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Prime Minister

"THE NHS REFORMS AND YOU" - A BOOKLET FOR USERS

Now that the National Health Service and Community Care Act 1990 is on the statute book, it is very important that the public are properly informed about what they can expect from the new style NHS.

My Department has produced a booklet - called "The NHS Reforms and You" - to tell the public what the changes will mean to them and to serve as a 'user's guide' to the changes in the NHS that the Act is intended to bring about. It also covers the reforms in the family doctor service resulting from the new GP contract.

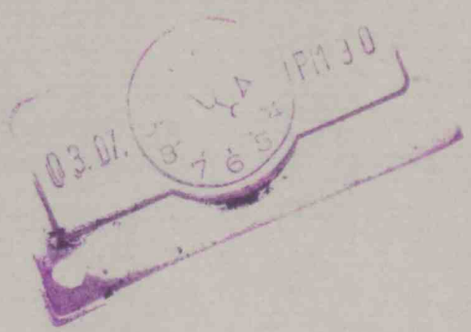
"The NHS Reforms and You" will shortly be distributed free to every household in England. I thought you would want to see it before it is sent out widely and a copy is attached to this letter. An abridged version of the booklet, translated into nine ethnic minority languages, will be available on request, using the order form at the back of the English language version.

I hope you find this useful.

I am copying this note to all members of the Cabinet.

3rd July 1990
Department of Health

KC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SCHEDULE FOR APPLICATION FOR SGT STATUS

29 JUNE 1990 - 1 APRIL 1991

ROYAL ASSENT - 29 JUNE

APPLICATIONS INVITED - 2 JULY

The Secretary of State invites formal first wave applications to be sent in. He directs relevant RHAs to launch full public consultation on the applications.

CONSULTATION PERIOD JULY - OCTOBER

Consultation will be conducted by the relevant RHAs through an appointed NHS Trust Co-ordinator. RHAs will make sure that applications are sent to all relevant bodies. Sponsors from the proposed Trusts will also undertake their own consultation process.

The Department has deliberately not specified which groups should take part in the consultation process. CHCs have a statutory right to do so and the Department is asking Regions to seek the views of all those bodies with an interest. Ex: Relevant health authorities, staff, GPs, FPCs and MPs.

APPLICATION DOCUMENTS

These will be made widely available. Each application will be prefaced by an Executive Summary. This will contain key point explaining why that hospital or unit wishes to apply for Trust status. The objectives and vision of the application will be set out and benefits to be gained through Trust status will be described.

BALLOTS

A great deal of attention has been given to the question of whether there should be ballots of various groups of staff or public on the question of Trust status for particular NHS units in addition to public consultation. Given the complex and detailed managerial, clinical and financial issues involved a simple yes/no opinion poll is not a sensible way to approach decision making. No management issue in the NHS has ever been decided by a ballot - not even the establishment of the NHS itself. Decisions on changes have always been taken in the light of consultation.

OCTOBER

RHAs will summarize comments they have received during the consultation period. Those comments will be sent to the Secretary of State and they will be made available to the public.

CRITERIA FOR TRUST STATUS

In reaching a decision on each application, the Secretary of State will look in particular for evidence that the proposed Trust will deliver tangible benefits to patients and improvements in the quality of the services it provides; that the proposed leadership and management arrangements are satisfactory, that key professional staff will be involved directly in management; and that the Trust will be financially sound. The Secretary of State will base his decision on each Trust application on full consideration of its implications for NHS services in the locality.

The assessment of Trust applications will not be a mere formality. Some units may not be in a position to take on the greater freedoms and responsibilities of Trust status. In such cases it will be in the interests both of the wider NHS and of the unit concerned for it to take more time to do what is necessary to be ready for Trust status.

GRAND FINALE - OCTOBER/NOVEMBER

The Secretary of State announces which applications have been accepted for NHS Trust status.

NOVEMBER 1990 - APRIL 1991

There will be a great deal of work to be done in the period between Trusts being established and their becoming fully operational. The units concerned will need to work with health authorities to arrange the transfer of staff and assets to be managed by the Trust. The Trusts will therefore run in shadow form before they are formally constituted in April 1991.

The Secretary of State will appoint the Chairman. With the relevant Region he will appoint the remaining non-executive directors. The Chairman and the non-executives will then appoint a Chief Executive, who in turn will appoint the other executive directors.

1 APRIL 1991

The newly formed NHS Trusts will start operating.

Conservative Medical Society

VALUE FOR MONEY IN THE NATIONAL HEALTH SERVICE

By

ROGER FREEMAN, MP

With a Foreword by
The Rt. Hon. Kenneth Clarke, QC, MP,
Secretary of State for Health

New Series No. 1

Roger Freeman has been MP for Kettering since 1983. He was Parliamentary Under Secretary of State for Health between December 1988 and May 1990 and is now Minister of State at the Department of Transport. The pamphlet was written whilst Mr Freeman was a Health Minister.

THE CONSERVATIVE MEDICAL SOCIETY

The Society is an independent body, founded in 1975, that has built up a considerable reputation in the health field and is the only important Conservative association dealing solely with health care. The three main aims of the society are to promote:

* the care of patients as the top priority in the health services;
* the concept of individual freedom of choice in health services;
* professional freedom as the greatest safeguard for achieving high standards of treatment for the sick in the National Health Service.

In order to achieve these objectives the Society:

* acts as a centre for discussion;
* develops new ideas in the health field;
* advises the Conservative Party and Government on matters of health and related services;
* spreads knowledge of Conservative principles and policies in health care.

THE CMS AT WORK

The Society promotes the views of its members through its publications, the annual Symposium, the Speakers programme, seminars and regular meetings with Ministers.

The "CMS Bulletin" is produced six times a year and is sent to all members. It carries articles as well as information on important topical events.

Pamphlets and papers are written by individual members and published by the Society.

The annual Symposium has become a notable and widely-covered event in the medical calender. Traditionally it is addressed by the Secretary of State for Health as well as by the Minister for Health.

A Speakers programme and seminars enable members to hear and to question prominent people in the health field.

MEMBERSHIP

Membership is available to anyone who supports the aims of the Society and has a professional qualification in the field of health care. Associate membership is available to any Conservative supporter with an interest in health.

Those wishing to join the Society or to learn more about it should write to: The Administrator, The Conservative Medical Society, 32 Smith Square, London SW1P 3HH. The annual membership subscription is £15.

