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SERVICE PLANNING IN THE RESTRUCTURED NHS

THE ROLE OF DISTRICT HEALTH AUTHORITIES

A Report of a conference held at The King's Fund Centre, on 10 th December 1981

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KING EDWARD'S HOSPITAL FUND FOR LONDON

SERVICE PLANNING IN THE RESTRUCTURED N.H.S. : THE ROLE OF DISTRICT HEALTH AUTHORITIES

Report of a Conference held at the King's Fund Centre on 10th December, 1981.

Chairman: TOM EVANS, Director, King's Fund College

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The Purpose of The Conference

This conference was organised by the King's Fund to provide a forum for discussion about the implications for service planning in the N.H.S., of the proposals outlined in the D.H.S.S. consultative paper HN(81)4.[1] Many participants had been closely involved with the development of planning in the N.H.S. Amongst those present were representatives from the Department of Health and Social Security, N.H.S. officers and members, and academics who had been associated with research into the operation of the N.H.S. planning system.

A list of the platform speakers is included at Appendix A and a total list of those who attended the conference at Appendix B.

Chairman's Introduction

The conference was chaired by Tom Evans, currently Director of the King's Fund College and formerly lecturer in Public Sector Management at the London Business School. Referring to the bibliography[2] on N.H.S. planning with which participants had been provided, Mr Evans remarked that its size reflected the ever-growing volume of literature on planning which was itself a mark of the complexity and imprecise nature of the subject. Many of the problems facing N.H.S. planners stemmed, not from the nature of the N.H.S., but from the nature of planning and hence were familiar also to planners in other areas.

New Policies : Old Problems

The first presentation was given by Rudolf Klein, Professor of Social Policy at the University of Bath and an eminent commentator on the N.H.S. Professor Klein stated his purpose as being to "set the scene" for later speakers. He declared however, that academic analysis could make only a limited contribution to solving the problems of planning in the N.H.S. His own experience as a health authority member had indicated that the principle benefit of such training was that it allowed him to ask questions of such complexity that he recognised they could not, given the present state of knowledge, be answered. The value of asking these questions should not however be ignored.

Currently, Professor Klein argued, the N.H.S. was in a state of agnosticism concerning rational planning. Whereas the process and structure of planning are easy to analyse, determining its effectiveness is the real problem. In Professor Klein's view many of the current issues central to

the reorganisation of the service and the planning system hinged on the "centre/periphery" problem which had been present even at the inception of the N.H.S. This was evident in the Bevan/Morrison debate over how far a service could be organised centrally but yet be responsive to local needs. Professor Klein went on to argue that the 1974 reorganisation and the planning system were not the creation of McKinsey or Brunel, but the culmination of at least ten year's thought and debate about the organisation and delivery of public services. The Plowden Report on the Control of Public Expenditure[3] illustrated this point, having as its aim the provision of a framework which would allow stability for planning. Further to this, was a belief that planning could bring about the conditions of its own success. Thus the 1974 Reorganisation had been the product of over a decade of intellectual development and a consensus based on optimistic forecasts of economic growth. The irony was that these philosophies merged in the N.H.S. at a time when the "economic rug" was whipped from under its feet!

One aspect of this economic optimism was the tendency of the early priorities[4] documents and the "Blue Book"[5] to concentrate on input - planning, that is identifying resources needed to supply a service and defining "norms" of provision.[6] This approach assumed that shortfalls identified could be made good. With the recognition of the unrealistic nature of this approach, Professor Klein felt he could detect a move away from "centralisation of credit" towards "diffusion of blame". That is, instead of central government taking credit for developments and expansion, operational authorities were being made accountable for identified deficiencies. A change had thus taken place in the language of planning and the use of norms had been replaced by general statements of direction as exemplified by "Care in Action"[7]. Although there was justice in moving away from the normative approach on the grounds of its crudity - it ignores the fact that the same inputs depending on how they are used, may have very different outputs, and it fails to allow for the "special" characteristics of individual locations - the absence of specific targets means that health authorities cannot assess their progress towards meeting priorities. What District Health Authorities now need are measures of <u>output</u>, to provide a vocabulary for accountability.

