REFERENCE
7

KING'S FUND COLLEGE

REFORMING THE NHS : MANAGED EXPERIMENTATION

A Submission to the
Prime Minister's Review of the NHS
from the
King's Fund College

June, 1988

King's Fund College, 22 Palace Court, London W2 4HU
Telephone: 01-727 0581

The King's Fund College

The King's Fund College is a part of the King Edward's Hospital Fund for London which was founded in 1897 by Edward, Prince of Wales, to mark Queen Victoria's Diamond Jubilee. The King's Fund is a leading independent charity which seeks to stimulate good practice and innovation in all aspects of health care including policy, practice and management.

As a part of the Fund, the King's Fund College has constantly reflected in its activities the rapidly changing circumstances of health services management in the United Kingdom. The College played an important part in both the development of thinking about general management in the NHS and its practical implementation. Today, when reviewing progress to date, we believe that the Faculty of the College has unrivalled experience to draw upon. This is because College Fellows have been working regularly both in the classroom and in the field with a wide range of regional, district and unit general managers as well as professionals from throughout the NHS. Furthermore, the College is, by a substantial margin, the largest of the many Management Development Centres working with the NHS. In consequence, it is probably visited in total by more doctors, nurses, authority members, senior (and junior) managers and administrators, than any other comparable institution. These practitioners in the field, inform us freely about their successes and failures. The College's evidence given below draws upon this breadth of experience as well as upon that of the Faculty's individual members.

This paper reflects the contributions of a number of members of the College as well as NHS managers and others. These were co-ordinated by:

Gordon Best	Director, King's Fund College
David Kenny	Regional General Manager, North West Thames Regional Health Authority
Robert Maxwell	Fellow in Health Service Policy and Institutions, King's Fund College and Secretary/Chief Executive of the King's Fund
Duncan Nichol	Chairman, King's Fund College Education Committee and Regional General Manager, Mersey Regional Health Authority

Others contributing to the paper were:

Cyril Chantler	Professor of Paediatric Nephrology Guy's Hospital
Tony Culyer	Professor of Economics, University of York
Peter Griffiths	District General Manager, Lewisham and North Southwark Health Authority
Chris Ham	Policy Analyst, King's Fund Institute
June Huntington	Director of Educational Programmes, King's Fund College
Alasdair Liddell	District General Manager, Bloomsbury Health Authority
Bob Nicholls	District General Manager Southmead Health Authority
Greg Parston	Director of Field Development Programmes, King's Fund College
Chris Spry	District General Manager Newcastle Health Authority
David Towell	Fellow in Health Policy and Development, King's Fund College

REFORMING THE NHS: MANAGED EXPERIMENTATION

1.0 Introduction and Background

1.1 This paper is a contribution to the Prime Minister's Review of the NHS. It addresses the following questions:

> 'How can the NHS be made more competitive and innovative? Is it possible to increase its efficiency, effectiveness and consumer responsiveness without simultaneously undermining its traditional strengths?'

A key premise of the paper is that this kind of change can be achieved. More important, the process of doing so has already begun.

1.2 In some parts of the NHS, better management - especially when supported by the use of incentives - has already led to significant progress in improving efficiency, effectiveness and consumer responsiveness (see below). The opportunity exists now to build on these beginnings and accelerate the process without undermining the founding principles of the NHS (comprehensiveness, equity and access not dependent on ability to pay) which are seen internationally and at home as its greatest strengths.

1.3 This paper tries to avoid repeating arguments and proposals made elsewhere, but the proposals below owe much to Best (1987); Culyer/IHSM (1988); Efficiency Unit/Ibbs (1988); Enthoven (1986); Marinker (1987);

NAHA (1988); Parston (1988); Peet (1987); and Willetts and Goldsmith (1988). Unlike many of these publications however, this paper argues that it is not possible to specify now, in advance, the details of the issues that will be facing the NHS in three, five or ten years' time and hence what organisational arrangements will be appropriate.

