Duncan Nichol: view from the apex

Richard Smith

Duncan Nichol has been chief executive of the NHS Management Executive for the past two years. Before that he was regional general manager in Merseyside. He has prime responsibility for the smooth take off of the new health service. Richard Smith spoke to him in London.

RS: Can you paint me a picture of how the NHS might look in five years' time?

DN: What we've put into place is a management framework, and what's important is what that framework delivers not how it functions. It will be judged by its ability to deliver improvements in health to local populations. The crucial question is whether the health service can show that its more accountable and better informed. It needs to be able to answer questions such as why it's tackling particular needs, why it has chosen particular quality targets, why it's looking to particular cost effective procedures, and what results it's achieving.

RS: Will the service look radically different from the way it looks now?

DN: In terms of shape and organisation it will look radically different. The split between purchaser and provider is a fundamental change. It puts primary responsibility for securing healthy populations in the hands of district health authorities and separates that totally from managing services. It asks providers to argue for their skills and to argue for the privilege of treating patients.

In five years' time we will see fewer purchasers—larger purchasing consortia. In the mean time it seems inevitable—and something to be looked forward to—that we are going to have more trusts so that more of the providers will be less directly managed. We will have considerably more practice fund holders. The shape of

that service will be much better focused to most patients' needs.

RS: What are going to be the biggest problems in getting from here to there?

DN: Changing the way that people think. Changing from having the responsibility for running the service to stepping back and considering what you're trying to do for a population is the main change. It's tough to get people to think differently after 40 years of one kind of behaviour. For the centre to let go to those at local level and let them determine how they are going to do things without interfering in the how is a major cultural change.

We will also need to build up our information services, and that's a considerable task.

Changing the atmosphere on the ground will also be difficult, persuading our staff that these changes are good for the patient and good for themselves.

RS: So everybody's got to change—the politicians, the administrators at the centre, the doctors, the managers, the nurses? It's not just certain groups?

DN: Not at all: it's not something that's being done by a handful of managers to the service. It's something that everybody's got to own as contributing to the health of populations.

Taking account of local requirements

RS: Is it possible to set a direction for the whole health service or will regions and districts set their own directions?

DN: The emphasis is on locally determining the health needs of populations. But there will be a strategic framework set at the centre, and the regions will have a vital role in ensuring that district health authorities operate as effective purchasers. That's what holds the whole thing together so that there is a national health service. The centre has responsibility for determining strategic priorities.

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RS: You say that the shape of the health service will look and feel very different five years from now. Might it also be different in one area compared with another?

DN: What the different areas will have in common is that they are looking after populations. But differences may arise because of different local priorities and differences in where they are starting from. Local health authorities may seek to produce a different balance between primary and secondary care.

RS: Do you think that the new authorities are going to take health and prevention more seriously than their predecessors have over the past 40 years?

DN: There is evidence now that family health services authorities are taking prevention more seriously. As a result of the new general practitioner contract we are

seeing improvements in immunisation levels that the new authorities will improve on even further. The emphasis on family care and prevention is strongly there.

RS: What about the district health authorities?

DN: The district health authorities have got to look across a spectrum of care—through from primary care to tertiary care—and they've got to look for partnerships and alliances with different agencies. If, for instance, a district health authority is looking to reduce mortality from coronary heart disease it has got to work alongside primary care, but it might also launch an initiative of its own through its health promotion campaign. It will be working increasingly with partners to get the right balance. We at the centre will be thinking afresh about the need to apply more resource and more pressure to prevention.

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RS: How will we know in five years' time if things are better? Will we have outcome measures?

DN: We'll certainly need to develop outcome measures, and I'd hope that in five years' time we'll have made some solid progress towards that. If you can't measure outcome you can't be properly accountable to the public for what you're achieving. We have to make progress with outcome measures. They are the ultimate guide to whether things are getting better.