Adding complexity to the current situation was the fact that whereas N.H.S. expenditure was being protected, local authorities were being forced to make cuts. The stable framework envisaged by Plowden was, inevitably in view of the changed economic position, being undermined. Family Practitioner Committees present special problems. They have very limited planning capabilities but since their contractors function as gatekeepers to the entire health care system they have a crucial role in determining demand. The

recently accorded independent status of F.P.C.s, Professor Klein saw as an institutional ratification of the status quo and an admission of political defeat.

Looking ahead, Professor Klein suggested that agnosticism and disillusion with planning are helpful if they suggest improvements for the future and force consideration of measures of output rather than concentrating entirely on inputs. Ideally consideration should be given to the impact of health services but this is made difficult given the current state of knowledge and the fact that health status is not purely dependent on N.H.S. services.

Discussion

During the short discussion period which followed Professor Klein's talk, participants pursued some of the issues he raised.

On the use of norms, it was pointed out that many parts of the U.K. were comparatively over-provided and in such places norms had a use as instruments of rationing as opposed to targets for expansion.

Some scepticism was expressed over the need for further planning tools such as "measures of output"since inadequate use is made of information which already exists. Professor Klein felt this was only partially true since, as David Came's[8] work in Winchester demonstrates, information will only be used when the power to effect change is also present and this therefore is the crucial factor. "Measures of output" were raised by other participants. Professor Klein agreed with the view expressed from the floor that the clue for deriving such measures lay in S.A.S.P. data and publications such as the London Health Planning Consortium's[9] report on acute beds. One participant made the point that considering output implies also considering groups who do not receive services and that this might be difficult to achieve. Professor Klein felt however that examining statistics made inferences about such groups possible. Concern was expressed that developing measures of output should not degenerate into an exercise which merely produced more paper. Measures should be locally relevant and regarded as expendable, their purpose served after they had stimulated debate.

The question of how much local diversity the health service could expect as a right was raised. Professor Klein felt this was very difficult to assess from ministerial speeches and that it would probably form part of the debate for coming years.

Health Service Planning - The Lessons So Far

In this presentation, Arthur Willcocks, Professor of Social Administration at the University of Nottingham, briefly described the programme of D.H.S.S. - sponsored research into the workings of the planning system and outlined some of its findings.

The research had been undertaken by teams from the Universities of Birmingham and Leeds and Leicester Polytechnic, who had examined the planning system in operation at Regional, Area and District level respectively.
Professor Willcocks had been appointed by the D.H.S.S. to co-ordinate the studies. The research teams had chosen locations broadly representative of their particular administrative tier, recognising however that each would have a claim to uniqueness in some respect. The three service levels studied were not in the same Region, hence the researchers had not been able to explore fully the inter-relationships between the various tiers in the N.H.S.

The findings were outlined under the following headings:

(a) Structure for planning

The roles specified by the D.H.S.S. had often been found unworkable in practice since they assumed staff numbers and skills which did not exist. How the role of the planner developed depended upon the other tasks that individual was expected to perform. It had been difficult to determine how far the structure for planning had accorded with D.H.S.S. specifications. (Alluding to the national survey of Health Care Planning Teams[10] conducted by Kearns, Mullen and Murray-Sykes, however, Professor Willcocks noted that the most commonly established teams had been discovered to be those suggested by the D.H.S.S..) Two features had been considered "striking" by the researchers: Firstly the attitude of chief officers to planning. In the early days they had regarded themselves as outside the system, their function being merely to comment on completed plans with planning not being seen as one of the tools of top management. This view was changing, however, towards the end of the research studies. Secondly there had been particular difficulty fulfilling certain roles especially that of the District Community Physician. Difficulties here were exacerbated by the previous background of many DCPs, by lack of supporting staff and skills and by tension between planning and "fire-fighting".

(b) Planning Process

Time and opportunity for consultation, collaboration and participation had been found to be inadequate. Confusion also existed over what exactly these terms meant. In some cases consultation between health authorities and CHCs and Trade Unions resembled negotiation. Some evidence of lack of consultation between tiers of management had been found, consultation with local authorities was half-hearted and confused; and Community Health Councils were often regarded as unfriendly tigers. Doctors could always manage to circumvent the formal systems.

