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THE PROMOTION OF INNOVATION IN HEALTH CARE

THE CASE FOR DEVELOPMENT AGENCIES

IN THE NHS

A Report of, and commentary upon a Conference held at the King's Fund Centre on Wednesday, 28th October 1981.

by

Chris Ham and Laurie McMahon

King's Fund Centre
126 Albert Street
ndon NW1 7NF.
l: 01-267 6111

Royal Institute of
Public Administration
3 Birdcage Walk
London SW1H 9JJ

Tel: 01-222 2248

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Foreword

Recent years have witnessed a growing concern with ways of promoting change in the NHS, particularly in regard to the organisation and delivery of services.

This concern is not new, but has become more pressing as financial constraints on health services have become tighter. A realisation that future developments in service provision may have to be funded out of existing budgets rather than through growth money has focused attention on alternative approaches to encouraging innovation and experimentation in health authorities.

One such approach, that of a development agency for the NHS, has been explored by a group of academics and health service administrators convened under the aegis of the Royal Institute of Public Administration (RIPA) by David Hunter, the Institute's Health Studies Officer.*

Based on a conference organised jointly by the RIPA and the King's Fund Centre, and held at the Centre on 28 October 1981, this report examines the development agency model, setting out the case for an agency, presenting a range of critical appraisals of the model, and drawing out general points of wider relevance to those concerned with change in the NHS.

We are grateful to Chris Ham of the School for Advanced Urban Studies, University of Bristol, and Laurie McMahon of the Health Care Studies Group, The Polytechnic of Wales, for acting as conference rapporteurs. They have sought not only to provide an edited record of the day's proceedings, but also, in the introduction and the conclusion, to place the proceedings in context and to identify key issues for the future. The King's Fund and the Royal Institute of Public Administration are publishing the report jointly as a contribution to the continuing debate on the subject of innovation in health care management.

David J Hunter
Health Studies Officer
Royal Institute of Public Administration *

David Hands
Assistant Director
King's Fund Centre

London
June 1982

* David Hunter left the RIPA to take up a new post as Research Fellow in the Department of Community Medicine at the University of Aberdeen in April 1982.

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1. INTRODUCTION

Background

The operation of the NHS at the local level has come under increasing critical scrutiny from a variety of sources in recent years. Parliamentary pressures, particularly through the Public Accounts Committee and the Social Services Committee, have highlighted discrepancies in performance between health authorities [1]; academic studies have illuminated the complexities of power relationships within the NHS, and have drawn attention to the key position held by professional groups in so far as resource allocation and priority setting are concerned [2]; and mounting evidence from a number of issue areas suggests a widening gap between the articulation of policies by the DHSS and the achievement of change in service provision. This evidence has led not only to a questioning of whether the DHSS has the ability to influence local services, but also to an examination of new approaches to reviewing management performance and overcoming inertia in the NHS.

These attempts to enhance the capacity for management (rather than clinical) innovation derive from four main sources: the NHS Review System advocated by Frank Pethybridge; the Management Advisory Service experiments; the work done by existing agencies and individuals; and the proposals for a development agency for the NHS formulated by the Royal Institute of Public Administration health policy group. Each of these sources will be considered in turn.

The suggestion that an NHS Review System should be established was first advocated by Frank Pethybridge, formerly regional administrator in the North Western RHA, in evidence to the Royal Commission on the NHS. The suggestion, which was developed in subsequent articles [3], was based on the argument that the NHS is not really a national service, but rather is a service in which there is considerable local autonomy. Pethybridge maintains that there is a need to monitor local services to see if appropriate standards are being achieved. His initial proposals were for an NHS Advisory Authority to undertake monitoring on a national basis. More recently, these proposals have developed into the idea of an NHS Review System to be carried out in the North Western RHA only. The Review System is one of the Management Advisory Service (MAS) trials supported by the DHSS.

The MAS trials represent the second source of ideas on management innovation. The proposals for a Management Advisory Service for the NHS were first mooted in 'Patients First' [4] in the context of the future role of RHAs, where it was suggested that "on an experimental basis in one or two regions, responsibility for monitoring the quality and efficiency of the ways in which health services are managed, and for advising on the development of services at district level, might be discharged not by the RHA, but by an advisory group of experienced NHS officers". This statement was followed by health circular (80)8 of July 1980 which announced that the Secretary of State would welcome experiments involving the establishment of a Management Advisory Group to monitor the quality and efficiency of the way in which services are managed. Subsequently, Management Advisory Service trials were developed in three parts of the country: the Wessex region, the North Western region, and the Oxford and South Western regions. An important influence on DHSS thinking was that the MAS would help the Department defend its position to the Public Accounts Committee and the Social Services Committee. The intention was to carry out the trials on an experimental basis over a period of two years beginning in April 1982, at the same time evaluating their operation with a view to establishing the MAS on a national basis.

The three trials have adopted somewhat different styles. The essence of the North Western scheme has already been described. The NHS Review System in the North Western region aims to devise standards for measuring performance and to disseminate good ideas. The System involves a team of officers - an administrator, nursing officer, medical officer and treasurer - being specially recruited to make an impartial assessment of management efficiency in health districts. The intention is that the team should spend a month in each district examining all aspects of management. Visits will be followed by reports to the DHA and RHA. The System is supervised by a steering group of health authority chairmen.

The Wessex approach is known as performance review. Within a common regional framework, DHAs themselves design and implement reviews of different services, for example maternity services or catering. A selective approach is therefore adopted, and in Wessex it has been stressed that performance review is a task of everyday management, not a separate activity to be hived off to an independent group. Thus, although a regionally based performance review group is overseeing the work, the reviews are managed by districts and are only undertaken with the agreement of districts.

The Oxford and South Western RHAs are collaborating on a cross-regional experiment seeking to monitor selected services in order to compare performance, spotlight differences, highlight deficiencies and alert the responsible authorities on the need for intervention. A supervisory board, including RHA and DHA members, has responsibility for the work of a specially recruited multidisciplinary team of experienced NHS officers. The team will undertake studies and reviews, advise DHAs on how management performance can be improved, and spread good practices as well as note deficiencies.

The third source of ideas on new approaches to promoting change is the work done by existing agencies and individuals concerned with innovation. For example, the Wessex performance review scheme developed out of the Regional Monitoring Policy pursued between 1977 and 1979. Again, independent bodies like the HAS and the Development Team for the Mentally Handicapped have served as a model for some of the proposals noted above. The experience of outside advisers and consultants has also informed these proposals. A general point follows: that a considerable amount of work is already being undertaken by a variety of bodies which has as its principal focus the development of innovation in health services. The fact that additional proposals have been made suggests that the demand for this work has not yet been satisfied, or cannot easily be met by existing agencies.

Fourthly, there is the development agency approach favoured by the Royal Institute of Public Administration group, prepared originally as part of evidence submitted by the group through the Outer Circle Policy Unit to the Royal Commission on the NHS. Initially the group called for the Health Advisory Service to be reconstructed and for its remit to be extended to acute services. This proposal was later evolved, with assistance from staff of the Institute for Health Studies at the University of Hull, into the idea of a development agency, and the idea was elaborated in response to 'Patients First'. At the outset, the group argued that the agency should engage in performance review and appraisal, but the emphasis subsequently changed, with

the importance of promoting innovation being stressed and the monitoring role taking a back seat. In the group's view, there was a need to promote innovation because the power of some local service providers was an obstacle to change. Also, comparisons between authorities carried out by an independent agency would enable good practices to spread more rapidly. The agency would be free standing, though its work would be guided by a steering group of RHA and DHA representatives, and it would operate for an experimental period of four to five years. The RIPA group emphasised that the agency should be independent of both DHSS and health authorities, and suggested that eventually five regional development agencies might be established, supported by a national development agency. (A fuller description of the agency is contained in appendix 1.)

Key Issues

One of the points which emerges from a review of the Management Advisory Service trials and the development agency proposals is the existence of important differences in emphasis and approach between the various suggestions. In large part, this derives from a different diagnosis of the problems which any new agency will be set up to tackle. The view of the DHSS, as expressed in evidence to parliamentary committees, is that there is a problem in monitoring the activities of health authorities, and in ensuring uniformity of standards between authorities. The Management Advisory Service trials will, in the Department's eyes, enable monitoring to be carried out more effectively, and will serve as a means of assessing whether services are developing in line with agreed strategies, and whether resources are being used to best advantage. The Service is seen as complementary to the role of the statutory auditors, both having the task of checking performance and identifying deficiencies. As the former Permanent Secretary at the DHSS, Sir Patrick Nairne, commented to the Public Accounts Committee, "The idea of a Management Advisory Service is the concept of an extended critical inspectorial eye translated into the National Health Service".[5]

This view of the MAS as an inspectorate appears similar to the thinking behind the trial to be carried out in the North Western RHA. The early descriptions of the trial mentioned monitoring as a key function of the visiting team, and carried the implication of a policing approach focusing on standard setting and departures from agreed policies.

A rather different approach, following on from a different diagnosis of the problem, is contained in the RIPA development agency model. The model is based on the premise that there is a problem in the NHS in promoting change because managers are preoccupied with the day-to-day tasks of running the Service. Consequently, managers often lack the time to engage in the kinds of strategic thinking needed to produce innovation. The development agency model is also based on the premise that there is a need to find new ways of disseminating ideas about good practices. The focus of the agency is therefore on innovation, development and good practice, rather than monitoring, review and standard setting.

The Wessex performance review scheme is closer in philosophy to the development agency approach than to the North Western RHA trial, although with this trial it shares a concern to establish standards against which performance can be compared. However, the Wessex approach has avoided the use of the word monitoring in descriptions of what performance review will involve. This is because of a view that monitoring is of doubtful value unless it is related directly to improvement in performance. It is this view which has influenced the decision to make performance review the responsibility of managers themselves.

The Oxford and South Western trial appears to lie somewhere between the other two MAS experiments. Unlike the North Western trial, the Oxford/South Western team will not operate through visiting and reporting on standards of management performance. Rather, the team will act in an advisory capacity, and will offer advice on the basis of a sound data base and practical experience. However, the existence of a separate team carrying out the advisory work distinguishes the Oxford/South Western trial from the Wessex approach which places the onus for producing change on local managers.

In the light of these comments, it is possible to identify three key issues which require attention in any examination of change strategies. These are:

(1) **the balance between a 'top down' or 'bottom up' strategy.** Perhaps not surprisingly, the DHSS approach to the MAS trials is highly centralist, in contrast to the localist orientation of the development agency model. It would appear difficult to combine both styles of working in one agency, and a choice may have to be made as to which to adopt;

(2) as we have noted, the Wessex performance review scheme stands out because of its **dependence on local managers.** All of the other approaches discussed envisage a special team being set up to carry out the work involved. Again, a choice has to be made between these options;

(3) **the timescale involved** would seem to be an important variable. The MAS trials will each be carried out over a two year period. The development agency model envisages a 4-5 year trial period. Existing work indicates that the process of change in some services may have to be spread over a number of years, suggesting that the longer time scale may be more appropriate in particular areas of service provision.