The whole process of reform will sponsor more work in developing outcome measures and a greater enthusiasm for measuring the cost effectiveness of various clinical procedures. We are going to look much more closely with doctors at what works well. And that's a healthy consequence of having to be more specific about what you're trying to achieve with a given level of resources.

RS: Do you think that the separation between primary and secondary health services that has bothered the NHS since its beginning is going to be improved over the next five years?

DN: If you concentrate on the health of populations then you are forced to ask yourself questions that might previously have been answered in different pockets. You'll have to ask yourself about the handling of, say, services for diabetic patients and how more can be done in the primary care services when that's appropriate. And the regional health authorities will be in the position for the first time to oversee the achievements of the two parties.

RS: Might it have been better to do away with the separation altogether?

DN: It's perfectly reasonable to think of that as a model, but that wasn't what the secretary of state wanted at this stage. It is important to be in the family health service authorities, to ensure that they make the move from administering contracts to managing primary health care services—and that is a huge move in its own right. It is important that they become established and that the importance of primary care as the hub of the system is not put in jeopardy.

RS: Which it might have been?

DN: With immediate amalgamation it might have been.

RS: So will family health service authorities eventually be able to write contracts in the way that district health authorities are going to do?

DN: That's ever such a long way off. We are going to

have central negotiations with primary health care practitioners for quite some time. But I do expect family health service authorities to make explicit to their family health care practices what they are looking for and set targets for local population needs.

Funding the service

RS: When I asked you about the difficulties of getting from where we are now to where you want to be you didn't mention funding. It is all this going to be possible without considerable increases in the funds spent on the health service?

DN: The whole point about a management framework of this kind is that at the end of the day it has to be neutral to the amount of money the government makes available. It should make more efficient use of what we do have, including investment in information systems to tell us how we are getting on in terms of value. The issue of how much the government makes available is a separate one. Management should deliver a more uniformly efficient service that is more responsive to the needs of the patient, and that doesn't depend on any particular level of resource. We'd all like to see more resources in the health service because there is infinite demand for its services.

RS: Let's look at it specifically. You've made cutting waiting lists a priority, but how can that be done when we see so many examples of health authorities reducing operating sessions. You seem here to be trying to achieve two contradictory aims at once.

DN: I don't think so. There are examples in the country of authorities living beyond their means, and one of our policy imperatives is to say to health authorities that they have to balance their books. And within that framework we want health authorities to give priority to long waiters. It's been shown that that can be done. You pick up examples of authorities having to get themselves on an even keel before they move forward. They've got the combined task of balancing their books and giving themselves some space to advance on waiting lists. They have to do it.

RS: What's worrying is that one way to deal with this would be to shift resources from other parts of the health service that are not so conspicuous.

DN: I don't think that's what health authorities are going to do. They are going to look at what the needs of their populations are, but if there are long waits for hip operations I think that they are going to conclude rapidly that that is not acceptable and make it a priority.

Some of the perverse incentives for maintaining a waiting list are going to disappear and people are going to be more efficient because it is better not to have a waiting list than to have one—and that isn't always a question of resources.

RS: Some people within the service might argue that other needs—for instance, for psychogeriatric care—cry out for more attention and resources than waiting lists. But waiting lists do have this high political profile. Is that why you made waiting lists a priority?

DN: No. I made it a priority because the public does. When asked about health services, patients say that they are not impressed with the way that they are received into some parts of the service or with the environment within which their care takes place. They also mention the information they want but don't seem to get. But above all they criticise the time that they wait for a first outpatient consultation and the long waits for operations. That's what the public is telling us, and we must respond. You can do something about waiting times, and in some places it's overdue. Even within some authorities facing severe financial pressure

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considerable results have been achieved in targeting those who wait a long time.

New responsibilities for managers

RS: Are you worried that managers who have had to manage expenditure budgets are now going to have to worry about income as well?

DN: Certainly once provider units and trusts have won a contract, which is clear about how much income they can expect to get and how much work they're expected to do, then they must make sure that they do the work and are paid for it. And, as now, they must ensure that they don't spend more than the contracted income. There are really no differences. There are some complexities in some areas where some providers will depend on a wide range of contracts with many purchasers. I accept the point that that complicates the transactions, but it doesn't alter the principle.