(c) Collaboration with Local Authorities

In the early days, collaboration with Local Authorities had been a failure. There was mutual lack of understanding by health and local authorities of their differing operational environments and goals. Joint financing had helped to overcome some misunderstandings but there had been too great a concentration on social service departments to the exclusion of other local authority departments.

(d) Skills/information used in planning

RHAs were described as having an ample array of skills but the problem lay in relating these to the planning process. Many of these skills did not exist at Area level and here pressure groups influenced the skills and information used. Within Districts there was a surplus of information and problems of selection. The planning system had called into question what the role of information specialists should be: what kind of information is needed; and how this information should be used.

(e) Views on the planning system

On the issue of local autonomy/national guidelines, the research indicated that Regions generally accepted guidelines and passed them on with comments to Areas. Areas appeared to pay them less attention but they did form a basis for dialogue between the Regional and Area tiers. Districts seemed to use guidelines to provide a basis for agreement on future direction. However it could not strongly be argued that national guidelines were a success. On attitudes towards the planning system itself, Professor Willcocks said that whereas RHA officers accepted it, RHA members had small understanding of it and contributed little to it. At Area level the acceptability of the system was less clear. For officers this may have been due to unease about their position in a situation where

Region had a clear role in capital planning and Districts in effect controlled operational planning. There was some evidence that AHA members were more subject to political and professional pressures but still their contribution to the planning process was minimal.

(f) Outcome

There was no doubt, according to Professor Willcocks that the planning system had been successful in introducing rationality into health service development at Regional and Area levels. However at District level pressure groups and powerful interests were more influential in maintaining the status quo. Speaking personally, Professor Willcocks felt sure that the planning system had influenced the attitudes of N.H.S. officers towards resource allocation and the balance of services. This was less true of members. The planning system had called into question the role of AHAs. Their function had apparently diminished and they became the system's "post-bags".

(g) Members

Professor Willcocks said he had been struck by the lack of a shared philosophy by AHA members. The selection processes produced representatives of sectional interests which militated against a united approach. With a few exceptions, he had not detected members having agreed on a strategy which, particularly in view of the considerable power and influence wielded by professionals in the N.H.S., Professor Willcocks felt was urgently required for the general good of the service.

In concluding, Professor Willcocks posed the following question - "if it is to continue to be the case that local diversity and central direction are to be balanced in the N.H.S. is the current system of issuing national guidelines appropriate, and if not what should take its place?"

Discussion

The role of members in planning formed a large part of the discussion which followed Professor Willcocks' presentation. The importance of involving members fully in the debate and formulation stages of proposals was stressed. This might require some members developing a specialist role but reservations were expressed about whether the level of commitment amongst members existed for such a development to take place. However it was felt that officers could encourage member participation by presenting plans and proposals in less intimidating form.

Involvement of all disciplines affected by plans was seen by Professor Willcocks as an important means of providing an incentive for planning. It would also be a less marginal and crude incentive than the traditional mechanism of allowing some control over the redirection of any savings accruing from planning. There should be some wider basis for rewarding effective planning.

There was some debate over the professional status of planners in the N.H.S. One view expressed was that designated planners should be more highly graded than at present. However the opposing view was stated that as long as chief officers had a commitment to planning and skill in communicating organisational direction to senior colleagues in other disciplines, the designated planning post did not necessarily need to be very highly graded.

The question was raised whether or not planning in the N.H.S. had failed, with the rider that if it had, this implied a failure of N.H.S. management also. In answer to this, one of the researchers into the planning system replied from the floor that the endorsement of planning in Patients First[11] and thereafter indicated it had had considerable success. Where shortcomings had occurred, investigation was proceeding. A result of such study might be to recommend a specialist planning function which combined analytical, political and negotiating skills, all of which experience had shown, were necessary for planning in the N.H.S.

Planning in D.H.A.s - The Challenge to Management

"Planning in D.H.A.'s - the challenge to management" was the title of the presentation given by Michael Fairey, Regional Administrator of North East Thames R.H.A. It was of paramount importance, said Mr Fairey, to have a clear statement of the aims of the N.H.S., particularly when resources were constrained. Such constraints necessitated choices - implicit or explicit - and it was much better for choices to be made consciously and explicitly. In one sense the structure of the N.H.S. was irrelevant to this process - all one could ask of structure was that it should not impede progress. In another sense however, the proliferation of health service Authorities after April 1982 meant that it would be vital for the future to have a clear answer to the question. "What is the N.H.S. trying to do?" A lamentable consequence of the concern given to the forthcoming restructuring was that it had diverted two years of N.H.S. time away from addressing this important question.