The Conference

These and other issues were the subject of discussion and debate at the joint RIPA/King's Fund conference based on the development agency concept held on 28 October, 1981. The conference was chaired by **Professor Rudolf Klein** of the University of Bath. A background paper presented the case for development agencies, (see Appendix 1) and the paper was introduced at the conference by two members of the group who had contributed to its preparation: **Stuart Haywood** of the University of Birmingham, and **Brian Smith,** Area Administrator of the Lincolnshire AHA. Critical appraisals of the development agency model were then presented by **Dr Donald Dick,** Director of the Health Advisory Service; **Tom Evans,** Director of the King's Fund College; **Duncan Nichol,** Regional Administrator, Mersey RHA; and **Wendy Pritchard,** Human Systems Development Adviser of Shell International Petroleum Company Ltd. Following these appraisals, study groups of conference participants - a mixture of academics, civil servants and people from the main disciplines in the NHS - discussed the case for and against development agencies. The reports from the groups formed the basis of a final discussion of the main points arising. In the pages which follow an edited account of the conference proceedings is presented. The report concludes with a summary and commentary on the key issues which emerged at the conference.

2. THE CONFERENCE PROCEEDINGS

Chairman's Introduction

Rudolf Klein in his introduction referred back to the cabinet debates in 1946 and in particular to the arguments between Bevan and Morrison. These arguments were pertinent to the issues raised in the development agency paper, because they drew attention to the endemic stresses in the NHS. These stresses included the tension between centralisation and decentralisation; the conflict between uniformity and variety; and the attempt to avoid bureaucracy while retaining accountability. Although Bevan thought that new institutional solutions were needed to cope with these stresses, the NHS has not been effective at devising solutions. The development agency paper is to be welcomed because it does encourage innovation. This is particularly important at a time of economic constraints, which will not go away. If anything, the financial squeeze on the NHS will become more severe and this puts a premium on the need for innovation. All social services have been characterised by the pattern of the last 30 years which has assumed an increment of development money which will fund innovation. That period is now over but an awareness that a new financial climate has arrived has not percolated down to service providers. As a result, there is a sense of baffled frustration and bewilderment among the providers.

Innovation needs to be considered in more complex ways than simply producing change. Perhaps the most important form of innovation should include policy determination. A possible value of a development agency would be to help lay members of health authorities. The development agency might be able to assist members to perform more effectively.

The proposal for development agencies needs to be considered in the context of the debate about a uniform national health service or a loose federation of two hundred local health services. Patrick Jenkin was tending to move towards the latter and if that is still the case then it raises the question of what is the role of information, of learning and of the transfer of experience and knowledge. A more devolved national health service might benefit from a development agency which would balance variety with uniformity.

THE CASE FOR DEVELOPMENT AGENCIES IN THE NHS

Stuart Haywood and Brian Smith

Stuart Haywood, speaking as a committed supporter of the NHS, raised three key points in relation to the general case for development agencies. The first was the preoccupation of the case with innovation. This is what distinguished the RIPA proposal from some of the management advisory service schemes. The RIPA proposal is not as concerned with monitoring and with checking performance. Its aim is to encourage innovation and the case for doing this is set out in the background paper. The need for innovation is particularly great at a time of no growth in the NHS and growing aspirations about what services can do. This situation is still new and not fully appreciated. This is not to say that the NHS has not done well. There are success stories but in the 1980s the NHS is faced with new problems, and old solutions may not be sufficient. For example, the development of private health insurance, which some predicted might soon cover one in five of the population, is a significant new development which will affect the NHS. There are likely to be other new problems in the 1980s. The development agency would be valuable in helping to tackle these problems.

The second key point was why is there a need for a development agency? Typical reactions to the suggestion included: Isn't this what we're already doing, for example through the HAS? Isn't this what the planning system is all about? Or isn't this what management consultants already do? The case for development agencies is set out in the background paper. This states among other things that an agency is needed because of the tendency within the NHS to neglect long term issues, and to neglect detailed analysis of problems. The development agency proposal will reinforce the pressure to look at long term options, and to consider a wider range of issues. The paper gives examples of the sorts of issues which the agency might look at: first there are log jams, that is, situations in which people know what can be done but can't actually innovate. An example of this would be the development of day surgery. A second kind of issue involves the testing out of new approaches to familiar problems. An example here was the research on clinical budgeting being done by a number of people. A third type of issue concerns generalising ideas about good practice. The key phrases in the background paper concerning the development agency are "reinforcing", "developing" and "harnessing" local effort, focusing on innovation.

The third key issue is what can a development agency offer? The answer was very simple. The agency could offer time and detachment; a knowledge of what was done elsewhere; and expertise in carrying out demonstration projects. A further question was what could the agency offer to whom? The answer was it could offer help to local line managers and providers. It would help them to increase the rate of innovation.

Brian Smith sought to demonstrate that senior officers in the new health districts would have limited time to devote to innovative management of the service, and began by developing the profile of a typical health district. This would serve a population of 250,000 and employ about 5,000 staff of whom 60 to 70 would be consultants. Its revenue budget would be £40m and it would probably be undertaking capital schemes of an annual value of about £5m, together with the management of a £½m joint financing budget. In addition to this formal relationship with local authorities, the health district would also have to maintain close working relationships with a county council and probably two or three district councils. Also important were the CHCs and the 250 or so GPs, pharmacists and opticians. This will be a big and complex organisation by any standards.

The administrative resources available to manage this organisation would cost about 5% of the revenue budget; around £2m. However, within this figure must be contained the overheads of all HQ buildings and the expenses of the authority members. Also included would be the salaries of all nurses of senior nursing officer grade and above, together with the costs of all doctors, dentists and pharmacists engaged in management, and the costs of senior works, catering, domestic and ambulance officers. It would also include all administrative and clerical staff in finance, supplies, personnel and general administration wherever employed, except for clerical and secretarial staff employed in hospitals and clinics.

This would total about 200 staff which broken down across each of these categories, would probably show five or six community physicians, pharmacists and dentists, 20 senior nurses mainly in hospitals and the community, 15 senior staff in ambulance, works, catering and domestic departments, and 160 administrative and clerical staff. Of this 160, roughly 90 would be employed in finance, 10 in personnel, 5 in supplies, 35 in unit management (from Scale 1). There may be 15 shorthand typists and junior administrative staff supporting all HQ, medical, nursing, finance and administrative officers, and only 3 or 4 middle and senior managers at district administration.

This should go some way to dispel the illusion believed of politicians, the media and the medical establishment, that there is a monstrous bureaucracy sitting like a cancer at the centre of every health authority.

Of all these staff only the chief officers in the four disciplines and one or two of their immediate subordinates are involved in top management issues, and thought should be given to how this handful of managers are expected to occupy their time.

The Community Physicians will of course be engrossed in detecting demographic and epidemiological trends in the district and looking at performance and output data. They will also be deciding what advice to offer the authority and colleagues on the most effective application of local health resources.

The District Nursing Officer is the top line manager of a hierarchy containing about 2,000 staff. This role involves communicating with, leading and training subordinate managers, the systematic checking of nursing standards, monitoring the ratios of nurses to patients and of trained to untrained staff, encouraging basic training, in-service and management training and planning advice.

The District Treasurer will be making certain that the 5,000 staff and thousands of bills are accurately and promptly paid, and that all expenditure is properly authorised and controlled within hundreds of budgets. Also from his storehouse of financial data he will be distilling relevant information on past performance and future trends so that the authority and its managers can take informed decisions based on sound financial advice.

The District Administrator will be meeting his unit administrators regularly to promote and ensure a consistent quality of administrative, catering, domestic and other support to the operational services. He will also be organising and contributing to the preparation of the district's strategic and operational plans together with communicating with the media, the RHA and the DHSS, and consulting with CHCs and the local authorities. He will also be responsible for preparing DMT and DHA agendas and ensuring that the meetings are serviced and that action is taken. Lastly he will have to devote time to counselling the Chairman and members of the authority.

In addition to these routine functions, however, our four paragons will of course be fully aware of the opportunities to use new technology to choose and train better staff in a buyer's market, to design new organisational structures and systems. They will be constantly searching for ways of making better use of skilled staff; improving industrial relations and staff motivation; improving decision taking by shortening lines of communication and better delegation; sharing services more effectively with local authorities; and promoting partnerships with private enterprise and voluntary organisations.

This is a somewhat unrealistic expectation of the senior managers, and the reality of day to day concerns may well be very different. For the next two years they are likely to be grappling with the problems of restructuring. At one level they will be worrying about which post they will get and whether or not they need to move again, but on the other they will be busy designing the new management structure. They will also spend considerable time appointing their staff and then adjusting to new personal and organisational relationships. Even after two years in 'peace-time' conditions our intrepid team are still unlikely to be spending much time on the 'expected' activities mentioned earlier.

Instead the DMO is likely to be negotiating consultants' contracts and chasing locums, together with dealing with disciplinary issues. The DNO will have a heavy burden of senior appointments, disciplinary issues and policy defaults that will arise from the large numbers of nursing staff. The treasurer will spend time chasing and correcting over or under spending, and dealing with unexpected variations in costs of living, pay increases, revenue allocations and the like, as well as securing the financial flanks against the many critical reviews of public spending. The DA will be grappling with serious complaints, disciplinary and medico-legal issues, as well as meeting the needs of tne authority.

This may be a somewhat dramatised view but it emphasises that the small number of senior managers in a typical district will be engaged principally in crisis management simply because of the scale, diversity and immediacy of the organisations they control.

At the same time there is an ever increasing surveillance of organisational performance through the PAC, auditors, CHCs, ad hoc enquiries and parliamentary questions. Local NHS management is in danger of being ground between the upper millstone of increasing external surveillance and the nether millstone of internal crisis management. This will leave little time to innovate or explore alternatives. Neither internal crisis nor more thorough surveillance is conducive to the imaginative process, leading as they do to time consuming defensive responses which have a generally negative effect.

An outside agency of the type proposed could provide a resource, albeit small, to which hard-pressed management could turn for help and stimulation from time to time without feeling that the outcome might be another enquiry into management's real or perceived shortcomings.

However, the question remains of where a development agency will find its experienced health service advice if existing NHS management is so hard-pressed. Perhaps the answer is the periodic release of senior managers to enable them to apply their experience and skill, free of 'fire-fighting' pressures, with benefit to the service, themselves and their subordinates who will have to act up in their absence.

Indeed, if the NHS is to continue to be under-managed, it might be argued that such activities are essential for existing managers to retain a sense of vision and perspective. The philosophy of reporting direct to a client rather than to higher authority, might prove attractive to many who might otherwise be reluctant to contribute.

The Chairman allowed a short period for comments on the papers presented by **Stuart Haywood** and **Brian Smith.** Several key issues were raised. The first suggested that **Brian Smith's** view of the work of the district administrator was pessimistic and that securing innovation should be part of the DA role. The second, concerning the way the words effectiveness and efficiency had been used, caused **Stuart Haywood** to comment that any development agency should not be simply concerned with cost reduction or with what he called 'input thinking', but instead must include the issues of value for money and ultimate benefit of health services. Another questioner asked if the RDA could support health authority members, to which **Stuart Haywood** replied that he saw most of the activity taking place at the operational rather than at the authority level, although the support of both members and officers at the DHA level would be essential.

