PO-CH/NL/0102
PART P

Part. P.

SECRET

(Circulate under cover and
notify REGISTRY of movement)

Begins: 19/10/88.
Ends: 19/12/88

Chancellor's (Lawson) Papers:

THE NATIONAL HEALTH
SERVICE REVIEW

Disposal Directions: 25 Years

14/8/95

PO -CH /NL/0102
PART P

SCOTTISH OFFICE
WHITEHALL, LONDON SW1A 2AU

CHIEF SECRETARY
REC. 19 OCT 1988
ACTION Mr Saunders / Mr Johnston
COPIES TO Cx, Sir P Middleton, Mr Bunsen, Mr Phillips, Mr Turnbull, Miss Pearson, Mr Griffiths, Mr Gussed, Mrs Sorrell, Mr Call

pl find full string
X behind + letter to which it replied

CONFIDENTIAL

Paul Gray Esq
Private Secretary
10 Downing Street
LONDON
SW1A 2AA

19 October 1988

Dear Paul,

STOCKTAKING REVIEW OF THE HEALTH SERVICE IN SCOTLAND

My Secretary of State minuted to the Prime Minister on 11 October to suggest that, at the meeting on 17 October to discuss the NHS review, it would be helpful to decide then whether and when the proposed stocktaking booklet on the Scottish Health Service should be published. I understand that this was not in fact discussed at the meeting, and you have since asked the latest date at which the stocktaking booklet could appropriately be published.

I should perhaps emphasise first that the stocktaking booklet will in no way conflict with any likely outcome of the NHS review. Indeed, we believe it will be positively helpful to have the document on the record as a base point, similar to those available in other parts of the UK, from which the review will develop.

An important factor in our timing is that the stocktaking booklet contains my Secretary of State's response to a report "Scottish Health Authorities Priorities for the Eighties and Nineties" (the SHARPEN report) which was submitted to him by the Scottish Health Service Planning Council in May this year. The intention was to publish the stocktaking booklet first, and subsequently to publish SHARPEN. There is increasing public impatience about SHARPEN, most recently shown by a question from the Social Services Committee to my Secretary of State's officials about when SHARPEN would appear.

My Secretary of State's judgement is therefore that he cannot without considerable difficulty delay the publication of SHARPEN beyond the end of November and the prior publication of the stocktaking booklet beyond mid-November; and that publication earlier than that would be preferable.

I have sent copies of this letter to Geoffrey Podger, Stephen Williams, Mike Maxwell, Carys Evans, Sir Robin Butler, Trevor Woolley and Richard Wilson (Cabinet Office), and John Whitehead (Policy Unit).

Yours ever,
David

DAVID CRAWLEY
Private Secretary

HMP293F6

20.10.8

SECRET

FROM: R B SAUNDERS

DATE: 20 October 1988

CHIEF SECRETARY

cc Chancellor
Sir P Middleton
Mr Anson
Mr Phillips
Miss Peirson
Mr Turnbull
Mr MacAuslan
Mr Griffiths
Mr Rayner

REVISED GDP DEFLATORS: HEALTH

I gather you have decided to phone Mr Clarke tonight to offer him the £85m package in my note of earlier today. I attach a speaking note.

2. There is only one minor point of substance: the knock-on effects for years 2 and 3. I suggest offering a flat 85/85/85. In theory, if we uprated for inflation and service growth, something like 85/90/95 would be more appropriate. But Mr Clarke is hardly likely to make an issue of that, since he will in any case be coming back with revised forecasts in next year's Survey.

R B SAUNDERS

20.10.7

SECRET

SPEAKING NOTE FOR MR CLARKE

Chancellor has decided to increase GDP deflator assumptions for this year and next year from 5½%/4½% to 6¼%/5%, increases of ¾%/½%.

No adjustments being made to expenditure totals this year. In your case pay costs already settled and health authorities already budgetting for price increases of this order on non-pay costs.

As to next year's revision, general rule is that agreed settlements must stick. But recognise this gives you problems in two areas in particular.

First is pay. Settlement allowed explicitly for pay increases in relation to GDP deflator for both Whitley and Review Body groups. Propose therefore to offer further £50m on HCHS current.

Second is FPS. Recognise that new GDP deflator next year will affect forecast. Moreover this year's new deflator will also affect drug price levels going into year, adding to additional cost on that element of programme. Offer £35m: £23m for extra ½% next year, £12m for effect of higher drug prices this year.

No increase for non-pay HCHS current, HCHS capital or CFS - reasonable to absorb these.

Total therefore £85m - £50m HCHS, £35m FPS. Propose same figures for years 2 and 3 - would involve spurious precision to try and uprate for later years. Would be presented to colleagues as integral part of settlement; say nothing about compensation for higher GDP deflators.

Generous offer. Not prepared to go any further. Are you prepared to accept on that basis?

week.17.10/m.17

CONFIDENTIAL

FROM: H PHILLIPS

DATE: 21 October 1988

MR SAUNDERS

cc PS/Chancellor
PS/Chief Secretary
Sir P Middleton
Mr Anson
Sir T Burns
Mr Culpin
Miss Peirson
Mr Turnbull
Mr Gieve
Mr Parsonage
Mr Tyrie
Mr Call

Mr Corlett - IR
Mr Kuczys - IR

REVIEW OF THE NATIONAL HEALTH SERVICE: PRESS ARTICLES

You will recall that on 15 June I circulated a letter from Sir Robin Butler's office about maintaining confidentiality on the work of the NHS Review. With this note I am now circulating a letter from Sir Robin Butler to Sir Peter Middleton of 14 October reminding us all of the need for continuing caution in the light of two recent press articles. The guidance contained in my note of 15 June still applies ie to be careful in our contacts with other people as well as journalists and to let me and Mr Gieve know if you are approached on this subject.

HP.

HAYDEN PHILLIPS

CONFIDENTIAL

CABINET OFFICE

70 Whitehall London SW1A 2AS

01-270 0101

From the Secretary of the Cabinet and Head of the Home Civil Service

Sir Robin Butler KCB CVO

Ref. A088/3017

14 October 1988

Dear Peter,

You will have seen my minute of 6 October to Nigel Wicks, and his reply of 11 October, about the article in the Guardian of that day on the review of the National Health Service.

My Private Secretary wrote on 13 June to the Private Secretaries of the Chancellor of the Exchequer and the Secretary of State for Social Services asking them to ensure that the dates of future meetings on this subject were not made available to the press and were notified only to those within Departments who needed to know them. He also asked that all officials and special advisers engaged in the review, and press officers, should be warned of the dangers of involving themselves in any conversation with journalists on matters related to the review, since they might inadvertently enable journalists to try out propositions in order to gauge reactions.

In the light of the Guardian article, the Prime Minister has asked that we should emphatically repeat these warnings, and I would be grateful if you could do this within your Department. The review is now entering its most sensitive state and it is most important to avoid any further articles like that in the Guardian and the article by Jill Sherman in the Times on 12 October.

I am sending copies of this letter to Chris France, Richard Lloyd Jones, Russell Hillhouse and John Blelloch, with a request to them to take similar action in their Departments.

Yours ever,

Robin

Sir Peter Middleton
HM Treasury

CONFIDENTIAL

DEPARTMENT OF HEALTH ~~AND SOCIAL SECURITY~~
Richmond House, 79 Whitehall, London SW1A 2NS
Telephone 01-210 3000

From the Secretary of State for ~~Social Services~~ Health

Paul Gray Esq
Private Secretary
10 Downing Street
LONDON SW1

24 October 1988

Dear Paul

NHS REVIEW : AUTUMN STATEMENT

During this year's Public Expenditure Survey discussions the Chief Secretary and my Secretary of State considered how to handle publicly any part of the HPSS settlement which was related to possible outcomes of the Review.

They decided that any public announcement of extra funding for Review-related items should be held back until the outcome of the Review is made known. The sums agreed in the Survey are for pilot experiments with internal markets and information technology investment in general practice. They amount to £10/28/28 million over the next 3 years. These sums will be included in the overall settlement figures announced in the Autumn Statement but will not be separately identified (or identifiable).

The sums are not large enough to overshadow the Review's main messages or to divert attention to questions of NHS funding , but will enable Ministers to make it clear at the right time that the necessary resources are available to finance Review outcomes without detriment to patient services.

The Chief Secretary has acknowledged that if there are further resource consequences arising from the Review which have not been provided for in the PES settlement, a claim will have to be made on the Reserve when these are known and can be costed.

I am copying this letter to Private Secretaries of Chancellor, Chief Secretary and Secretaries of State for Northern Ireland, Scotland and Wales.

Yours sincerely

Andy

ANDY McKEON
Private Secretary

DEPARTMENT OF HEALTH ~~AND SOCIAL SECURITY~~
Richmond House, 79 Whitehall, London SW1A 2NS
Telephone 01-210 3000

From the Secretary of State for ~~Social Services~~ Health

CHIEF SECRETARY
REC. 24 OCT 1988
ACTION Mr Sanders
COPIES TO Cx, Sir Phil Middleton, Mr Anson, Mr Phillips, Miss Pearson, Mr Tomlinson, Ms Parsonage, Mr Call

CONFIDENTIAL

PMG,
Sir T. Burns,
Mr Culpin
Mr Griffiths
Mr Sussex

The Rt Hon John Major MP
Chief Secretary to the Treasury
H M Treasury
Parliament Street
LONDON SW1

24 October 1988

Dear Chief Secretary

NHS REVIEW: MANAGEMENT OF CAPITAL ASSETS AND INVESTMENT

The Prime Minister's Group has asked us to look at a number of issues connected with the treatment of capital in the NHS. The principles of charging, and of access to private sector funds, were addressed in my paper HC45. The two annexes to that paper, which contained the meat of the issues, have been discussed in detail by our officials. At least on the former subject, I am glad that a good deal of progress has been possible. We are to meet soon to agree the way forward, before the next meeting of the Group, and will have before us two papers on charging and private sector capital, as agreed by our officials.

On charging for capital I think we have the basis for a sensible (and indeed overdue?) reform of the way we fund the NHS. As the paper points out, there are some important technical issues to be worked out, so that a simple scheme can be developed giving the right incentives to the efficient use of capital assets. But I entirely support the conclusion that a system of real charges across the board is the best way to manage the devolved and diverse trading situation which we envisage for the future.

As to access to private capital, I am disappointed that it has not proved possible to agree how to adapt the Treasury's rules on "unconventional finance" so as to meet the changing needs of the NHS, in which we want the private sector to play a larger part. Whilst I well appreciate the need to constrain the public sector's claim on overall resources, I believe that we are making a rod for our own backs by setting unrealistic targets for "value for money", and failing to distinguish between the NHS buying in services, and the NHS selling services.

Subject to our discussion of these subjects, I would wish to incorporate the substance of these papers into the further policy papers which I am to work up for the next meeting of the Prime Minister's Group.

It might be helpful if we could discuss four other points connected with capital which came up at the last meeting of the Group in the context of self governing hospitals:

E.R.

- dropping the "interest" element of capital charges;

- devolving more responsibility for capital matters to hospital level, especially for disposal of assets;

- a £ for £ scheme for community fundraising;

- responsibility for opening a major new hospital.

On the application of an interest charge, the main issue is the "level playing field". The total capital charge is just a percentage of the current value of the asset: how it is made up is of secondary importance. Either it broadly reflects the total charges which the private sector faces, or it does not. I believe it should; this is no more than the reality of market forces. And to have one rule for self governing hospitals and another for DHA managed ones would create a minefield. But we should at the same time ensure that there are no needless obstacles in the way of the self governing hospital, and I am giving further thought to this.

On devolution of the management of capital, managers already have flexibilities in carry-forward, virement and increased delegation of decision-making. I take the view, which I believe the Treasury shares, that the scope for further (administrative) widening of these flexibilities should be explored as experience of the major organisational changes arising from the Review develops.

On the particular question of greater delegation of responsibility for disposal of assets, I see two balancing considerations:

- giving real responsibility for the control of assets which self governing hospitals will come to own;

- ensuring the broadest benefits from public assets (whoever owns them), so that windfall gains in, say, the south-east, can benefit the community as a whole.

While the discipline of real capital charges will help ensure this balance, I believe that we still need a degree of Regional oversight of disposals and investments, as set out in paragraph 13 of paper HC46. For example, we might require that any disposal amounting to more than x% of the hospital's total stock would require Regional approval.

As to community fundraising, I floated the idea of a £ for £ scheme for self governing hospitals in HC46. I would like to see it announced in principle in the White Paper. There would need to be some basic rules:

- the Exchequer contribution would form part of the overall allocation of public expenditure to the NHS capital programme;

- fundraising would need to be for a specified purpose, and that purpose would need to be accepted as a priority within the Regional capital programme;

- time - and cash-limits would need to be set to avoid open-ended commitments.

E.R.

Perhaps we could discuss the terms in which this idea might be developed in future papers.

Finally, on the question of opening a major new hospital I continue to believe that the Region has an important part to play. This is not primarily a question about self governing hospitals, because by definition no hospital exists. Whether the new hospital is managed by the District, or is created self governing from scratch, would be for the Region, and if need be the Secretary of State, to decide.

I hope all this provides a helpful agenda for our discussion.

Yours sincerely

A.J. McKean
PPS.

p.p. KENNETH CLARKE

Approved by the Secretary of State and signed in his absence
AJM

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

24 October 1988

CHIEF SECRETARY	
REC.	24 OCT 1988
ACTION	Mr Saunders/Mr McKinnon
COPIES TO	Sir P Middleton, Mr Broom, Mr Phillips, Mr Turnbull, Miss Peirson, Mr Griffiths, Mr Sussex, Mrs Wiseman, Mr Call

STOCKTAKING REVIEW OF THE HEALTH SERVICE IN SCOTLAND

The Prime Minister has seen your further letter to me of 19 October. In the light of the further discussions on the NHS Review, the Prime Minister is now content, subject to the views of colleagues, for your Secretary of State to proceed with the publication of this booklet.

I am copying this letter to Andy McKeon (Department of Health), Stephen Williams (Welsh Office), Mike Maxwell (Northern Ireland Office), Carys Evans (Chief Secretary's Office), Trevor Woolley (Cabinet Office), Richard Wilson (Cabinet Office) and Ian Whitehead (No.10 Policy Unit).

Paul Gray

David Crawley, Esq.,
Scottish Office.

CONFIDENTIAL

dg26.10.3 **CONFIDENTIAL**

As v. slightly amended

1. MR SAUNDERS

2. CHIEF SECRETARY

FROM: D P GRIFFITHS
DATE: 26 October 1988

cc Chancellor
Sir P Middleton
Mr Anson
Mr Phillips
Miss Peirson
Mr Turnbull
Mr MacAuslan
Mr Parsonage
Mr Call

NHS REVIEW: AUTUMN STATEMENT

The letter of 24 October from Mr Clarke's Private Secretary to PS/ Prime Minister is in fulfilment of Mr Clarke's agreement to report to the Ministerial Group the decision you reached on the relationship between the PES settlement and the NHS Review.

2. The letter fairly reflects what was agreed except on the question of a possible call on the Reserve where your willingness to entertain further bids was not as broad and firm as the Department of Health are seeking to make out. When this issue was discussed in the third bilateral you made clear that it would be legitimate for Mr Clarke to make a bid if a fresh and unexpected measure involving expenditure in 1989-90 was endorsed by the Review. There was certainly no carte blanche to consider a bid for any measure for which provision had not been made in the Survey. And the question of provision for 1990-91 and 1991-92 will be a matter for future Surveys. We should ensure that the correct version of the understanding is on the record. This is best done by adding a gloss to the DoH statement rather than by directly challenging it.