CONSERVATIVE MEDICAL SOCIETY

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SECRETARY OF STATE FOR HEALTH

CONTENTS

VALUE FOR MONEY IN THE NATIONAL HEALTH SERVICE

FOREWORD

by the Rt Hon Kenneth Clarke QC MP, Secretary of State for Health

This pamphlet is about our plans to achieve better value for money in the National Health Service by improving financial management. By value for money we mean getting the most economic, efficient and effective use of resources. We are firmly committed to a public health service which is largely financed by taxpayers' money and provided free to all. But with any free health-care service there are inevitable pressures of almost infinite demand, so it is vital that we get the best possible use of finite resources, which of course we have ensured will grow year by year.

So better financial management of our near £30 billion budget for the NHS in the UK will help us treat more patients and continue to raise the quality of care and treatment. Given more choice and flexibility in the flow of resources in the NHS, I strongly believe that good quality health care will be sought out by GPs and patients and that this process will encourage the best and challenge the second-rate to improve. Better financial planning will also enable hospitals to abandon the bad tradition of ward closures at short notice half-way through each year, usually caused by increases in demand for non-emergency work getting out of step with planned resources.

Our proposals for better financial management will bring to the NHS the modern tools of good management practice used in other great enterprises and help us obtain better value for money. Why should we deny ourselves these benefits? We shall not be introducing an unnecessary army of accountants or excessive bureaucratic paperwork but we will prudently increase our expenditure on financial management training and modern information technology.

Above all, we will not lose sight of the vital need to promote quality. We will insist that management strives for improved quality. We will require that contracts include provision for quality measurement. We will help doctors improve their procedures through medical audits, and we will give patients greater opportunity to insist on better quality of care through greater choice and to register their views and complaints if quality is compromised.

Our aim is therefore clear - to get even better value from NHS resources which will always be finite however rapidly we increase our spending. This will mean wider use of the best modern management techniques and disciplines. The Government plans for reform of the NHS are not foolhardy or over-hasty. They represent pragmatic progress making the most of the NHS's existing experience and practices.

May 1st, 1990.

SUMMARY OF KEY POINTS

1 The NHS has relatively good cash control mechanisms but under- developed financial management information systems. Clinical responsibility is not generally aligned with budgetary responsibility.

2 Implementation of the White Paper "Working for Patients" proposals will be an incremental process, building on existing information systems, and allowing contracting to become more sophisticated over time. Many early contracts between the purchaser (District Health Authorities) and the main local provider (the District General Hospital) will be simple "block contracts" specifying the need for a quantity of health care to be provided; essentially a capacity agreement.

3 The NHS now has a comprehensive set of information in the new Korner data (named after the adviser who recommended it) used to produce comparative performance indicators. This data will help contracts to be set and monitored from 1991/92.

4 For 1991/92, districts will be funded according to the existing use of services by their resident populations and allocations will begin to move towards a weighted capitation basis reflecting the size, age and health structure of populations. Contracts in 1991/

92 will broadly reflect existing referral patterns so no great upheaval will result. Contract prices will be based on allocating direct and indirect costs to the services covered. The aim will be for the prices to reflect full recovery of these costs.

5 The new contracting system will drive the need for better information technology. The NHS is relatively unsophisticated in IT. The Department of Health is studying development of properly integrated IT Systems in the NHS, to allow the linkage of all parts of the service. GP's have a programme of financial assistance for introducing IT help. The development of IT in the NHS will not be at the expense of patient care.

6 The system of capital charging will, for the first time, put a consequential price on new hospital building thereby requiring proper provision to be made for maintenance. This system will encourage a properly balanced decision to be made between investment and refurbishment.

7 Resource Management is separate from, but complementary to, the move to contracting to be introduced in 1991/92. The so called 'Resource Management' scheme is essentially about involving doctors more in the management of scarce resources. The necessary information systems to provide doctors with clinical data on patient activity and care is funded by the Department of Health. The success of Resource Management depends crucially on the goodwill of, and use by, doctors. It is for their benefit and that of their patients. The success of contracts also depends for providers of, course, on the commitment and involvement of medical staff. This will be crucial in the area of quality specification. Resource Management will provide important lessons in this respect.

8 Compulsory competitive tendering for certain non-clinical activities has already saved some £110 million cumulatively, all ploughed back into patient care.

9 The private sector has a role to play in working with the NHS in achieving better value for money. Examples include possible capital investment schemes; income generation; and jointly used facilities reaping the benefit of economies of scale.

10 NHS Management must monitor and review performance to ensure we are always achieving the best possible value for money.

INTRODUCTION

The National Health Service is a large enterprise by any standards with over one million staff and a UK budget of nearly £30 billion. One of the basic principles of the White Paper "Working for Patients", published in January 1989, is that by improving the financial management of our finite resources, we improve in turn the quantity and quality of health care available to meet constantly increasing demand. Better financial management is not a substitute for increasing taxpayers' expenditure on health care; it is now an essential requirement for a great and dearly loved British institution over 40 years old and showing its age. Of course, the more efficient use of health resources is not the only objective; we have to improve the quality and effectiveness of clinical care. Costs are not a poor distant relation, they are a close part of our family of concerns.

How are we setting about improving financial management systems and building on the solid foundations of the Griffiths' general management reforms of the early 1980's? First, we plan to build upon the Resource Management Initiative in 1986. What is Resource Management? Essentially it is about involving hospital clinical staff, particularly doctors, in the responsibility for managing resources. One way of achieving this is to follow the model used at Guy's Hospital, London, of establishing clinical directorates. This gives a consultant lead responsibility for managing a department and gives him other budgetary responsibility and nursing and administrative support to do so. Six pilot sites have introduced the initiative over the last few years and now 130 more hospitals have joined them in the scheme to be followed by the remainder of the 260 major acute hospitals in England. It is a long road but the Government will provide extra cash to develop Resource Management. A major part of the cash is for the computer based clinical information and nurse management systems which give clinicians the information they need to manage. In the end, with the co-operation of the doctors, clinicians and other health service professionals, we shall be able to give clinical decision makers responsibility for their budgets.

Second, at the heart of the White Paper proposals is the costing system for hospital activity. Upon a more robust and workable costing system we intend to build the contracting system and the pricing of services. The House of Commons Social Services Select Committee Report of July 1989 recognised this but doubted whether we could introduce the benefit of a contracting system, with resources following patients across district boundaries, because of limitations in our existing costing systems. We recognise a lot needs to be done but we wish to keep contracts simple. Most patients will continue to go to their local hospitals and the district health authority will be placing a "block contract" for most of these services which will simply be a more formalised expression of the budget normally set. Certainly block contracts will be crude but they will also provide the opportunity for better monitoring of achievement and a clearer indication to management and clinicians of what is being required in terms of output for a given amount of money. They will be the vehicles for explicit agreement about quality and, to the extent possible, outcome measures.