RS: So they will manage the principles well even if the details will be tricky in some places?

DN: The details are going to be tricky, and we are taking a first look at this in a week or two's time, when we will see the early intentions of purchasers and providers mapped out for the first time. We will be able to see the risks that some providers are carrying and to think about how we can tackle them.

RS: Do you see any risk of providers running out of money three quarters of the way through the year?

DN: No. What is clear in a contract system is what work you are expected to deliver and to what quality criteria and what you will be paid if you do that. So in that sense there is greater stability and visibility. Certainly there's a new system of payment, and we need to make sure that we've got a robust contract system. It's going to get more sophisticated over time, and it's crucial to the reforms, but I've got no doubt that we will secure the block contract system. There won't be cash risks that providers shouldn't be able to manage.

RS: What about the problem of general practitioners sending people all over the place?

DN: If you have a picture of maverick behaviour then I

can see why that kind of question is raised. But the whole point about this system—whether you're a fund holder or not—is that there is an expectation that you will be clear about your intentions to refer patients. We need to develop a regimen in which due notice is given and there are no surprises. Authorities need to be given notice so that they can respond—by downsizing if necessary.

RS: What do you mean by that?

DN: If they're not getting the volume of activity they have to reduce their capacity. The point I'm making is that this is not a "catch you out system." You do business openly in the patients' interest.

... one of my objectives will be to seek a new concordat with doctors.

RS: Presumably downsizing will have to happen somewhere. That's the logic of the system. Some places will flourish and others won't.

DN: The process will be progressive, although it won't happen that fast.

RS: Let me ask you about audit. Something doctors wonder is whether you and local managers will act if audit shows deficiencies in facilities. Will you give more funds, more facilities?

DN: It's not a question of us giving more funds. We already give massive funds—not necessarily being spent to best effect. I welcome the fact that audit procedures will make more explicit the effectiveness of clinical work. It will also raise issues about the need for further training and, as you indicate, the need for further facilities. At the end of the day we will be better informed. Health authorities within a cash limited system have still got to determine their own priorities across the board.

Introducing information systems

RS: Are you confident that all the information that is going to be needed is going to be there for the start of the new health service?

DN: Yes, the information to kick off block contracts based on specialty costs will be there. But that compared with the picture we have in mind for five years down the road is an unsophisticated system.

RS: There will have to be a lot more money spent on information over the next five years. Have you any idea what the information costs will be?

DN: We haven't put a figure to that. And one reason that we haven't is that there's a whole range of investment in information technology from small management systems through to sophisticated clinically based systems. It will be a local judgment as to how far people want to go and what return in quality and value they can get from an investment. The whole point is that they will justify it in their own terms. There will be pump priming and experimental work, but the notion that capital is a free good will not be the way that investment decisions will be made in the future about technology at the local level. It will have to be worth it locally. The cash and quality benefits will have to be real. And those considerations will determine how sophisticated a system local units will go for.

RS: Do you think that we will have in a couple of years' time publicly available batting averages for hospitals and doctors?

DN: I think that we've got to think very carefully about

The NHS Management Executive. From left to right: back row: Eric Caines, director of personnel; Ian Oddy, estate adviser; Michael Fairey, director of information systems; middle row: Michael Malone-Lee, director of operations and planning; Bryan Rayner, director of family health services; front row: Peter Griffiths, deputy chief executive; Diana Walford, medical director; Duncan Nichol, chief executive; Sheila Masters, director of finance; Catherine McLoughlin, director of nursing

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that. I'm acutely aware that hit lists of cross infection or mortality are dangerous in that these indicators require sensitive interpretation. But, on the other hand, it's perfectly reasonable to argue that the public should be better informed about the quality of the local health services. Therefore we should look positively at making information on quality meaningful, accurate, and helpful to an informed consumer.

RS: What about information on costs? Is it progressing well?