3. There is a further point worth noting. In his press release and briefing on the Autumn Statement Mr Clarke does not intend to mention the extra provision for the extension of the Resource Management Initiative. Apparently the consultation with the representatives of the hospital doctors on the evaluation of the existing RMI pilots has not been completed and DoH think it best not to say anything at this stage. In view of this it would seem sensible to defer an announcement until we are ready to go public

on the conclusions of the Review - DoH are envisaging making a separate statement on the RMI before then. We would not recommend that you press the point if DoH resist but it is worth drawing this to the attention of other members of the Ministerial Group.

4. I attach a draft Private Secretary reply.

D P Griffiths.

D P GRIFFITHS

dg26.10.4 CONFIDENTIAL

DRAFT LETTER FROM PS/CHIEF SECRETARY TO

Andy McKeon Esq
Private Secretary to the
Secretary of State for Health
Department of Health
Richmond House
79 Whitehall
London SW1A 2NS

Copies to
PS/Prime Minister
PS/ SOS Scotland
PS/ SOS Northen Ireland
PS/ SOS Wales

NHS REVIEW: AUTUMN STATEMENT

The Chief Secretary has seen a copy of your letter of 24 October to Paul Gray.

agrees in general
He ~~is~~/~~content~~ that this reflects the understanding he reached with your Secretary of State on the handling of the Review-related items in the HPSS settlement. In the Autumn Statement figures sums of £10/28/28 million have been included for internal market experiments and information technology for GPs but these will not be separately identified until the announcement of the outcome of the Review. On the question of additional funding, it was /~~He also~~ agreed that, if a fresh and unexpected measure involving expenditure in 1989-90 is endorsed by the Review Group, it would be legitimate for your Secretary of State to make a bid on the Reserve. The question of any additional provision for later years would, of course, be a matter for discussion in a future Survey.

He also understands that, as consultations with hospital doctors' representatives on the Resource Management Initiative have yet to be completed, your Secretary of State does not now intend to announce the extension of the Initiative when the Autumn Statement is made. In view of this the Chief Secretary's preference would be to defer the announcement until the conclusions of the Review are published.

I am copying this letter to recipients of yours

CONFIDENTIAL

DEPARTMENT OF HEALTH ~~AND SOCIAL SECURITY~~
Richmond House, 79 Whitehall, London SW1A 2NS
Telephone 01-210 3000

From the Secretary of State for ~~Social Services~~ Health

Mr Griffiths

You will be preparing a draft CST letter. I'm asked the CST's office to forestall any No 10 response.

RR
26/10

Paul Gray Esq
Private Secretary
10 Downing Street
LONDON SW1

24 October 1988

Dear Paul

NHS REVIEW : AUTUMN STATEMENT

During this year's Public Expenditure Survey discussions the Chief Secretary and my Secretary of State considered how to handle publicly any part of the HPSS settlement which was related to possible outcomes of the Review.

They decided that any public announcement of extra funding for Review-related items should be held back until the outcome of the Review is made known. The sums agreed in the Survey are for pilot experiments with internal markets and information technology investment in general practice. They amount to £10/28/28 million over the next 3 years. These sums will be included in the overall settlement figures announced in the Autumn Statement but will not be separately identified (or identifiable).

The sums are not large enough to overshadow the Review's main messages or to divert attention to questions of NHS funding , but will enable Ministers to make it clear at the right time that the necessary resources are available to finance Review outcomes without detriment to patient services.

The Chief Secretary has acknowledged that if there are further resource consequences arising from the Review which have not been provided for in the PES settlement, a claim will have to be made on the Reserve when these are known and can be costed.

I am copying this letter to Private Secretaries of Chancellor, Chief Secretary and Secretaries of State for Northern Ireland, Scotland and Wales.

Yours sincerely

Andy

ANDY McKEON
Private Secretary

CHIEF SECRETARY	
REC.	24 OCT 1988
ACTION	Mr Saunders
COPIES TO	Cx Sir P Middleton, Mr Anson, Mr Anson, Mr Phillips, Miss Penson, Mr Turnbull, Mr MacAuslan, Mr Parsonage, Mr Call

422/10

chex.md/mw/78 **CONFIDENTIAL**

FROM: MISS M P WALLACE
DATE: 27 October 1988

PS/CHIEF SECRETARY

cc Sir P Middleton
Sir T Burns
Mr Anson
Mr Phillips
Mr Culpin
Mr Turnbull
Miss Peirson
Mr Gieve
Mr Saunders
Mr Parsonage
Mr D Griffiths
Mr Call

NHS REVIEW

The Chancellor wants to hold a meeting in the second half of next week to take stock of progress in the NHS Review. Mr Saunders will be circulating a paper before then, as a basis for discussion, and this office will be in touch about timings.

MOIRA WALLACE

21.10.3

CONFIDENTIAL

FROM: R B SAUNDERS

DATE: 28 October 1988

CHIEF SECRETARY

cc Chancellor
Sir P Middleton
Mr Anson
Sir T Burns
Mr Phillips
Miss Peirson
Mr Turnbull
Mr Parsonage
Mr Richardson
Mr Griffiths
Mr Sussex
Mr Call

Ch/CST's in seeing Mr C in the morning, so you can get rapid debrief @ Stocktaking NHS mtg in afternoon.

[Complexity of DoH proposals vindicates our pressure to sort out bilaterally before bring to full Review]

NHS REVIEW: CAPITAL

You are holding a briefing meeting on Wednesday for your meeting with Mr Clarke on Thursday. Mr Clarke has written to propose you discuss the issues in his earlier note to the Review Group and the capital aspects of self-governing hospitals which were remitted to you at the Prime Minister's meeting. On the first of these, we and Department of Health officials have prepared papers on the two main issues - private finance and capital charging - and these are attached.

2. There is one point of procedure. Mr Clarke's letter talks about a paper which "I am to work up for the next meeting of the Prime Minister's Group". This is quite wrong. The remit is quite clearly to produce a joint paper, and you will wish to establish this at the start of the meeting.

Private finance

3. This is by far the most difficult issue. As you will see from the paper, we have reached no agreement at official level. We have persuaded the Department to drop their more spurious points, so that their arguments now look pretty thin. But Mr Clarke may nevertheless attract quite a bit of support when the question comes to the Review Group - witness, for example, Mr Walker's minute of 13 October to the Prime Minister.

4. The private finance rules consist of two principles:

a. best value for money must be secured in all public sector projects, whether privately or conventionally financed;

b. privately or indirectly financed projects have to be taken into account in setting public expenditure control totals.

5. Mr Clarke's earlier paper accepted these principles:

"As means of ensuring respectively value for money and effective control over the size of the public sector these rules are eminently sensible."

But he proposes three relaxations, which are set out in paragraph 3 of the paper. At the meeting it will make sense to consider each in turn.

6. To clear the ground, you should try to get Mr Clarke to sign up at the outset to these proposals:

- whatever we do must give optimum value for money;

- so simple leasing transactions by Government, which are bad value for money, should always be avoided;

- private finance must not be used as a way of getting round agreed limits on public expenditure.

3.1 - Schemes "not constituting an NHS facility"

7. This proposal reflects the desire of health authorities to get on with income generation without being constrained by what they regard as artificial controls. The new breed of general managers have been encouraged to go into such schemes, and have come up with more and more novel ideas. But I would advise you to

be cautious: the NHS Management Board have already had to issue warnings to health authorities not to get carried away, for fear that too much management effort might be diverted into this area. Income generation should be about making the best use of assets, not about going out into the market to find new ways of making money. Joint developments with, say, private sector health care providers are to be welcomed, but health authorities should be going into them in order to secure more cost effective public health care.

8. It follows that such proposals - whether building a new private patients wing or developing a shopping mall for patients and visitors - should compete for capital funds in the same way as ordinary hospital building projects. The logic is the same as applying an EFL to a nationalised industry: we try to control the size of the public sector, even if new investment generates income. It makes no difference if the development is financed privately if ultimately the risk remains with the NHS and hence with the Government.

9. There is a difference if risk is transferred - for example, if the hospital lets the space to a franchisee. In that case, the private finance rules do not apply, since the project is genuinely in the private sector. This gives a clear incentive for schemes such as shopping malls to be operated as wholly private undertakings, which is clearly right on policy as well as financial grounds. You should therefore say that you see this as the way forward.

10. There is one concession you might offer. Even if the space is being let to an operator who will do it up for himself, preparatory works may be needed just to create the necessary space. In principle, the health authority should be prepared to do this, since it will make a return in the form of rent. But you could suggest that officials try to draw up some ground rules which would exclude some proposals, for example where the trader does the work himself, in return for a reduced rent initially, so long as the works are mostly concerned with adapting the accommodation to its new purpose.

3.2 - Building against security of future land sales

11. NHS land sales have grown from £19m in 1982-83 to a planned £290m in 1989-90, as a result of community care policies, rationalisation in RAWP losing London districts, and a more positive approach to estate management generally. The Department have come to see land sales as not simply an offset to gross capital expenditure, but rather as a source of new investment over and above the capital programme. (You will remember John James at one of the Survey bilaterals suggesting that the higher land sales receipts had been offered as an offset only to the additional bids, and not to the baseline.) On this view, new capital investment should be allowed to go ahead if it frees up land for sale, almost irrespective of other calls on the capital programme.

12. This has led health authorities and property developers to propose schemes in which the developer builds a new hospital in return for vacant possession of the old site when the project is completed. Such deals could come in two forms, either of which would expose the Government (and Department of Health's Accounting Officer) to criticism.

a. A barter deal whereby the prospective vacant land is sold forward in payment for the construction of the new hospital.

b. An agreement to a prospective price with the department or contractor as the case may be making up the difference to the actual value (independently assessed somehow) when the time came.

The first is particularly objectionable. If the value of the site increases more than expected, as it is bound to do in at least some cases, the Government would be out of pocket compared with the normal practice of selling land when vacant. The sort of problems now being encountered with Royal Ordnance could recur. Under the second arrangement there is at least a facility for adjusting the price, eg to take account of changes in planning status.

13. But under both proposals, the price the developer would pay for land several years earlier than he would normally acquire it will be depressed by his additional financing costs. The Government would, in effect, be borrowing via the contractor but at his higher financing cost, though it would be difficult to identify what the premium might be. It is to be expected that the NAO and PAC would investigate transactions on either basis and would be particularly on the look-out for any undervaluation of land or any implication of higher financing costs, as they have done with the GDN."

14. DoH seek to justify such schemes - involving rationalisation of facilities and freeing up land for sale - by arguing that they will always get lower priority in regional capital programmes than new hospital building or major upgrading of sub-standard hospitals. But this is unconvincing. If regions give schemes low priority, why should they go ahead at higher cost to the taxpayer?

15. There is moreover another and better way of tackling the problem. That is by top-slicing regional capital allocations (the "capital loan fund" proposed by DoH in this year's Survey). This would allow land to be sold when it becomes vacant, not several years in advance, and the costs would be entirely transparent. The Department have told us that the agreed capital programme is not big enough to allow this to be set up. But this is also thoroughly unconvincing. We have just increased the gross capital programme by 15% to £1.2 billion next year. A revolving fund of £100m could surely be set up within this, so as to provide a much lower cost of achieving the same result. You should tell Mr Clarke firmly that this is the way to proceed.

3.3 - Long term contracting out

16. The proposition here is that, should contracting out be pursued on a greater scale than so far - as we are pressing in the Review more generally - it should not be discouraged by the private finance rules. In practice, this means whether the second rule - control total adjustments - should apply when contracts are

agreed. There should be no difficulty about the first, value for money, rule. Contracting-out procedures require the full costs of different options to be compared. Indeed, the introduction of capital charges (see below) would make the comparison of in-house and external options even more transparent.

17. The distinction between contracting out and private finance is an uneasy one. At one end of the spectrum, it would be ridiculous to ask for an offset because a contract cleaning firm has to spend some money on equipment. At the other extreme, if a health authority contracts its general hospital services out to a hospital which is financed and managed entirely by the private sector, then clearly the NHS's need for capital investment is reduced to the tune of one general hospital, and the capital programme should be reduced.

18. But in between there is a grey area, which is related to how much capital the contractor puts in. Consider the contracting out of pathology services. If the contractor is building a new laboratory himself, whose costs are incorporated in the fees charged to the health authority, then an adjustment to the capital programme is right. On the other hand, if he simply takes over the hospital's own lab, there is no case. In between the two, if he is making extended use of his existing capacity it is not immediately clear: an NHS building is freed up, but on the other hand there is no new investment to set against the capital programme.

19. We need to clarify some ground rules for when a control total adjustment is needed, and when it is not. On the face of it, the following factors are relevant.

a. The length of the contract. If it is renewable by competitive tender every three years, say, it will look a lot less like leasing than would a contract spread over 10 years or some other period approximating to the life of the assets.

b. The proportion of the discounted costs represented by capital. The more capital-intensive the service contracted out, the stronger the case for an adjustment.

c. Scale. There might be a de minimis limit below which capital costs could be ignored.

d. The proportion of the contractor's business which the contract represents. If the NHS is contractually bound to buy all his output, the arrangement is arguably a lease in all but name.

Some rules have already been drawn up in relation to proposals for contract energy management. If you agree, you and Mr Clarke could invite us and DoH officials to draw up an extended and generalised version applicable more widely.

Capital charging

20. In contrast, this paper should not, I hope, take up too much time. We are agreed on the objectives of bringing home to NHS managers the full costs of the capital assets they use, and ensuring that these are reflected in decision-taking. Department of Health believe this requires a system of capital charges to be effective, while we are a bit more sceptical. But there is no need for us to stand in the way, so long as it does not damage any of our wider interests.

21. Paragraph 14 of the paper lists some points to watch. There are two significant ones. First, health authority current budgets would be increased to enable them to pay the new charges but, for classification reasons, there might be no offsetting decrease in capital budgets. We would not want to see an apparent increase in public expenditure as a result. But there are also problems if the receipts are netted off and give a negative net capital expenditure programme - some people might argue that this showed that more could and should be spent on NHS capital. It would be best if the system were set up to have no effect either on Votes or on the public expenditure programmes.

22. The other problem is transition. Health authorities would have to pay charges according to the asset structure they inherited. Some would have a lot of new assets and would have to pay high charges, while others would face a much lesser burden. If the extra money to pay the charges is divided up on the basis of existing allocations, those facing high capital charges will be squeezed, while others will make windfall gains. If, on the other hand, the money is allocated according to existing asset structures, the high asset value authorities will be better placed to cash in through rationalisation, while the low asset value ones will find it even more difficult to upgrade their facilities. To a large extent, of course, it is precisely in order to introduce these effects that the system has been proposed. But there will be messy transitional problems for several years.

Line to take

23. No problems in principle. Need to watch points in paragraph 14 of paper. Officials should work up more detailed scheme to test practicability.

Other issues

Delegation

24. This was mentioned in Mr Clarke's paper. We have already agreed some increases in delegated limits for approval by regions (up from £5m to £10m) and by DoH without reference to Treasury (up from £10m to £15m). We have proposed to the Department some relaxation of health authority carry-forward, as part of the general review of end-year flexibility. This however mainly affects current rather than capital. Otherwise, Mr Clarke proposes that officials should keep the possibility of further relaxations under review as the organisational changes develop. I suggest you agree with that.