RESPONSES TO THE CASE FOR THE DEVELOPMENT AGENCY

Donald Dick, Tom Evans, Duncan Nichol and Wendy Pritchard

A View from the Health Advisory Service (HAS)

Donald Dick reminded participants that, after restructuring, there are to be 200 health authorities in England and Wales, each providing a range of complex health services. The largest will employ about 17,000 people. It will be very difficult to resist dividing the whole into segments for review. As it is the HAS visits separately the services for the elderly, the mentally ill, chronic sick children in hospital and the mentally handicapped as well in Wales. It is time consuming to develop the necessary working relationships with the people in a district who are concerned with specialist services. It took over 600 Health Advisory Service visits to get around all the services once. And then it was plain that to visit hospitals, or indeed health services, in isolation was unsatisfactory. Other authorities, especially the social services, are deeply involved in the way that a service performs. Most of the decisions about bed usage where there is any element of chronic illness or disability are outside immediate health service responsibility. They are social and economic decisions or concern housing, family support and the contribution of the local community.

For example, if a social services committee decides to reduce home help hours or social work staff, it is inevitable that a percentage of elderly people who are supported at home will have to be moved to residential care. This begins to put pressure on the residential system that is always upwards towards the expensive health based end. There is less room for more dependent people in Part III homes. This reduces the bed turnover in long-stay geriatric units, that slows down transfer from the geriatric assessment unit, which means that the geriatrician cannot take over patients from the surgical or general medical units. That means a rise in waiting lists for cold surgery or an inability to admit emergency cases. It is all a matter of percentages and changing criteria. That is where the tension arises between the component parts of services. The result is static services.

To say something credible about such a situation requires time, knowledge and the ability to talk together. To look at services for the elderly or the mentally ill takes at least three weeks and that is hectic enough. To write a useful report in the fourth week of a month's allocation to a visit is more hectic still. So there are problems of size, of time and therefore expense. To keep a team of five experts in the field with administrative and clerical support costs, at present rates, about £10,000 a month. Visiting 200 health districts would therefore cost around £2m in total.

We do not have anything like enough ways of judging the performance of a service. We concentrate almost entirely on inputs and procedures. The judgement of performance is very subjective. We have only such crude measures as bed turnover, waiting lists, recurrence and readmission rates, mortality figures, length of stay, number of attendances and such like. Very little relates to quality of care or the imponderables like dignity in death, choice, privacy, comfort or flexibility of response. The vast majority of patients' letters received by HAS are concerned with friendliness, comfort and care.

It seems essential at the outset to be very sure what the purpose of the RDAs is to be. Is the agency going to collect innovative ideas? Is it to be involved in implementation? Are there to be sanctions or rewards? Will it concentrate upon the leaders in the field or on the laggards? How will it arrive at an understanding of which of a selection of innovative ideas is appropriate for the organisation under scrutiny? Hiring experts by secondment is really quite difficult. There are plenty of people with strong opinions that they would like to air and time to do it in. The real expert in health care is already extremely busy and can only spare a little time. Most of them are not available for routine visiting work. If someone is readily available: why? Two hundred visits require a lot of experts.

What people see as problems in a health service are usually concerned with the interaction between people and rarely are they technical. The commonest observation of an HAS team about a service that seems to perform badly is that it lacks leadership or the necessary skills to run the organisational side of a clinical department. The best are characterised by a core group of people working well together, properly serviced by management with mutual understanding of objectives, resources and limitations. The prescription for development is almost invariably to improve the personal and group skills. Again we seem to have very little to offer the poor performer.

Visiting bodies cannot be executive and therefore the only sanctions are to withhold approval. This is a prescription for the good to get better and the worse to give up. If the RDAs are given money to encourage, then all visits will shift to compete for funds and much time will be taken up in advocacy and not on the gaps in services that need to be filled. If there is some money, it should be available to improve performance failure by sponsoring visits to good practice seminars or problem-solving activity.

It is not difficult to identify good ideas. The NHS and social services are full of them. We are an inventive race and well used to being ingenious when short of cash. We need a central information service that can be kept up to date and readily dispensed. The difficulty is in implementing good ideas in diverse local conditions. Progress seems to take the form of a wave. Yesterday's innovation is today's orthodoxy. Any development agency is likely to influence the rate of spread, not initiate.

At present, health authorities can readily buy advice if they do not have resources within their own health district, area or region. It is common for bodies like the HAS and national professional and voluntary groups to be asked to suggest the names of people who will contribute to the solution of problems. The DHSS used this technique in constructing the Rampton Review team with much success. It seems that RDAs with strong academic links and research based ways of working would greatly improve this network but would not replace it.

The trouble with standards, guidelines, good practice and checklists is that they need to be stated, generally agreed and constantly renewed. If they are not met, there have to be consequences. Each part of this requires considerable resources and an excellent information service that allows comparison of performance according to circumstances.

If the RDAs are to develop, these are some of the needs which have to be met:

A surveillance or scanning system

We have almost certainly amongst the best health care and social services statistics in the world. We do not use them. Modern information processing should allow us to identify where services are performing differently and so visit to find out what is happening. There may be good practice, so we want to know what is happening. There may be poor performance. We want to know how to help.

A means of remedy

Where problems are identified we ought to have a remedy to offer. One possibility would be a central or regional organisation that can mount problem-solving or training activities with the help of outsiders, when problems have been identified. The organisation would be a cross between a consultancy agency, a training service and a mobile staff college. The National Institute of Mental Health in Washington has just such a body that can mount problem-focused activities locally tailored to known problems.

An information service

There needs to be a point at which information about innovation, good practice, workable solutions can be gathered for everyone to use.

Community negotiation

Each community, identified as based upon the health districts, should from time to time have a proper open discussion on what it desires for the health and welfare of its citizens. This includes what is to be tolerated for vulnerable people, where the gaps are and how each part has to mesh in with the others. Such a forum should include health and social service authorities, the CHC, but also housing, education, employment and voluntary bodies. An outside agency would make an important contribution to such a debate. It could provide information, describe good practice and encourage fair play.

A visiting system

It seems inevitable that visiting should be rationed to meet known need. If health services within a region have problems left over after trying internal resolution by sharing local experience, there are some that could be helped by outside assistance. To construct a visiting group to meet the known needs would require a national knowledge of who is suitable. This should not exclude the inclusion of academic or research based members, especially if the exercise calls for hard evidence on which to build change.

In discussion, **Dr Dick** agreed that exhortation was not sufficient. Any development agency, whether the HAS or some new body, had to follow up its recommendations and exhortations. A questioner asked whether the development agency would work just by visiting. **Brian Smith** said the agency would use a variety of working methods.

A View from Management Education

Tom Evans agreed that there was a strong case for a development agency, both to pull together experience and to provide facilitating arrangements for managers in individual authorities. However, the current proposal contains ambiguities which need to be explored for the debate to be carried forward, but the points raised should in no way be considered sufficiently critical to override an underlying support for the RDA proposal; they were instead designed to help strengthen the case.

It is necessary to diagnose the management problems with which we are trying to deal, since it is too facile simply to suggest that organisations have limited innovative capabilities. In the first place it may be argued that there are difficulties in the spread of 'best practice', in that the developments in one area are not spread to another. Secondly, it may be suggested that there is a rigidity in the responses of managers to new problems. Thirdly, it might be argued that the ability of managers to innovate is limited by a lack of managerial autonomy. These three views of the problem give rise to three entirely different responses in helping managers to cope.

Firstly, there is the role of enabling people to solve their problems by helping them develop managerially. This is widely know as 'process consultancy'. Here we are not concerned simply with interventions of an interpersonal kind, but with the whole question of helping people recognise the nature of their problems, what options are available to solve them, and the effect of selecting particular options. The process consultancy role is therefore primarily directed at managers' learning. The second approach is that of persuading managers to adopt specific innovations, and depends on the assumption that we can actually identify things which can be regarded as universal good practice in all situations. The third consultancy role is raised in the RIPA paper and concerns using external consultants to regulate relationships between district and region. To quote from the paper the RDA 'would be a key element in regulating the interdependence between the two levels' and would thus become part of the way the system is governed. The distinction then must be made between helping or forcing managers to innovate and adopt 'best practices' on the one hand and helping them to increase their flexibility, adaptiveness and sense of purpose on the other.

All of these roles are suggested for the development agency, and each of them is individually sustainable. However, the agency may need a greater degree of role clarity, so that it can make up its mind whether it is part of the management structure or instead dedicated to the development of management skills and processes. If one is too casual about the kind of roles being assumed, it would be easy to undermine any legitimacy the agency may have as a base for process consultancy, where a high degree of mutual trust is required, simply because of the existence of formal links with other parts of the hierarchy.

This problem is highlighted in the RIPA paper when the 'right of access' by the agency to other parts of the organisation is discussed. The paper recommends that the RDA should not have right of access because as a process consultant, the last thing you want is to 'insist' on entry since you should only be working with those who want to work with you. You may finish up working primarily with 'progressives', but this is almost inevitable when adopting a process role.

The proposal itself demonstrates a further problem faced by the NHS in managing innovation. Setting up development agencies is a very 'institutional' response to the problem. In other words when external support is required, we establish a regionally designated organisation with appropriate formal funding. Since there is scope for a whole series of different approaches to these kinds of questions, perhaps a more pluralistic approach should be adopted.

We should therefore be asking how can we develop a number of external resources with sufficient 'critical mass' to provide different sorts of approaches to the question of external consultancy and development. Some of these may be specifically concerned with issues of spreading best practice and developing an information base, and some specifically concerned with developing process consultation. Then individual organisations can make their choices as to which form is most appropriate to their needs.

A Regional Administrator's Perspective

Duncan Nichol began by referring to the work of the Public Accounts Committee and the Social Services Committee which had both recommended a more centralist approach to the NHS. This was in contrast to 'Patients First' and circular 80(8). The parliamentary committees were concerned with comparative information which would enable the centre to examine local services. Also, the PESC negotiations had led civil servants to want evidence of 'more and cheaper'. The Health Service agreed on the need to improve the machinery for disseminating ideas about good practice. This could be achieved through the development of informal forums such as 'Drop In Centres' attached to the NHS Management Centres. But the important thing was to negotiate new relations between the centre and the periphery. In this context perhaps the Management Advisory Service could assist. Another development to note was the extended role which was being suggested for audit in the planning system.

Regions lay in the middle ground. Regions should explore a development of their role as a link between the centre and districts. Policies should be negotiated into agreements with districts. Regions have a key role in negotiation and compromise. There may also be a need for new techniques but the RIPA document does not allow for a more sensitive response by regions. Regions feel vulnerable at present, but their role could be developed. It is necessary to develop a relationship between regions and districts which is not dissimilar from the relationship between districts and units, and between health authorities and clinicians.