Planning, said Mr Fairey, was of importance to all parts of the N.H.S. The current planning system was in force unevenly throughout the country. Since planning was a lengthy, cyclical process there were bound to be initial problems until the cycle had been completed at least once. For this reason the revised planning system could be held to be premature and at any rate it, in Mr Fairey's view, lacked "bite".

Planning was not about writing a plan but about achieving change. Opposition to change was a hazard which applied to all planning systems and was not confined to the N.H.S. It was a human problem which required "managerial guts" to overcome.

"Care in Action" which was vague and imprecise in its approach was seen by Mr Fairey to be a positive regression from its preceding priorities documents. As a consequence Regions and Districts might adopt vague and imprecise guidelines, the worst of all faults, or they might be driven to formulate their own priorities. Mr Fairey noted that although there were national policy statements, there did not exist a national strategic plan for the N.H.S. Such a plan could be formulated by modifying an aggregation of the 14 Regional strategic plans. Such a document might pose problems in political terms but in the long term it could only be beneficial - whether by encouraging the production of more realistic guidelines or in promoting greater planning efforts in the N.H.S.

Referring to the planning process in his own Region, Mr Fairey said that as part of its preparations for restructuring, North East Thames R.H.A. had

re-examined its strategy and disaggregated and restructured the Regional Plan to take into account the greater number of new Health Authorities. This had been a particularly valuable exercise since it highlighted a number of areas of activity which had not been properly thought out and which therefore required further consideration.

The current emphasis on Units within District Health Authorities necessarily led to the conclusion that there should be a planning statement for each Unit. Unless each Unit had clear and specific objectives, the District Plan would be bound to fail. For the future, Mr Fairey saw the District Operational Plan as possibly fulfilling a number of important functions: it could be used to measure progress towards strategic objectives; it could pull together the allocation of funds; it could act as an overt method of bidding for resources; and it could be used to monitor performance.

Discussion

Following upon Mr Fairey's description of the functions which planning could fulfill, one participant asked whether it could also serve to reward explicitly local efforts to plan effectively. Mr Fairey said that there would be difficulties in achieving this since funding was determined via the Regional Strategic Plan which involved distributing revenue objectively on the basis of RAWP targets. Another drawback in rewarding effort was that such rewards would go to the 'good guys' but they might not be the same as districts with the greatest needs. The difficulty in trying to encourage the 'bad guys' was illustrated by Mr Fairey with reference to one Area which had a demonstrable need to rationalize its major capital and services but whose plans took no account of this need. The Region referred the plans back to the Area with no success. In the end the impasse was broken only after a change of chairman and administrator.

Another participant picked up Mr Fairey's declaration of the need for 'managerial guts' and asked who should exhibit this quality in view of the conflicting professional/hierarchical pressures which will be exacerbated in the new structure with the emphasis on units. Mr Fairey replied that such pressures were inevitable in any human organisation. The problem should be tackled differently. It should start with a clear statement of organisational objectives which experience had shown to be the most fruitful approach. In answer to another question, Mr Fairey affirmed that chief officers must make it their business to be involved in planning, describing this as perhaps the most important major management task.

Information for Effective Planning

The information required to plan effectively in District Health Authorities was the theme of the talk given by Alan Jennings, Consultant Anaesthetist from Northampton AHA and a member of the Steering Group on Health Services Information.

Opening on a provocative note, Dr Jennings declared that most "planning" was merely a legitimation of what had already taken place by stealth! Technological advances had resulted in increased resource provision in the acute sector which had been accompanied, as Dr Jennings demonstrated using data from 1796 onwards, by more intensive and efficient use of these resources. However, whereas supply had increased arithmetically, demand had increased geometrically. Such a situation required a radical answer not peripheral solutions as had been suggested to date. D.H.S.S. expressed policy of moving resources from the acute to the Cinderella services was as likely to be effective as the exhortations of King Canute!