1.4 Purposeful change in the NHS will not be achieved by prospective detailed prescription from government. Rather, it will be far better and far more effective to:-

a) concentrate government attention on broad strategic themes (e.g. the use of market-led incentives to increase consumer choice)

b) translate these themes into a change agenda (e.g. the encouragement of greater competition);

c) create conditions within which local initiatives consistent with this are encouraged (e.g. rewards for successful competition); and

d) create a surveillance function which (a) sanctions and establishes the ground-rules for local experimentation; (b) manages the risks invariably associated with such local initiatives; (c) ensures that successful local initiatives become the basis for defining good practice; and (d)

allows for 'earned' local autonomy by ensuring that those responsible for successful experiments are given increasing scope and encouragement to innovate.

1.5 Most suggestions for change in the NHS produce blueprints or sets of options which (presumably) Ministers are to choose between. It is important to stress at the outset therefore, that while alternative visions of the future are an important backdrop against which to set a change agenda, good management practice suggests that successful change in complex organisations cannot be pre-ordained in detail. Richard Beckhard, a respected advisor to many of the largest and most successful U.S. and U.K. corporations has put this view forcibly:

> 'The future is not the result of choices among alternative paths offered in the present - it is a place that is created - created first in the mind and will; created next in activity'. (Beckhard, 1985).

1.6 The introduction of General Management in the health service and the increasing pressures to find new and locally appropriate ways to stretch resources further, has already set in train the change in the mind to which Beckhard refers. The IHSM (1988) report, for example, represents an important statement about managers publicly committing themselves to new values, experiment

and innovation. It was a key strength of the Government's management review, chaired by Sir Roy Griffiths in 1983, that it recognised that releasing the management development process was far more important and would be far more productive than detailed prescriptions about what managers should do and how they should do it. The challenge now is to manage consciously - and thus accelerate - the process of change that has already begun.

2.0 What is there to build on?

2.1 This section addresses two questions: first, what evidence is there that the change process has already begun? and secondly, what evidence is there that incentives and better management will deliver beneficial change reasonably quickly?

2.2 The introduction of general management and the closer scrutiny of financial and other aspects of NHS performance over the past five years have been in part or in whole, responsible for a wide variety of changes within the Service. (The publications by Best (pp 1 - 10); Culyer/IHSM (sections 3.3 - 3.6); NAHA (pp 1 - 3); and Peet (Chapters 2 - 6) all document many of these changes). Some of these changes have emanated from Management Board level. These have included the introduction of Individual Performance Review and Performance Related Pay for top and senior managers; temporary contracts for top managers and the strengthening of the Performance Review process; and Resource Management as a combined national/local initiative breaking new ground in the management of clinical and nursing services and in information systems support. There have also been a number of local initiatives sometimes involving partnerships with the private sector. For example, a number of health authorities now buy and/or sell acute services, while many sub-contract long-stay services to the private and voluntary sectors. There has also been a significant

move away from bureaucratic models of management with unprecedented and widespread differences in local organisational and management arrangements. For example, performance review and income generation managers have been appointed and unit structures have been designed specifically to bring about desired change. Many of these changes can be seen as measures intended to build upon and strengthen the general management function while others make use of incentives to influence managerial and organisational performance.

2.3 There are many instances where the particular energy of District and Unit managers has produced beneficial change on an unprecedented scale. One well-documented example is that of a major London teaching hospital which (a) has used the introduction of general management to involve clinicians directly in the management of resources; (b) in so doing, has completely turned around its financial performance; and (c) is now completing the process of introducing incentives so as to improve morale and ensure that these major structural changes result in an improved service to patients. Appendix A attached describes these changes in detail.