The background paper presented the development agency as being concerned with innovation and as being non-threatening. In contrast the regional health authority/district health authority relationship was presented as being concerned with compliance and as being threatening. The paper presented the development agency in the role of 'contrived neutrality'. The question arose of how the development agency would maintain and sustain change. David Towell's work had shown the need to leave a catalyst within an organisation [6]. Would the development agency be able to make a contribution in the short term? In contrast with the emphasis placed on the development agency, the RIPA document undervalued the role of regions in sustaining change. Regions and districts could benefit from working together. It was not sufficient to say that because regions had not promoted change in the past they would not be able to do so in the future. An organisationally-based development programme for managers might be an alternative to a development agency. An action learning programme would encourage officers themselves to become change agents.

It is necessary to be sceptical about the development agency idea. The middle ground is already too crowded and shrouded in uncertainty. For example, there is doubt about the future role of regions. It might be valuable to experiment in a region in order to explore the development of a collaborative relationship with one or two districts. The Wessex version of the Management Advisory Service idea is perhaps an example. To institutionalise the agency would be provocative and threatening. There is still at heart a need for regions to develop contact with districts.

A View from Industry

Wendy Pritchard commented on the proposal from the basis of experience in setting up and running two organisational development departments in different organisations over the last 12 years, together with some ideas resulting from attempts during this time to implement effective ways of trying to help organisations introduce and manage change and innovation.

Concerning strategies for developing innovation, one needs to think about change as a learning process. The most effective way to adapt and innovate is for people to carry out their own diagnosis and to develop and implement their own plans rather than having solutions prescribed and imposed. This approach may be seen as slower and possibly more risky (because nobody is apparently 'in control'), but it is longer lasting, more effective and provides more commitment and ownership. The role of OD or other change agent resources is to help with this process rather than to prescribe expert solutions. Organisation development is best seen as a process rather than a product.

With that in mind, it can be suggested that the following points may well provide the basis for effective strategies. In the first place commitment from the top of the organisation (or its appropriate sub-units) to the particular approach to change and innovation is essential if the change effort is going to be sustained. It is also important to work with the problems that are perceived by the organisation. This means that OD consultants work with their clients, and using the clients' language, make sure that any help they give is related clearly to the overall objectives of the organisation. However, a balance must be struck between applying OD approaches to assist with the maintenance of the existing organisation, and using them to develop the organisation in the future. Whilst the future may be more important, maintenance issues can often be the starting point for relationships with line managers. It also seems to be easier to encourage innovation by working with those in the organisation that are already committed to change rather than working 'uphill' with unwilling parts of the organisation. OD activities should therefore not be imposed on the organisation but should instead be initiated by the line management concerned. It is possible to seed ideas and experiments at different receptive points in the organisation, and this will encourage the cross fertilisation of ideas and organisational growth. This may well produce a 'critical mass' for change which becomes self-sustaining and no longer needs to be driven by OD resources. Part of the strategy should be to develop resources and skills within the organisation itself, and it is also clearly important that those engaged in OD activities are sufficiently skilled to do their work, and since they are quite often isolated within the organisation they should be able to withstand the stresses and strains of the role.

Regarding comments on the RIPA proposal for establishing development agencies in the NHS, it is easy to be sympathetic with much of what is written there. However, there are some specific comments to be made.

First, it would seem that the role of the RDAs is confusingly defined and somewhat contradictory. It would be easy for the RDAs to be seen as threatening to line managers if there is any ambiguity between a facilitating and an auditing role. It is also important to determine exactly where the RDAs will fit into the NHS organisation, since this will determine how their status is perceived by the rest of the organisation and will therefore influence their power. The question of the style of operation of the RDAs is raised often in the paper. A difficulty here is that if the RDAs are perceived as experts, they will be expected to produce expert solutions. This is compounded by the tendency for newly formed units to try and establish credibility by tackling immediate problems in a presumptive way. Instead of adopting this approach they should tackle longer term problems and be seen as experts in the process of change. Within the proposal there is some lack of clarity about how work would be initiated. Whilst low key marketing approaches can be used (particularly through third party reference), it is essential that the agency should be invited in by the line managers. The question of the criteria for evaluation of the work of RDAs is important, as is the time scale in which effectiveness is measured. The advantages are often quite long term, and are difficult to determine. However, measures can be constructed which analyse the way in which the diffusion of RDA initiatives actually occurs, and the degree of satisfaction there may be amongst the development agency's clients.

Finally, it would be helpful perhaps to view the RDAs as temporary facilitators, since in the longer term we should concentrate on developing the innovative skills within line managers.

In response to the speakers, **Brian Smith** and **Stuart Haywood** accepted the point that the development agency paper envisaged a number of roles for the agency. This was necessary in order to promote debate. There is no evidence to support the view that RHAs are able to perform the functions of a development agency. Additional impetus is needed because the existing arrangements will not produce change. A development agency will perform a number of roles, and will operate by being invited in and by prompting invitations. Although not only concerned with promulgating best practices, the agency will aid learning by disseminating ideas about innovation.

In summary, **Rudolf Klein** made three points. First, that the development agency might be a solution in search of a problem. It was not clear what the problem was that the development agency was intended to tackle. Innovations were of different kinds, and were not necessarily good. Innovation could not be divorced from implementation. The second point was to question how the agency would deal with the 'laggards'. It was not clear what would happen to laggards who didn't invite the development agency in. The third point was that underlying the debate were two different conceptions of the NHS. The first was the conception that the process of improving management was an end in itself. The second was that management is a tool for achieving objectives, which is a less pluralistic view of the NHS.

PRESENTATION AND DISCUSSION OF STUDY GROUP REPORTS

Group A

This group had strong reservations about the development agency model, but it did feel that there was a need for innovation. However, several agencies filled the 'middle ground' and there were a number of candidates for this development role: the region, community health councils, the press and media, auuthority members, and top management. There was a changing climate in relationships between regions and districts. The regional role was important especially as it has financial powers, and perhaps a regional fund could be set up to help people with innovation, rather like joint financing. There was also a need for regional information exchange.

Group B

This group made five points. First there was a need to separate three roles for a development agency: spreading best practice; auditing or checking minimum standards; and process consulting. An agency should be concerned with the last of these. Second, the group was sceptical about institutionalised solutions. The structure was too complex already. Instead, there was a need for flexibility and for catalysts who were light on their feet. Third, authorities already under-used their existing resources such as in personnel and training. Fourth, greater clarity is needed in the relationship between regions and districts. Fifth, process consulting should be for line managers. Management would have to invite the consultants in and there was a need to concentrate on the development of individuals. An agency might look at issues across districts and might support districts which were short of revenue.

Group C

The group drew a distinction between managed change and creeping development. There was a case for improving the scope for managed change and for getting a better grip on creeping development. In order to promote innovation, district managers need to draw on credible professionals and outsiders but there was a need for a variety of responses. The agency should not be institutionalised but instead a smaller, looser, catalytic role was favoured by the group. One question discussed was whether the agency should spread its resources thinly or concentrate them. It was suggested that a short term involvement by a development agency would be effective when there was a pre-existing definition of the problem. A further question related to the power structure of the NHS. Management consultants traditionally worked with the power holders, and this might only reinforce the existing distribution of resources. Within the group there was sympathy for the idea that the region might be an alternative to a development agency.

Group D

This group identified a problem in converting good ideas into practice, and there was a need to institutionalise good ideas to some extent. But a development agency would not necessarily help. The problem was that the agency might take on a life of its own, examining only the interesting aspects of health authority work. Instead, there were resources which could be used within authorities, for example management services. Resource centres

Group E

The Health Service needs a centrally coordinated information network, and there is also a need for process consulting. Outside help is needed to enable change to occur although regions are capable of doing more, and further additions to the structure may not be the panacea some expect. An experiment would be welcomed. An omission from the discussion and the paper was the role of doctors and their power. The development agency was the right way forward.

Group F

There was a need for critical self appraisal. A number of bodies were already doing related work. Opinion was divided concerning their success. Two functions were identified for an agency, monitoring and auditing; and facilitating change. The two should be kept separate. The case was not proven for a development agency, but there was value in some of the principles behind it. There was a need for longer term work and for the use of information brokers. Funding should not come from the regional health authority but from districts.

Group G

The group favoured a pluralistic approach and felt that an agency should not become institutionalised since a variety of vehicles were necessary. It would be vital to break down professional barriers and to create a climate within which risks could be taken. The group was not entirely convinced by the argument that no innovation was going on. Tools for innovation do exist but need to be sharpened and developed. Perhaps a management development programme was an alternative. The group was not convinced by the case as it stood.

Group H

This group also felt a need to look at the role of doctors and the doctor-patient relationship. Change was different from innovation. There was a need for work in this area but the development agency was not necessarily the right approach. The group favoured a pluralistic approach for the encouragement of experimentation, but there was concern about where the agency should be based. The approach would clearly need the acceptance of the professions. The group was not sure whether it should be staffed by generalists or by experts. Funding should come from external sources.

FINAL DISCUSSION

David Hunter responded to the group discussions by saying that although it had been said that the RDA proposal was 'a solution in search of a problem', he was reassured by the realisation by many of the groups that there was indeed a problem in securing innovation in the NHS that needs some kind of remedy. There was also some confusion between the auditing, policing and monitoring role and the development role. The RDA proposal is concerned solely with the developing and facilitating role, the other functions being left to other agencies such as the HAS. The RDA represents one idea about how that development role might be fulfilled and it is well accepted that there may be other valid approaches. Regarding the issue of role clarity, the ambiguous mix contained in the paper was deliberate, precisely because it was realised that different people operating in different parts of the NHS on various projects would undoubtedly require a variety of approaches in order to establish meaningful contacts with clients.

With regard to the words of warning about institutionalised answers to development problems, it was vital that those responsible for securing innovation were made responsible for what they do. This, however, left a problem of allowing independence on the one hand and making people accountable on the other. The proposal may not contain the perfect solution but at least it is an attempt to tackle that dilemma. Perhaps the most constructive thing to have emerged from the group discussions was the idea of setting up a trial since many of the proposals can only be evaluated and tested by the establishment of a trial in a sympathetic district.

David Towell suggested that the RDA should be seen as a transitional stage in helping the NHS develop its own competence in securing innovation. Any 'external' agency should be problem centred and should work with those in the system who are most relevant to that problem. Finally, the process of organisational change is a very long one, and this produces a need for some degree of institutionalisation. Ad hoc and temporary arrangements will not be adequate if effective change is to be secured.

Bob Nicholls mentioned the Oxford/South Western experiment, and, after agreeing that a trial period of two years was too short, suggested that there was a need to formalise rather more than the 'pluralists' may suggest. It was hoped that the experiment would go beyond monitoring and include the stimulation of change at both district and region.

Robert Maxwell commented that when we consider the problem of innovation there is a tendency to look at the difficulties we have experienced in the past. If we look into the future, the growth of the private sector may mean that we do not have a bureaucracy that is simply rather reluctant to change, but rather an organisation which is disinterested. The problem then is to ensure that when innovations are discussed, these are related to improving the quality of health care provided rather than simply improving management performance.

Stuart Haywood responded by saying that he feared that some of the 'pluralists' in the morning's discussion seemed to be advocating going on as we were. With the threat of the private sector, this will just not be good enough. He hoped that the 'pluralists' therefore meant that more of all these different approaches must be undertaken, otherwise the NHS as we know it may not exist for very much longer.