In providing resources for high technology developments in medicine, the assumption was made that benefits increased with cost. However no measurement of such benefits was offered which contrasted strikingly with the highly costed and quantified bids for extra resources. The task of a District Health Authority must be to measure the benefits arising from various parts of the health care system to maximize the total value to patients. Such a task required a response to the issue of supply and demand different from the traditional service response. At its most sophisticated this response attempted innovative and analytic examination of current practice which still however avoided a radical rethink. In Dr Jennings view a "strategic response" was required which would consider the issue afresh and without preconceived notions.

Planning should not attempt to meet all demands by drawing up ever more unrealistic shopping lists, or confine itself to forecasting or predicting. Planning should be regarded as a continual process of evaluation and shifting of resources. In order to plan in this way, D.H.A.s needed information about the resources and demands affecting services for which they were responsible. Dr Jennings classified information requirements under the following headings:

1. Capital stock
    - a Buildings
    - b Apparatus
    - c Consumables

2. Manpower by discipline and deployment

3. Patient services - a) expressed demand - e.g. new outpatient referrals
   b) met demand - e.g. patients admitted
   c) attempts to meet demand - e.g. offers of service not taken up
   d) unmet demand - e.g. waiting-lists.

4. Long stay specialties and chronic services

5. Population and particular local features

Inter-district comparisons would be necessary to help assess performance. Data should not however be accumulated if it would not be used. Data does not become information until it has been analysed and acted upon.

Concluding on a challenging note Dr Jennings declared that, armed with information as ammunition, District Health Authorities could undertake a strategic rethink to challenge the existing powerbases in health care provision.

Planning Objectives - The Clinical Dimension

The reconciliation of clinical activity and health authority policies was the theme of the presentation given by Iden Wickings, Project Co-ordinator of CASPE Research and formerly District Administrator for Brent Health District. Dr Wickings opened by declaring that the N.H.S. had not yet come to grips with how to deal with doctors, when as often occurred, the expressed medical view differed from the policies of the statutory health authorities. Relating this issue to the N.H.S. after the restructuring of 1982, Dr Wickings posed three problems for consideration:

1. What disadvantages might accompany the concentration on units? Would this emphasis make care group planning and community service developments more difficult?

2. Ministers at meetings with shadow chairmen had reaffirmed the established national priorities but had again encouraged the participation of doctors in planning and management. Would active medical involvement help or impede progress towards these goals?

3. Economic constraints meant that planning currently needed to be redistributive whereas previously it had been distributive. Would N.H.S. managers and health authorities have the skills to achieve redistribution?

Dr Wickings referred to declared D.H.S.S. policy that health authorities should provide services in response to locally-defined priorities, while at the same time exhorting them to observe national guidelines to transfer

resources to the long-stay and chronic services, child care and community services. These national priorities are largely social and not medical; if the new health authorities are to come to grips with the problems of redistribution, they would need robust members.

Illustrating the difficulty in redistributing resources, Dr Wickings referred to the findings of South East Thames Regional Health Authority that despite explicit Regional policy to spend more on the priority services, as a matter of fact more resources had continued to be spent on the acute services and less on the 'Cinderella' services. Specialty costing which would allow accurate identification of resource usage and facilitate any necessary 'corrective' action was advocated by Dr Wickings as a method whereby declared policies could be achieved.

In considering how District Health Authorities might come to terms with the allbeit natural and commendable inclinations of clinicians in acute specialities to pursue the development of services offered to their patients, Dr Wickings made three proposals:

1. A series of meetings with senior staff to discuss the development of D.H.A. strategy. If this resulted in a clear sense of direction being given by the authority to its DMT, then the latter should have the managerial capacity to execute this policy direction.

2. Positive steps should be taken to avoid the dangers of rigidity threatened by the renewed concentration on units. From the outset, planning and resource allocation should be conducted on a care-group basis and only subsequently should resources be broken down into unit budgets. As yet Dr Wickings could not advocate clinical budgeting for national use although he felt this the right direction for future development.

3. Service planning could be used as a way in which the frequently different objectives of health authorities and clinicians could be reconciled. It must involve frank discussion, increased understanding and finally, unambiguous decisions.

If these steps were achieved, many of the difficulties inherent in improving the often scandalous conditions still prevailing in the Cinderella services, could be resolved.

Discussion

The last discussion session of the day covered points raised by both Dr Jennings' and Dr Wickings' presentations.

