TALKING POINT

Promoting innovation in the NHS

DAVID J HUNTER

The National Health Service is slow to introduce new ideas in health care organisation and delivery. This lack of innovation could be tackled by creating a development agency that would offer participating health authorities a service that they could use to promote innovation in their localities.

The idea of a development agency emerged from discussions between a small group of academics and NHS administrators.¹ The proposal was the product of earlier commentaries^{2,3} by the group pointing to the limitations of purely structural change and the need to attend to process and attitudes if real change is to be fostered in the NHS. This approach to innovation is only one of several available. In a state of uncertainty and imperfect knowledge about stimulating change it would be presumptuous to claim that the approach outlined here is either the only way forward or superior to other approaches. Its virtues, if any, are not proved, and at this stage I suggest only that a trial might be launched, in much the same way as the three trials with a management advisory service now running in four health regions. Other approaches to innovation will be familiar and include clinical and specialty budgeting; development based training programmes for managers; and management, or organisation, development.

In this article I have tried to answer three questions. Why is innovation necessary in health care? Why is it difficult to achieve? How might a development agency help to overcome some of the obstacles?

Why is innovation necessary?

Innovation is necessary to keep pace with, and to anticipate, a rapidly changing operating environment, including changing needs, resources, demands, and expectations. Conditions in health care that are likely to prevail in the 1980s and beyond will demand more of NHS managers. The environment will be dominated by demographic trends and economic realities. Britain faces a dramatic increase in the number of very old people, most of whom will require considerable care whether formal or informal. Furthermore, the NHS faces a period of standstill budgets and the Secretary of State for Social Services has announced that future developments in patient care will largely have to come from savings and the redeployment of existing resources. Thus there is a premium on the ability of health authorities to innovate and develop.

The NHS is not devoid of innovation, but it is uneven and ad hoc. Moreover, rapid innovation in drugs and high technology medicine has not been matched by innovation in the organisation and delivery of health care, especially for priority services in the Cinderella sectors. Yet the scope for innovation in these services is wide, though all too often the call is for "better and more" rather than for the "new and different." Drucker⁴ defines innovation as "activity or developments . . . that result in the adoption of a new product . . . or way of doing things"

(my italics). It is innovation as a new way of organising and delivering health (and social) services that is my concern here, and innovation depends on the ability of those who make policy and provide the services to implement new approaches.

In practice, it is not always possible to separate clinical innovation from service or organisational innovation. The two types often interrelate, and the success of a particular clinical innovation may hinge on organisational innovation or adaptation. Computed tomography illustrates this process. Such technologies, as Stocking and Morrison⁵ found, may have a major impact on the entire Health Service, affecting its shape—that is, the emphasis on high technology medicine—its staffing, and the need to make difficult decisions on resource allocation. The latter often have to be made in the absence of a thorough assessment of the innovation in question and handicapped by inadequate information. A development agency could help to link clinical innovation with organisational innovation, where the former has implications for the latter and where the two need to go hand in hand for maximum benefit. Promoting day surgery for specific conditions like varicose veins and hernias is an example where organisational innovation lags behind clinical innovation.

The quest for innovation is commonly seen in the context of industrial development and multinational conglomerates seeking new markets. Current developments in subjects as diverse as biotechnology, cable television, fibre optics, and laser technology illustrate the importance of innovation in the wealth producing, manufacturing sector. But innovation is just as necessary in the service sector—including health and social care—and never more so than now, when resources are diminishing and demands for services are rising. Managing scarce resources is more difficult than managing resources when growth is steady. So long as development funds were reasonably plentiful it could be argued that change was possible as well as using some of the allocation to bolster up existing services. But, paradoxically, as change becomes more difficult it also becomes more necessary. Despite this, public service organisations, including the NHS, lag behind many private companies in acknowledging and promoting the need for innovation.

Why is innovation difficult to achieve?

Innovation is difficult to achieve in most organisations though the difficulties—or, to put it another way, the lack of incentives—may be greater in the public sector.

There are at least six contributory factors. Firstly, professional bureaucrats generally have protected jobs, are anonymous, and in many respects are unaccountable. All this may—and often does—promote inertia and resistance to change.

Secondly, change is all too readily perceived as a threat rather than a challenge or an opportunity.

Thirdly, innovation is neglected because the administrative function of management—the task of keeping going, of improving what is already known and what is largely being done—militates against creativity. Both tasks are necessary but different, and they require particular skills. So if innovation is to work it should perhaps be organised separately.

Fourthly, a hierarchical structure may not help innovation or facilitate obtaining the support of individuals at lower levels. Resistance to change may occur because it is regarded as interference by a higher authority. Moreover, experimentation tends to run counter to

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the demands of the formal organisation for fairness, consistency, and uniformity. We are far from achieving what one commentator⁶ calls "self-renewing organisations," which are engaged in continuous adaptation in the light of changing problems.

