigation of how incentives can be strengthened.

Recommendation 24: Separation of the tasks of service provision and commissioning is an important factor in sharpening incentives. However, the most appropriate structures (eg single pan-Northern Ireland commissioner; devolved GP commissioning etc) needs further investigation.

Recommendation 25: Alongside changes in the performance management system, there is a need to explore the development of a more transparent priority setting process at national level, together with an explicit 'NHS Plan for Northern Ireland' which sets out outcome-based targets linked to new spending paths.