2.4 The scale of change described in Appendix A while impressive on such a short timescale, is by no means an isolated example. Other examples include major changes in the delivery of mental health services in Exeter and Newcastle DHAs; collaboration with the private and voluntary sector in the care of the elderly; quality

assurance initiatives in Wessex RHA and Brighton DHA; and personal service initiatives in Trent and Mersey RHAs. Such examples leave little doubt that, in the favourable circumstances of proactive, confident managers and a solid coalition between managers and clinical leaders:

* **Improved management can be a key ingredient in effecting major change in an organisation as complex as the NHS in a relatively short period of time.**

* **These changes do have a major impact on the performance of the organisation, including the standards of service that it provides.**

* **Even in conditions of financial stringency it is possible to create positive incentives for change.**

* **It is possible to work with the private sector in ways that create further scope for incentives and which, as a consequence, strengthen both elements of the partnership.**

2.5 There will always be special circumstances peculiar to each local initiative. It is important not to allow this to distract attention from the fact that successful change has almost always occurred in circumstances where a) the managerial structure has both enabled and rewarded successful initiatives; b) higher levels in

the NHS hierarchy have given a clear sense of direction, but not tried to manage in detail; and c) there has been a recognition that it is important both to motivate and to control the process of experimentation.

2.6 This experience gives rise to two major practical questions: (a) **can such local initiatives and experiments be encouraged and promoted more widely?** and (b), **if so, how should the process of experimentation be managed in order to promote beneficial change while minimising risk?** The next section considers these two issues.

3.0 Managed Experimentation

3.1 If the process of introducing beneficial change in the NHS is to be accelerated, the key is to find ways of identifying, fostering, encouraging and monitoring more local initiatives and experiments. Equally, it will be necessary to ensure that only those experiments that represent reasonable risks are embarked on; that the range of experiments is broad; and that the learning from them is captured, disseminated and acted upon so as to promote change on an increasingly broad front. In short, if such a process of experimentation is to succeed, it will need to be managed. The remainder of this paper considers how this can be done.

3.2 Establishing a change agenda

3.2.1 Any agenda for change in relation to the NHS must reflect both political and managerial considerations. It is the responsibility of ministers and their advisors to agree in the light of governmental priorities what changes they would like to bring about (see below). To maximise the chances of these changes occurring and achieving what ministers intended however, local managers should be given the maximum freedom to decide how best to deliver these changes. This is an important lesson which the public sector needs to learn from industry. Indeed, the recent report by the Prime Minister's Efficiency Unit

suggested that while "... strategic control must lie with the Minister and the Permanent Secretary ... once the policy objectives and budgets ... are set, ... management ... should have as much independence as possible in deciding how those objectives are met." (Page 9).

3.2.2 The Ibbs Report suggested that political and managerial concerns within Government departments could be reconciled through the creation of 'agencies' established to carry out the executive functions of Government within a policy and resources framework set by a department:

> 'An 'agency' of this kind may be part of government and the public service, or it may be more effective outside government. We use the term 'agency' not in its technical sense but to describe any executive unit that delivers a service for government. The choice and definition of suitable agencies is primarily for Ministers and senior management in departments to decide. ...
>
> These units, large or small, need to be given a well defined framework in which to operate, which sets out the policy, the budget, specific targets and the results to be achieved. It must also specify how politically sensitive issues are to be dealt with and the extent of the delegated authority of management. The management of the agency must be held rigorously to account by their department for the results they achieve.
>
> The framework will need to be set and updated as part of a formal annual review with the responsible Minister, based on a long-term plan and an annual report. The main strategic control must lie with the Minister and Permanent Secretary. But once the policy objectives and budgets within the framework are set, the management of the agency should then have as much independence as possible in deciding how those objectives are met. A crucial element in the relationship would be a formal understanding with Ministers about the handling of sensitive issues and the lines of accountability in a crisis. The presumption must be that, provided management is

operating within the strategic direction set by Ministers, it must be left as free as possible to manage within that framework.' (Page 9).

It would be managerially attractive to see these recommendations as applying to the NHS Management Board. But the NHS is so large, diverse and politically sensitive that it is unlikely that a single agency could, by itself, provide an effective mechanism for managing the whole complex process.