Self-governing hospitals

25. There are two sets of issues arising out of the Prime Minister's meeting last week:

- the pound-for-pound capital raising scheme proposed for them

- the role of regions.

26. On the first, Mr Clarke is keen to introduce a scheme under which money raised locally for a self-governing hospital would be matched by the Government. The Prime Minister and you expressed misgivings about this. This was because voluntary fund raising is not, at the best of times, a good way of financing hospitals - there are a lot of under-used scanners around the country as a result of present efforts. The Government should be allocating funds for capital expenditure on the basis of need and proper investment appraisal, not the effectiveness of local fund-raising campaigns. Mr Clarke's letter however proposes constraining this quite tightly: the Government contribution would be met from within the capital programme, subject to time and cash limits, and would support only projects which are accepted as a regional priority. Provided Mr Clarke is happy that his scheme is proof from accusations that he is returning the NHS to dependence on charity, I do not think we need press the earlier objections to the idea.

27. On the second, the Prime Minister expressed concern at the last meeting that the proposals for regions to approve new investment by self-governing hospitals and major disposals would hamstring the hospitals unacceptably. Mr Clarke now proposes a de minimis limit below which self-governing hospitals could dispose of assets without regional approval. This seems reasonable, so long as the limit is fairly low (say 5% of total stock), and I suggest you go along with it, subject to agreement on the limit. He argues also that regions should continue to be responsible for opening new hospitals. Again, given the amount of public money involved, this must be right.

Pay

28. The pay arrangements for the staff of self-governing hospitals were also remitted to Treasury and Department of Health. It is not proposed to discuss that at this meeting. You might like to be aware, however, that Mr Phillips will be convening a meeting on the subject in due course.

R B SAUNDERS

CONFIDENTIAL

USE OF PRIVATE CAPITAL FINANCE

Note by DH and Treasury Officials

1. Private or unconventional finance for public sector projects is one of a number of possible private sector inputs which may contribute to improved efficiency. Its use is subject to two requirements:

1. the proposal must offer best overall value for money (just like any other expenditure proposal);

2. where the unconventional finance substitutes for publicly financed provision, offsetting adjustments should be made to expenditure control totals, unless Ministers specifically decide otherwise.

2. A purely financing proposal, such as sale-and-leaseback, is unlikely to meet the first requirement, since the Government is able to borrow directly in the markets more cheaply than through a private sector intermediary, and there is little or no transfer of risk to justify the difference in financing costs. The privately financed option would offer the best value for money only to the extent that other associated efficiency gains offset the financing costs. The second requirement is to ensure that the level and balance of public sector activity are not distorted by the method of financing.

3. These questions do not arise for the great majority of health capital projects, which are publicly financed in the conventional way. The Department of Health believes however that there is a minority of schemes which the Government would otherwise wish to encourage, but which are inhibited by the existing rules. It proposes that health authorities and self-governing hospitals should be free to:

1. finance from private sources development schemes such as private patient facilities and shopping malls in hospitals which can be distinguished as not constituting an NHS facility;

2. contract with a developer who would pay for, design and construct a new hospital or facility against the security of future released land values;

3. enter into long-term arrangements to contract with private health care providers;

in each case without being subject to existing rules on unconventional finance. A power to enter into joint ventures with private sector companies is seen as an important corollary.

4. The proposals would require legislation to cover the borrowing powers sought, and to regulate the joint venture activities.

5. The Department considers that the rules as applied to the NHS discourage schemes which the Government would otherwise wish to encourage. In most cases the cost of servicing privately-financed capital means that a scheme will fail the value-for-money test against public finance even though this option is not available because the Region's capital programme is fully committed; while the requirement for compensating reductions in publicly-financed capital allocations are a discouragement to developments not principally directed to NHS services because they reduce the capital available for direct service provision. The Treasury considers that neither of these points is valid. Best value for money must be secured in health authority expenditure, as elsewhere. If a scheme is not included within a regional capital programme, that is because the region does not attach sufficient priority to it; in that case, there is no justification for financing it at higher cost by unconventional means. Nor does the Treasury accept that health authority activities should be removed from the normal disciplines of public expenditure control simply because their purpose is something other than the provision of health services.

6. The Department proposed [therefore] that schemes in 3.1 should, subject to defined and auditable criteria, be exempt from unconventional finance requirements. They would, however, be required to demonstrate a positive return on the investment on standard commercial criteria and, where a scheme covered both NHS and non-NHS elements, the NHS part would remain subject to unconventional finance controls. The principle inherent in this approach is that schemes which substitute for publicly-financed provision are properly within the unconventional finance rules, but schemes which do not substitute but are outside the scope of the NHS as such should be exempt. [The Department would accept that income generated from such sources should be taken into account (implicitly, not necessarily explicitly) in assessing the NHS's future revenue requirements.]

7. While the Treasury welcomes the income generation initiative, and favours the development of private patient facilities within NHS hospitals, it carries the primary purpose of these policies is to make best use of existing NHS assets. It is not however for health authorities to engage in activities which are best carried out in the private sector. The Treasury considers that shopping facilities, etc in NHS hospitals would normally be provided by letting space to franchisees, in which case considerations of private finance would not affect the decision one way or the other. Only exceptionally would health authorities need to make major investments on their own account. But in such cases the Treasury considers that there should still be requirements for best value for money and for the capital investment properly to score as public expenditure. Similarly, it sees no reason why

investment in private patient facilities should be outside the scope of the normal value for money and public expenditure control disciplines.

8. The suggestion at 3.2 arises from propositions such as that at Bromley where the cost of a new hospital would be more than offset by released land values at the end of the development but the District is unable to secure a place in the Region's capital programme. The Department considers that, provided there has been an open competition to secure the best deal, and subject to standard capital approval procedures, such schemes should be permitted without any offsets against overall capital allocations.

9. The Treasury considers that such schemes should always be undertaken at the lowest cost. Any other course implies less health service provision or an increased burden on the taxpayer. The NHS hospital capital programme is over £1bn a year, which is enough to accommodate the largest project.

but considers that contract terms adjustments are appropriate in cases of long-term contracting out.

10. The proposal at 3.3 is designed to secure that any capital elements in long-term contractual arrangements are disregarded. The Treasury wishes to encourage contracting out in clinical areas, such as radiology and pathology. Capital assets previously owned by the NHS would be freed up, so that less net capital investment would be needed in the NHS: existing facilities could be put to alternative use, or capital receipts increased by higher land sales. The introduction of a capital charging system would make this more transparent, since the health authority would benefit from reduced capital charges which would offset the capital element of the fees it paid to the contractor.

X

11. Taken together, the Department considers that ~~the~~ its proposals can be justified as promoting improved co-operation between the NHS and the private sector both directly in the field of health care and in the improved utilisation of NHS-owned assets. There should be an expansion in the supply of private health provision, closely linked with the NHS. The Treasury supports these objectives. It believes however that they can be secured within the existing system of capital controls, and the existing guidance on private finance. The relaxation proposed by the Department would produce less value for money and have very damaging effects for public expenditure control not only in the health programme but also more widely if similar concessions were sought for other programmes.

CONFIDENTIAL

ACCOUNTING AND CHARGING FOR CAPITAL

Note by DH and Treasury Officials

Introduction

1. Changes to arrangements for accounting for capital follow on from decisions concerning the future structure of the NHS. In the long term prices need to reflect the full economic cost of resources in both the public and private sectors, and there should be incentives for local managers to make optimal decisions on the use of the capital stock and on investment and disinvestment. There should be a level playing field for all participants in the competitive health services market.

2. Any new developments in accounting for, or charging for capital, should be consistent with cash limits and with other control and management devices - such as option appraisal - that have proved their worth over the years. They should be consistent with present public expenditure classification conventions and with the Parliamentary supply and Vote accounting procedures.

Existing arrangements

3. The health authorities capital programme constitutes about 8% of the gross budget for hospital services. Proceeds from land sales finance about 25% of this. The current practice in the NHS is that investments are written off in the year they are made. Except in a few special circumstances there is no subsequent accounting for the cost of capital. Existing assets appear as a 'free good' to managers unless, of course, they have alternative uses within the NHS or can be sold off (health authorities are allowed to keep the proceeds of sales). There are no charges made to operating accounts in respect of depreciation of, and interest on, the capital stock. This means that services provided with authorities' own assets appear cheaper than they should be and there is a cash incentive to retain such services in house, at least during the life of the assets concerned.

Capital accounts

4. A necessary requirement for handling capital more satisfactorily, is for health authorities to set up a system of capital accounting. This would value all assets at their "current" or "replacement" cost to the NHS, or on any other appropriate basis, depreciating them as necessary according to their age. Such an accounting system would include appropriate charges to operating accounts for the assets used, based upon these valuations.

5. Valuation of Regional hospital estates has been carried out in the past and experiments are under way in a number of Districts to build full asset registers and capital accounts from the bottom up. But further development is required before full NHS capital accounting can be introduced.

6. Capital charges would consist of annual depreciation plus interest on the current value of the capital stock. Differential land and building costs between RHAs would need to be addressed in setting any capital charges, in order to preserve the level nature of the playing field as between the public and private sectors, region by region.

7. Once such accounts were in place it would become easier to make comparisons of unit costs internally and externally and to set prices, with appropriate apportionment of capital costs. Such accounts should also help in identifying surplus and underused assets.

Management accounts versus full cost charging systems

8. The NHS Review is working towards a mix of three main different forms of financing services in future:

i. the familiar form of block budgeting for health authorities in a management line relationship;

ii. internal trading, at arm's length, between different health authorities and between health authorities and self-governing hospitals;

iii. more external buying and selling services with the private sector.

9. Existing Treasury guidance on fees and charges and on contracting out already recommends full cost charging for trading and comparisons between government bodies and the private sector. It also recommends full cost charging for trading between government bodies themselves. This would apply to self-governing hospitals, and to inter-authority payments for patients treated under contract in the "internal market".

10. Under the proposed arrangements, health authorities and self governing hospitals would need to include in their contract prices the full cost of capital used in providing services as described in para 8(ii) and (iii) above. It follows that they ought to pay the income received in respect of capital charges to the higher authority supplying capital. Correspondingly, purchasing authorities would need to be provided with larger revenue budgets to cover these capital charges on services purchased from providing authorities or self governing hospitals - as happens now, in principle, with contracting out. To this extent, therefore, a system of real charges for capital is inevitable.

11. The question remaining therefore, is what, if anything, should be done about accounting for, or charging for, capital under the continuing arrangements involving the type of financing described in para 8(i) above - the familiar block budgeting in a management line relationship. The main options are either a system of notional management accounts, or actual charges as would apply in "trading" situations.

12. A system of management accounts could be set up resembling those used by some private companies to control their subsidiaries. They would entail notional budgeting and "repayment" arrangements to reflect capital charges, together with performance targets such as preserving the net worth of assets. The basic discipline would be enforced by the line management relationship, and managers would need to take account of the capital costs shown in their management accounts when setting prices in "trading" situations.

13. Instead of relying on management accounts, and performance indicators based upon them, it would be possible to move to a system of full cash budgeting for, and repayment of, capital charges within and between NHS management tiers. Most of the management processes would be the same, but there would be a number of differences. The advantages would be:

i. a cash system would provide stronger and more consistent incentives for authorities than a system of management accounts, because they would apply automatically, across the board;

ii. there would no longer be any need for adjustments to revenue (as opposed to capital) budgets for the scale of contracting out, or for the scale of the internal market, because all NHS expenditure would appropriately reflect capital charges;

iii. there could be greater incentives to efficiency savings because authorities could retain capital charge allocations (instead of the proceeds of asset sales) after disposing of assets. They could then use the released capital charge element for other purposes. (However, it would be necessary to guard against any running down of assets to enhance short term performance);

14. There would, however, be a number of difficulties to overcome in establishing a cash-based charging system:

i. If funds for meeting capital charges are allocated to authorities on a capitation-type basis, then relatively high asset value authorities will face pressure to improve efficiency (in the use of capital, or otherwise) to meet capital charges. Conversely, relatively low asset value authorities will receive

net gains that may be quite substantial. Losing health authorities may seek to use politically damaging service reductions to balance income and expenditure or as a lever to extract additional resources. Some transitional easements may therefore be necessary for those authorities most out of line, but at the cost of diluting, in the short to medium term, the stimulus to greater efficiency. On the other hand, if funds were allocated (at least at first) in line with the level of charges, the fact that real money was at stake would still provide a significant incentive to efficiency; hospitals would be able to keep the revenue savings after reducing their use of capital, but at the cost of effectively rewarding authorities with high capital values and penalising those with low capital values.

ii. There will be practical problems with an early move to cash charging, such as agreeing appropriate depreciation profiles and interest charges. It will also be necessary to work out in detail how allocations of new capital will be affected. This will require a further input of management and accounting resources, at a time when NHS managers will be fully stretched in implementing other changes arising from the review.

iii. There would also be presentational issues. If the system were based on interest payments to the Exchequer these would not score as negative public expenditure but as Government revenue, and the increase in current expenditure to allow payment of the charges would therefore score as increased public expenditure.

iv. If to avoid this problem the interest payments were retained by RHAs as the suppliers of capital, a different presentational problem would arise. Net capital expenditure could be less than the sum of interest and depreciation payments and thus appear as a negative figure. This might lead health authorities and others to argue - either mischievously or mistakenly - that there was scope for higher capital expenditure at (in some sense) no net cost.

Conclusion

15. It is necessary in any case to improve capital accounting in the NHS so as to determine full costs and charges for internal and external transactions and comparisons. It will also be necessary to set up a complementary system of budgeting for and repayment of capital charges for the purposes of trading between health authorities and self-governing hospitals and the private sector. As to the choice between cash transfers and management accounts for directly managed services, cash accounts would put

all internal budgetary transfers between tiers of the NHS on the same footing as the external and internal market transactions of the NHS.

16. This would have merit both in fully levelling the playing field and in obviating the need for continual adjustments to revenue budgets for changes in the scale of contracting out and the internal market. In order to avoid public expenditure problems, it would be best to set up the system in such a way that it did not affect either the presentation of HCHS in public expenditure totals, or in the structure of annual Supply Estimates. While there would be costs associated with the extra cash flows which would have to be set up, these should in the longer term be outweighed by increased efficiency and effectiveness of capital management. There would also be transitional adjustment problems which would be likely to persist for several years.

17. There are clear attractions of principle in a system based on cash transfers. But it needs to be designed in such a way as to minimise or avoid the problems identified in paragraph 14. Further work is needed to establish how this can best be done, taking account of the other claims on NHS management resources which will be made by other changes arising from the Review.

CONFIDENTIAL

10 DOWNING STREET
LONDON SW1A 2AA

CHIEF SECRETARY	
REC.	31 OCT 1988
ACTION	Mr Saunders,
COPIES TO	Cx, Sir P Middleton, Mr Anson, Mr Phillips, Miss Parsons, Mr Tombs, Mr Call, Mr Passmore, Mr MacAuslan,

From the Private Secretary

31 October 1988

NHS REVIEW: AUTUMN STATEMENT

Thank you for your letter of 24 October which the Prime Minister has seen together with Carys Evans' response of 28 October. The Prime Minister agrees that the public announcement of extra funding for Review-related items should be deferred until the conclusions of the Review are published.

I am copying this letter to Alex Allan (H.M. Treasury), Carys Evans (Chief Secretary's Office), Mike Maxwell (Northern Ireland Office), David Crawley (Scottish Office) and to Stephen Williams (Welsh Office).