On the practical issue of how exactly members could be brought together to discuss general policy direction, Dr Jennings advocated a semi-social atmosphere. The formal agenda of authority meetings tended to stifle not promote debate. Dr Wickings supported this, adding that sub-committees would also be disastrous. He suggested half-day discussions focussed on the main services in the District to provide enough opportunity to formulate clearly the problems faced. The point was made by one participant that it was also necessary to create fora for different groups including Community Health Councils and Trade Unions.

The use of member questionnaires or Delphi techniques were suggested as possible means for eliciting members views. Dr Wickings had reservations about this however since using Delphi techniques could cause resentment if they caused a "Delphi-like democracy". That is a situation where responses are accepted if they accord with the questioner's own preferences but not otherwise!

One participant asked Dr Wickings to elaborate on ways in which the rigidity which he saw stemming from the unit concept, could be avoided. In reply, Dr Wickings argued for a planning and resource allocation method to counter-balance units. Allocations should be determined by ends, - possibly but not necessarily by care-group, - not means. Dr Wickings' concern about the unit structure was echoed by Dr Jennings who saw geographical units as recreating H.M.C.s.

CHAIRMAN'S SUMMARY

Reflecting on the day's discussions, Mr Evans stated the importance of appreciating the outstanding dilemmas in the practice of planning. Planning theory, he said, is not in such a state that it provides clear guidelines for practice in any organisation. It is important therefore not to indulge in the reification of planning, giving it a substance and tangibility which the present state of the art does not warrant On the contrary, it is critical to ask basic questions about the influence of planning and what changes occur in the organisation as a result of its presence. This approach is manifest in the ongoing tension between planning and management. Planning which seeks primarily to influence management must emphasise the purposive and evaluative fostering of change rather than purely analytical skills. In particular, planning for redistribution or decline is critically different from that which is based on the expectation of growth. The concept of planning is one whose success depends in part on the clarity of the concept of strategy. In many organisations the idea of strategy is moving from that of a grand design to that of diagnosis and issue development. We must accept a commensurate change in emphasis in planning. Finally, the Chairman picked up a distinction which he said had been emerging throughout the conference. The use of formal planning systems as a means of public expenditure control and performance assessment of one level of organisation by another will result in a different emphasis than a commitment of planning to the management of change within D.H.A.s. Without arguing which is a preferable emphasis, he suggested that it may be asking too much to try to achieve both within the confines of a single planning system.

Allan McNaught
King's Fund Centre
February 1982.

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LIST OF PLATFORM SPEAKERS

TOM EVANS	Director, King's Fund College
MICHAEL FAIREY	Regional Administrator, North East Thames Regional Health Authority
ALAN JENNINGS	Consultant Anaesthetist, Northampton Health District
RUDOLF KLEIN	Professor of Social Policy, University of Bath
IDEN WICKINGS	Project Co-ordinator, CASPE Research
ARTHUR WILLCOCKS	Professor of Social Administration, University of Nottingham.