Brian Smith responded by counterbalancing the heavy emphasis on ideas of rational evaluation of the RDA by suggesting that one of the things the NHS lacks is an ability for colleagues to get together and discuss common problems in a free atmosphere. There was also a need to redress the heavy management orientation of much of the day and state that the involvement of clinicians in development agencies was certainly not precluded and should be actively encouraged.

Rudolf Klein concluded the session by suggesting that there had been two major steps forward. The first was that the discussion had been responsible for a much clearer conception of the differences between policing and auditing, and the development and problem-solving role. The other was that there seemed to be strong advocacy for the brokerage role, though there was some disagreement about how it might be structured. Of course there was nothing to stop districts if they felt that the development agency was a good idea, from simply going ahead and establishing these facilities locally without the benefit of any agreed national guidelines. He closed by thanking the RIPA and the King's Fund for organising and providing hospitality for the conference. **William Plowden** for RIPA, thanked the Chairman and speakers, and the day was concluded.

3. CONCLUSION

This conclusion does not attempt a summary of all that was said during the conference, but seeks rather to cut across the specific contribution and draw out the main points of both consensus and contention. In so doing the author's prejudices should perhaps be declared at the outset.

Our starting point is a belief in the need for innovative management behaviour in the NHS. In any large mechanistic organisation the pressure on managers to act in a conservative way is considerable. The NHS is not the only enterprise in which the more adventurous pursuit of primary goals can be displaced by safer prescriptions for conformity. It has often been argued that such conservatism is suited to stable environments, and the case was well made both in the RIPA paper and by commentators during the day, that the future environment of the NHS would be characterised by turbulence rather than stability. The key factors disturbing the calm are, first, the current economic climate in which there are no additional resources with which to facilitate change and development; second, is the challenge posed by the growth of the private health sector and the related expectations of a more demanding and informed public; third, a general antipathy towards the public sector and an increasing concern that agencies such as the NHS may not provide good value for money; and finally, the current reorganisation of the NHS with its anticipated benefits of greater efficiency and effectiveness. Old responses to these new problems will not be enough, and innovative management can no longer be considered a fanciful luxury for administrators. Rather, it is a necessity for organisational survival.

To overstate the position only slightly, we would argue that asking the NHS to be innovative may be asking the old dog to learn one too many new tricks. This is not to say that health authorities are incapable of change since it is obvious that through a process of natural adaptation the Service has managed to cope with a wide range of new situations. However, there is a need to draw a distinction between these passive and usually ad hoc responses to specific problems (called by one of the groups 'creeping development'), and the more active and synoptic attempt to secure wider goal achievement that is implied by the term innovation. Whilst we would not wish to suggest the adoption of the idealistic, comprehensively rational strategies which have been characteristic of health planning in recent years, we would argue that there is a need for an approach which extends beyond the disjointed incrementalism which is so much a feature of day to day management. This would require making available both time and skilled resources to encourage and stimulate innovation.

It is precisely the absence of time and resources which forces senior administrators and professionals to forego strategic management as the pressures of day to day problems increase.

The inbuilt barriers to innovation are undoubtedly strong, and may become stronger in the light of the recent move by the DHSS to ensure greater conformity by health authorities to central policies. The proposal that RHAs should be held accountable for the implementation of national priorities, and that DHAs should in turn be held accountable to RHAs, may render even the more able manager unlikely to seek radical solutions to problems. Such a move reinforces the doubts expressed in the RIPA paper about the ability of RHAs to promote innovation because of their hierarchical relationship with DHAs. Attempts to strengthen the "chain of command" in the NHS enhance the case for an independent agency charged specifically with developing new approaches.

Many of these points were accepted by conference participants. Yet against this general agreement of the need for some sort of development agency, the discussion groups produced several reservations about the RIPA proposal. The main concerns were about the nature of the relationships between the RDA and the various levels in the reorganised health service, and the danger of producing an institutional answer to the problem. The point was also made in many of the groups that there were a number of agencies already working to secure innovation in health care. There was strong advocacy for what was called a 'pluralistic approach' in which various forms of organisation could exist, each tailored to local needs and resources.

Speakers also distinguished between the different types of activity that development agencies might undertake: **policing activity** where an external agency would ensure that services met certain accepted standards; **promulgating activity** where agencies would be concerned with the spread of good practice; and finally **process activity** where agencies would work with local managers in defining and resolving their own problems. This third approach is distinct from the other two since it is about management learning rather than about ensuring, however indirectly, that specific proposals are adopted. It is this approach that forms one element of the RIPA paper, and was the centre of concern in the discussion groups. The question of whether process activity and/or promulgating good practice could be successfully combined with policing activity remained unresolved, though several participants argued that policing activity should be kept separate from the other kinds of agency work.

To return to the three key points raised in the Introduction, the conference revealed a variety of opinions. While many participants apparently favoured a bottom up approach, it is clear that this is out of line with current DHSS expectations. Also, encouraging local managers to make their own changes might help the 'leaders' but not the 'laggards'. Related to the question of responsibility for innovation, many participants suggested that this might be the manager's responsibility rather than that of a special team. This would produce the need for new action learning programmes so that managers might develop appropriate skills. It might also involve engaging in process consultancy with some form of outside agency. If responsibility is located in a specialist team this raises the problem of recruiting people of the appropriate calibre. The third issue raised in the Introduction concerned timescales for evaluation. The MAS trials are to be carried out over a two year period, which is considered by many to be too short. The more subtle processes of a development agency may require four or five years to allow meaningful evaluation.

A fourth issue also emerged. That was the realisation amongst participants that innovation involved challenging those with vested interests in maintaining the status quo. Discussion of power relationships produced ambivalent feelings about how much a development agency should have financial or other rewards and formal sanctions to stimulate innovation. The availability of pump priming money might be a valuable carrot to offer local managers, but equally it might be insufficient in overcoming problems of team working or professional communication where change does not rest on the availability of financial rewards. Sanctions carry negative connotations appropriate only to policing activity and to bringing poor performers up to agreed standards. Participants doubted the place of sanctions in the development agency model, but clearly they may have a place in the MAS trials.

The RIPA/King's Fund Conference was designed to carry the debate forward, and so where has it left us? It would seem that the NHS is in need of more innovative management and that external agencies could certainly provide resources, skills, time and perhaps most important, the impetus to enable NHS administrators and professionals to take a wider and more creative view of the management of the service. That the precise nature of these agencies is difficult to specify is not, in our view, sufficient reason to ignore the extent of the need and therefore do nothing. Perhaps the question that should now be in the minds of those at district and region and in the DHSS, is not whether the idea of development agencies is a good one, but how best to deploy the resources to establish them. The answer to that question cannot be drawn from conference deliberations and what is now required is for practitioners and professionals with particular interests in the refinement of these ideas to come together and determine how best they can be operationalised. The need for doing this, and in particular for experimenting with a number of approaches, has been well argued by Aaron Wildavsky -

"Evaluative man must learn to live with contradictions. He must reduce his commitments to the organisations in which he works, the programmes he carries out, and the clientele he serves. Evaluators must become agents of change acting in favour of programmes as yet unborn and clienteles still unknown. Prepared to impose change on others, evaluators must have enough stability to stick to their own work. They must hang on to their own organisation whilst preparing to abandon it. They must combine political feasibility with analytic purity. Only a brave individual would predict that these qualities can be found in one and the same person and organisation." [7]

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RIPA

Royal Institute of Public Administration

DEVELOPMENT AGENCIES FOR THE NHS IN ENGLAND: THE PROMOTION OF INNOVATION*

The Problem

1. The current reorganisation of the NHS is intended to free local management from unnecessary central controls which will, in turn, stimulate flexibility and initiative in the new DHAs. This is desirable since it acknowledges that innovation and experimentation are most likely to occur at local level. At the same time, we recognise that many DHAs will be preoccupied with operational management and be unable to devote sufficient attention to the promotion of innovation. The search for innovation (the new and different) is a separate task from that of maintaining and improving what is already being done (more and better). Moreover, certain skills are required for innovation and it is unlikely that all DHAs, or even all RHAs, will be able to employ them. This is partly because the necessary skills are not available in abundance and partly because of the management costs exercise. Despite these difficulties, the need for innovation has possibly never been greater. Changing patterns of illness coupled with a 'low growth' climate mean that new developments and innovations can occur only if existing resources are put to different uses. Securing changes of this kind will require changes in attitudes and methods of working within the NHS, and a recognition that the current round of structural upheaval will not be sufficient, in itself, to effect them. The need to find ways of acting more directly on the processes of decision-making at the operational end of the system is now more widely recognised. We believe DHAs will welcome support to help them to meet the challenge facing them and to fulfil their potential for innovation. This paper outlines a possible way forward to meet this need.

2. There is concern that the reorganised NHS will have certain inbuilt barriers which will hinder its ability to modify current practice and respond to the social and economic changes that are taking place. Service and administrative boundaries are in continual danger of becoming barriers, especially when they are ill-suited to changing patterns of illness with their implications for other agencies (eg personal social services, housing, education, etc). The record shows that hierarchical relationships within the NHS emphasise managerial controls which are insufficient,

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* This paper is a revised version of a memorandum submitted to the DHSS in March 1981. The membership of the working group which produced the memorandum is listed in Appendix 1. The views expressed in this paper are not necessarily shared by members of the RIPA or its Council.

of themselves, to introduce new perspectives and necessary fresh thinking. Too often such controls merely make for conformity, rather than innovation, because they are primarily concerned with ensuring uniformity, consistency and fairness in the application of existing policies, and with securing compliance. They are essential but we firmly believe that managers would welcome, and profit from, access to independent forms of advice and support, focusing on alternative strategies and procedures. The need to promote risk-taking and innovation is reinforced and accentuated by the present 'low growth' climate which demands a new response.

The Response

3. In meeting the challenge identified above, a variety of responses is possible. The options include:

- more pressure (from bodies like the DHSS, CHCs and the Health Advisory Service)
- more policing and checking (through an inspectorate or accreditation schemes)
- more standard-setting and appropriate, effective sanctions against non-compliance (by DHSS, RHAs)
- more dissemination of good practice (through the DHSS, HAS, etc)
- an improved problem-solving capability (consultancy work, action research).

4. Each of these initiatives, some of which are being, or will be, tried, give rise to different relationships between levels of authority in the NHS (e.g. between regions and districts) and between individuals. We firmly believe that while more pressure, more policing, more monitoring and more standard-setting may help health authorities to become aware of problems, their usefulness in solving problems through positive action is limited: while they may provide a stimulus to thought and lend support to internal pressures for change, they do not address many of the practical and organisational problems which authorities will have to confront if actual change is to occur. Inevitably, too, such initiatives will, on occasion, lead to misunderstandings between tiers (including the DHSS) rather than a joint search for solutions.

5. Our central proposal is for a regional development agency (RDA). It is aimed at complementing the three trials that are to be launched in 4 regions under the umbrella heading of a management advisory service (MAS)* Although of expected value (and it will be the purpose of the trials to determine this), we believe that what is proposed in the trials will be insufficient if it is accepted that there is a need to go beyond problem-identification to problem-solving and service development through innovation. For this task, a new and different approach and institution are required.