3.2.3 This is particularly clear when considering what would be involved in establishing an agreed change agenda and then translating this into real change. A national change agenda will need to reflect governmental priorities - for example, increasing consumer choice; fostering increased competition between providers in order to achieve a higher quality of service and better value for money; promoting increased partnerships with the private sector; and so on. In addition, criteria will need to be established against which local initiatives intended to translate these priorities into real change, can be judged. A number of the publications cited above suggest such criteria - for example, impact on access to services, contribution to service effectiveness, community acceptance, and so on. The process of moving from Government priorities to fostering and promoting local initiatives which, when judged against such criteria, stand a good chance of success, is a complex task. It will, for example, require prospective judgements to be made about the quality of

local management; the scope for cross-organisational co-operation; the scope for competition between providers; the timescale within which the results of innovation can be measured; and the means of assessing consumer satisfaction.

3.2.4 It would be impractical for a central body such as as the DHSS or the NHS Management Board to scan 190 DHAs, over 90 FPCs and a similar number of other potential public and private providers and then to identify those specific, local opportunities that offer the greatest potential for fruitful experimentation, let alone to keep in close touch with them as they progress. The DHSS and the NHS Management Board are too remote from the field to be able to exercise informed judgements about more than a handful of local management initiatives. In addition, both are too close to government to provide the necessary distancing of ministers from the risks which are inevitably associated with experiment and change.

3.2.5 By contrast, regions are relatively well-placed organisationally to negotiate a change agenda with the Centre and then to seek opportunities to translate that agenda into successful action. In particular, regions should be close enough to local service delivery to make well-informed judgements about the potential for successful experimentation, and about its progress, while also sufficiently divorced to take an overview. Slimmer Regional Health Authorities,

freed from many of their service provision and operational responsibilities and re-structured as agencies with a smaller board of executive and non-executive directors, could play a key role in translating political priorities into successful local initiatives.

3.2.6 Under such an arrangement, the role played by the Centre (i.e. the Department of Health) will also be crucial. Following the Ibbs' recommendations, the Centre would:

* advise Ministers on the management implications of policy;

* agree a policy and resources framework with each Regional agency;

* challenge performance against that framework;

However, even with the model of Regions as 'Ibbs' agencies there is still a need to retain (in close conjunction with DHSS) something like the Management Board. There are several reasons why this is so:

a) The negotiation of the change agenda, the subsequent communications and the measurement of success requires the Centre to be conversant with the values, risks, language, and tools of management. Without such knowledge and

experience the Centre will not understand the perspectives of management in the field;

b) Conversely, a core of people with managerial experience at the Centre will enable the Government's political perspectives both to be absorbed by Regions and translated into managerial programmes and controls in a way more likely to create credibility and commitment in the field;

c) A managerial presence at the Centre is essential in certain key fields such as the pay and conditions of staff, policy on procurement, and the governance of national standards in data collection.

These important factors in the relationship between the Centre and the field would be lost if the Management Board were dissolved without the creation of something equivalent to take its place. Indeed it needs strengthening, not weakening, and a clearer recognition of its role.

3.2.7 The Centre is at present not internally structured in a way which reflects or can respond to the imperatives of running one of the world's largest organisations. No doubt the internal lines of command could be altered but two more fundamental issues would need to be resolved. One issue relates to the problems

continually generated by the artificial separation of policy from management. A second issue concerns the sets of problems thrown up when two very different kinds of organisation are trying to address a shared task. There is growing organisational friction as the NHS becomes increasingly a managed service while the Centre remains an administered and indiscriminately centralising undertaking.

3.2.8 Achieving the required change will require firm support of Ministers and Permanent Secretaries. It would be all too easy for Whitehall to acquiesce with the concept of the NHS Management Board as an agency, but to then stifle innovation by retaining excessive authority and continuing to involve itself in wholly unnecessary detail. The drive towards delegation and the commitment to liberate NHS managers for innovative change must be genuine and sustained.