PAUL GRAY

Andy McKeon, Esq.,
Department of Health.

CONFIDENTIAL

FROM: D P GRIFFITHS
DATE: 1 November 1988

PS/ CHANCELLOR

cc PS/ Chief Secretary
Mr Anson
Mr Phillips
Miss Peirson
Mr Turnbull
Mr Gieve
Mr MacAuslan
Mr Pickford
Mr Saunders
Mr Bush
Mr Call

SOCIAL SERVICES COMMITTEE: UNDERFUNDING THE NHS

Today's FT contains a short article on the latest report of the Social Services Committee on NHS resources. The Committee return to the charge on the question of the alleged cumulative under-funding of the hospital service between 1980-81 and 1987- 88 and come up with a figure of £1.5 billion. The basis for the Committee's estimate is their contention that health services need to grow by 2% a year in order to keep up with demand (increasing numbers of elderly etc). In previous calculations the Committee have not taken into account the increase in productivity in the HCHS. However, this time they claim to have taken account of efficiency gains as well as cash-releasing cost improvements.

2. The report has not yet been published and neither we nor DoH have seen an advance copy. We cannot therefore comment in detail on the Committee's claims. I suggest instead we concentrate on the real terms growth in resources for the HCHS (1989-90 plans including cips and superannuation savings) since 1978-79.

3. I attach a further question and answer for the defensive brief.

D P GRIFFITHS

Hospital service underfunded by £1½ billion since 1980-81 according to Social Services Committee

Have not seen Committee's report so cannot comment in detail but ridiculous to talk about underfunding when spending on the hospital service is up by over 38% in real terms between 1978-79 and 1989-90.

Chancellor's crystal ball

MR NIGEL Lawson has an additional reason for making his Autumn Statement to the House of Commons tomorrow sound good. He is due to speak immediately before the Government motion to reinstate plans to levy charges for dental tests and eye check-ups, on which more than 70 Conservative MPs are threatening a back-bench revolt. An encouraging Treasury forecast for the economy next year (added to the announcement of a generous NHS settlement by Mr Kenneth Clarke) should persuade some of the Tory rebels to hold their fire—and it looks as though the Chancellor will be able to deliver.

Two of the best-known forecasting groups, The London Business School and Oxford Economic Forecasting, are both predicting that Mr Lawson's high interest rates should serve to cut Britain's vast current account deficit in the two years after 1989 without dragging the country into recession. Interest rates are likely to stay at present levels, or even higher, until late next year, but both forecasters expect inflation to peak at around 7 per cent in the first quarter of 1989 and then begin to drop (although not to below five per cent in the early 1990s).

As has been said many times, high interest rates are ultimately an ineffectual weapon for Mr Lawson to wield, since they hit manufacturing industry and lessen our competitiveness abroad. Higher domestic spending taxes are fairer and more accurate in their effect. Nevertheless the latest forecasts suggest that gross domestic product will show a healthy 5 per cent growth this year, which suggests that there is enough momentum in the economy to stave off recession. What with Mr John Major's success, for the second year running, in keeping down Whitehall budgets without recourse to the Star Chamber, it would appear that Mr Lawson's luck is holding. Let us hope he doesn't push it too far tomorrow by promising more income tax cuts, which would fuel the still-booming demand.

FINANCIAL TIMES

HEALTH FUNDS

Health care shortfall estimated at £1.5bn

By Philip Stephens, Political Editor

THE cumulative underfunding by the Government on hospital and community care services between 1980/81 and 1987/88 totalled about £1.5bn, a cross-party House of Commons committee said yesterday.

In its latest report on public expenditure on the social services, the Social Services Committee re-affirmed its view that spending on hospitals and community care needed to rise by 2 per cent a year in real, or inflation-adjusted, terms to meet increased demand.

The committee said that even if it took account of efficiency gains and other cost improvements claimed by the Department of Health, real spending had risen by an average of only 1.5 per cent. That translated into a cash figure for underfunding in the region of £1.5bn.

Separately, the committee, chaired by Mr Frank Field, the Labour MP for Birkenhead, called on the Government to move further to eliminate the poverty trap caused by the withdrawal of social security benefits from those on low incomes.

It said that the new benefits system introduced earlier this year had been successful in eliminating the previous effective marginal tax rates of 100 per cent or more for those on low earnings. But the number of families facing very high marginal rates of 80 per cent or above had actually increased.

The report says that on that basis, the social security reforms comprised "at best" only the beginnings of the process of eliminating the poverty trap. It could be argued that the present system was worse that the previous one.

Sixth Report of the Social Services Committee, to be published as HC689.

THE INDEPENDENT

Power and water costs expected to rise

By Jeremy Warner and Patrick Donovan

HIGHER prices for both electricity and water are likely to be foreshadowed in today's Autumn Statement from the Chancellor.

The Government is expected to underline its commitment to tough financial targets for the nationalised industries, including a continued net reduction in borrowings.

The electricity industry has already put consumers on notice of average price rises of around 6 per cent next financial year so that it can meet Government demands to repay its borrowings by the time it is privatised. Bills rose by 9 per cent this year.

Water prices are also set to rise steeply once more to meet tougher financial targets and higher environmental standards.

Nicholas Ridley, the Environment Secretary, warned recently that the need to control pollution would mean real costs of water rising over the next decade.

Some experts have predicted price increases of more than 50 per cent above the rate of inflation over the next five years to pay for environmental standards.

There were fresh warnings yesterday of electricity privatisation leading to higher power costs for the consumer. Eight leading unions joined with academics and consumer groups to condemn the Government's plans at a conference organised by the TUC.

John Prescott, Labour's energy spokesman, said that selling off the industry could result in Britain paying the most expensive electricity prices in Europe.

The plans would be a disaster for the economy, he declared. How could it make economic sense to sell for as little as £14bn publicly-owned assets which would cost £40bn to replace?

"Jobs will be lost," he said. "Dependent industries such as coal, power manufacturing and transport will also suffer."

Derek Prentice, of the Consumers' Association, alleged that the concerns of the consumer were being "hijacked" by the Government's proposals.

DEPARTMENT OF HEALTH ~~AND SOCIAL SECURITY~~
Richmond House, 79 Whitehall, London SW1A 2NS
Telephone 01-210 3000

From the Secretary of State for ~~Social Services~~ Health

CONFIDENTIAL

David Crawley Esq
Private Secretary
Scottish Office
Whitehall
LONDON
SW1A 2AU

CHIEF SECRETARY
REC. - 2 NOV 1988
Mr Saunders/Mr AM White
cc Sir Michael Scholar
Mr Brown, Mr Phillips, Mr Tomlinson,
Miss Peirson, Mr Griffiths, Mr Sussex
Mrs Roberts, Mr Call

1 November 1988

Dear David

STOCKTAKING REVIEW OF THE HEALTH SERVICE IN SCOTLAND

My Secretary of State has seen your letter of 19 October to Paul Gray. He is content for your Secretary of State to publish the stocktaking booklet.

I am sending copies of this letter to Paul Gray (No 10), Stephen Williams (Welsh Office), Mike Maxwell (Northern Ireland Office), Carys Evans (Chief Secretary's Office), Richard Wilson (Cabinet Office) and Ian Whitehead (No 10 Policy Unit).

Yours

Andy

A J McKeon
Private Secretary

26.10.3

SECRET

RP

FROM: R B SAUNDERS

DATE: 1 NOVEMBER 1988

CHANCELLOR —

cc Chief Secretary
Paymaster General
Sir P Middleton
Mr Anson
Sir T Burns
Mr Phillips
Mr Culpin
Miss Peirson
Mr Turnbull
Mr Parsonage
Mr Griffiths
Mr Sussex
Mr Call

NHS REVIEW: STOCKTAKING

You are holding a meeting on Thursday to take stock of what the Review has now got to, and where it might be going.

2. I attach a note prepared by Mr Griffiths which sets out, from the Treasury's point of view, which of the conclusions of the Review so far can be regarded as beneficial and which not. Overall, we have done quite well in fending off expensive bad ideas (save perhaps the concession we had to make on benefits in kind), but we must suspend judgement as to how far we have succeeded in ensuring that effective financial control is not undermined.

3. The main themes of the Review as it has evolved are now:

a. improving accountability within hospitals by, for example, better management and financial information systems, improved VFM audit, medical audit and reforming consultants' conditions, notably the merit award system;

b. freeing up the controls within the system by introducing self-governing hospitals, delegating more decisions to hospital level, and improving public/private sector co-operation;

c. making the system more responsive - hence the "package for patients", GP budgets for elective surgery, and performance funding.

4. We need to think about how some of these proposals will turn out in practice. Some look on the complicated side, while others still need a lot more work done on them before they can be unveiled as part of the outcome of the Review. We must look at the potential pitfalls, before we start getting into drafting a White Paper.

Accountability within hospitals

5. This is making good progress. The resource management initiative is being accelerated, and we are in touch to ensure that DoH drive it through properly. We have agreement that the Audit Commission will take over statutory audit of health authorities and FPCs. So long as DoH come up with positive proposals on medical audit and consultants, we have the makings of an attractive package here.

Self-governing hospitals

6. This too is coming along quite well. There may be political problems in pressing self-government in particular cases against opposition from at least some local groups. But the proposals now stand up reasonably well in procedural terms. The main problems are likely to be about pay. Clearly, if self-government is to have any meaning, the hospitals must have more freedom than at present over terms and conditions. But the political and possibly legal difficulties of taking some people out of national pay bargaining systems and review bodies, but not others, should not be underestimated.

7. Rather than treating the staff of self-governing hospitals differently from the rest, we need to try and reform the pay system more generally so that it offers employers the sort of freedom that self-governing hospitals would expect in terms of, eg geographical and performance-related pay. Abolition of the review bodies would be the ideal, though probably an unattainable

meaning what?

one. Instead, we might look at the relationship between review bodies and collective bargaining, particularly for nurses. We shall be having an initial discussion about this with DoH officials shortly.

Public/private sector co-operation

8. This is to be the subject of another DoH paper, on how to encourage the private sector and, as the record of the last meeting put it, blur the distinction between public and private. In considering this, we must keep in mind the distinction you made at an earlier stage between finance and supply. It is on the supply of health services that we want to blur the public/private distinction - eg by competitive tendering in clinical services. We most certainly do not want to blur it on finance. We have sought to maintain this distinction clearly and have resisted schemes for health vouchers or "opting out of the NHS", which involve new and expensive subsidies to those who pay for their own private health care. This will be the essential point to bear in mind when the DoH paper appears.

9. A specific instance in which it could arise is GP practice budgets. If GPs are to be allowed to refer patients directly to private hospitals, there is a danger of public finance substituting for private finance - in effect a new subsidy for private treatment. If your GP can refer you privately using public funds, you do not need insurance, so the net private funds going into health are reduced. This is quite different from a district buying bulk from a private hospital in order to reduce waiting lists: that is substituting private provision for public provision, a completely different kettle of fish.

10. The DoH proposals for more private finance for capital projects are also relevant here. The Chief Secretary will have held his meeting with Mr Clarke earlier on Thursday.

GPs and family practitioner committees

11. This however is a rather unclear tangle of three quite distinct themes: GP budgets, management control of GPs, and cost control.

12. The first is mainly about giving GPs new powers to try and make the hospital system work better. It has little to do with management of the FPS (so talk of "opting out" is misleading). It is looking for a mechanism to get waiting lists down, either by discouraging unnecessary referrals or by targeting resources on those hospitals who deal with patients most expeditiously. The link made with top-sliced performance budgets at the last meeting is quite right: these two proposals, both aimed at waiting lists, need to be knitted together in some way. Tackling waiting lists must be a big objective for the Review. The proposals should be designed with this clearly in view. But beware the point about referrals to private hospitals (paragraph 9 above).

13. The minutes of the last meeting are muddled on the second theme: management control. DoH have been asked to produce a paper on how the capacity of FPCs to enforce their contracts with GPs should be strengthened. But the minutes talk about this in terms of those GPs who have not "opted out", completely ignoring the fact that GPs with practice budgets will have an identical relationship with their local FPC. It is through their contracts with FPCs that GPs are remunerated and enabled to provide primary health care. The practice budget proposal is simply an add-on. If GPs with practice budgets are to come under some new remuneration system - as the minutes seem to imply - then the issue needs to be addressed explicitly and quickly. The present system is much more complicated than simple capitation fees, which account for less than half of GPs' remuneration. In my view, we do not want to propose a new remuneration system for GPs with practice budgets. We want the stronger FPC management to apply to them as well as to other GPs.

14. The third - cost control - is the important one for the Treasury. We have got proposals for drug budgets, cash limits (including DHA/FPC merger) and controlling GP numbers in play, but are still some way from achieving any of them. Indeed the proposal to allow GPs to retain underspends on practice budgets will tend to ratchet FPS costs upwards: those who opt for practice budgets will tend to be those whose costs are below the average on which the budgets will be based. We should keep it a high priority to get something worthwhile in this area out of the Review.

15. We should be looking for an acceptable result on all three of these, to form a coherent package. We should not accept GP budgets without better cost control and management of the FPS generally.

Funding

16. The Department have a remit to produce a paper for the next meeting, including the "abolition" of RAWP and its replacement by a capitation-based system. We need to be clear what this means. There will need to be some system for allocating resources according to population, adjusted for differences in age structure and morbidity (ie how sick the local population are). In practice this will be little different from the present calculation of RAWP targets, the formula for which is not all that complicated. In a fully-fledged system of buyers and providers, these allocations would go to the buyers who would use them to purchase appropriate health services. But, initially at least, the two roles will continue to be closely intertwined in health authorities. So the money going to health authorities would be very much like allocations according to RAWP targets (with the possible exception that it would allocate to district rather than regional level, which would require a more finely-tuned formula). In other words, the effect would be to speed up the process of moving to RAWP targets, since it would be done at once rather than over a period of years. It will be interesting to see how DoH address this in their forthcoming paper, but they

territorial formulas

might make a bid to buy out regions who are at present below target. We should not let them get away with the impression that RAWP is being "abolished" in return.

17. The changes so far proposed will make the system more complicated than it is now. It is now a fairly simple top-down process through regions and districts to hospitals. The new system, in contrast, would fund hospitals by a combination of at least three different methods ("core", "contract" and "performance"), have different arrangements for financing district-managed and self-governing hospitals respectively, and partially fund some services through GP practice budgets. It is hoped to simplify the treatment of one aspect of the present arrangements - cross-boundary flows - but even here it may not be possible to get rid of the present adjustment entirely (eg for "core" services).

18. Still on the theme of complexity, the objective was once to slim down, if not abolish, regional health authorities. The net effect of the proposals so far, however, is to beef them up considerably. No proposals are yet on the table which would take functions away from regions sufficient to compensate for the following additions so far proposed to their terms of reference:

- overseeing the transition of hospitals to self-governing status

- some controls over acquisition and disposal of assets by self-governing hospitals, a responsibility which now resides primarily with districts.

- oversight of FPCs, whether or not merged with districts

- allocation of budgets for elective surgery etc to GP practices who so opt

- running the performance-based element of hospital/ district funding

- responsibility for the proposed new system of capital charges

- approving voluntary capital raising schemes which will attract pound-for-pound public funding.