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* It is not our purpose to compare the RDA with the MAS trials because each approach has different aims. However, in order to highlight the differences in aims, some of these are set out in Appendix 2. The DHSS's conception of the MAS approach is also outlined.

6. There are numerous methods of problem-solving, some of which are already employed by some health authorities. Consultancy firms, self-review, and local management action are all possibilities. But we think there is a need to build upon, and supplement, these sometimes ad hoc and irregular initiatives by establishing an organisation whose sole purpose would be to support health authorities in making progress on the problems they face. Agencies of this kind operate in other health care systems. A trial would establish whether such an agency would prove of value in the British context and have something to offer health authorities which they cannot themselves supply.

Remit

7. The following criteria underpin our concept of the RDA:

- The agency must act with local decision-makers at region and district: a ground-up initiative is necessary, which will derive its support and authority from local service providers, rather than a solution imposed from above. The most likely way of securing the commitment of local decision-makers to the outcome of agency activity is by agreeing at the outset terms of reference and objectives for the particular activity out of which will emerge an 'informal contract' between both parties (ie agency staff and field staff).

- While the search for improved efficiency must continue, if the agency concentrates exclusively on this it is in danger of adopting too narrow a remit and ignoring the scrutiny of overall effectiveness which is of overwhelming importance in health care where, to a large extent, 'the organisation is the product'.* This is because there is a high degree of substitutability between different health care inputs and a low degree of certainty as to how particular resources will be used. Much depends upon how a given mix of resources is used at the point of delivery.

8. On the basis of these criteria, we recommend that the RDA should:

- assist the improvement in performance of the average health authority, or areas of inadequate performance in otherwise satisfactory authorities, with the focus not on minimum standards, or compliance with norms, but on the promotion of desirable practices and outcomes applicable to the local situation

- act on the processes through which decisions are made, injecting a concern with the impact of services and not merely the inadequacy of inputs

- focus on mid- or long-term problems which will require, or will lead to, innovation

- stimulate an examination of alternatives and/or assist in their implementation

- be free to endorse appropriate unorthodox solutions to problems and promote action research and development activities

- have as wide a remit as possible embracing all activities, including clinical decisions with organisational and managerial implications but excluding those of an individual and technical nature that arise from doctor-patient encounters

- encourage officers, clinicians (within the limits prescribed above) and others to become their own change agents and to review their own procedures

- disseminate information likely to be of value to health authorities in general.

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* Professor Rudolf Klein has made this point on several occasions.

9. It is important to stress what the RDA would not do. It would not:

- work directly to higher NHS authorities since this is inappropriate if its task is to engender local enthusiasm for innovation
- replace management responsibilities in relation to poor performance or the flouting of agreed policies
- focus on efficiency narrowly defined rather than effectiveness in the sense of exploring alternative ways of assisting in the development of an improved service to the community
- be concerned with short-term problem-solving or operate in a fire-fighting role, settling disputes or sudden crises.

Structure, Composition and Operation

10. In using the term 'regional' we refer to a territorial area and not to a regional health authority. It is essential that the RDA is regarded by all health authorities as independent and not as an agent of an RHA. This means that the agency must be free-standing within the region it serves, operate with its own title and notepaper and preferably have its own base and address.

11. In setting up the RDA we suggest that representatives of the RHA and DHAs form a steering group which would be responsible for setting priorities for the agency and superintending its performance. The group might comprise senior officers, authority members, professional and CHC representatives. We also recommend a small multi-disciplinary core group whose tasks would include servicing the steering group and identifying suitable development projects. In their capacity as project leaders, members of this core group would undertake some project work as well as engage appropriate outside skills when necessary. Specialists could be seconded from academic units and independent consultancies with an interest in health policy and public sector management for specific assignments or periods of time. In addition, health care professionals would be seconded for particular projects. Both outside specialists and seconded health care professionals would work closely with staff working for the DHAs since the project team's chief aim would be to encourage service providers themselves to innovate and not impose solutions upon them. Whatever their source, agency personnel (permanent and seconded) must be of high calibre if they are to command the respect of their peers in the field and to succeed in stimulating innovation.

12. The RDA would operate on the basis of visiting teams, although the duration of visits would vary according to the nature of the problem. A visiting team could either be problem-oriented or could undertake a general review of services in a particular authority. On balance, a mixed approach may be best. That is to say, a team's entry into an authority on a selective, problem-oriented basis would be preceded by fairly intensive background study to familiarise team members with the authority in question. This general scan would provide a context for the more detailed project work, much of it inevitably involving collaboration with the DHA's (or RHA's) staff.

13. When engaged in consultancy work in an authority, agency staff would work closely with practising professionals. Since the project team would operate primarily by encouraging service providers themselves to innovate, hopefully the consultancy activity may prove to be the effective change agent rather than the particular project. Written reports, while of value, would be a less important product of the RDA's actions than actual influence. Given its intermediate location in the NHS between RHAs and DHAs, and its use of outside specialists, the RDA might well be more acceptable in certain local situations than intervention from a higher authority. This is not mere speculation and support for this view may be found in the work of independent consultants who have undertaken assignments in the NHS.*

14. Since a major task of the RDA would be to improve the capacity of DHAs to innovate, and to promote higher standards, a difficulty arises over whether the agency should have a right of access to authorities. Without such a right there is a possibility of the agency concentrating on the more progressive authorities which least require its services. On the other hand, unless some positive support exists for the agency's involvement with a particular authority, it is hard to see how the agency could be successful. Careful negotiation and persuasion in advance of gaining access will be necessary to agree terms of entry which should be assured in the majority of cases. The RHA and DHAs can also suggest initiatives to the steering group if they wish. An initial experimental period of operation will assist in determining whether peer group pressure or skilful persuasion is sufficient in enabling the RDA to gain access to all authorities, or whether a right of entry under certain circumstances, but with its attendant difficulties, is desirable. For the present we think it best to initiate the RDA without this right, although the very existence of a joint RHA/DHA steering group may be regarded as giving the agency a general right of access.

15. Given its particular position in the NHS, separate from the regional and district health authorities, the RDA, as well as assisting authorities to innovate, will be favourably placed to respond to those delicate local situations where there are differences between levels of authority or management, or between disciplines. In these areas, as more generally, it is to be expected that it will take time for the RDA to earn the right to be consulted and so demand for its services will emerge rather than be anticipated in advance.

16. Although this is not the place for a detailed description of the RDA's activities, even supposing they could be predetermined, some examples will suffice for illustrative purposes. For instance, the RDA might concern itself with the following: the organisation of maternity services; the management of waiting lists and waiting times; expenditure on drugs; the management of surgical workloads;

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* David Towell's (Assistant Director, King's Fund Centre) work is a good example. See, inter alia, Towell and Harries, C., Innovation in Patient Care, Croom Helm, London 1979.

establishment of mobile domiciliary teams in psychiatry; augmented home care for the elderly as an alternative to long-stay care; patterns of referral between primary care services and other health services; pathways to discharge from hospital to home. In each of these, and other, areas the RDA's aim would be to stimulate an examination of alternatives or to assist in their implementation.

17. We are under no illusion that goodwill among service providers (where it exists) will of itself always be sufficient for the RDA to make an impact. A range of incentives may also be necessary to promote change. We put forward two suggestions for consideration. First, there is a powerful argument in favour of giving the RDA virtual control over a small sum of money for 'pump-priming' purposes. This fund would be used to get projects started or fund modest action research projects. Second, if new developments prove their worth and are to succeed beyond the 'pump-priming' stage, we think a revolving loan fund might be established upon which health authorities could draw to finance new developments. Health authorities with their own good ideas could draw on this fund without the RDA's involvement, while other authorities might be encouraged by the RDA to avail themselves of the facility. An example is the build up of alternative services to long stay hospitals prior to the eventual capital sale of the latter, as outlined in the consultative document on resource transfers between the NHS and local authorities.*

18. In addition to project work, the RDA would also endeavour to promote the adoption of good practice derived from its project work through the publication of reports, organising information conferences, seminars and so on. Suitably publicised inter-authority comparisons may also act as a spur to innovate among the less progressive authorities. The adoption of good practice could also be promoted if the RDA, backed by a national development agency (see below), acted as a clearing-house for guidelines and standards produced by others. It is currently difficult to obtain comprehensive information on good practice in a particular sphere from one resource centre.

19. While we wholeheartedly endorse the Government's support for a series of regional experiments in monitoring in order to establish how best to develop services, we must express our concern over the timescale. It seems that two years may be the length of the experimental period. We think that this is much too short a period for an experimental scheme to yield worthwhile results and propose that the experiments should run for a period of 4 to 5 years which will also allow a reasonable period of time for their evaluation. Evaluating the RDA will require careful consideration.

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* DHSS, Care in the Community: A Consultative Document on Moving Resources for Care in England, July 1981.

National Dimension

20. Our principal, and immediate, concern in this memorandum has been with a proposal for a RDA. However, if, upon evaluation, a trial with a RDA proves successful and it is decided to continue, and possibly extend, its operation, then we believe it may also be necessary to consider establishing a national development agency (NDA) which will, inter alia, coordinate the activities of the RDAs. We neither think it realistic, nor desirable, to anticipate 14 RDAs since the necessary skills and resources are simply not available. But we think there may be some merit in setting up 4 or 5 RDAs for England backed by, and interlocking with, a NDA.

21. We regard a NDA as pivotal in the evolution of a new relationship between centre and periphery in the NHS which we are convinced is necessary if DHAs are to enjoy the discretion Ministers wish them to have without unnecessary interference either by the DHSS or RHAs. In keeping with our general philosophy, which we have stated elsewhere,* of the need for a 'shared response' between central and local levels in the NHS, we believe a NDA would provide an appropriate linking mechanism between centre and periphery and would be a key element in regulating the interdependence of the two levels. A NDA would do at a national level what we envisage a RDA doing at regional level, that is, acting as a link between the Department and the NHS field authorities in much the same way as a RDA will act as a link between RHAs and DHAs in the sphere of innovation and development.

22. In addition to rendering national policy guidelines more sensitive to local practice and problems, a NDA will also be able to assist in the dissemination of good practice and act as a national clearing-house to complement the RDA's efforts.

23. If a NDA is established, then there may be a strong case for looking afresh at the future of the Health Advisory Service (HAS) and the Development Team for the Mentally Handicapped. The remit we have in mind for the development agencies, regional and national, suggests they will be rather different bodies from the HAS and the Development Team. Initially, therefore, it may be appropriate for the various agencies to operate separately. In the longer term, a review of their tasks may be in order.

Cost

24. We are aware of the financial implications of any new apparatus superimposed on the existing structure of the NHS, especially at a time of resource restraint. However, because of the nature of the exercise, it is not possible to give accurate details of the costs of operating a RDA. An assessment of these, and their value, would be an important feature of the evaluation of a trial.

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* See The Outer Circle Policy Unit, A New Perspective on the National Health Service, London 1978; and Health First: A Comment on 'Patients First', London 1980.