3.3 Creating the conditions for encouraging local experimentation

3.3.1 A key reason for suggesting the creation of Regional Agencies is that they would be well-placed to establish ground-rules for local experimentation (e.g. to negotiate and monitor service standards); to identify potential risks (e.g. gaps in service coverage which might arise from competition); and to manage risk (e.g. to underwrite financial risk in part or in whole by providing a 'banking' service or,

for example, ensuring that alternative provider arrangements are available in situations where an experiment may not meet the needs of all patients).

3.3.2 It is also likely that despite their relative distance from most aspects of service delivery, **regions are close enough to see opportunities for experimentation within and between districts and in the private and voluntary sectors.** Regions are also close enough to amplify the learning from experimentation and to take responsibility for ensuring that such learning is generalised and incorporated as a basis for good practice. This is critical if local experimentation is to be encouraged on a wide enough scale to create models for more widespread change within the NHS.

3.3.3 To discharge these responsibilities successfully, it will be necessary for Regional Agencies to encourage local initiatives which, if introduced successfully, would promote greater patient choice, a more efficient use of resources, an increase in public/private partnerships, and so on. Measures often suggested include:

* **internal trading between health authorities** (for example, the buying and selling of acute services between authorities)

* **competition between health authorities and between health authorities and the private sector** (for example, competition for the provision of pathology services on a multi-district basis)

* **the separation of responsibility for finance from that for provision** (for example, the creation of a special authority to purchase hospital, primary care and social services from both public and private providers)

* **the strengthening of general management** (for example, the introduction of general management in FPCs and/or the creation of 'units' of management incorporating primary care services within the RHA structure)

* **the wider use of performance incentives** (for example, the use of performance bonuses and/or the extension of the designated area allowance to modify GP referral behaviour)

3.3.4 The introduction of these kinds of initiatives presents both a number of **practical problems** (e.g. lack of adequate information; legislative obstacles, etc.) and certain **risks** (e.g. internal trading leading to greater inequalities in access to services). It is a key premise of this paper that **provided these measures are introduced as a part of a carefully managed and selective process of**

experimentation, neither of these types of danger need delay progress.

3.3.5 In order to make significant progress in a reasonably short period of time, however, it is necessary to create enough managerial freedom for significant experimentation to take place. There is a need to remove or modify particularly significant barriers to more effective management. These include:

- over-centralisation and inflexibility in pay bargaining;

- over-elaborate and time-consuming public consultation currently applying to the smallest changes in patterns of service delivery;

- inflexibility between capital and revenue, coupled with an inability to raise capital or to account for capital depreciation in a commercial way;

- inability to develop appropriate measures of health care effectiveness and consumer satisfaction, resulting in the current preoccupation with methods and systems of measuring what is happening and how it is happening, rather than concentrating on where health care effectiveness and consumer satisfaction need to be improved;

- inability to trade between hospitals within the public and private sector because of the lack of basic information about treatment 'tariffs' and because of professional rigidities (e.g. barriers to the transfer of patients from a consultant's waiting list to a service elsewhere);

- confusion within health authorities around the role of members as consumer representatives, staff representatives or non-executive board directors;

- inability of managers to be directly involved in consultant appointments or to review/reward consultant performance against contracts with a five or ten year 'break clause'.

3.3.6 Perhaps most important, there is an urgent need to introduce organisational incentives which would (a) motivate DHAs, FPCs and other providers actively to seek out opportunities for experimentation and (b) motivate Regional Agencies to want to sponsor and facilitate successful experiments. For example, Regional Agencies and other authorities ought to be able to 'earn' additional revenue and/or have the freedom to reinvest earned surpluses if they are a party to successful experimentation which promotes the agreed change agenda. In general, success should be

rewarded. Similarly, agencies which do not perform well should risk losing resources (e.g. another agency taking over some of their responsibilities). The agency model offers a very real prospect of removing most if not all of the worst features of 'boundaries' around Regions as well as around Districts.