Fifthly, organisational and interpersonal barriers, or blockages, which reflect the structural, organisational, and political composition of the NHS, may impede change.

Sixthly, there are difficulties in deciding what sort of change is required since policy goals and action are seldom clear and unambiguous.⁷

Change in the Health Service can no longer, if it ever could, just be expected to happen, and the challenge is to find ways of successfully promoting it. The 1982 reorganisation of the NHS, like the 1974 one before it, does not really meet this challenge, largely because a structural solution per se is not the solution. Certain skills and styles of operating are desirable to promote innovation. It is unlikely that district health authorities, or even all regional health authorities, will be able to employ the necessary skills—partly because they are not available in abundance and partly because of the impact of the management costs exercise. The size of many district health authorities is an additional factor that will make the deployment of requisite skills difficult. These constraints may prove a blessing in disguise, for it is often preferable for innovation to be promoted from outside the management system. Managers should not, however, absolve themselves from all responsibility for innovation because an external resource is an aid to management, not a substitute for it.

The role of a development agency

Despite much talk about the need for organisations to innovate, little is said about how to stimulate innovation and make it work. A development agency could help to remedy this omission. Innovation cannot be left to chance or to the vagaries of the management system—it has to be systematically worked for. Innovation does occur in the NHS, albeit haphazardly. A development agency should make innovation less of a hit and miss activity. As well as promoting innovation it would help to spread good practices from elsewhere in the Service. Finally, the agency would be a resource for managers—an aid to help them.

Four principal criteria underpin the development agency proposal.

- The agency must enjoy independence from line management if it is to operate effectively. It should not be responsible directly to higher NHS authorities (the DHSS, regional health authorities) as this is inappropriate if the aim is to engender local enthusiasm for, and commitment to, innovation.
- The agency's *modus operandi* is possibly its most distinctive feature. It would act locally with those who make decisions and provide the service, encouraging them to become agents for change. The agency would be a catalyst operating on a consultancy basis offering help and support to service providers. Solutions would not be imposed and the agency would not have automatic right of entry to authorities.
- The agency would not be a monitoring device and it would not try to persuade authorities to comply with national or regional policy priorities or both. Poor administrative performance or the flouting of agreed policies must remain the responsibility of the management system. So the agency would not replace or weaken either existing or future management control systems. Instead, it would support and strengthen these through its development work and by helping management to explore alternative ways of developing services.
- Finally, the agency's chief concern is with effectiveness and not with efficiency. In the NHS, as in other service agencies, achieving effectiveness is more of a problem than achieving efficiency since, as Rudolf Klein⁸ has argued, the "organisation is the product"—that is, there are many possibilities for substitution between different health care inputs and little certainty about how particular resources should be deployed. Thus there is a strong case for innovation, experimentation, and diversity.

REQUIREMENTS FOR AN AGENCY

Five main issues must be faced in launching a development agency.

Firstly, a steering group is necessary, made up of representatives of, say, a regional health authority and district health authorities in the region. This would set the agency's priorities and superintend its performance. The agency would comprise officers, health authority members, professional representatives, and members of community health councils.

Secondly, the agency would concern itself with a range of issues that might include preventive child care; organisation of maternity services; augmented home care for the elderly (which would concern local authorities); expenditure on drugs; and so on. The agenda would be determined by local concerns.

Thirdly, in tackling these and other subjects the emphasis would be on promoting innovation through action research and development. This work demands skills not commonly found among senior officers and professionals or, if present, rarely deployed because of day to day pressures. The agency would require a small secretariat which would engage appropriate specialists as necessary or suggest experts who might be engaged on a consultancy basis. Apart from outside specialists, health care professionals seconded from the NHS would also be needed for project work. The importance of a flexible response makes it inappropriate to prescribe in advance how the agency should operate or be staffed. The purpose of a trial would be to discover the market for a development agency and also to establish appropriate staffing arrangements and operating style.

Fourthly, an important priority would be to disseminate good practices derived from the agency's project work and from initiatives by other health authorities. Useful precedents, like the good practice in mental health project sponsored by the International Hospital Federation, already exist in the United Kingdom, and the work of organisations overseas, such as the Swedish Planning and Rationalisation Institute, merits attention. Jointly set up in 1968 by the Swedish government and health care authorities, the institute's main function is to unravel and solve a range of problems confronting the health care sector. Other tasks include disseminating information and supporting research and development work in health care administration. Taking its cue from the institute, a development agency might publish reports as well as hold seminars, conferences, and workshops. A stimulation of interauthority comparisons by such means could act as a spur to innovation among less progressive authorities. The DHSS's initiative on performance indicators has a similar aim, though it cannot be assumed that such comparisons will by themselves be sufficient to promote change.