19. Greater complexity is not in itself an argument against change. If we are to break up the present monolithic arrangements, and introduce new incentives to improve performance and efficiency, a more complicated funding system is inevitable. We were aware of this when we proposed the idea of performance funding, reasoning that the new incentives would have benefits outweighing the administrative costs. A stronger role for regions is also inevitable, since the alternative is to centralise these functions into the Department of Health and the NHS Management Board. But the Group should be aware of the extent to which the proposals complicate rather than simplify, and therefore seek assurances about the capacity of the people in charge to absorb and manage these changes. You will wish therefore to ask Mr Clarke whether he thinks that the regions, in particular, have strong enough managements to tackle the changes which he has proposed. We shall feed this thought in to DoH officials, who are preparing a paper on the reconstitution of regional and district health authorities for the next meeting.

Have you seen what they pay them? Not much.

Direct effects on patients

20. Finally, we must not lose sight of this. Insofar as the other proposals will improve the efficiency and effectiveness of the NHS, patients can be expected to benefit in the longer term. But the White Paper will need to contain some convincing ideas for tackling the worst waiting list black spots and for getting hospitals to raise the non-clinical treatment of patients from its present unacceptable standard. Mr Clarke is to put a paper on this to the next meeting.

R B SAUNDERS

ANNEX A

NHS REVIEW: STOCKTAKING

Treasury Objectives

1. Better value for money in the NHS through reforms to improve efficiency and enhance services to patients without a significant increase in public expenditure.

2. Ensure maintenance and, where necessary, development of effective public expenditure control over NHS.

3. Introduce more of a price mechanism into the NHS eg

- more patient charges [what's happened to optional extras as a form of income generation?]
- internal markets

Achievements

1. Acceptance of principle of introducing performance-related financing eg creation of funding mechanism more attuned to rewarding performance and use of top-slicing of resources to help efficient hospitals through practice budgets for certain GPs or waiting list funds for GPs. [But methods still not quite agreed.]

2. Agreement on importance of measures to provide better service to NHS customers (reforms to appointment systems, visiting hours, improving waiting rooms etc).

3. Some progress on promoting greater use of price mechanism eg commitment to extend the Resource Management Initiative throughout the NHS acute sector, introduction of capital charging.

4. Agreement to transfer responsibility for NHS audit to Audit Commission. [but still practical problems to sort out, eg relationship with NAO]

5. Rejection of opting out and health voucher concepts. ~ hope so, but is it dead?

6. No significant diminution (so far) of public expenditure control in the HCHS.

Failures

1. No progress on extending charges.

2. Concession of private medical insurance tax relief for pensioners and all employee company schemes.

Still to play for

1. Better public expenditure control over the FPS. Ideal would be to merge DHAs and FPCs and impose cash limits. If cannot achieve this, seek to secure as many as possible of the necessary conditions for application of cash limits - implementation of controls over numbers of GPs entering the FPS, establishment of drug budgets for GPs. Minimum objective is to ensure that GP practice budgets do not lead to reduced financial control over, and unnecessary increase in, FPS expenditure.

2. Maintain effective control over capital expenditure with minimum derogation from the private finance guidelines.

3. Action to reform consultants' conditions. Agreement that this should be done but not on the measures necessary.

4. Competitive tendering for clinical services.

5. Pay in relation to self-governing hospitals and its impact on the rest of the NHS.

6. Accountability and the structures to support it (NHS organisation)

docs.1 2.11vj

FROM: R B SAUNDERS

DATE: 2 NOVEMBER 1988

PLEASE SUBSTITUTE ATTACHED REVISED

CHANCELLOR

cc Chief Secretary
Financial Secretary
Paymaster General
Economic Secretary
Sir P Middleton
Mr Anson
Mr Phillips
Miss Peirson
Mr Turnbull
Mr Gieve
Mr MacAuslan
Mr Pickford
Mr Bush
Mr Griffiths
Mrs Chaplin
Mr Tyrie
Mr Call

Ch/ Do you want X done?

OK -

AUTUMN STATEMENT: HEALTH

I attach a note designed to clear up any confusion between the £2 billion you quoted in the Autumn Statement (the increase in the 1988-89 plans for the UK) and Mr Clarke's 1.8 billion (the year-on-year increase in England between 1988-89 and 1989-90). If you agree, this could be handed out to journalists or any other interested parties.

X

R B SAUNDERS

chex.ps/mw/21 UNCLASSIFIED

FROM: MISS M P WALLACE
DATE: 3 November 1988

MR R B SAUNDERS

cc PS/Chief Secretary
PS/Financial Secretary
PS/Paymaster General
PS/Economic Secretary
Sir P Middleton
Mr Anson
Mr Phillips
Miss Peirson
Mr Turnbull
Mr Gieve
Mr MacAuslan
Mr Pickford
Mr Bush
Mr Griffiths
Mrs Chaplin
Mr Tyrie
Mr Call

AUTUMN STATEMENT: HEALTH

The Chancellor was grateful for your minute of 2 November. He has made one or two amendments, marked on the attached copy. Subject to that, he would be happy for this to be handed out as you suggest.

MOIRA WALLACE

docs.2 2.11vj

AUTUMN STATEMENT: NHS EXPENDITURE IN 1989-90

Net NHS expenditure in England for 1988-89 and 1989-90 ~~in~~ ~~The~~ January 1988 Public Expenditure White Paper and the November 1988 Autumn Statement ~~is as follows:~~ give the following figures for ↓ :

		£million	
	1988-89	**1989-90**	**growth**
January 1988 White Paper plans adjusted for classification etc changes	17,540	18,470	+ 930
Autumn Statement	18,380 (est outturn)	19,720	+1340
Increase	+840	+1250	

The increase in 1988-89 largely reflects the increased provision announced in April and October for funding the nurses' and doctors' pay awards. This increase is carried through to future years as part of the survey settlement.

To the ~~Autumn Statement~~ cash increase in plans for 1989-90 announced in the Autumn Statement should be added the effect of reducing employer superannuation contributions (£277 million) and a new round of efficiency savings (£150 million). ~~This~~ These two factors increases the resources available for health care next year by £427 million.

So the approximate **increase in resources for 1989-90, as compared with the previous plan** is 1250 + 427 + 100 (for an increased projection of land sales receipts) or about £1¾ billion (England). The consequential increases for Scotland, Wales and Northern Ireland take the UK figure over £2 billion, of which rather less than half is the consequence of fully funding the pay awards.

The approximate **increase in resources next year over this year** is 1340 + 427 + 25 (higher income generation receipts), or about £1.8 billion. This is an increase of 9½% on the estimated outturn for 1988-89, or about 4½% in real terms after forecast inflation. The cash increase between the two years is in addition to the costs of the 1988 pay awards, but includes provision for forecast inflation in 1989-90.

HM TREASURY
2 NOVEMBER 1988

0009A

DEPARTMENT OF HEALTH ~~AND SOCIAL SECURITY~~
Richmond House, 79 Whitehall, London SW1A 2NS
Telephone 01-210 3000

From the Secretary of State for ~~Social Services~~ Health

SECRET

Paul Gray Esq
No 10 Downing Street
LONDON SW1

3 November 1988

Dear Paul

NHS REVIEW

I attach seven of the papers commissioned for next Tuesday's meeting of the Ministerial Group. The paper on capital, which reports the outcome of this morning's meeting between the Chief Secretary and the Secretary of State, will follow tomorrow.

The Secretary of State has been considering how the papers might be handled in a way that is most helpful to his colleagues. His conclusion is that it would not be possible to do justice to each of the eight papers if they were all put down for discussion at next Tuesday's meeting. Mr Clarke suggests therefore, if the Prime Minister is agreeable, that the following four papers are put on the agenda for discussion in the order given:

Medical Audit
Funding
Reconstituting Health Authorities
Managing the FPS

The other four papers cover:

Capital (not attached)
A better service
Public and private sector
Professional and employment practices

Mr Clarke suggests that colleagues might like to let him have any comments on these papers so that if there are any major issues arising they can be discussed at a later meeting.

I am copying this letter and enclosures to the Private Secretaries to the Chancellor of the Exchequer, to the Secretaries of State for Scotland, Wales and Northern Ireland, to the Chief Secretary and to the Minister of State and to Sir Roy Griffiths in this Department, and also to Professor Griffiths and Mr Whitehead in the No. 10 Policy Unit and to Mr Wilson in the Cabinet Office.

Yours ever

ANDY McKEON

Mr Saunders – 3/11
CST, Sir P Middleton, Sir T Burns,
Mr Anson, Mr Phillips, Mr Culpin, Ms Perrin, Mr Turnbull,
Mr Parsonage, Mr Griffiths,
Mr Call

SECRET

Copy No: 2.

HC 50

NHS Review

MEDICAL AUDIT

Note by the Secretary of State for Health

1. This paper sets out my proposals for securing the accountability of doctors for the quality and cost-effectiveness of medical work.

2. In brief, I propose that we work with the medical profession, nationally and locally, to establish

* a system of medical audit in every District and self-governing hospital, based on self-audit and peer review and with a facility for management to initiate an independent professional audit; and

* a parallel system for general practice.

I HOSPITALS

Context

3. A major objective of the review is to ensure that consultants take more responsibility for the management and delivery of hospital services, and are more accountable for the quality and cost-effectiveness of what they do. There are two main aspects of this:

i. on primarily management issues, such as whether doctors are putting in the hours they are contracted to work, accountability will be secured through the management of consultants' contracts, supported by financial and VFM audit as appropriate. We have agreed on the steps we must take to make both the management of contracts and VFM audit more effective.

ii. on primarily professional issues, such as whether a doctor is using the most appropriate procedures for diagnosis and treatment, we need to secure accountability through medical audit. Medical audit will need to cover both the clinical treatment of individual patients and services to the population (cancer screening programmes and child development surveillance, for example).

SECRET

4. This paper is concerned mainly with (ii) - although we must also ensure that nothing falls into the cracks between (i) and (ii). The main focus is on the quality of medical care, which stands up well in comparison with other countries but remains, in places, uneven.

Medical audit in practice

5. Medical audit is a systematic, critical analysis of the quality of medical care, including the procedures used for diagnosis and treatment, the use of resources, and the resulting outcome for the patient. It necessarily requires both a specialised knowledge of current medical practice and access to medical records (which are the medical audit equivalent of accounts). I suggest that we should aim to have a system of medical audit in place, within the next two years, in every District and self-governing hospital.

6. It would be a mistake to prescribe precisely what each system should look like: medical audit is, by definition, primarily a professional matter, and it cannot be implemented by Government without the active participation of the profession. We also need to recognise that

i. medical audit is a relatively recent development in this country. Opinions about its use and value vary, and knowledge of its aims, scope and methods is thinly spread. Yet we need all hospital doctors to be intellectually convinced of its validity.

ii. medicine is an inexact science. Every diagnostic technique and treatment has an inherent element of risk. Medical audit must not encourage doctors to be reluctant to take on difficult but essential clinical work.

iii. we lack comprehensive, robust and professionally acceptable measures of the outcome of the work of individual doctors or of services.

7. In my view, therefore, we must consult the profession nationally about exactly how medical audit would work, and how prescriptive we (or they) should be, so that we can carry them with us. But we must do so on the basis of the kind of system we have in mind. I envisage a two-part approach: medical audit as a regular part of local medical practice; and a system of independent medical audit which can be initiated by management.

8. Subject to the outcome of consultation, I see regular, local audit working along the following lines:

i. every consultant would be expected to participate in a locally agreed form of medical audit, covering both self-audit and peer review. Accountability for the quality of work would be built into the standard job description for all consultants. Medical audit would become a fundamental element of continuing medical education.

ii. District management would be responsible, and accountable, for ensuring that this system was in place; that the work of each consultant's team was subjected to peer review at whatever regular, frequent intervals were agreed locally; and that there was a rolling programme under which the treatment of particular conditions was reviewed by the relevant doctors collectively at regular intervals.

iii. the system itself would be medically led. One approach might be for local practice and procedures to be overseen by a hospital or District medical audit advisory committee, chaired by a senior clinician. Peer review findings would normally be confidential to the consultants involved, unless they agreed otherwise, not least to avoid the risk of exposure to legal action. But it would be all the more important for the lessons learned to be published more widely, as the profession is already beginning to do.

iv. there would probably be a similar advisory committee or equivalent at each Region: partly to oversee the medical audit of less common specialties where a Regional approach seemed sensible; and partly, when necessary, to help doctors at District or hospital level to find consultants from outside the locality to help with peer review.

9. The ability of management to initiate an independent professional audit will be particularly important in the grey area between "management" and "professional" issues (paragraph 3(i) and (ii) above). Typical examples might be an unusually low proportion of day surgery or an unusually high rate of diagnostic tests: both might consume more resources than management believed to be necessary, yet either might be justified by the consultant concerned on clinical grounds. An independent audit could also be important where there was cause to question the quality of a service (for example evidence of unexpected outcomes such as a high death rate), or where the quality of a service was being examined in relation to its cost.

10. The fuller integration of consultants into hospital management should help considerably in such circumstances, but it will remain essential for management to be free to call on some form of peer review. This might often be done through any local advisory committee (8(iii) above), and there might

also be advantage in a formal mechanism for approaching the Region - preferably with the agreement of the local advisory committee chairman. A District general manager should, I think, be free to invoke such a procedure either in respect of a District service or in respect of a self-governing hospital with which the District has a contract.

11. In both routine medical audit and independent professional audit the best results will be achieved where the system works on the basis of consent, both as between doctors and as between clinicians and management. Nor should we underestimate the impact on a doctor of praise, advice or criticism from his peers. But there remains a risk that some consultants would refuse to participate in whatever form of medical audit was agreed locally, or decline to act on the findings of an independent professional audit. I propose we deal with this as follows:

(i) The General Medical Council (GMC) is likely to recommend soon that the medical records of all patients treated within the NHS should in principle be available for peer review, and that audit of medical work should be an obligatory element in continuing medical education. This will be more acceptable, and at least as effective, as any management attempt to enforce participation, and I suggest that we encourage the GMC to proceed accordingly.

(ii) Where a consultant refuses to act on the findings of an independent professional audit, management should invoke the normal disciplinary procedures, on grounds of professional incompetence.

(iii) The quality of medical work should be taken into account in the criteria for distinction awards.

12. An effective system of local medical audit needs strong leadership. This in turn requires time and - experience suggests - some secretarial support (for example to collate and present relevant data). More generally, all hospital doctors will need to devote a significant proportion of their time to taking part. Even assuming every consultant devotes just one-twentieth of his week to medical audit the cost in consultants' time would be around £25 million.

Other Action required

13. If we are to put in place arrangements of the kind described in paragraphs 6-12 of this paper, and are to do so within the two years I suggest, we need to build on the current growth of interest and experimentation within the profession itself. For example:

i. The Confidential Enquiry into Perioperative Deaths (CEPOD), a major study of all deaths within 30 days of surgical operation in 3 Regions, showed that in a small proportion of deaths there were preventable factors. This study is now to be extended nationally, with DH funding, and will be run by the Association of Surgeons, the Association of Anaesthetists, and the Royal College of Surgeons.

ii. The Royal College of Surgeons is now insisting that medical audit is a prerequisite for recognition of a unit for training purposes.

iii. A Royal College of Physicians Working Party will shortly publish a report commending the need for audit and requiring it as a prerequisite for the approval of training posts. They will also publish guidelines on how to undertake audit.

iv. Medical audit is already widely practised in many branches of pathology, where the quality and accuracy of the work is more readily measurable than that of other disciplines. The Royal College of Pathologists have developed protocols for checking standards.