Some contracts will have to be more precise; there will be specific contracts for a given number of patients for a given speciality service like hip replacement. Hospitals should be able to set local standardised costs and hence prices for such work. The information on costs for such an initial contracting system in 1991/92 will be based upon our existing information systems. Only over time will more sophisticated costing systems allow specific individual patient costing to be introduced.

A frequent question asked of Ministers is whether the White Paper proposals will require an army of accountants and involve a sea of paper. No. The NHS employs some 11,000 finance staff of whom 3,000 are really in financial management. About 40% of the latter are qualified accountants. Some health service managers forecast a need for up to 1,000 additional financial management staff, or on average about 5 per district. This is of the right order of magnitude. Set against the million NHS staff, it is a reasonable, affordable and achievable increase. We are anxious to develop the finance function in the National

Health Service and have provided significant extra cash for training and recruitment.

Is all this effort worthwhile? Emphatically yes. The extra costs, to be provided on and above increasing resources for patient care, will be repaid relatively quickly in savings, principally in staff time. A bigger and better NHS will come about not only with extra taxpayers cash but with better financial management.

1. PRESENT POSITION OF FINANCIAL MANAGEMENT

The introduction of the first Griffiths general management reforms in the early 1980's was a first step in enabling financial managers to play their proper role alongside general managers in running health authorities. Indeed proper management of the health service needs an integration of clinicial, financial and general management. But the process is not yet complete and financial managers sometimes show their "treasurer" roots too much. Obsession with in-year cash management can dominate the budgeting process, saying "no" rather than "this is how". The best are fully integrated into the management team and support the decision making process with timely, relevant information. Not enough of the best yet exist.

There are good financial control systems in operation at present - authorities generally do stay within their cash limits, but management information systems tend to be underdeveloped. Budgets and monitoring too often focus on cash, and functional budgets have little or no relationship to activity. This is because budgetary systems are not aligned with the responsibility for committing resource held by the doctors. This weakness has been long recognised but only with the Resource Management has there been any prospect of real change.

The National Audit Office report of July 1989 "Financial Management in the National Health Service" aptly commented; "Accountability demands sound financial management served by modern financial and cost accounting systems" (Conclusions, paragraph 8).

The House of Commons Social Services Select Committee published its eighth report "Resourcing the National Health Service" in July 1989. The Committee's main concern was over the pace rather than the direction of the NHS reforms. Indeed the Committee shared a significant degree of common ground with the Government not only in the need for reform but on the details of policy. They maintained, however, that the Government was trying to introduce the contracting system too quickly without adequate costing information and other infrastructure necessary for a market approach.

The Government believes the Select Committee has not taken sufficient account of the Department's approach to implementation. We are not aiming for an overnight transformation of the NHS. Implementation of the White Paper proposals will need to be an incremental process, with many of the reforms continuing to evolve well into the 1990's. Subject to any necessary legislation, the aim is to have the central elements of the White Paper in place by April 1991. Good progress is being made to this end, assisted by a considerable number of projects throughout the country to develop workable information, financial and management systems. This will enable the introduction of the first NHS Trusts, the first GP fund holding budgets and the new contractual arrangements in April 1991. These reforms will be refined and evolved throughout the decade. The experience of the first NHS Trusts and of fund holding by GP's will influence subsequent development of these programmes. Similarly, the system of contracting for services within the NHS will initially operate largely on the basis of existing information systems. To begin, the Government expects most services to be provided under block contracts which give access to a defined range of services for an annual fee. In their simplest form, these contracts therefore closely resemble current arrangements whereby DHA's give their hospitals budgets and these block contracts can be supported by relatively simple information and costing systems. As the experience of the NHS with contract funding grows, authorities will wish to develop their costing and information systems to support more sophisticated forms of contracting.

2. OUR EXISTING INFORMATION SYSTEMS

Some ten years ago the Steering Group on Health Service Information was set up under the chairmanship of Mrs Edith Korner. The group reviewed the entire range of data

collected in the NHS and made recommendations about reforming the flow of statistics into those essential to a modern service.

Data is not just calculated for management purposes but also for broad public health uses. This covers not simply epidemilogical information but also data to help us analyse and evaluate health outcomes.

The first year of the new data flow was 1987/88 and the results for all district authorities have been published. Although we now have a comprehensive range of data including speciality-based units, the time series only really effectively commences in 1987/88 as direct comparison with earlier years is difficult.

Performance Indicators, based upon the Korner data can now be produced for about 400 different kinds of health care service. These range from the proportion of day to in-patient surgery, right through to the cost per consultant episode for different categories of acute care. The Department of Health circulated details in July 1989 of the different values of the main Indicators, showing the range of values for all 190 English district health authorities.

We are keen to see Health Service Indicators more widely used in discussions about health care services. Analysis of variations between authorities can only improve our understanding of the way resources are being used and the opportunities for improved management. The critical examination of performance as a routine part of service management will be particularly important in future for those hospitals providing, and district authorities purchasing, services in order that the performance can be judged either in deciding where to place a contract or in monitoring a contract.

In the past, Indicators have also been used to compare figures for the same authority over time. In the booklet, "Comparing Health Authorities", published by the Department in March 1988, examples were given of this type of analysis. The Indicators listed in the new booklet in July 1989 are the first to be based on the new statistics produced as a result of the Korner review of health service information. This set is therefore not directly comparable with those for earlier years. Comparison between years can begin properly with the publication of the Indicators for 1988/89.

In addition to the creation of performance indicators, the Korner information data sets can serve as the basis for the new contracting system. Market economies require much more information to work effectively than command economies. NHS managers need speedy access to sound information. Large and complex organisations need to invest substantially in information and information technology systems.

But there is a relatively low level of sophistication of computer based information systems in acute hospitals. Existing systems covering patient data, payroll, and personnel records, were largely installed as part of the implementation of the Korner recommendations on health service information. Such systems are often District orientated since the Korner Group was concerned with the information needed by district management.

Therefore, at the start, existing Korner cost systems, particularly specialty and departmental costs, will be the basis for setting prices for services. Broad costs of this nature should be sufficient to negotiate block contracts at least for the first year.

There is currently a Korner minimum data set which all hospitals collect. Subject to a few important changes it will suit post-Review purposes well. Of course, some hospitals, will have more detailed and sophisticated knowledge of costs in particular specialities. They will be better placed for contracting. Whilst the changes required to Korner systems will not be substantial, there will need to be amendments to Patient Administration Systems and for the Korner information systems they feed. Authorities will need to be prepared for these changes. Some of the vital information needed to make contracting work include the home address of the patient (so the hospital providing the service will know which district health authority to charge), together with an indication of diagnosis and treatment category. The data set will also have to identify the contract

number and the provider number.