25. In an attempt to be a little more precise about cost, we estimate that the total cost per annum, including all overheads, when the RDA is fully operational might be around £250,000 at current prices. This figure includes the cost of: a small core group; staff seconded from the Service for development work; and specialists seconded from outside the Service for development work. The cost excludes a 'pump-priming' fund and a loan fund. The cost of operating a RDA should not differ greatly, if at all, from that of operating a management advisory service.

Conclusion

26. We believe that a new approach and a new organisation would be valuable in promoting innovation in the NHS. The advantage of a specific agency which would supplement existing innovatory activity in the NHS is that it could build up a reputation as a fund of knowledge and expertise. The price of not creating a RDA, or its equivalent, is the likelihood that improvements in the quality of service and relations between authorities may fail to meet expectations.

27. The success of the RDA would lie in its operating style - in its negotiating and persuasive skills and in the ability of agency staff to build alliances, and mobilise resources and support for change. The agency would not seek perfection so much as less imperfection, and its advice would be offered in an attempt to optimise local performance within the resources available to particular authorities and within the bounds of national and regional policy guidelines.

28. The RDA's predominant mode of operation would be to work with local staff on projects designed to test alternative approaches to problems. Its focus would be less on examining what people are already doing and much more on exploring alternative ways of developing services. An emphasis on current performance would lead to a focus on efficiency rather than effectiveness: while initiatives concerned with efficiency are important they should be seen as part of the normal function of the NHS and complementary to the functions of the RDA with its wider remit.

29. At some stage, particularly if the agency's remit is extended, it may be worth considering whether a national dimension to the RDA's work is in order.

30. We believe there will be valuable spin-offs for health policy from the activities of the RDA and, in the longer-term, the NDA. Agencies at both regional and national levels could be useful sources of advice on the development of plans and priorities. Health authority members and CHCs may also find the RDA a useful support to enable them to fulfil their tasks more effectively and, hopefully, with improved understanding.

31. In proposing a RDA the main issues at this point in time are primarily about our analysis of why innovation is necessary, and yet lacking, and the philosophy underlying the approach to innovation we have enunciated. Our analysis and approach

to innovation need to be agreed upon before considering the practical and organisational details of setting up the agency. If agreement is forthcoming then, in the first instance, we favour a trial to establish (a) the market for the RDA; (b) appropriate staffing; and (c) the appropriate style of operation.

September 1981

Summary of Main Points

- The need for innovation and the stimulation of new developments in the NHS has never been greater - a RDA could assist in remedying the situation.

- It is crucial that the RDA should not be regarded as an agent of central government or the RHAs; its independence from line management must be upheld.

- The RDA must be able to focus on developmental work, which, given the structure of the NHS, means influencing local staff; monitoring centrally unacceptable deviations from practice, and standard methods of achieving efficiency could, and should, be the tasks of health authorities.

- A concentration on management services and efficiency, while valuable activities in themselves, will not tackle effectively the central problem of stimulating change; the RDA, set apart from the management hierarchy and appropriately staffed, could provide the necessary stimulus.

- The composition of the RDA is vital to its success; high calibre staff must be recruited since competence is a key factor if credibility and respect are to be forthcoming.

- Incentives for promoting change may be necessary to lend the RDA weight and ensure a more receptive audience; virtual control of 'pump-priming' funds for action research projects would be useful, and the agency's advice might be influential in accepting applications to a loan fund.

- There could be valuable spin-offs from the RDA for broader health policy concerns both locally and nationally; in the case of the latter, a NDA might be necessary as soon as it could be set up and might greatly strengthen the quality of the NHS's input into national policy-making.

- The cost of setting up, and operating, a RDA is not easy to determine at this stage although we reckon a figure of £250,000 per year is reasonable.

Appendix 1

Membership of NHS Group

Keith Barnard	Nuffield Centre for Health Services Studies, University of Leeds
S.R. Engleman	Department of Community Medicine, University of Edinburgh
Chris Ham	The School for Advanced Urban Studies, University of Bristol
Stuart Haywood	Health Services Management Centre, University of Birmingham
David Hunter*	Health Studies Officer, Royal Institute of Public Administration
Robert Nicholls	Area Administrator, Newcastle Area Health Authority
Mike Norris	Centre for Organisational and Operational Research, Tavistock Institute of Human Relations
Brian Smith	Area Administrator, Lincolnshire Area Health Authority
Nigel Weaver	District Administrator, Ealing, Hammersmith and Hounslow Area Health Authority
Derek Williams	Health Services Management Centre, University of Birmingham

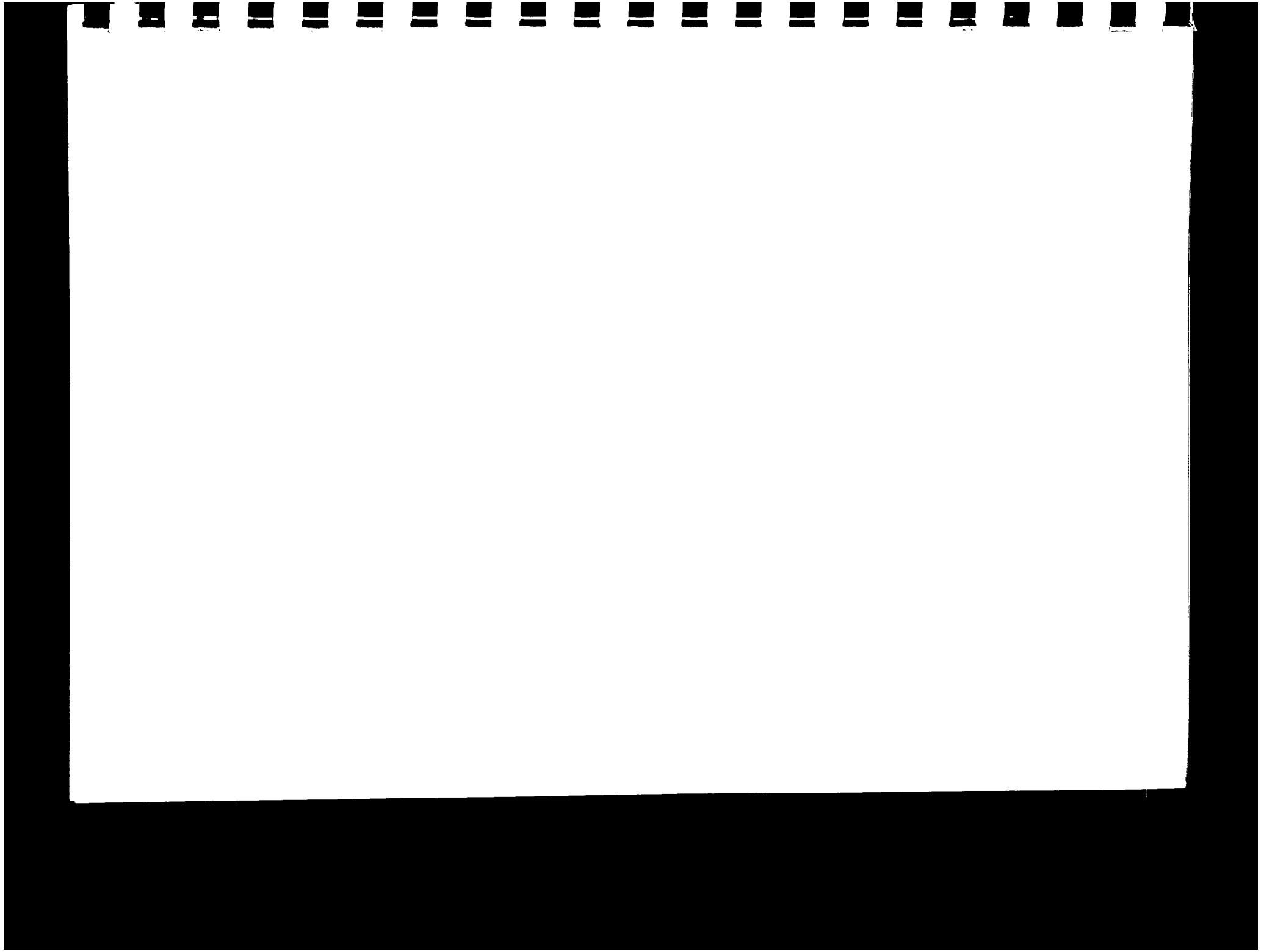
Valuable assistance has also been received from:

Drummond Hunter, Secretary, Scottish Health Service Planning Council;

Andy Alaszewski, Institute for Health Studies, University of Hull; and

Dr Charles Shaw, Senior Registrar in Community Medicine, Gloucestershire Area Health Authority.

* Group convener and principal author



A. KEY DIFFERENCES BETWEEN RDA PROPOSAL AND MAS TRIALS

1. The differences between the RIPA proposal for a RDA and the three MAS trials vary and do not follow a consistent pattern because the trials themselves vary. Most important, the RDA is not a monitoring body, nor is it concerned with performance review (although self-review among professionals may be a by-product of its work). Of the 3 MAS trials, 2 are concerned with monitoring (ie North Western and Oxford/South Western) while the Wessex trial will focus on performance review. Since the Wessex trial will follow the model and framework used in the Regional Monitoring Policy between 1977 and 1979, an element of monitoring seems likely although self-monitoring by each authority rather than by other authorities or by independent teams is stressed.

2. The RDA would be jointly supervised by Region and Districts. This is also the pattern envisaged in the MAS trials, although the region will remain influential in each case. For instance, the Wessex performance review programme will be initiated and coordinated by the RHA, which will also provide assistance in setting up performance reviews and with information systems; in North Western, the NHS Review System will submit a report to the RHA and the Secretary of State; and in Oxford/South Western, the supervisory board will be accountable to both RHAs. There would be no special link between the RDA and the RHA.

3. The tasks of the various schemes put forward differ. Essentially, the 3 MAS trials are concerned with identifying problems and alerting authorities to their existence. The RDA, on the other hand, aims to go beyond this and provide advice, assistance and support to those in the field who seek it and who wish to go beyond problem-identification to trying to find solutions to the problems.

4. The RDA's mode of operation differs from that envisaged for the MAS trials. With the exception of Wessex, the MAS trials envisage a programme of visiting teams drawn from the NHS which will survey health authorities on a regular basis. The RDA would not operate in this way. Although visiting teams, or task groups would be set up, these would be formed around specific problems following discussions between agency staff and professionals on the ground. These teams would work with professionals for as long as they were needed. Outsiders would be co-opted onto teams if necessary. Wessex does not rule out the need for teams but these would be involved in setting up the performance reviews and would not visit and monitor performance.

5. The RDA proposal places an emphasis on the value of drawing upon outside expertise when appropriate. This is not ruled out by Wessex although the commitment to employing such skills is weaker than in the RDA proposal. Neither Oxford/South Western nor North Western mentions the possible need for these skills.

B. A DHSS VIEW OF THE MAS

1. The Committee asked for a note on the Management Advisory Service (MAS).

2. Both the consultative document "Patients First" and Health Circular (80)8 on the future structure and management of the National Health Service foreshadowed the possible establishment of an advisory group to monitor the quality and efficiency of the way in which health services are managed.