14. Action by Government must be carefully judged to go with the grain of these developments. Our aim must be for Government and management to be supporting, using and reinforcing procedures developed by doctors themselves. There is nonetheless much we can do to generate still greater momentum by working with the profession nationally. In particular:

i. I have asked the statutory Standing Medical Advisory Committee, which represents the full range of authoritative medical opinion, to consider and report on how the quality of medical care can best be improved by means of medical audit, and on the development of indicators of clinical outcome.

ii. we should press all medical colleges to make participation in medical audit a condition of a unit being allowed to train junior doctors, by an agreed date.

iii. we should invite the profession to take part in a national initiative to support and monitor the development of medical audit locally. This might build on existing inspections of training posts, carried out nationally by the Royal Colleges. It might also be possible for each College to establish guidelines for the diagnosis and treatment of common conditions.

iv. we should encourage the further development by the profession of national audit schemes such as CEPOD.

15. I believe we should also insist that a hospital has an acceptable system of medical audit before we can agree to self-governing status. I am considering how best to reduce to a minimum the criteria for self-governing status, but I suggest that adequate medical audit remains one of them. This should prove a useful, additional incentive. Districts buying the hospital's services will no doubt wish to ensure, through their contracts, that an effective system of medical audit remains in place subsequently.

The private sector

16. In principle, medical audit should apply to private as well as public sector hospitals. At present quality control is generally weaker in the private sector: for example, an untrained person can offer surgery, such as cosmetic surgery; and a laboratory can offer to undertake tests, or to provide a service such as breast cancer screening, without any quality control. Medical records tend to be relatively scanty.

17. There is no legal framework within which the Government could impose standards or require the adoption of medical audit. I suggest that the best approach would be to

i. encourage the profession nationally to extend medical audit into private practice. One example of this approach is a current Royal College of Pathologists' proposal to establish an accreditation scheme for private sector laboratories.

ii. encourage the GMC to make peer access to medical records obligatory in the private sector too.

iii. ensure that Districts which buy services from the private sector insist on adequate medical audit being in place before they do so, just as I am suggesting where they buy services within the public sector.

18. These measures, taken together, should prove an effective stimulus to the development of medical audit in private sector hospitals, and should also help further to blur the distinction between the public and private sectors.

II GENERAL PRACTICE

The problem in general practice

19. The circumstances of primary care differ from those in the hospital service in several ways which bear on the nature of medical audit. For example:

i. the GMC should be encouraged to require peer review access to GP as well as hospital consultants' medical records.

ii. medical audit locally would be based primarily on self-audit by GPs and GP practices. Local practice and procedures would be medically led, supported and encouraged by a medical audit advisory committee established by each FPC.

iii. each FPC would establish a system for identifying possible signs of poor quality care. Many different indicators could be relevant: inadequate records or equipment; inappropriate referrals; emergency admissions resulting from poor health surveillance or failure to refer sooner; avoidable deaths; and so on. Local clinical protocols could be developed on a selective basis (setting out the action required during antenatal care, for example), and clinical records assessed against these protocols. The local advisory committee would help to arrange an external audit of a GP or GP practice where necessary.

iv. each FPC, in consultation with its GPs, would set up a small unit of doctors and other staff to support and monitor the audit procedures of contracting practices. The unit would be accountable to the FPC manager and work under the guidance of the local steering committee. The staff costs and travelling expenses each FPC's unit might average as much as £100,000 a year, or approaching £10 million for England as a whole.

23. In short, as with hospitals, I would suggest a system which is based firmly on the principles of self-audit and peer review but in which action can also be initiated by management.

November 1988

Copy No.

HC 49

NHS Review

FUNDING ISSUES

Note by the Secretary of State for Health

1. I was asked to submit a note describing how cross-boundary flows will be funded in the future and how our proposals on rewarding performance by allocating an element of "top-sliced" money will operate. Discussion of these topics necessarily draws us into future funding arrangements generally and the timetable for change, and I have therefore taken the opportunity to outline my proposals on transitional arrangements.

2. In summary, the key proposals are:

(i) the replacement of RAWP in 1990/91 as the basis for financial allocations to Regions, to be replaced by a simpler system of distributing incremental growth money.

(ii) sub-Regional RAWP targets to be discontinued as indicators for financial allocations to Districts.

(iii) a carefully managed transition to funding Districts as "buyers", on a weighted capitation basis.

(iv) from 1990/91, changes to the present arrangements for funding cross-boundary flows, to make them reflect the work carried out more accurately pending the full implementation of (iii).

(v) a short-term, performance funding scheme to allocate £50m of "top-sliced" money on the basis of a proven track record of efficiency or to encourage targeted improvements in output, including additional consultant posts.

Funding cross-boundary flows

3. One of the key themes of the review is that hospitals should be rewarded for their success in attracting business. This means that money must follow the patient.

4. Under present arrangements, cross-boundary flows of inpatients between Regions are reflected retrospectively in the RAWP formula. The adjustments affect targets - and hence Regions' distances from targets - and so the impact on allocations is indirect. Quite significant changes in flows may

have little or no immediate effect on allocations. Other disadvantages of the present system are:

(i) the adjustments are based on past data, so can never be less than a year out of date.

(ii) the adjustment to reflect casemix - and hence the costs of flows - is too broad adequately to reflect the costs associated with treatment.

(iii) the costs used are national averages, and so give no incentive to the "exporting" authorities to shop around.

(iv) neither "exporters" nor "importers" can control flows.

5. At Regional level, net cross-boundary flows represent a relatively small proportion of targets, as Annex A illustrates. Flows are much more significant between Districts. Arrangements for allocations to Districts vary from Region to Region, but are likely to reflect planned rather than actual flows. Districts which exceed their planned inflow will not necessarily receive additional funding for the extra business undertaken. So the disadvantages in paragraph 4 apply generally to flows between Districts also.

6. Paper HC35 outlined proposals for the future funding of hospital and community health services (HCHS). In particular it proposed a move towards a contractual approach to the management and funding of services, differentiating DHAs as buyers of services from hospitals - DHA managed, self-governing or private - as providers. Our proposals on GP practice budgets are a further development of this approach.

7. Under these proposals Districts would receive an allocation which would be used to fund services for their resident populations. In some cases GPs would be responsible. The present system for funding cross-boundary flows would be phased out, since these flows would be funded directly by the "buying" authority and by "buying" GPs, under contracts with hospitals outside their own District boundaries. A model contract developed by my Department and MoD earlier this year as a framework for health authorities to buy services from MoD service hospitals provides one example of this approach, although by no means a fully developed model (Annex B). The following paragraphs set out how the new financial allocation system might work and how we might manage the transition.

Allocations to Regions

8. HC35 proposed a simple capitation based formula with adjustments to reflect geographical variations in input prices and the numbers of elderly people. For allocations to Regions, I suggest that:

(i) all Regions would receive an equivalent percentage growth figure, subject to:

(ii) extra funding for those Regions which had a relatively fast-growing population or a particularly rapid growth in the number of elderly people. (Annex C presents population projections by Region.)

Funding in respect of medical teaching, together with other "top-sliced" money, would be handled separately.

9. This approach has many attractions:

(i) simplicity: the complicated adjustments in the current formula for assessing "relative need" would be abandoned on the grounds that over time these are relatively stable between Regions. The relative position of Regions would not change rapidly. We would have to examine this assumption periodically, however.

(ii) it avoids the distinction between target and actual allocations, the differences between which always provoke rows.

(iii) it emphasises the fact that RAWP has largely fulfilled its objective of redressing geographical imbalances in funding, and that we can now draw a line under it by preserving the redistribution in resources achieved over the last 12 years. Eleven of the 14 Regions are now within 3% of target.

10. However, there would be considerable political and managerial difficulties in simply abandoning the present arrangements. Over half the country would be up in arms, regarding themselves as having been robbed of their due under the RAWP equalization process. It would in any case be impractical to try to implement the proposed new system for the next financial year. It should be possible to build into the allocations for 1990/91 a special sum for those Regions who are significantly below their RAWP target in order to "buy out" significant under-resourcing.

Allocations to Districts

Funding authorities as buyers

11. Under the contractual approach to funding services outlined in HC35, Districts as "buyers" should in principle be allocated the funds they need - no more and no less - to buy services for their resident population. The location of services would be irrelevant. Districts using their own services would "buy" them through management budgets, but would be free to buy them from other Districts, from self-governing hospitals or from the private sector.

23. Similar considerations apply to the extent to which allocations reflect geographical variations in input costs, for example due to "market forces" or London Weighting, of the kind which will feed through into the prices charged by hospitals. Where a District is effectively constrained to buy locally, for example emergency services, they will need to be compensated for the higher prices they will have to pay. But Regions will also need to take a view on the extent to which Districts should be compensated in this way, bearing in mind the need to preserve incentives to shop around to secure the best deals.

GP Practice Budgets

24. Our proposal to allow large GP practices the opportunity to have their own budgets means that funds for these budgets must be split away from the balance of HCHS allocations at some point. It does not seem defensible to vary capitation payments to GP practices according to the District in which the patient happens to live, at least not until the District itself is funded purely on a weighted capitation basis. I propose that the earmarking is best left to Regions, on the basis of central guidance over the scope of GP practice budgets.

Specialist Services

25. HC35 recognised the need for separate funding arrangements for highly specialised hospital units which provide services to patients from a wide catchment area. Many of these services have been developed on a supra-regional or regional basis, for example heart transplantation and neonatal care respectively.

26. The current central funding arrangements for supra-regional services are outlined in Annex F. I propose that these arrangements should continue. It is particularly important to avoid wasteful duplication of these often expensive services, and to be able to underwrite important new developments like heart transplantation as they get off the ground.

27. The current approach to regional services differs between Regions. Some Regions, for example Yorkshire, are already exploring the use of a contractual approach to the planning, management and funding of "multi-district services", under which Districts enter into prospective service agreements with providing Districts on the elements of service to be provided. I expect our proposals on the funding of services to give further impetus to such developments.

Timetable for implementation

28. For the new funding arrangements we envisage to be put in place, a number of other things are needed:

(i) primary legislation is needed to permit cross-charging between health authorities (Annex G). We are planning

legislation for the 1989/90 session giving authorities the necessary powers to cross charge from autumn 1990.

(ii) both "buyers" and "providers" must be in possession of better cost and activity information. As outlined in HC43, we are planning an accelerated programme for implementing the resource management initiative (RMI); in the meantime improved information is available following the implementation of the Korner recommendations, and further improvements will flow naturally at local level in response to the demands of an increasingly contractual approach to management and funding.

(iii) we must attract into the service finance and other staff capable of negotiating, monitoring and controlling contracts. This will have implications for pay levels and the costs of management, and will take time.

(iv) direct funding for the training of medical, nursing and other staff. Under current arrangements DHAs bear a considerable proportion of the costs of training (Annex H). Training is generally undertaken on behalf of either a group of authorities or the NHS as a whole. Hospitals providing training should not be at a cost and price disadvantage when competing for business; Districts buying services should not be expected to bear an undue proportion of the training costs incurred on behalf of other authorities; and self-governing hospitals, many of whom will be teaching hospitals, will need contracts in respect of their teaching activities. Non-medical training will need to be planned, as now, on a Regional or, exceptionally, national basis.

29. We will clearly not be able to introduce our funding proposals universally until after the next General Election. Rapid implementation without adequate attention to the management infrastructure and to the underlying arrangements for transferring funds between buyers and providers will fail.

Interim Proposals

30. During this interim phase we must make the present arrangements for funding services work better. In accordance with the outline proposals in HC35, I intend to:

(i) amend the present arrangements for funding Regions in respect of cross-boundary flows to ensure that changes in flows have a more immediate impact on allocations to hospitals; and

(ii) introduce a performance funding scheme for allocating an element of "top-sliced" money on the

basis of either a proven track record of efficiency or in order to encourage targeted improvements in efficiency or output.

Cross-boundary flows

31. On cross-boundary flows I propose the following steps:

(i) Regions should enter into discussions with each other during 1989/90 to establish the appropriate sums for "exports" and "imports", concentrating on the major flows. We could then begin to reflect these agreements in allocations for 1990/91. The initial sums would be based on the estimated actual costs (to the providing authority) of recent cross-boundary flows.

(ii) until legislation to permit cross-charging was available, the Department would make any necessary adjustments to cash limits as agreed between Regions.

(iii) as cross-charging became possible, allocations would need to be adjusted so as to relate primarily to resident populations (though Regions might initially still be required to provide services for "de minimis" flows, from within their allocations, so as to avoid unnecessary bureaucracy).

Whilst these changes will not address all the disadvantages of the present system, they will ensure that authorities are compensated more accurately, albeit still on the basis of past flows, for the work carried out.

Performance Funding

32. Once fully implemented, our approach to funding services on a contractual basis, in combination with a more competitive environment, will provide the necessary incentives for hospitals to improve their efficiency; money will also flow to those hospitals successful in attracting business. I therefore regard any scheme which allocates an element of "top-sliced" funds in accordance with actual or potential performance as short term only, on the principle that the new funding arrangements should make redundant any "top-down" performance funding scheme.

33. Measurement of performance is difficult. Ideal measures of effectiveness - based on health outcomes - and efficiency - relating outcomes to inputs - are not available. Assessment of performance requires taking account of a range of performance measures. A mechanistic approach would cause public complaint; and reliance on only a few indicators might distort behaviour and focus activity narrowly on improving the indicators chosen. Local management judgements will be needed. There should be no presumption, however, that all Regions will receive similar amounts, pro-rata to their main allocations.

34. Possible indicators of efficiency and effectiveness include:

* changes in "cost weighted activity" in relation to expenditure;

* throughput per bed;

* waiting times for inpatient and outpatient treatment;

* percentage of treatments on a day basis (a cost effective form of treatment for many conditions);

* percentage of unplanned admissions;

* significant changes in avoidable mortality.

The Group will be familiar with many of these. Annex I provides a further description of "cost weighted activity" and avoidable mortality.

35. The emphasis within the scheme will be to reward those hospitals which have demonstrated recent improvements in efficiency, having regard to the scope for further improvements. Hospitals which have already secured significant improvements in efficiency should still be in a position to be rewarded for further, albeit smaller, improvements. There should also be scope for Regions to allocate funds in a more targeted manner, for example where allocations would secure improvements in waiting times and permit additional patients to be treated. This involves an element of prospective funding, but I suggest that this should be permitted only if the recipient has already demonstrated improvements in efficiency; we must avoid allocating funds solely to hospitals which, by dint of their poor track record on efficiency - as reflected, say, in long waiting times - have the greatest potential for improvement.

36. Even if the scheme is short-term there could be some overlap in time with the beginnings of self-governing hospitals and GP practice budgets. It would seem sensible in these circumstances for the money to go directly to "providers" - that is to self-governing hospitals but not to GPs - since it is on providers that the scheme's incentives are intended to operate.

37. Performance based allocations will be funded out of "top-sliced" money. I propose a sum of £50m a year for the duration of the scheme. I would need to make a bid for additional funds. The merit of keeping the scheme modest is that it enables a simple method of allocation and it would be easier to justify why some Districts receive no additional funding. Allocations in respect of improved performance would be built into baselines for future years.