An objective for the longer term might be to have a single NHS patient identification number which could be used throughout the departments of a hospital, and indeed in all parts of the NHS. Too often at present we are collecting information about patients without necessarily having the means of collating it when needed. In the longer term, we could move to a system whereby NHS patients carry a plastic magnetic card recording vital registration data and they could produce this whenever health care is provided.

An important change to our procedures for gathering information is to concentrate on collecting data about the care of residents in a district, rather than those treated in a district. We plan to have districts collecting patient data, based on residency basis, by 1993, thereby completing the shift of responsibility of districts to care of residents rather than managing district activities.

It is envisaged that district information systems will need to:

* maintain information about district contracts, including prices and performance of all potential providers, to ensure the best value for money.

* hold minimum data sets about residents from which national Korner and other requirements can be satisfied.

* in the longer term linking to a master patient index, to link child health, immunisation, vaccination, screening, health education, recall and disease prevention programmes.

Some systems will also enable districts to fulfil their new role of assessing local health needs and performance in meeting these needs.

The Department of Health will take the lead in ensuring that the NHS only generates the minimum information needed. The Department is set to reduce its own demand for data. By July 1990 the Department will have completed the first stage of a complete review of data at present requested from districts and hospitals. The aim is to reduce significantly the data collected centrally. In setting out our requirements for data needed in the future we must ensure that we keep this to the absolute minimum.

3. MONEY FOLLOWING THE PATIENTS: THE NEW CONTRACTING SYSTEM

From April 1991 health authorities will pay for the treatment received by their residents in hospitals - whether the hospitals are situated within the district or not. Money will go to where patient activity takes place. If quicker or better service is available in non-local hospitals, contracts can be written so that patients will be able to take advantage. They will not, of course, be forced to travel and their doctors' judgement of the right medical treatment will remain of crucial importance. But for a number of patients with some illnesses there will be genuine choices to be made. Our new contracting system will help to give real effect to these choices.

NHS Trust Hospitals will have special financial and managerial freedoms. They will own their own assets and be able to borrow to acquire new ones. They will, however, remain fully a part of the NHS; their income will depend to a very considerable extent on their contracts with NHS health authorities.

Contracts will replace the system of hospital budgets that currently exist but we should not see this, at the outset, as a major change. Most contracts - so called block contracts - will evolve out of the budgets which are already a part of our financial systems but they will specify more precisely what is covered and who bears the responsibility for unforseen changes. These contracts will not be full legal documents but will be formal agreements between authorities and hospitals: some authorities have already been moving this way anyway. To achieve contracting in 1991 we will use the information systems we already have: there is no need for sophisticated information systems. As the new Resource Management information systems become more widespread and as doctors and managers become more familiar with handling this detailed patient-based

information, so the contracts will develop, becoming more specific and detailed themselves.

Some doctors in general practice will have the option to hold their own budg[redacted]. We believe that doctors are the right people to decide what is best for their patients and that giving them budgetary responsibility will encourage them to obtain the best value for money for their patients overall. The budgets will apply to out-patient treatments and certain elective surgery, but will not apply to the cost of hospital care for any one patient in any one year above a certain maximum sum - we have suggested about £5,000.

From April 1991, revenue resources will be allocated to district health authorities on the basis of the use of services by their residents. This contrasts with the present system whereby districts are funded on the basis of the services provided within their boundaries. This is a significant change from funding existing activities to providing funding for residents to use on services. Over the next few years districts will move to a more automatic and fairer basis of allocation, with weightings given to their relative resident population's demography, morbidity and other factors deemed relevant by the regional health authority; these might include the extra costs of purchasing services from higher cost providers in other districts, for example, Central London.

The financial reforms are very far-reaching but they will be introduced on a pragmatic basis. Contracts, and the level of detail in them, will evolve as information systems evolve. We are not expecting a major upheaval in the way in which referrals take place in 1991 but are trying to create better systems which will exert pressure towards greater efficiency for the benefit of patient care in the longer term. So in the first year of contracting in 1991/2, we expect to see contracts generally reflecting existing referral patterns. District authorities will need to understand where and why patients are being referred by their local GP's. Changes to these referral patterns can then be considered, if warranted, but only with the benefit of proper medical advice. Several authorities are already carrying out their own experiments, for example setting up contracts between authorities and hospitals. In Cambridgeshire the local districts commenced pilot inter-district contracts in October 1989. We will encourage these trials and hope to be able to disseminate the practical experience gained for the assistance of authorities generally. The Department, in February 1990, published guidance on contracting, including examples of specimen contracts already drafted.

It is very important that the prices that NHS hospitals set are fair. In some cases hospitals will be in a dominant position and it may be tempting to abuse that position. Hospitals must not operate predatory pricing practices to eliminate, for example, local private sector hospitals or other NHS hospitals. Hence we will be working towards a system of allocation of cost rules to ensure that hospital charges are fair to all kinds of NHS buyers and for different kinds of treatment. It is also important to ensure that GP practice fund holders, who will not be large in terms of economic strength, will be able to buy from NHS hospitals at fair prices relating to underlying costs.

We will be providing further guidance on costing and pricing policies. We have already provided further guidance about contracts and the prices in contracts will be publicly open to scrutiny. Costs will be based normally on the full allocation of expenses, not just at the margin, and there will be no planned cross-subsidisation. There will, of course, be occasions when short-term marginal capacity can be used to the benefit of hospital and district. It is up to audit and sound management and financial practice to make sure that the occasional and short-term availability of marginal costs is not abused.

It is vital to preserve postgraduate and undergraduate medical and dental education and a high quality of research as an investment in the future of patient care. Therefore, all these need to be covered and maintained under the contracting system.

"Knock for knock" has worked well for many years. This is a system whereby medical teaching schools and associated hospitals effectively cross-subsidise each other. In effect, it assumes that the benefits that hospitals receive from the associated medical

schools are roughly counterbalanced by the benefits that those medical schools get from acc[redacted]to the NHS facilities. But we do not know whether this system will stand the test of[redacted]. In the past, it has been said that insufficient information has been available about the costs involved in "knock for knock" arrangements. That may well be true and we are currently trying to find this out by further study.

In any event, as hospitals costing systems become more sophisticated, it is quite likely that all involved will want to identify with more precision what both sides give and receive. Regional health authorities will be playing a key role in the introduction of the market. They will be ensuring that health authorities are open about the contracts that they have entered into so that information on prices is widely available. They will also need to ensure that individual hospitals are in a position to apply the costing and pricing rules properly.