DN: Information on specialty costs is developing well, and there have been many ad hoc cost inquiries. I have no worries about not having enough information on costs for the launch of the new service, but we are going to get more refined—particularly as we move from block contracts to cost and volume contracts. They will require a quantum leap in information on costs.

RS: And is that two or three years away?

DN: There are some authorities which are out in front with collecting this information and which have gone quite a long way down the road. These will provide the examples from which others can learn. But there will not be a uniform move from block to cost and volume contracting just as there will not be a uniform move to investment in information technology. I don't see that as a problem: it's a fact of life in a service as large as ours.

RS: How will the new slimmed down health authorities with their business orientation get information on what communities want? How representative are they going to be?

DN: They are going to commission market research on what communities think of their services and what gaps and opportunities exist. The new authorities are, to my mind, better placed to assimilate and evaluate that kind of information than the old authorities. They are also primed to go out and seek that information and are required to do so. Before, we had a mixed system, and we might have believed that we were getting information on people's needs through a representative system—but I don't think that that was the case.

Needs of health service staff

RS: We've talked about the cultural change that is going to have to happen within the NHS. Is it not very difficult to manage such change when so many employees are unhappy with the reforms?

DN: Yes, it is. A disgruntled workforce passes on bad messages to the patients and bad vibes to the public at large. There's a huge exercise that we are embarked on to improve communications within the service. One of the main reasons for disillusion and disgruntlement is uncertainty and fear on the part of staff. It is important

Vital signs of the NHS

RS: I have a list from an American business school of 15 vital signs of organisational health. Perhaps you could give me a quick reaction about the NHS in response to each. The first is strong values and beliefs.

DN: The NHS has difficulty identifying with any national value but local beliefs and values are strong.

RS: Common purpose?

DN: Again locally but not so strong nationally.

RS: Commitment, conviction, confidence, and pride?

DN: We have a long way to go with those. The idea of giving local communities the ability to make decisions is designed to improve those qualities.

RS: Exceptional people?

DN: Yes, we have some very exceptional people.

RS: Superior services?

DN: In some places, but we are trying to bring the standard of all up to the standard of the best.

RS: Customer driven?

DN: No, I don't think it is. We want to ensure that the professions put patients at the centre of things to turn round the sense of a large monopoly giving service. That's what it can feel like, and we've got to change that.

RS: Good economics and solid financial condition?

DN: We've had problems in establishing a strong financial base, and that is a priority for us.

RS: And it's still a problem.

DN: It is, but we are on the way to resolving it in most authorities by the end of this financial year.

RS: Clear and well executed strategy?

DN: Again we can improve on our ability to be clear about our strategic priorities and ensure delivery down the line.

RS: Attention to business fundamentals—performance evaluation, effective management control, budgeting, cash flow, etc?

DN: Management has made tremendous strides in recent

years. An important part of the reforms is to improve our ability to know how well we are doing things.

RS: Creativity and innovation; positive attitude to change; people not afraid to make mistakes?

DN: We have clinical creativity and innovation, but managerial innovation and risk taking needs to be monitored constantly. There is a resistance to new ideas. We don't encourage a risk taking environment.

RS: But you want to?

DN: Yes.

RS: Non-bureaucratic, lean, and decisive?

DN: We're a slim organisation but our tradition of telling people how to do things is over the top, and we intend to allow decisions to be taken at as low a level as possible.

RS: Mutual trust, good communication, and teamwork?

DN: No, but we've launched a major initiative. We need to improve our internal and external communications. We must find out what our staff think, to listen to staff, and to respond.

RS: Willingness to see and act on reality?

DN: What do you mean?

RS: Well, you might argue that the doctors don't have it if they continue to spend resources on their particular activities without looking more broadly.

DN: I think that people see the reality. They are sometimes frustrated by that in professional practice. The task is to create a better partnership between managers and clinicians so that we can move forward in what is a cash limited system.

RS: Long term orientation?

DN: We need to develop a better perspective on where we are taking health in the longer term.