38. Paper HC36 discussed the feasibility and cost of establishing additional consultant posts in acute specialties.

These posts could be funded out of performance based allocations; Regions would be informed of the number of additional posts they could create. The use of funds in this way would introduce an element of inflexibility into the scheme; and the costs would be uncertain, varying by specialty and location. Nevertheless, I am pursuaded by the argument that additional posts will act as a counterweight to other changes which the profession will find less attractive. I propose therefore, a target of an additional 120 consultant posts over 2 years, 60 each year. This would cost around £15m a year after year 2, assuming (perhaps conservatively) that the average cost - including associated staffing and facilities - was £250,000 a post. An increase of this order would be feasible in terms of the availability of qualified senior registrars.

39. I propose that these additional posts should be permanent. We have discussed in the past the possibility of short term appointments as a means of making an impact on waiting lists without incurring long term costs. I am not persuaded by this argument because:

(i) except under rather unusual circumstances, an additional consultant surgeon will need additional supporting facilities which would become redundant after his appointment was terminated.

(ii) short term appointments are likely to attract lower quality applicants.

Short term appointments would necessitate amending the Regulations on the appointment of consultants.

November 1988

B:D5.30/4

Annex A

NON-PSYCHIATRIC PATIENT FLOWS AS A PERCENTAGE OF POPULATION OF EACH REGION (1988/89 ALLOCATIONS)

NORTHERN	- 0.38
YORKSHIRE	- 0.04
TRENT	- 4.45
EAST ANGLIAN	5.70
NORTH WEST THAMES	- 13.64
NORTH EAST THAMES	4.60
SOUTH EAST THAMES	0.78
SOUTH WEST THAMES	- 11.65
WESSEX	- 1.10
OXFORD	- 1.55
SOUTH WESTERN	0.56
WEST MIDLANDS	2.04
MERSEY	- 0.73
NORTH WESTERN	3.08

1. "-" Signifies a net outward flow.

2. Figures include cross-boundary flows into and out of Scotland and Wales.

3. The patient flows for North West and South West Thames Regions are more marked because of the number of patients treated by Special Health Authorities on their behalf.

B:D5.29/6

ANNEX B

MOD/DHSS FINANCIAL ARRANGEMENT FOR NHS USE OF SERVICE HOSPITALS

1. The Ministry of Defence and DHSS have agreed revised arrangements for the treatment of NHS patients in Service hospitals in the United Kingdom.

2. Service hospitals are established to train Defence medical staff in all aspects of their work so as to fulfill their roles in periods of tension or war. To meet that training requirement, the hospitals, in peacetime, treat Service personnel and NHS patients, which includes Service dependants, mainly free of charge.

3. Under the new arrangements, NHS patients will continue to be treated, mainly at MOD expense, within a baseline which reflects the training requirement. Beyond that level, any spare capacity will be offered to Health Authorities on marginal cost recovery terms to help relieve NHS waiting lists and maximise the Service hospitals' contributions to civilian health care. Under the new arrangements, provision is also made for planning agreements where defence and health facilities can be rationalised or integrated to mutual local advantage.

4. The intention is that the implementation of the arrangements should rest at local levels and negotiations take place directly between Health Authorities and individual Service hospitals who will need to convert the national principles into contracts and planning agreements to reflect local needs.

B:D5.29/6

ANNEX C

POPULATION PROJECTIONS 1985 - 1995

Total Population (thousands)

Region	1985	1986	% change
Northern	3,086	3,038	- 1.6
Yorkshire	3,599	3,635	1.0
Trent	4,625	4,741	2.5
E Anglian	1,965	2,149	9.4
NW Thames	3,482	3,589	3.1
NE Thames	3,751	3,832	2.2
SE Thames	3,602	3,743	3.9
SW Thames	2,962	3,061	3.4
Essex	2,854	3,093	8.4
Oxford	2,437	2,678	9.9
South Western	3,150	3,345	6.2
West Midlands	5,183	5,265	1.6
Jersey	2,423	2,379	- 1.8
Mersey	3,992	3,982	- 0.3
Regional	47,112	48, 530	3.9

Population 75+ (thousands)

Region	1985	1995	% change
Northern	185	210	13.5
Yorkshire	234	253	8.0
Trent	282	328	16.5
E Anglian	134	167	24.7
NW Thames	206	227	10.4
NE Thames	243	263	8.2
SE Thames	273	302	10.7
SW Thames	220	239	8.1
Essex	210	244	16.3
Oxford	128	155	20.8
South Western	243	284	16.8
West Midlands	290	340	17.1
Jersey	146	162	10.8
Mersey	259	269	4.1
Regional	3,051.9	3,441.0	12.7

TABLE 2

TUNBRIDGE WELLS HEALTH AUTHORITY: FLOWS OF RESIDENT AND NON-RESIDENT LOCAL ACUTE INPATIENTS, 1985

	Inflow of non-residents	Outflow of residents
South East Thames Region		
- Brighton	21	10
- Eastbourne	2,841	9
- Hastings	498	188
- S E Kent	71	42
- Canterbury	11	11
- Dartford	125	31
- Maidstone	1,118	142
- Medway	26	10
- Bexley	10	34
- Greenwich	10	59
- Bromley	63	1,536
- W Lambeth	5	143
- Camberwell	6	63
- Lewisham	8	373
SETRHA sub-total	4,813	2,651
North West Thames	16	188
North East Thames	39	295
South West Thames	1,716	145
TOTAL	6,584	3,279

B:D5.29/6

ANNEX F

DESIGNATIONS OF SUPRA-REGIONAL SERVICES

1. Supra-regional services are those clinical services that in order to be clinically effective or economically viable, need to be provided by centres, each serving a population significantly larger than that of a single health service region. The criteria for selecting services to be funded supra-regionally are:

* The service should be an established clinical service, not a research or development activity (for which alternative sources of funding exist).

* There should be a clearly defined group of patients having a clinical need for the service.

* The benefits of the service should be sufficient to justify its cost when set against alternative uses of NHS funds.

* The cost should be high enough to make the service a significant burden for the providing regions.

* Supra-regional funding, as opposed to regional or sub-regional development, should be clearly justified either

  a. by the small number of potential patients in relation to the minimal viable workload for a centre, or

  b. by the economic and service benefits of concentrating the service in fewer and larger units shared between regions (this does not include services organised mainly at regional level in which two regions agree on joint provision as a matter of mutual convenience), or

  c. as an interim measure, by the scarcity of the relevant expertise and/or facilities.

* The units to be designated should be capable of meeting the total national caseload for England and Wales.

2. Supra-regional services are funded directly by the Department of Health. Applications for supra-regional designation and funding are made by Regional and Special Health Authorities. These are considered by the Supra-regional Services Advisory Group, which consists of representatives of the medical profession and NHS management and is chaired by a Regional Health Authority chairman. The Group makes recommendations on the identification of services to be funded supra-regionally and on the appropriate level of provision. Supra-regional status is not guaranteed permanent, but is reviewed regularly.

The designations for 1988/89 are as follows:

Service	Number of Centres	Central Funding £000s	
		Revenue	Capital
Craniofacial	2	376	
Chorioncarcinoma	2	563	
Endoprosthetic Services for Bone Tumours	2	1732	
Heart Transplantation	5	6778	877
Liver Transplantation	4	5038	358
National Poisons Information Service	1	316	113
Neonatal and Infant Cardiac Surgery	10	8933	133
Psychiatric Services for Deaf People	2	1260	
Specialised Liver Services	4	2112	
Spinal Injury Services	8	13734	
		40842	1481

ANNEX G

CROSS-CHARGING BETWEEN HEALTH AUTHORITIES

1. The essential principle of trading within the NHS is that one health authority should be able to recoup the costs of treatments provided on behalf of another.

Existing practice

2. There are four means by which a health authority may presently recover the costs it has incurred in providing goods and services for another authority:

(i) By adjustment to cash limits effected by a superior Authority tier or by the Department. An example of this is the London Ambulance Service, administered by the South West Thames Region on behalf of all four Thames Regions.

(ii) By the system known as Inter-Authority Non-Cash transfers. Under this, authorities issue one another with cross-accounting vouchers in respect of the cost of services provided to one another. The vouchers are copied to and used by the Department to allow authorities to draw either more or less than their cash limits, but without formal adjustment to the cash limits as such. An example of this is the payment for central supplies provided by Mersey RHA for other authorities. The gross value of transfers in 1986/87 was £3,813m.

(iii) By direct payment between authorities using commercial bank accounts.

(iv) By direct payment between authorities using the Paymaster General Accounts system. Under this, cash never leaves the Exchequer, and the charges are in effect book transfers.

Legislative Implications

3. The requirement that "money flows with the patient" implies a move towards more explicit cross charging between authorities than hitherto. Only direct payment - methods (iii) and (iv) - would seem to satisfy this requirement. This requires primary legislation.

4. Section 16 of the NHS Act 1977 permits authorities to carry out functions on behalf of another but does not provide for charging. This is only permitted where functions are contracted out to the private sector (Section 23). The Act is also quite specific about the source of authorities' money for treating patients: the Secretary of State. It may be inferred, therefore, that authorities cannot expect to receive money from other authorities for treatments on out-of-area patients.

ANNEX H

PRESENT ARRANGEMENTS FOR THE FUNDING OF TRAINING

Medical

1. Responsibility for the management, organisation, funding and provision of medical undergraduate education is vested in several bodies - the Health Departments, the Committee of Vice-Chancellors and Principals, the UGC, the NHS and the GMC. Similar arrangements exist for dental education.

2. Under current funding arrangements the UGC is responsible for student support and the employment of clinical academics and support staff. Nevertheless, clinical academics and NHS doctors carry out a similar mixture of tasks - clinical teaching, patient care and research. There is no precise accounting for the sharing of costs which are borne on a "knock for knock" basis. Within the revenue allocations to RHAs is an allowance - Service Increment for Teaching (SIFT) - for the additional service costs incurred by teaching hospitals in respect of their teaching duties.

Nursing Staff

3. At present the English National Board (ENB) holds responsibility for approving courses of education and training leadiing to the admission to the register; and for post-registration courses in clinical nursing skills. All pre-registration and most post-registration nurse training takes place in the NHS. There is a very small element of post-registration in the private sector and discussions are taking place on increasing this proportion.

4. Save for the 200 or so students undertaking pre-registration nursing degrees who are maintained by the DES, student training allowances and salaries are paid by the DHA's who have control over the numbers, and the range of specialist training programmes. In addition, DHAs are financially responsible for the cost of nursing school premises and the provision of supervision during clinical placements. The ENB funds the tutor posts and some teaching resources. Oversight of ENB funds is provided by Regional Educational Advisory Groups.

5. Project 2000 is beginning to change this pattern. Some authorities have already started to make arrangements for students to undertake degree courses, with support either coming from DES awards or via current health authority training allowances.

6. The arrangements for post-registration training are similar to basic nurse training in that the health authority is responsible for student salaries. For student midwives, the ENB provides for teachers' salaries etc. For training which takes place within the higher and further education sector, for example

Health Visitor, health authorities pay fees. All other forms of post-registration training are entirely the financial responsibility of health authorities in terms of student salaries and teaching costs.

Para-medical staff

7. Most para-medical professions receive their predominantly non-degree training either in higher education or NHS schools. Student support is predominantly via NHS grants save those on degree courses where support is provided by DES awards. Accreditation for the most part is by the Council for the Professions Supplementary to Medicine (CPSM). The CPSM has no direct funding responsibilities so the costs of teachers, accomodation etc are funded via the UGC and NAB or fees paid by the NHS or both. In all cases health authorities remain responsible for supervision during clinical placements.

ANNEX I

PERFORMANCE FUNDING: DEFINITION OF INDICATORS

COST WEIGHTED ACTIVITY

1. The Department of Health calculates each year a cost-weighted activity index for the NHS as a whole. The index aggregates different types of service activity by weighting by the relevant unit costs. Table 1 lists the components of the index.

2. The index provides a broad estimate of what activity in a given year would have cost had there been no change in unit costs. Setting this against actual expenditure (adjusted for HCHS pay and price increases), provides an indication of changes in overall efficiency.

3. The indicator as presently constructed is not particularly sensitive to casemix variations, quality of care, or policy. It is proposed that for the purposes of performance funding, the following improvements are made:

* separate inpatients, day cases, outpatients and A&E activity;

* disaggregate inpatient activity by specialty and apply specialty specific unit costs available from Korner;

* for long stay specialties such as Mental Illness and Mental Handicap, adopt a measure of activity other than Deaths and Discharges which reflects workload more accurately, for example inpatient days.

* use of Regional (and District), rather than national unit cost weights, in order to take into account regional variation in input prices.

4. In addition to providing an indication of movements in "efficiency" over time, the indicator can be used to illustrate the relative unit costs of Authorities. Table 2 provides illustrative figures by Region.

AVOIDABLE MORTALITY

4. For a small number of disorders mortality rates can be used as indicators of the success of the health service in curing disease. These are the potentially "avoidable causes of mortality" where clinical treatment is most likely to save life and normally does so in younger patients under 65. Table 3, taken from last year's Health Service Annual Report, shows the record over the last 5 years at a national level. Potentially "avoidable deaths" account for just under 3% of all deaths, but one in every eight deaths before the age of 65.

5. Avoidable mortality rates are already included in the Health Service Management Centre's Performance Indicator dataset for Districts, although the data is "pooled" from a number of years

due to the small number of observations for some conditions. At Regional level this would be unnecessary, particularly if attention was concentrated on the overall rate and some of the major components - e.g. Hypertension/Cerebrovascular disease and Perinatal mortality.

6. Changes in avoidable mortality will depend both on the effectiveness of primary and secondary care and is arguably, therefore, more applicable to the health service in general than Health Authorities in particular. There may also be time lags. Nevertheless, in the absence of alternatives, its use as a broad indicator of effectiveness can be defended, particularly when used in conjunction with other indicators.

Table 1

Components of National HCHS Cost Weighted Activity Index

Inpatient plus Day Cases (Inpatient Discharges & Deaths and Day Cases)

Outpatient plus A & E (Attendances)

Day Patients (Attendances)

Health Visitng (People visited)

Home Nursing (People treated)

Ambulances (Cases carried)

Blood Transfusion (Bottles of Blood issued)

Table 2

ILLUSTRATIVE CALCULATIONS OF RELATIVE UNIT COSTS

RELATIVE UNIT COSTS
1985/6

NORTHERN	105.53
YORKSHIRE	109.71
TRENT	107.88
EAST ANGLIAN	102.61
NORTH WEST THAMES	85.61
NORTH EAST THAMES	87.40
SOUTH EAST THAMES	94.53
SOUTH WEST THAMES	85.96
WESSEX	105.57
OXFORD	105.92
SOUTH WESTERN	102.13
WEST MIDLANDS	99.53
MERSEY	101.49
NORTH WESTERN	111.69
TOTAL	100.00

Notes:

1. Relative unit costs: estimated expenditure using national cost weights divided by actual expenditure.

2. Variations will reflect, in part, the effects of regional variations in input prices - London Weighting etc.

B:D5.29/6

Table 3

'Avoidable Causes of Mortality'
Percentage Changes in SMRs 1981-86[3], England and Wales

Cause	Age Group	Percentage Change 1981-86
Perinatal deaths	-	-19
Tuberculosis*	5-64	-36
Cancer of the Cervix	15-64	- 1
Hodgkin's Disease	5-64	-22
Chronic Rheumatic Heart Disease	5-44	-47
Hypertension/cerebravascular Disease	35-64	-18
Surgical deaths[2]	5-64	-11
Respiratory Disease	1-14	-56
Asthma	5-44	0
Total of above	as above	-16
All causes except those shown above	all	0
All causes	all	0

*Omits late effects of tuberculosis

[2] Appendicitis, choleolithiasis, cholecystitis and hernias

[3] SMR for 1981 equals 100 SMR = Standardized mortality ratio; a measure of the death rate which takes account of changes in the age structure of the population

B:D5.29/6

HC 52

SECRET

Copy No. 2

HC 52

NHS Review

RECONSTITUTING HEALTH AUTHORITIES

Note by the Secretary of State for Health

Introduction

1. We are agreed that we should review the constitution of health authorities in the light of our review proposals, with the aim of making them excecutive bodies. This paper sets out my proposals for achieving this. It also considers the implications of our review proposals for the NHS Management Board.