APPENDIX B

KING EDWARD'S HOSPITAL FUND FOR LONDON

King's Fund Centre

SERVICE PLANNING IN THE RESTRUCTURED NHS : THE ROLE OF DISTRICT HEALTH AUTHORITIES

Conference held on 10th December 1981

List of Participants

DR A ALASZEWSKI	Lecturer, Institute for Health Service Studies	University of Hull
Mrs G T BANKS	Under Secretary, Finance Division	DHSS
Mr K BARNARD	Deputy Director, Nuffield Centre for Health Services Studies	University of Leeds
Mr C BATTYE	Lecturer, Centre for Health Services Management	Leicester Polytechnic
Mrs M BELSON	Member	Victoria DHA
Mr G BEST	Health Economist	
Miss J H BISHOP	Senior Service Planning Officer	South East Thames RHA
Ms P BLAIR	Journalist	Times Health Supplement
Mr J BRIDGE	Senior Lecturer in Management	University College, Cardiff
Miss A I BROMLEY	Chairman of Council	Chartered Society of Physiotherapy
Mr M BROWN	District General Administrator	Eastern District, Wakefield AHA
Mr F BURDETT	Head, Centre for Health Services Management	Leicester Polytechnic
Dr A L BUSSEY	Area Medical Officer	Kent AHA
Mr P C CATCHPOLE	District Administrator	Cuckfield and Crawley HD
Mr J C CATTERALL	Area Treasurer	Hampshire AHA
Mr R CHARMAN	Senior Planning Officer	Oxford RHA
Dr D CLAYDEN	Senior Lecturer in Health Statistics	University of Leeds
Mr J P CURLEY	Assistant District Administrator	Guy's Health District
Mr J T DANN	District Administrator	Leicestershire East District
Ms L DARKE	District Planning Administrator	East Roding Health District
Mr B DICK	Senior Registrar in Community Medicine	South West Thames Regional Health Authority
Mr G B ELLISON	Assistant to District Finance Officer	Eastern District, Wakefield AHA
* Mr T EVANS (Chairman)	Director	King's Fund College
* Mr M J FAIREY	Regional Administrator	North East Thames RHA
Mr C E FELTHAM	District General Administrator	East Dorset Health Care District
Mr K FORD	Principal Assistant Treasurer	North East Thames RHA
Ms A FOSTER	Project Officer (Planning)	King's Fund Centre
Mr S E GALE	PAA Service Planning	Leicestershire AHA
Mr C GRAHAM	Director of Health Care Industries and Exports	DHSS

Dr G GUEST	Regional Management Services Officer	Wessex RHA
Mr S HALPERN	Journalist	Health and Social Services Journal
Mr C HAM	Lecturer	SAUS University of Bristol
Mr R HAMBLETON	Senior Research Fellow	SAUS University of Bristol
Mr D HANDS	Assistant Director	King's Fund Centre
Mr J S HARRIS	General Administrator (Planning)	Greenwich Health District
Mr B A HARRISON	Assistant Secretary	DHSS
Mr D R HEMMINGS	Assistant District Administrator	Tunbridge Wells Health District
Mrs D M HOADLEY	District Nursing Officer	Cuckfield and Crawley Health District
Mrs S HOWELLS	Regional Capital Services Officer	South West Thames RHA
Ms J HUGHES	Project Officer (London Project)	King's Fund Centre
Dr L B HUNT	Senior Medical Officer	DHSS
Dr D HUNTER	Health Studies Officer	Royal Institute of Public Administration
Mr T D HUNTER	Secretary	Scottish Health Service Planning Council
* Dr A M C JENNINGS	Consultant Anaesthetist	Northampton Health District
Miss B M JOHNSTONE	Director of Nursing Services	The National Hospital for Nervous Diseases
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Mr C KIRK	Area Planning Officer	Oxfordshire AHA
* Professor R KLEIN	Professor of Social Policy	University of Bath
Mr J KNIGHT	Regional Service Planning Officer	South East Thames RHA
Mrs E KORNER	Chairman, Steering Group on Health Services Information	
Mr K LEE	Lecturer, Nuffield Centre for Health Services Studies	University of Leeds
Mr A M LIDDELL	Area General Administrator	KCW AHA (T)
Ms V LITTLE	Planning Administrator, Financial Information Project	West Midlands RHA
Mr M LONG	Chairman	Cuckfield and Crawley DHA
Mr J S McCELLAND	Regional Forward Planning Officer	South Western RHA
Mr P McGINITY	Director Corporate Planning	St Thomas' Health District
Mr A McNAUGHT (Rapporteur)	Community Administrator	South Camden HD
Dr E J McGUIRE	District Community Physician	Cuckfield and Crawley Health District
Mr J A MASKELL	Treasurer	National Hospital for Nervous Diseases
Mr R J MAXWELL	Secretary	King Edward's Hospital Fund for London

Mr R MEARA	District General Administrator	North East District KCW AHA (T)
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Mr I NICHOLLS	Assistant Regional Management Services Officer	West Midlands RHA
Mr H D OAKES	Area General Administrator	St Helens and Knowsley AHA
Mr D C de PEYER	Under Secretary HPSS Policy and Planning Unit	DHSS
Ms J REYNOLDS	Researcher	Social Services Select Committee
Mrs V RICHARDSON	Service Planning and Development Officer	Westminster Hospital
Mrs B V ROBERTS	Regional Nurse	Oxford RHA
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Mr M SKINNER	Health Services Policy and Planning Unit	DHSS
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* denotes speaker