3.3.7 It is important to underline the importance of such incentives. Many of the practical barriers to experimentation noted above have on occasion already been overcome within the Health Service. Districts are already trading internally and both competing with, and working in partnership with, the private sector (see Appendix A). There have also been examples where cross-organisational co-operation has been successful (for example, between FPCs and DHAs). In almost all cases, however, the prospect of reward (for example, additional income; access to earmarked joint planning monies, etc.) provided the spur for such developments. The prospect of securing additional resources and having the freedom to invest those in improving services can have a major motivating effect: it can lead for example, to an active and successful search for information which is 'good enough', even though imperfect. It is quite likely that many of the practical barriers to successful experimentation can be circumvented if the motivation is strong enough.

3.3.8 It is also important that experiments only proceed in circumstances where the chances of success are judged to be high enough and where arrangements for managing the risks involved are in place. In particular, if the legislative and other barriers listed on pages 18 and 19 are removed, the ability to utilise these additional freedoms should have to be 'earned'. Regional Agencies and delivery bodies such as DHAs and FPCs should be required to earn additional autonomy by association with local initiatives that are likely to advance the national change agenda.

3.3.9 Finally, if Regions are to fulfil these roles successfully, there is a strong case for freeing them of some of their existing responsibilities. In particular, a combination of devolving some services to Districts for them to manage (e.g. Ambulance Services and Supplies) and contracting out (e.g. Regional Design and Project Management and Regional Computing) will free Regions to concentrate on their core agency functions, as well as their more traditional strategic roles of planning and allocating resources; stimulating a strategic vision for Districts; challenging District performance; and promoting the development of better managers and management practices.

In these circumstances, the re-structuring of Regions should almost certainly also involve the creation of smaller boards of executive and non-executive

directors, chosen in part for the ability to contribute to the work of the Agency, to replace existing RHAs.

3.3.10 In summary, it is suggested that a managerially-orientated NHS Management Board (or its equivalent), Regional agencies, organisational incentives and increased statutory freedoms are the key ingredients in creating a process of managed experimentation. Building on recent NHS achievements and working to a national change agenda, such a process holds out the prospect of bringing about significant beneficial reform reasonably quickly. The idea is to create within the NHS many of the stimuli, incentives and sanctions of the market, so that innovation becomes part of everyday life rather than being imposed from above. Precisely the configuration of services and management arrangements that will result is not specified in advance, but will emerge from many competing efforts to do the job better than others, within the framework of government policy and government decisions on funding.

APPENDIX A

A SUMMARY OF RECENT CHANGES AND DEVELOPMENTS AT GUY'S HOSPITAL - 1984 - 1988

A.1 Guy's Hospital exploited the opportunity afforded by the introduction of general management to introduce a decentralised clinical management structure with each major specialty coming under the management of a senior consultant from within that specialty:

A.1.1 Each clinical firm within each Directorate has accepted explicit responsibility for meeting prospectively negotiated caseload and financial targets.

A.1.2 To facilitate this process, most of the support departments within the hospital (e.g. medical records) have been de-centralised with about 70% of all staff reporting through clinical directorates.

A.1.3 The management of admissions and waiting lists and authority over ward budgets have also been decentralised to clinical teams and/or directorates.

A.1.4 The 14 clinical directors (i.e. consultants) meet as a management board on a monthly basis to monitor expenditure, quantity and quality of

activity and where appropriate, agree changes in policy and/or operations.

A.2 Many of these changes were introduced in part to address the severe financial difficulties facing the hospital in 1984. At that time, the hospital's annual deficit was £1.2m on a budget of just under £60m. In 1985/86 this deficit grew to £1.7m. During that year and throughout 1986/87 however, the Management Board agreed actions which effectively cleared the deficit. In 1986/7 the hospital broke even (while every other teaching hospital in London registered a significant overspend) while in 1987/88, the hospital underspent its budget. During the period 1984/85 to 1987/88, management in the hospital reduced expenditure by £7.8m per annum (15%); reduced its bed complement by 340 (28%); and its staff complement by 17%. Moreover, while the volume of patients treated fell during the early phase of these changes, they rose by about 5% in both 1986/87 and 1987/88 and are expected to reach 1982 levels (the highest year on record) during 1988/89.