In a relatively simple system, workable by April 1991, we expect that many authorities will be framing some contracts in the form of block contracts which effectively purchase hospital capacity for local patients. These block contracts are quite likely to account for the great proportion of the activity of hospitals, except for some of those which have high volumes of referrals from outside their locality (largely the teaching hospitals). For this great bulk of the work, therefore, the simple system which will evolve out of the existing budgeting process will provide the necessary initial financial stability. Block contracts are essentially defining what capacity a hospital should provide but the contract should set targets for patient workload within the capacity financed. The benefits of Cost Improvement Programmes will be assumed under contracts when setting the aggregate price to be paid. These programmes are already saving some £150 million pa and cumulatively have saved over £1 billion. We expect district authorities to place as many contracts as possible in 1991/92 direct with hospitals, even those outside the home district which are not NHS Trust hospitals.

Similarly, we will be developing simple systems to fund supra-regional services based on the level of costs which should be met by central payment and the level of payment which should be met by referring districts; the principal aim here is to ensure that when money does follow a patient, it genuinely allows additional activity to take place.

For those parts of activity which are not covered by block contracts but are covered by "cost per case" contracts on an individual basis, we expect hospitals to be working with existing information. The district health authority will be specifying the output of health care rather than the input (ie capacity) under the less sophisticated "block contract". All hospitals have specialty costs and all hospitals have the ability to work out the cost of particular procedures or the cost of a day's stay in hospital. These are the basic financial building blocks that are available to all hospitals. While this might not represent the most sophisticated approach to contracting which we expect to see emerge during the 1990's as resource management systems come on stream, it will be perfectly adequate to allow authorities to move into the contractual environment in 1991.

It is important to stress that we are not proposing to introduce an individual patient costing and billing system which the USA hospital system employs. We need to calculate some individual costs for work done outside block contracts, in for example cost per case contracts, but these can be based on local average specialty costs. We have no plans for a regional tariff of acceptable costs as the American Diagnosis Related Group cost system entails.

During 1990 we shall be advising district authorities on the various forms of contracts and costing methods which the Department is developing with the aid of local trials.

4. INFORMATION TECHNOLOGY

The reforms outlined in "Working for Patients" will assist in integrating the NHS. There will, for example, be better links between primary and secondary care. District health authorities will need to work closely with GPs to take account of their views when

agreeing patterns of provision. GPs holding their own funds for elective and diagnostic services will be involved in direct transactions with hospitals.

These changes come into effect in April 1991, and health authorities, hospitals and GP practice fund holders will need to be ready for them. In the first instance, block contracts will predominate, but with experience contracts will become increasingly sophisticated. To reap to the full the considerable benefits of these changes, the NHS will need to make major progress in such matters as the letting and management of contracts, the definition and measurement of quality of care and costing and resource management. To do all this they will need improved information systems and investment in technology to support them. The new contracting system will drive the need for information technology.

Spending on computing in health authorities has risen from £36 million in 1983/84 to around £130 million in 1988/89 and some 2,500 staff are involved in its work. This very considerable resource indicates the priority which we - and health authorities themselves - have given to information and IT in managing the delivery of health care. Computerisation is not, of course, an end in itself. District health authorities and the family practitioner services need to base IT developments on careful assessment of their information needs and the best means, clerical or IT, of meeting them. We expect the development of IT to be an evolutionary process.

The past developments in IT already complement the general direction of the proposals in "Working for Patients" and the IT systems now in use in the NHS provide a firm base on which to build. For example, the new arrangements for contracting for services in the NHS, which will be introduced in April 1991, will initially be able largely to operate on the basis of existing information systems. In the longer term, as more sophisticated forms of contracting develop, we would expect changes in the information which is needed and the way it is provided. We believe that IT will have an important role in supporting such developments.

We believe strongly that IT systems can benefit patients, not only by making NHS administration more efficient and by helping healthcare professionals to manage their resources better, but in more direct ways, such as the Eurodiabeta project at St Thomas' Hospital, which is developing better management of care for diabetics.

In addition to the £130 million expected to be spent direct by health authorities in 1990/91, the Department of Health will be funding approximately a further £100 million in IT support in 1990/91 for the Hospital Resource Management Systems and Hospital Information and Support Systems.

We have made funds available to enable the two Hospital Information Support Systems (HISS) projects in Darlington and Greenwich to move ahead towards completion and for work to continue on the Nottingham HISS project - which is using new methods of specifying and designing hospital computer systems. We shall also fund other projects in this field in 1990/91 to broaden our experience both in achieving integrated systems and in obtaining the maximum benefit from them. Nearly every large acute hospital in England already has at least some form of computerised patient administration system. An integrated hospital IT system would link this to new and existing systems, for example in pathology laboratories and pharmacy, to form one comprehensive hospital system.

District health authorities, too, will need information systems to help them carry out their new functions, such as placing and monitoring contracts, and most importantly, assessing the health needs of the population they serve.

Although we are intending to fund a number of different initiatives at sites throughout the country, we will take steps to ensure that the money is spent in a coordinated way, irrespective of the level at which the initiative takes place. We also believe that the NHS could make more use of its considerable purchasing power to get even better value for money in IT and we will be taking steps to encourage this in concert with the NHS Procurement Directorate and the Centre of Responsibility for Computer Procurement

based with the South Western Regional Health Authority.

We are well aware that information systems require expertise - people to design, build and operate them, as well as to use the information they produce. These people need training and we have established a number of centrally financed projects - some £4.5 million will be spent over the next two years - to build up a training infrastructure for information management and technology in the NHS. As the need for exchange of information between different parts of the Service grows, there will be increasing need for an electronic network which facilitates this exchange. This will, of course, require careful planning to ensure acceptable common standards of coding, message format and communication. The Department has recently entered into negotiation for a private network for the NHS under the umbrella agreement between the Central Computer and Telecommunications Agency and Racal Data Networks Ltd for the Government Data Network. The first links to the network will be between family health service authorities (FHSA's) and the newly computerised NHS Central Register, starting in mid-1990. Thereafter it is planned to link other FHSA administrative bodies and those FPS practitioners with computer systems meeting the required communications standards. We expect this FPS network to evolve over time to be capable of handling most of the needs of the wider NHS.

At Northampton District General Hospital, the NHS is trialing the linking of different hospital systems and general practice through what is called the 'Open Systems Interconnection project'. OSI is a set of international standards, intended to permit the interconnection of IT equipment from different manufacturers to enable them to work with each other.

FHSA's are already working to improve the quality of the data they hold - data which will assume an increasing importance in a contractual environment. The management information requirements for FHSA's arising from "Promoting Better Health" have been examined and work has begun to develop some of the information systems required.