3. Following discussions between the Secretary of State for Social Services and Regional Chairmen in November 1980, four regions agreed to mount MAS trials. Briefly, the *North Western Region* proposes a multi-disciplinary team to visit Districts on a regular interval basis to look at all aspects of management. *Oxford and South Western Regions* are collaborating in a joint trial, which will be a cross-Regional exercise with the team visiting selectively and commenting on particular aspects of the Service in each series of visits. The *Wessex* approach is substantially different, with the Region developing a "do-it-yourself" audit kit for local management.

4. The trials will start in April 1982 and will continue for two years. They will be the subject of a common evaluation, details of which have yet to be finalised. The regions concerned are still working up the details of their trials but the full-year costs are likely to be about £400–450,000 in total.

5. Whichever model is adopted nationally in the longer term, Ministers see the MAS as complementing the monitoring role of RHAs; it will introduce a "roving-eye" approach at the national or Regional level, in which intervention is more selective, either on a regular interval basis or in response to specific causes for concern. The MAS should also help to strengthen local accountability by giving District chairmen and members an independent assessment of the services for which they are responsible. Thus Ministers see the possible development of an independent "monitoring" service as an important instrument to help to meet the requirements of Parliamentary accountability without undue involvement in district affairs by RHAs and the DHSS.

Source: Note prepared for the House of Commons Social Services Committee. Public Expenditure on the Social Services, Third Report from the Social Services Committee, Session 1980-81, Volume II, HMSO, London, 1981, Appendix 1: Supplementary memorandum by DHSS, pp 145-6

The details of the trials have not yet been finally settled but are broadly expected to be:

(i) North Western RHA proposes to establish a multi-disciplinary team to visit Districts to provide an impartial assessment of all aspects of management. The object of reviews will be to look at the quality, efficiency and effectiveness of the service provided within whatever constraints affect the authority. The aim would be to visit each Authority within the Region within two years, with about one month being allowed per visit.

(ii) Oxford and South Western RHAs propose to set up jointly an independent inter-regional team to examine *selected* operational services, compare performances, identify differences and deficiencies, and alert Authorities to the need for change. It would disseminate information on the development of good practice.

(iii) Wessex RHA propose to mount a series of performance reviews of selected services, looking at both the efficiency and effectiveness of those services and achieving changes as a result. All authorities in the region will participate and the reviews will be conducted by the management staff of the DHA concerned. The RHA will co-ordinate and will provide information systems and assistance in setting up reviews. Explicit standards of performance will be agreed by the Authorities concerned which they will seek to achieve. At the end of the programme, the methods and results of the work will be reviewed objectively.

Source: ibid., para 9, p 5

APPENDIX 2

King Edward's Hospital Fund for London

King's Fund Centre
126 Albert Street London NW1 7NF

THE PROMOTION OF INNOVATION IN HEALTH CARE: THE CASE FOR DEVELOPMENT AGENCIES IN THE NHS

CONFERENCE - WEDNESDAY 28 OCTOBER 1981

List of those who were present:

MR R L AKEHURST	Senior Fellow, Institute of Social and Economic Research	University of York
MR A ALASZEWSKI	Lecturer, Institute for Health Studies	University of Hull
MR W P N ARMOUR	Regional Personnel Officer	North West Thames RHA
MR K BARNARD	Deputy Director, Nuffield Centre for Health Services Studies	University of Leeds
MR I H BEACH	District Administrator	SW Leicestershire HD (T)
MISS J BISHOP	Health Care Planning Officer	South East Thames RHA
MRS R J BLACKWELL	Area Nurse, Service Planning	Doncaster AHA
MS P BLAIR	Journalist	Times Health Supplement
DR P W BRIGGS	Area Medical Officer	Hillingdon AHA
MR J H BUTTON	Area Administrator	West Glamorgan HA
MR I J CARRUTHERS	Support Services Manager	Southend Health District
SIR CYRIL CLARKE	Director, Medical Services Study Group	Royal College of Physicians
MR P COOPER	District Administrator	East Roding HD
MRS A COULSON	Service Planning & Development Co-Ordinator	West Midlands RHA
MR P COOKE	Regional Administrator	Oxford RHA
MR R E P CRAIL	Acting Area Administrator	Norfolk AHA
MR G C DAVY	District Administrator	Redbridge & Waltham Forest AHA
MISS M A DAY	District Nursing Officer	City & East London AHA(T)
* DR D DICK	Director	NHS Health Advisory Service
MR I L DONNACHIE	Regional General Administrator	Yorkshire RHA
DR S DOWLING	Lecturer in Community Health	University of Bristol
MR J DENNIS	District Administrator	Havering Health District
MISS M DIXON	Associate Director	King Edward's Hospital Fund for London
MR J R EVANS	District Administrator	Lincolnshire (North) HD

*	MR T EVANS	Director	King's Fund College
	MR W F FARRANT	Assistant Secretary, P4A/B	DHSS
	MR V FLINTHAM	Reorganisation Coordinator	North West Thames RHA
	DR C FOSTER	Consultant Geriatrician	Queen Mary's Hospital, Sidcup, Kent.
	MISS M FRASER	Principal Lecturer (Health Studies)	Brighton Polytechnic
	MR K A P GILL	Area Administrator	Sefton AHA
	MISS O GOLDSMITH	Area Administrator	Coventry AHA
	MISS M GOOSE	Area General Administrator (Planning and Information Services)	Croydon AHA
	MR P A GRIFFITHS	Acting Area Administrator	Kent AHA
	DR G GUEST	Regional Management Services Officer	Wessex RHA
	MR C HAM	Rapporteur	School for Advanced Urban Studies, University of Bristol
	MISS C HANCOCK	Area Nursing Officer	Camden & Islington AHA(T) (am only)
	MR R HARDIE	District Administrator	East Dorset Health Care District
	MRS S HARDY	Administrator - Diagnostic & Scientific Services	St Thomas' Health District
	MR C HAYTON	Area General Administrator	Salford AHA (T)
*	MR S HAYWOOD	Hon. Research Fellow, Health Services Management Centre	University of Birmingham
	MRS S HOWELLS	Regional Capital & Services Planning Officer	South West Thames RHA
	MR T HUNT	District Administrator	St Mary's Hospital, Paddington, W2.
	MR T D HUNTER	Secretary	Scottish Health Service Planning Council
	MR J G HUNTER	Principal	DHSS, BELFAST
	MRS M JOHNSON	Principal Administrative Assistant (Planning)	Bristol & Weston HD (T)
	MR L M JONES	Senior Lecturer in Management of Health Services, Department of Community Medicine	University of Edinburgh
	MISS W JONES	Assistant Director (Development, Research and Planning)	London Borough of Hammersmith & Fulham
	MR D J KENNY	Area Administrator	Kensington & Chelsea & Westminster AHA (T)
	MR F J KENNY	Assistant Regional Administrator	Trent RHA

	DR P A KITCHENER	District Community Physician	North East Health District (T), Kensington & Chelsea & Westminster AHA (T)
*	PROF R KLEIN (Chairman)	Professor of Social Policy	University of Bath
	MR D J KNOWLES	District Administrator	North East Health District (T), Kensington & Chelsea & Westminster AHA (T)
	MRS A R M LEWIS	Ph.D Research Student in Social Administration	London School of Economics
	DR S LITTLE	Department of Child and Family Psychiatry	Medway HD
	MR A LISTER	District Administrator	Harrogate Health District
	MISS N M LYNE	District Nursing Officer	Ealing Health District
	MR D K McCAUL	District Nursing Officer	Cheshire AHA, Halton Health District
	DR J W McCLENAHAN	Principal	Arthur Anderson & Company (Management Consultants)
	PROF N McINTYRE	Professor of Medicine, Academic Department of Medicine	The Royal Free Hospital
	MR L McMAHON	Rapporteur - Senior Lecturer, Health Care Studies Group	Polytechnic of Wales
	MR R P MacMAHON	District Administrator	Kensington & Chelsea & Westminster AHA (T) (South District)
	MR D J MARLOW	Area Administrator	Ealing, Hammersmith & Hounslow AHA (T)
	MR R J MAXWELL	Secretary	King Edward's Hospital Fund for London
	MR G MILLARD	District Administrator	Harrow Health District
	PROF S MORRISON	Centre for Medical Research	University of Sussex
*	MR D NICHOL	Regional Administrator	Mersey RHA
	MR R M NICHOLLS	Regional Administrator	South Western RHA
	MR M NORRIS	Centre for Organisational and Operational Research (COOR)	The Tavistock Institute for Human Relations
	MR R A PENGELLY	Under Secretary	Welsh Office
	MR A PERKINS	Chief Training Officer, NHS	DHSS

	MISS D PLATT	Principal Hospital Social Worker	Hammersmith Hospital
*	MISS W PRITCHARD	Human Systems Development Adviser	Shell International Petroleum Company
	MR A PURKIS	Head of Policy Analysis Unit	National Council of Voluntary Organisations
	MR J RANKEN	Senior Tutor	King's Fund College
	MR M RENDALL	Clinical Superintendent	Guy's Hospital
	DR R REYNOLDS	Registrar, Community Medicine	Mersey RHA
	DR Z REYNOLDS	Registrar, Dept. of Community Medicine	University of Manchester
	MR S RIISAGER	District Administrator	West Dorset Health Care District
	MR J ROGERS	Principal	DHSS
	MRS B E SCAMMELL	Nursing Officer	DHSS
	DR C SHAW	Senior Registrar in Community Medicine	Gloucestershire AHA
	DR R STEWART	Fellow in Organisational Behaviour	Oxford Centre for Management Studies
*	MR B SMITH	Area Administrator	Lincolnshire AHA
	DR A SMITHIES	Senior Medical Officer	DHSS
	MR J A SPENCER	Area Administrator	Oxfordshire AHA (T)
	MR J R SULLY	Area General Administrator	East Sussex AHA (T)
	MR J STURT	OD Department	Trent RHA
	MR S R TAYLOR	Senior Consultant	Hay Management Consultants
	MR A WALL	District Administrator	Bath Health District
	MR R W T WALKER	Senior Assistant District Finance Office	W Surrey/N Hants HD
	MR N WALTON	District Administrator	North Camden District
	MR B WATKIN	Editor	Health and Social Service Journal
	PROF A WEBB	Head of Department and Professor of Social Administration	Loughborough University
	DR I WICKINGS	Project Coordinator	CASPE Research

MR G WISTOW	Research Fellow	Loughborough University
MRS J WOOD	Research Fellow, Department of General Practice	University of Manchester
PROF W M WILLIAMS	Director, Health Care Studies Unit	University College of Swansea

ROYAL INSTITUTE OF PUBLIC ADMINISTRATION

MR W PLOWDEN - Director-General
DR D HUNTER - Health Studies Officer up until April 1982. (Now Research Fellow in Department of Community Medicine at the University of Aberdeen).

KING'S FUND CENTRE

MR D HANDS - Assistant Director
DR D TOWELL - Assistant Director
MISS N DAVIES - Secretary to Mr Hands

* denotes contributor/speaker