As might be expected, this scale of change has had a traumatic impact on the hospital. Aware of this, the hospital's management has continually sought ways to guard against sacrifices in the quality of care and staff morale. Action has included:

A.2.1 The establishment of an observation ward associated with the accident and emergency

department to take pressure off beds, and a five-day ward and day surgery unit. (It is widely believed that these changes have been responsible for the sharp fall in waiting lists which began in mid-1987).

A.2.2 The establishment of a quality assurance committee (chaired by a consultant member of the Management Board) which, amongst other activities, monitors inpatient re-admission rates and has introduced a new system for planned discharges for the elderly or chronically disabled with a reporting system to judge inappropriate discharges to the community.

A.2.3 The establishment of a centrally-administered development fund made up in the first instance (see below) or fortuitous savings and a proportion of planned directorate savings: (this fund is held centrally against the possibility of a hospital-wide overspend; in the absence of an overspend, the Management Board invites directorates and other parts of the hospital to bid against these monies to fund new developments).

A.2.4 To increase revenue the hospital has in the past, provided acute services to other DHAs with long waiting lists for given conditions.

A.2.5 To effect further savings (and therefore increase income to the development fund) the hospital has contracted out the management of its hotel and support services. (Although the hospital continues to employ the staff involved (with the exception of management) the private contractors have agreed to meeting significant savings targets while adhering to explicit standards of quality, respecting existing conditions of employment and making no reductions in staff save those agreed with the Unions as a result of 'natural wastage'.)

A.2.6 Perhaps most significantly, the hospital has raised the capital (through its Special Trustees) to open its 'own' private hospital (to be opened in the Autumn of 1988). The management of this hospital is contracted out to the private sector which again, has agreed to quite rigorous conditions including quality standards, the purchasing of all medical support services from the 'parent' NHS hospital and so on. In addition, a significant proportion of the surplus earned from the private hospital will be channelled into the parent hospital's development fund: (these monies together with the income from the provision of medical support services will create an annual development fund in excess of £2m/annum).

A.3 Although there is no doubt much to be learned from this experience (and others), the point of covering it in detail here, is that it provides a concrete illustration of how incentives and better management can be used to bring about significant change within the NHS in a reasonably short period of time.

REFERENCES

1. Best, G., 'The Future of NHS General Management: Where Next?', King's Fund Project Paper No. 75, King Edward's Hospital Fund for London, 1987.

2. The Institute of Health Services Management, 'Alternative Delivery and Funding of Health Services', IHSM, 1988.

3. Efficiency Unit (Kate Jenkins, Karen Caines, Andrew Jackson)/Ibbs, 'Improving Management in Government: The Next Steps', Report to the Prime Minister, London, HMSO, 1988.

4. Enthoven, A.C., 'Managed Competition in Health Care and the Unfinished Agenda', Health Care Financing Review, 1986 Annual Supplement.

5. Marinker, M., 'Experimentation: The Next Step', Journal of the Royal College of General Practitioners, pp 125-128, March 1987.

6. National Association of Health Authorities, 'The Nation's Health - A Way Forward', NAHA's Evidence to the Prime Minister's Review of the NHS, NAHA 1988.

7. Parston, G., 'Memorandum to the Treasury and Civil Service Committee Sub-Committee to Enquire into Civil Service Management Reforms', King's Fund College, 1988.

8. Peet, J., 'Healthy Competition - How to Improve the NHS', Policy Study No. 86, Centre for Policy Studies, 1987.

9. Willetts, D., Goldsmith, M., 'A Mixed Economy for Health Care: More Spending, Same Taxes', Centre for Policy Studies, 1988.