Fifthly, the development agency will need some clout to get new developments off the ground. Good intentions alone are not enough to ensure action. Pump priming by allocating small amounts of money to launch new initiatives could prove valuable, particularly if, as the present director of the Health Advisory Service claims, the problem does not lie in a shortage of good ideas but in implementing them in diverse local conditions.⁹

Conclusions

There is no model in the United Kingdom for the development agency I have described, though the Health Advisory Service and the National Development Team for the Mentally Handicapped come close. But these bodies experience difficulty in offering sustained support to service providers so that they can deal with problems identified during visits. A development agency would aim to close this gap by offering prolonged help—it is about how things may be done differently rather than about what may need to be done. David Towell's consultancy work in mental health¹⁰ shows how necessary such work is, though

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he warns against quick results and instant success—the work is painstaking and time consuming and not always successful.

So far, the notion of a development agency has attracted insufficient interest to enable a trial in a health region to proceed. The agency's underlying philosophy and commitment to innovation, however, have been picked up and may even contribute to whatever emerges from one of the management advisory service trials. Moreover, the Social Democratic Party comes close to the agency proposal with its suggestion for an employment and innovation fund to encourage experiments and innovation.¹¹

A major issue in management is the inherent conflict between hierarchical control systems and imaginative thinking. I doubt whether the two activities are compatible or that they can be executed in the formal management structure—innovation tends to be squeezed out. A development agency could tackle this dilemma: it would not be responsible for achieving innovation in health care but would help to create the conditions for innovation to occur. Without some such initiative we are thrown back on nature's answer, "while there's death there's hope." A less macabre answer lies in a parable about a soldier in New Zealand.¹² While on manoeuvres he was ordered to build a bridge across a river though he had insufficient men or materials for the task. He stared along the bank looking glum, when a Maori woman came along asking, "Why so sad, soldier?" He explained that he had been given a problem for which there was no solution. Immediately the woman brightens, saying, "Cheer up! No solution, no problem."

In the context of the NHS, perhaps the lesson of this parable

is the need for caution and healthy scepticism rather than the abandonment of the search for solutions.

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(Accepted 11 January 1983)

Review of NHS ophthalmic services

The Government has decided that there should be a "thorough independent review" of the National Health Service's ophthalmic services. Ministers want the review started speedily and, along with other "interested bodies," the British Medical Association has been asked for its comments by 21 March 1983. The association's ophthalmic group committee is already at work preparing evidence.

Members of the review committee—to number about seven or eight—have yet to be appointed, but the government has published the committee's terms of reference:

"(a) To examine and review the structure, administration and financing of NHS General Ophthalmic Services, including the methods used to reimburse and remunerate practitioners, taking account of studies already underway and any subsequent ministerial

action; and to consider the consequences of any change for the hospital eye service.

"(b) To consider the proper role of the NHS in the provision of General Ophthalmic Services.

"(c) To review the working of the Opticians Act 1958, in particular the structure of the ophthalmic professions, the constitution and powers of the General Optical Council, and, taking full account of the outcome of the Office of Fair Trading review and any subsequent ministerial action, the effect of the present opticians' monopoly and the extent of competition among opticians.

"(d) To consider the state of the UK ophthalmic and manufacturing and service industries and their relationships to the NHS and DHSS.

"(e) To review the role and working of the DHSS in respect of ophthalmic services.

"(f) To make recommendations compatible with the maintenance of comprehensive ophthalmic services within the UK that, while maximising the efficiency of NHS services and minimising cost to the exchequer, take account of the interests of the ophthalmic industries, the ophthalmic profession and the patient."

Association Notices

Rheumatology and rehabilitation subcommittee

Nominations are invited from senior hospital medical staff in rheumatology and rehabilitation in the NHS for representatives to serve on the rheumatology and rehabilitation subcommittee of the Central Committee for Hospital Medical Services for the period 1983-6 (two representatives) and 1983-4 (two representatives).

Nomination forms may be obtained from the undersigned, BMA House, Tavistock Square, London WC1H 9JP and must be returned to reach him not later than Friday, 11 March 1983. Four representatives will be elected by a ballot of all senior hospital medical staff in rheumatology and rehabilitation.

J D J HAVARD
Secretary

BMA handbook for trainees in general practice

The BMA has just published a handbook for trainee doctors in general practice. The 88 page publication, edited by Dr Ian McKim Thompson, head of the association's membership and regional services division, gives extensive advice on the problems commonly met by trainee general practitioners. It contains information on such subjects as voca-

tional training regulations, partnership agreements, and terms of service as well as providing advice on financial aspects of general practice and how to choose a practice. (*BMA Handbook for Trainee Doctors in General Practice*, free to GP trainees and trainees who are BMA members, otherwise £3; obtainable from BMA House, Tavistock Square, London WC1H 9JR.)