RS: Strong and effective leadership? A good place to end.

DN: Yes.

RS: Throughout the service?

DN: In a service as big as this there is inevitably patchiness, but we do have some outstanding leaders.

GORDON WHITING

to remove that by talking through the objectives of the organisation and getting commitment. The management executive must improve its communication. That's not going to ensure that everybody will be totally happy overnight, but I believe that it will transform some of the unhappy feelings that we can lay firmly at the door of inadequate communications.

RS: Do you think that the health service has adequate managerial talent to make the changes work?

DN: We are not talking simply about general management but management across the health service by doctors and, most importantly, by nurses. The sense that nurses currently have of being marginalised in management is a problem. But if we add up the collective capacity of doctors, nurses, heads of departments, and general managers then we have the clout to get the system off to a good start.

RS: Do you fret about the conflict that there seems to be between doctors and managers?

... what we can criticise about the old NHS is the extremely variable performance across geographical areas, specialties, institutions, and individuals.

DN: Yes, it's very counterproductive. One of my objectives will be to seek to secure a new concordat with doctors based on the principles that the government has signalled. My sense is that now the NHS and Community Care Act 1990 has received royal assent there is a willingness to talk through how to use the new principles to improve patient care. But it is important that we establish that new concordat, and I want to do my best at the centre to achieve it.

RS: Is that just a matter of talking?

DN: Talking is where we begin, but joint participation in learning as we go and looking at the results and implications of demonstration projects will be important. It doesn't need to be formal, but we need to think together.

RS: Eric Caines, the personnel director on your executive, said recently that the NHS is a bad employer — "capital B, capital E." How will it become a better employer?

DN: To be a good employer you need to have within your control the ability to pay and reward your staff according to your local judgments. So increased pay flexibility and opportunities to manage locally and to involve staff in the organisation are the ways forward. Increasingly it's not just self governing trusts that will have these opportunities. The whole idea will be to devolve pay negotiations increasingly to the local level.

RS: So that means an end of the Whitley councils?

DN: Depending on the extent to which managers take

up pay flexibility the government will need to look at the implications for the central bargaining machinery.

RS: So the impetus for change is likely to come from the periphery rather than the centre?

DN: What we will offer is the opportunity. The extent to which it is taken up and how quickly is a local matter. Depending on how that goes the centre then has an obligation to review the machinery.

About Duncan Nichol

RS: Let me ask you some personal questions. Do you wake up on Monday mornings raring to get to work?

DN: Yes, I enjoy the job. With these kinds of changes and challenges its got to be an exciting job. I'm certainly glad to be here. I was glad to be here at the beginning, and I'm still glad to be here two years into the changes. I'm looking forward to the 1st of April 1991.

RS: Do you think it is important that you have reached your present job after working your way up through the NHS?

DN: Yes. The fact that I know the health service and have worked at every level within it and have worked closely with doctors all my working life means that I have some street credibility. But, more importantly, I have a fundamental understanding of the tensions and different perspectives that people in the service have. I understand why some people are nervous about these changes, and in that sense I'm in a good position to give leadership to the service.

RS: You spent two years working in hospitals in Chicago. Did that give you experience that is helpful now?

DN: That was 20 to 30 years ago, and what stayed with me was not the accounting systems or the free market but the internal organisation of those hospitals—the triad system of the doctor, the nurse, and the business manager. I believe that the way forward to managing our large hospitals is based on multidisciplinary management built around care and specialty groups. That's the best way to devolve decisions and get commitment.

The old NHS

RS: Finally, was the "old NHS" a failure? If so in what ways?

DN: It can't have been a failure in that the principles on which it was based are retained. What we can criticise about the old NHS is the extremely variable performance across geographical areas, specialties, institutions, and individuals. Other problems were the lack of any sense of accountability or need to stay on your toes, and the lack of any substitute for the market discipline. But grafting on the reforms to the basic principles will improve the service. But there was nothing fundamentally wrong with its founding mission.