As far as IT in GPs' practices is concerned, the Government have already made clear that it is backing moves towards more and better computerisation. Quite apart from the importance of IT to link family doctors to family health service authorities and hospitals, we are keen to encourage them to use computers to secure clinical benefits for their patients, to provide a wider range of services and to manage their practices more effectively. Computers can be used to facilitate repeat prescriptions, patient registration, call/recall screening, and clinical record-keeping. To encourage this, we announced earlier this year that, from 1 April 1990, GPs will be able to claim 50% direct reimbursement of their computer maintenance costs, the balance to be reimbursed indirectly through the setting of general fees and allowances. In 1990/91, additional resources amounting to £24 million will be made available for computerisation in general practice. From 1 April 1990, all GPs will be able to claim 50% direct reimbursement of the costs of purchasing, leasing, and upgrading their computer systems, together with 70% of the initial staff costs of setting up the systems. The balance of these costs will be reimbursed indirectly. These allowances will be subject to upper limits based on a sliding scale according to practice list sizes and will take account of systems obtained in 1989/90. These measures will enable about half of all practices to be computerised by the end of 1990/91. We expect that almost all of the larger practices eligible to become fund holders will be computerised by the end of 1991.

The wider use of computers in general practice will be of enormous value, enabling busy GPs to keep summary medical records, accessed by desk-top terminals. Information can be stored on medical history, drugs prescribed, health checks and hospital diagnosis results. Ultimately hospitals should be able to send computer data direct to the GP's so speeding up diagnosis and smoothing the path to recovery after discharge. Computers will help GPs discharge their new wider responsibilities for health screening. However, the introduction of computers is expensive in terms of skilled staff and time

needed to master new systems. Systems need to be as "doctor-friendly" as possible so as to convince as large a number as possible to introduce them and use them fully.

We have also set aside funds to develop and pilot systems to provide GPs with information on waiting times for hospital treatment. This, together with other information relating to availability, cost and quality of service, will enable them to refer their patients to hospitals which provide a good quality service in a reasonable time.

As well as information about their patients and practices and the contracts held by their DHA, GPs will also require information about their prescribing costs. This will help them to monitor expenditure against their indicative prescribing amounts. We are funding the changes necessary to provide them from the enhanced Prescription Analyses and Cost (PACT) system being developed at the Prescription Pricing Authority. All GPs will be able to monitor such information without computer assistance but, over time, information technology will be of growing assistance in this field.

The NHS spends about 1% of its total budget annually on information technology. This is quite a lot of cash - some £130 million in 1988/89 - but how does it compare with what others are spending? In the United States the figure is about 6% of health care expenditure, the European average is between 2% and 3%, with Finland planning to increases its expenditure on IT to 3.5% of its total budget by 1992. Judged by comparisons with other industries UK expenditure is also extremely low. Banking, for instance, has an average spend of about 6%.

Computerisation is not an end in itself. Health authorities and professional health staff are using computers to provide better information which enables the delivery of a higher quality, more effective service to patients. And NHS IT expenditure plans will not be at the current expense of improving patient care.

5. CAPITAL CHARGES

We propose to introduce a new system of accounting for the consequences of capital expenditure (through a depreciation charge reflecting the wear and tear of capital assets), and for the funds tied up in holdings of capital assets (though recovering a positive real rate of return on the assets employed).

Capital charges for hospitals represent an annual sum of depreciation (excluding land) and interest, initially at 6%, on the current value of all assets. The charges are payable by hospitals to the regional health authority which will re-allocate the full total received to districts in revenue allocations. Over time the amounts paid by a hospital may differ from the amounts received by the district in which it is situated because the revenue allocation to districts will depend on the number of residents in the district concerned, while the capital charge depends on the value of the assets of the hospital.

NHS Trusts will depreciate their assets but they will retain, rather than pass on to regional health authorities, the depreciation flow in order to replace the assets. The depreciation charge will however be reflected in total costs. These hospitals will also meet a financial target, initially of 6%, on the current value of their assets. Their prices will thus reflect both depreciation and a 6% return. NHS Trust hospitals will therefore be calculating their prices on the same basis as directly managed hospitals and also the private sector.

The opening capitalisation of NHS Trusts will be made up of loan bearing debt and public dividend capital (more like equity) and the total of the two will be equal to the current value of the assets they take over. Interest and public dividend capital payments on the capitalisation of NHS Trusts will be made to the Treasury.

The advantages of the system are:

(1) The true cost of new capital investment will be revealed, compared with, for example, refurbishment and maintenance of existing buildings. Henceforth, new capital schemes will carry an on-going financial commitment for capital charges - unlike the present system where there is no difference drawn between capital and

revenue. This charge on capital assets should enable management to make more informed judgements between new investments and better maintenance of the existing stock and hospital buildings.

(2) There will be an added incentive to release surplus assets as these will reduce annual capital charges.

(3) Over time, district health authorities will take into account, when placing their contracts for services in hospitals in high land value areas, the comparatively higher cost of so doing in comparison to cheaper financial costs in lower land value areas. District health authorities, which have high cost hospital services for specialities which must be provided locally, will be funded by regions for these comparatively higher, unavoidable, costs.

Arrangements have been made for District Valuers to value all NHS land and buildings as at December 1989. This work commenced in September 1989 and valuations will be completed in time to enable the capital charges scheme to become operational and be based on open market values for hospital use. No assumptions will be made about the value of land for alternative redevelopment. Other assets, including plant and equipment in buildings, will be valued by health authority staff,using guidance and data being supplied by the Department of Health.

6. RESOURCE MANAGEMENT: DOCTORS IN MANAGEMENT

The Resource Management Initiative was launched in 1986 prior to the NHS White Paper. Stripped to its bare essentials it can be expressed as comprising two elements:

1 The involvement of doctors and other clinicians in the management process.

2 The provision of information which supports both clinical and general management.

It is no more than this. It is not about particular Information Technology (IT) systems, though there is a minimum requirement for IT support to produce the information needed for clinical and general management purposes. Resource Management has been introduced in a number of ways at the first six pilot sites. For example, at Guy's Hospital and Arrowe Park Hospital, Wirral, emphasis is placed upon introducing clinical directorates whereby, in each major speciality, clinicians supported by nurses and administrators manage budgets. At other sites such as the Royal Hampshire Hospital, Winchester, an integrated computer information system supports an existing but developing, clinical management system.

We would have implemented Resource Management regardless of the White Paper which succeeded it. This is because Resource Management is at the heart of good management in hospitals. All hospitals, whether NHS trusts or not, need good management systems in both financial and operational senses, and all major acute hospitals will be brought within Resource Management by April 1992. Of course not all hospitals will have fully implemented Resource Management systems by then, but they will have started the process.

NHS hospitals will want the best operational and financial systems in due course but provided that their basic management arrangements are currently sound, they will be candidates for trust status whether they have introduced Resource Management or not. Thus the Resource Management and NHS trust initiatives are separate.

The Resource Management is closely linked to medical audit which relies on clinical data about individual patients. The Resource Management systems feature a "case mix" database which stores details about individual patients and groups it to provide information on activity. Medical audit needs some data which is not needed by Resource Management, but medical audit systems can sit alongside the case mix database or be integrated into it (depending on the particular IT solutions chosen by the hospital). Until Resource Management systems are widely available, medical audit will rely, as it has done already where it is in operation, on smaller scale data capture systems.

Also Resource Management is not about Diagnosis Related Groups (DRGs) though

the initial pilot sites are experimenting with these as a way of grouping the large numbers of codes used for diagnoses and operations (10,000-20,000) into a smaller number of around 470. This is an interesting area but we still have an open mind on the overall usefulness of DRGs. The introduction of Resource Management depends crucially on the goodwill of the doctors. The system is designed for their assistance. The clinicians therefore have an interest in making sure that the data used is accurate and that patient activity codes are carefully assigned. They also will decide what minimum useful output data are needed. They literally will "own" the data and this will be the best guarantee of its accuracy and value.

We agreed back in 1986, when the Resource Management Initiative was launched with the agreement of the Joint Consultants Committee (JCC), who are the major representative group from the Medical Royal Colleges and the British Medical Association, that we would evaluate the initiative in terms of whether or not it had achieved its objectives. The principal objective was to see whether Resource Management results in measurable improvements in patient care with subsidiary objectives directed to providing information for clinicians.

We are now discussing with the JCC what form our joint evaluation will take. Evaluation is perhaps the wrong word as it implies that we will be reaching a final and absolute judgement on Resource Management. In practice we will be seeking to establish what lessons we have learned from the six pilot sites to inform the process of extending Resource Management. Evaluation will not be about whether to proceed but how best to do it. The White Paper contained the Government's commitment to extend Resource Management to all 260 acute sites by April 1992, and there are few who seriously disagree with the objectives of Resource Management. We will expect the guidance that emerges from our evaluation to be taken into account in the next phases of Resource Management. We have announced a total of 130 hospitals which are now within the Resource Management programmes, 20 of which have already progressed to full Resource Management systems.

The centrally paid costs of the programme to date have been £33 million in 1989/90 and will be £80 million in 1990/91. Each hospital will, of course, have extra revenue costs associated with introduction but these must and will be recovered quickly through savings in staff time. Nurse Managers have already found savings in using staff more efficiently under the Nurse Management Systems and junior doctors need spend less clerical time summarising patient activity reports as they can be reproduced quickly by computer.

Resource Management is therefore about involving doctors in management. If they are to realise their full potential by being involved in the management process, doctors need some managerial skills to complement their medical ones. The Government has recently launched a scheme designed to give doctors the opportunity to take part in senior management training outside the NHS in business schools. This scheme is funding 100 places on an experimental basis in 1990 and we hope to learn from this how best to enhance doctors' wider management skills. Such residential courses of about four weeks each also involve senior managers from outside the health service, so that both groups can benefit from each other's experiences.

As the National Audit Office commented in July 1989 in its report on Financial Management in the NHS, "The NHS does not yet have costing and information systems, which identify the cost of treating individual patients and thus allow budgets to be aligned with clinical responsiblities" (Para 2.11). Resource Management has a key role to play in enabling current costs to be attributed to a clinical activity.

Resource Management will in due course give hospitals a lot of detailed information about the actual treatments received by individual patients and this will assist the development of sophisticated contracts. To begin with, of course, contracts will be largely block contracts and detailed costings will be needed only for a small amount of

patient activity. In those cases, existing information (for example, specialty costs) will prove adequate. But in due course the Resource Management will help the contracting systems become more sophisticated and accurate.

7. COMPETITIVE TENDERING

The Competitive tendering initiative in respect of NHS laundry, catering and domestic services was launched formally in September 1983. It involved over 1500 tender exercises in England and took 5 years to complete.

The aim was to use competition to promote efficient practice and thus to release extra resources to plough back into improved patient care.

The policy has been an undoubted success. The overall cost of the three services before the initiative started was of the order of £800 million. The aggregate net annual savings achieved against previous costs is £110 million, or 13.5%. Domestic services costs were reduced by an average of 22% per contract, laundry costs by 14% and catering costs by 8%. In addition the NHS has gained from improved productivity, increased flexibility, more innovative ideas and techniques, and better management skills.

Criticism that the savings were at the expense of quality standards and staff conditions are ill-founded. In fact, 85% of contracts were awarded in-house, and in-house tender bids accounted for three quarters of the aggregate savings achieved. Efficiency and effectiveness have replaced custom and practice as the main guide to action. In addition the provision of written specification of service requirements gives a clear measure against which any successful bidder can be monitored. Very few contractors, out of the over two hundred contracts with the private sector, have been found wanting and only a handful of contracts have been terminated prematurely. Two contractor companies alone each employ some 6,000 staff on NHS work - a clear indication of their commitment and investment.

The central initiative was geared to the three services where there was the most obvious market place for competition. But it has been backed up by initiatives at more local level which has reflected more local circumstances and opportunities. An estimated £1.25 billion of support services is now routinely subject to regular competition in the NHS and the list extends to over 20 separate services, including works, design, portering, grounds maintenance, security, computer services, legal services, equipment maintenance and transport and distribution.

As indicated in the Government's response to the Social Services Select Committee's Third Report, health authorities are already free to put clinical services out to tender - some already do so to a limited extent. There is considerable expertise available within the NHS to advise on the general principles and procedures needed for value-for-money tendering. Authorities, when going to tender, are learning to prepare tender documents which clearly specify the work to be done, including the performance and quality standards to be achieved. They also need to see that only competent and reliable potential service providers are invited to tender. Authorities can, for example, test contractors' ability to recruit and retain sufficient staff of an adequate quality at the wage rates and conditions on offer. It is not for health authorities however to set these for contractors' staff.

For the support services there is a need to try to reduce the overall number of separate tendering exercises with which NHS management has to get involved. This means rationalisation and simplification of contracts wherever possible. A number of major companies can now offer "facilities management" contracts for a wide range of support services over a single site or district.

Regarding award of a contract, unless there are serious doubts about the ability of the tenderer to deliver the service in accordance with the contract terms and to the specified quality standards, the lowest bid should be accepted. The salient point is the need to

obtain the best value for money and then to monitor compliance with the contract's requirements.

Finally there is a need to identify and develop new forms of "partnership" a[illegible]ge-ments with private contractors covering more flexible mixes of services and capital provision. The rules of public financing and accountability, and differences in tax provision, mean that the benefits of leasing, as commonly used in private industry are less clear cut in the public sector. Some clear examples have emerged where innovative use of private capital in supporting public NHS services has led to better value and faster provision.

8. WORKING WITH THE PRIVATE SECTOR

We do not necessarily propose to change the balance of health care provision as between the NHS and the private sector but we do want to see prudent and innovative co-operation between the private sector and the NHS. These are three examples of how this might be achieved.

First, private sector capital used as a bridging mechanism between the need for facilities to be built before, rather than after, the closure of redundant facilities. Approval has already been given for one health authority to proceed with the first stage of a competitive tendering exercise to establish the relative cost of using private sector finance for the development of a new hospital to be funded largely from the subsequent sale of land vacated on closure of hospitals to be replaced. The implicit cost of such a scheme is the higher cost of capital of the private sector constructor. The NHS would have to ensure that this higher cost of financing than the cost of Government financing is outweighed by a cheaper and quicker procedure for construction by the private sector as compared to conventional construction procedure.

The Department of Health is considering a limited number of other capital schemes as possible candidates for unconventional finance application. These schemes are all in the mental health field where is is important to ensure that community facilities are built before a mental health hospital closes.

A key issue that still has to be considered with projects for unconventional finance is whether it should rank as a deduction from assumed public sector capital investment programmes or be supplemental. The macro-economic implementations will obviously have to be taken fully into account as unconventional finance effectively accelerates capital investment schemes.

A second example would be generation of income from the private sector by such means as franchising retail outlets in the reception areas of hospitals, the sale of spare computer processing capacity and the greater use of private patients facilities. Of course, services to private patients must not be at the expense of providing acceptable services for NHS patients. District health authorities can keep the income so generated so this source can add useful sums to local budgets. Income generation in the NHS is rising fast and is now at the rate of some £30 million per annum. It should be capable of increasing by a significant amount each year.

Finally, private sector finance can be a true partner for the NHS in developing facilities which can be jointly used. For example, an expensive item of equipment such as a Lithotripter, which removes kidney stones, can cost £0.5 million. A private hospital investment in such equipment can be of value to the NHS through offering joint use by appropriate contracts for treatment of public service patients. That has occurred at the private sector Priory Hospital in Birmingham. Similarly the construction of a private hospital or private nursing home close to an NHS hospital can be beneficial to both through economies of scale. The NHS could agree to send patients to the private hospital for certain specialities and receive private patients for other specialities. This is working with the partnership between the Leighton Hospital and the local NHS hospital at Crewe. The NHS spends about £50 million per annum on sending patients to private hospitals

on long term contracts. As the National Audit Office has recently reported, the NHS gets goo[illegible]lue for money.

9. FINANCIAL MANAGEMENT STAFF

The latest detailed census of finance staff, in late 1987, showed that there were around 11,000 employed in finance functions, of whom 3,000 or so in broad terms we can take as being equivalent to finance management staff. That represents around 15 financial management staff per district.

About 40% of these are qualified accountants with the rest being unqualified or part qualified.

The Healthcare Financial Management Association have said that we need 1,000 further accountants and the Government does not dispute this estimate. This represents approximately five additional qualified accountants for the average district where the annual expenditure could be of the order of £60 million.

How do we go about recruiting them? There are two key elements. The first is pay and the second conditions.

Pay is clearly important. Our new flexibility for administrative and clerical staff together with local pay determination, which NHS Trust hospitals will be able to have, will start to bring pay levels for key staff into line with competitive levels. But it is important to note that pay is not the dominant factor - two independent studies have shown that other aspects like career development potential are as important as pay in determining whether or not people stay within the NHS.

This means that we need to ensure that health service financial managers are working within a system which not only rewards them properly but also develops their professional skills in a way that represents the best in employment practice. The NHS is already starting to address this.

In addition to the well received Financial Management Training Initiative, a further £10 million was made available in 1989/90 to assist the NHS Review implementation related to strengthening the financial management functions. This will start the process towards building the additional financial management strength that the Service needs. In 1990/91 a total of £60 million will be available for White Paper issues and a major part of this is expected to be available for recruiting additional financial management staff and for financial management training. It is most important that, in addition to recruiting extra finance staff, we use our existing staff to the maximum extent possible, through better training.

Difficulties in recruitment and retention of IT staff span both the public and private sectors. The Government has taken a number of steps to improve the NHS position. It has launched a substantial IT Management Training Programme. IT staff benefit from a separate grading structure which reflects their executive skills and senior staff can be brought into the senior managers' grade structure. IT staff with the necessary skills are also eligible for national ADP allowances of up to £1464 pa (up to treble this amount in the Thames Regions and double elsewhere to meet local problems of recruitment and retention). In addition, a recent Whitley Council agreement enables all employing authorities to pay local supplements to any group of administrative and clerical staff for whom there are recruitment and retention difficulties.

Finally, let us hope that district health authorities and hospitals will appoint suitable qualified financial staff to their managing bodies. Good financial management is essential to the development of the NHS in the 1990's to continue the solid progress of improving the health of the Nation achieved over the last decade.

10. ABOUT EVALUATION

The NHS Review takes the health service into a new world of contracting, separating

the purchaser of health services from the hospital provider. It is clearly important for the purchaser to monitor how the terms of the contract are being performed. Both the quantitative and qualitative aspects should be evaluated so as to suggest, perhaps, changes in the terms of future contracts.

Contract monitoring will need proper information systems and also openess of access to information. District health authorities are mostly unused to measuring clinical progress against a predetermined target, largely because the problems of demand upon finite resources reinforce the confusion in roles of planner and manager. The authority is simply glad to reach the end of a year without taking too much trouble to review and reflect.

The Department of Health has launched development work in eleven district health authorities in England to make sure the new responsibilities for planning health care, contracting for its provision, and then evaluating hospital performance are all well prepared.

In addition to the need to check the performance of contracts, we need constantly to be checking we are achieving value for money not only in individual hospitals, but in types of services across the whole of the NHS. For example, in the way we purchase supplies, roster nurses for duty, use energy, rely on day, as opposed to in-patient, surgery and so on.

The Government intends to rely on the Audit Commission to carry out not only the statutory audit of the NHS but to report on specific value for money reviews. The Audit Commission is an independent body and already carries out this function for local government. The value for money reports will be published and will be of great value to Ministers and managers.

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