2. In summary, the key proposals are:

(i) District health authorities (DHAs) would devolve more functions to hospitals but retain responsibility for directly managed services and for monitoring and planning local services. As buyers, they would be accountable to Regional Health Authorities (RHAs) and Ministers for services provided for their residents.

(ii) To minimise disruption, boundary changes would be kept to a minimum. But where DHAs become too small to be viable, for example when hospitals become self governing, mergers may be necessary.

? (iii) DHAs should be reduced from their present 16-19 to 5 non executive and 5 executive members plus a non executive chairman.

(iv) Appointment procedures would remain broadly as they are. But local authorities would no longer be able to appoint members.

(v) DHAs would continue to meet in public, with private sessions where necessary.

What do they do?

(vi) No change would be made to Community Health Councils (CHCs).

(vii) Slimmed down regional health authorities would have a continuing role in ensuring that Ministerial policy is carried out and in overseeing the implementation of the review proposals.

(viii) Membership of RHAs should be similar to that of DHAs.

B:D5.26/6

SECRET

(ix) RHAs would be streamlined by delegating or contracting-out existing non head office functions e.g. hospital design and computer and legal services.

(x) The NHS Management Board (NHSMB) under Ministerial chairmanship would continue to be part of the Department of Health (DH), not divorced from it.

(xi) The Board would focus on strategic and policy issues. The present Health Services Supervisory Board would go.

(xii) Day to day operational issues would be handled by an executive committee, chaired by the Chief Executive.

District health authorities

(a) Existing responsibilities

3. Annex A lists current DHA responsibilities. Briefly, these are to assess the health needs of the local population and monitor the effectiveness of the services provided; to manage health services in the district, including the provision and development of community health services; to integrate, with primary care and social services, the planning of general hospital services and services for the priority groups - the elderly, mentally ill and mentally handicapped; and to provide clinical facilities for medical education.

(b) Future role

4. One of the themes of the White Paper will be the need to build on the introduction of general management into the hospital service by pushing down further decision-making to the unit level. I shall need to scrutinise their functions to make sure this is done to the fullest possible extent. The proposals in HC46 for introducing self-governing hospitals will accelerate the process in those DHAs where the main acute hospital becomes self-governing. DHAs will however retain responsibility for the management of the remaining services, including hospitals for the priority care groups and their key responsibility for monitoring and planning the provision of services in their locality. Crucially, as the buyers of services for their resident population, they will also continue to be accountable to RHAs and Ministers for the quality and cost-effectiveness of the services provided for their residents.

(c) Size of districts

5. While these changes will signal a major shift in responsibilities in all DHAs from the health authority to the hospital unit, it is in the smaller, single DGH districts where the impact will be greatest. It may therefore be desirable to merge some of the smaller districts in order to create a viable health authority. District mergers are disruptive and can cause considerable controversy locally. I would therefore want to keep

the number of boundary changes to the minimum necessary. In putting forward proposals for self governing hospitals, RHAs should be asked to consider the options for sensible mergers as part of their submissions.

(d) Membership of DHAs

6. Annex B sets out the present constitution and membership of health authorities and their statutory basis. It is clear from this that health authorities are not presently constituted as management bodies. As a result, they do not always supervise their managers adequately. Neither does the size and membership of DHAs lend itself to crisp decision-making. In recent years, there have been many examples of health authorities becoming bogged down in local politics. I therefore propose that DHAs should be reduced from their present 16-19 members to 5 (non executive) members and 5 executive members plus a non-executive chairman. The non-executives would be chosen in particular for their managerial and financial skills and there would no longer be any local authority members as of right. DHAs that covered a teaching hospital should include a representative of the medical school. The executive members would include the general manager and up to 4 other officers. This would enable the district medical, nursing and finance officers to be included.

7. The basis for the appointment of DHA members is set out in the 1977 NHS Act and we shall need primary legislation to amend this.

(e) Members' appointment procedure

8. As I have indicated, a central role of the newly-constituted DHA will be to act as the buyer of services on behalf of its resident population. It is therefore operating in effect on behalf of the local community. The removal of local authorities' (LAs) statutory right to appoint members directly will be highly contentious and will need careful presentation, not least to some of our own supporters. RHAs should retain the right of appointment of DHA members in order to avoid complaints about excessive centralised patronage. In future RHAs would not be bound by the LAs' recommendation but where there are good candidates, they would be appointed on their merits. DHA Chairmen would continue to be appointed by the Secretary of State.

(f) Community Health Councils

9. Because of the sensitivity of the DHA membership issue, I am not proposing any changes in the LA membership of Community Health Councils (CHCs). At present, local authorities appoint half of the CHC membership. The remaining third are appointed by the voluntary organisations and a sixth by RHAs. While this

inevitably politicises many CHCs, DHAs are experienced at dealing with them. I therefore see no need to alter the membership of CHCs or make any other changes to their role. In the White Paper we can stress their continuing importance as the local consumer watchdog.

(g) DHA meetings in public

10. As we recognised at our last meeting, there is no need to make any change in the existing requirement under the Public Bodies (Access to Meetings) Act 1960) for health authorities to hold their meetings in public. Authorities already have some discretion under this Act to exclude the public e.g. because of the confidential nature of the business to be transacted.

Regional health authorities

(a) Role and functions

11. Annex C lists current RHA responsibilities. I believe that a slimmed down regional tier should continue to be the main vehicle for ensuring that Ministerial policy is being carried out on the ground. RHAs will also have a crucial role in managing the changes brought about by the White Paper. In my view the size and nature of the management task are such that these changes could not be managed by regional arms of the Department. RHAs contain the necessary local knowledge and act as an important buffer between Ministers and the operational level. The changes I propose below in the membership of RHAs will strengthen them for their task of ensuring that our proposals are carried out in the most efficient and effective way.

(b) Membership of RHAs

12. Membership at regional level should match that at the district level. That is, RHAs should comprise 5 non executive members and 5 executive members plus a non executive Chairman. It would be desirable for medicine, the relevant university and FPC interests to be represented if the latter are made accountable to RHAs. As at present, members and Chairman would be appointed by the Secretary of State.

(c) Reducing the size of RHAs

13. Following the introduction of general management into the NHS, RHAs are already signed up to devolving as many functions as possible to districts and their units. But I have no doubt that there is further scope for reductions in RHAs' staffing and costs. It is important however to distinguish the "head office" functions invested in RHAs - principally the development and monitoring of services and the allocation of resources - from RHAs' current responsibilities for providing certain technical and support services such as computers and supplies.

14. The scope for savings in RHAs' "head office" functions will be modest, if they are going to manage districts effectively and spearhead the introduction of many of the reforms which will emerge from the Review. But I am convinced that scrutiny of the remaining RHA functions will produce many blocks of work which can be streamlined, delegated to districts, or contracted out altogether. Indeed many Regions have already begun the process, so the scope for action varies from Region to Region. The work which can be streamlined or disposed of includes management services, design of hospitals, storage and distribution of supplies, computer services, and legal services. The effect of these proposals on the size of RHAs will vary from region to region but I would expect to see a significant reduction. My aim is that, after taking account of the additional work Regions take on in implementing our proposals, there should be a net reduction in their staffing and costs.

The role of the NHS Management Board

15. There are many people and bodies within the NHS who demand that the NHS Management Board should be divorced from my Department, under independent chairmanship. Although the distancing of NHS management from Ministers clearly has some attractions, the disadvantages are even greater. I do not think so large and politically sensitive a public service, which is going to continue to be overwhelmingly vote financed, can in practice be separated from the political process. A separate Board would resemble nothing so much as the Board of a nationalised industry. Parliament would not tolerate Ministers trying to hide behind the Board to avoid responsibility for key issues. An independent Board would quickly become an extra tier in the management chain between Ministers and the real health services and, almost certainly, a new lobby for more public money. I believe therefore that we should use the opportunity of the White Paper to refute the case for separating the NHS Management Board from Ministers and the Department of Health.

16. We would however streamline management arrangements within the Department by giving the Board a clear role in major NHS strategic issues.

17. I propose four main changes:

why not then lower down

first, responsibility for the family practitioner services will be brought under the Board. The better integration of primary care with hospital services is an important objective.

second, the Board, - as now under Ministerial chairmanship - would deal with strategic and policy issues, as well as the more critical operational matters. The Board would be reduced in size and reconstituted to contain a higher proportion of non-executive members appointed from the commercial and industrial worlds.

third, as in most companies, much of the day to day work would be handled by an executive committee of the Board chaired by the Chief Executive.

fourth, the Health Services Supervisory Board would no longer have a role to play and would go.

ANNEX A

THE RESPONSIBILITIES OF DISTRICT HEALTH AUTHORITIES

The functions of DHAs are as follows:

1. Promoting health, preventing illness and planning services

   - review the status of health of the population and assess needs;
   - develop strategic and operational plans;
   - implement plans;
   - liaise with local authorities; FPCs and voluntary sector;
   - produce guidelines for local service developments;
   - evaluate outcome.

2. Performance and review

   - setting objectives and targets for units;
   - monitoring and reviewing performance against targets.

3. Provision of Patient Services

   - hospital and other accommodation;
   - medical, dental and nursing services;
   - facilities for the care of expectant and nursing mothers and young children;
   - facilities for the prevention of illness, including health education and promotion;
   - arrangements for surveillance, prevention and treatment of communicable diseases;
   - arrangements for the proper care of persons suffering from or recovering from illness or disability;
   - other services required for the diagnosis and treatment of illness including domiciliary nursing and other forms of care provided in the community, including collaboration with local authority;
   - medical and dental inspection and treatment of school children;
   - family planning advice, treatment and supplies;

- facilities for private patients.

- services to local authorities to enable them to carry out their social services and education functions;

- facilities for clinical teaching and research;

- health centre accommodation;

- assistance in the conduct of relevant research.

4. Finance

- provide management accountancy function;

- analyse financial data including identification of potention over/under spends;

- ensure DHA financial strategy is achieved.

5. Personnel

- reconcile units' collective demand with national etc policies and estimate impact of local authority, private or voluntary sector requirements; determine manpower requirements for District functions; reconcile collective demand with resource assumptions;

- identify sources of supply for staff groups where district can be self sufficient (e.g technical and nursing staff);

- establish policies and targets for recruitment, retention, return, deployment; monitor performance; establish manpower targets (where relevant, eg. (Administrative and Clerical);

- monitor effective skill mix;

- promote image of NHS as employer locally; maintain contact with local education system, careers service, Department of Employment.

6. Building and Estates

- management of delegated capital budgets;

- procurement of minor health building schemes;

- monitoring of unit compliance with fire, health and safety standards; etc

- control of smaller disposals and Joint planning with local authorities and FPCs on estate matters;

- monitor cost effectiveness of unit based maintenance staff.

7. Support Services

- ambulances;
- transport;
- sterile supply;
- laundry.

ANNEX B

CONSTITUTION AND MEMBERSHIP OF HEALTH AUTHORITIES

Regional and District Health Authorities

1. It is the duty of the Secretary of State by order under Section 8 of the NHS Act 1977 to establish Regional and District Health Authorities for such regions and districts as he may specify. Under Schedule 5 to the Act, the Secretary of State may specify how many members shall constitute a RHA or a DHA. The chairman and members of a RHA shall be appointed by the Secretary of State, as shall the chairman of a DHA. The Secretary of State shall consult on the appointment of members of a RHA except in some prescribed circumstances. A specified number of members of a DHA shall be appointed by the relevant local authority and the remainder by the relevant RHA, either after consultation with or on the nomination of various other bodies, including any university whose medical school is associated with the district. There are limited exceptions to the RHA's duty to consult.

2. RHAs are constituted and their regions specified under subordinate legislation (SI 1981/1836 and SI 1975/1100). The constitution of DHAs and the districts for which they are to act are specified in SI 1981/1838 and SI 1981/1837. Under these provisions, 14 RHAs and 190 DHAs have been constituted. These each consist of a chairman and between 16 and 19 members. The composition of DHAs is set out in the appendix.

3. SI 1983/315 provides for the appointment and tenure of office of chairman and members of RHAs and DHAs and for the procedures of those authorities. Terms of office shall not exceed four years. The procedural requirements include rules as to meetings and proceedings of authorities, disability on account of pecuniary interest and the appointment of committees and sub-committees.

Special Health Authorities

4. The Secretary of State has discretion to establish Special Health Authorities by order under the NHS Act 1977 to carry out such functions as he shall direct. The Secretary of State specifies by order the number of members who shall constitute each SHA and appoints the chairman and members. There are regulations governing the procedures of SHAs and the appointment and tenure and office of their chairman and members.

APPENDIX

COMPOSITION OF DISTRICT HEALTH AUTHORITIES

1. The membership of DHAs is governed by Schedule 5 to the NHS Act 1977, the NHS (Constitution of Districts) Order (SI 1981/1838), and by Departmental guidance (Health Circular (81)6). The position is as follows:

Chairman

Appointed by the Secretary of State who is not required to consult before doing so.

Membership

There are 16-19 members per DHA. On average 12 are appointed by the RHA and 4-6 by relevant local authorities. The membership is comprised as follows:

Appointed by RHA

(i) one hospital consultant (ii) one general medical practitioner (iii) one nurse, midwife or health visitor.	The Act only requires RHAs to consult appropriate medical and nursing bodies before making appointments. These specific appointments are required under HC(81)6.
(iv) a nominee/s of the appropriate university medical school (1-3 members)	The Act requires the RHA to appoint a university nominee - Teaching Districts and those with a dental school have additional members under SI 1981/1838
(v) On average 8 generalists including members drawn from the wider TU movement	The number of generalists is prescribed in the constituting SI 1981/1838 but under the Act the RHA has to consult "any federation of workers organisations who appear to be concerned". There is no TU place as of right.

Appointed by Local Authorities

(vi) 4-6 LA members	The Act gives LAs direct right of appointment. The RHA has no leverage here whatsoever. The

Constitution Order (SI 1981/1838) specifies the numbers of members which relevant LAs can appoint to each District. Maximum 4 year term, but LAs decide expiry date.

RESPONSIBILITIES OF REGIONAL HEALTH AUTHORITIES ANNEX C

functions of RHAs are as follows:

Planning, Performance and Review

- establish regional strategic and operational plans;
- management of capital programme;
- management of performance and accountability review process;
- facilitation of joint planning.

nance

- allocation of resources to districts;
- monitoring of spending against operational objectives;
- monitor cost improvement and other VFM activities;
- anage funds for regional specialties and capital rogramme.

onn

- idance to districts on personnel and industrial lations;
- ld medical consultants', registrars' and senior istrars' contacts.

ng and Estates

- vision of design services;
- ision of specialist technical services;
- se on disposals;
- sion of technical advice/skills on estate matters.

services

e

- transfusion service
- nce service

HC 51

SECRET

Copy No: 2

HC 51

NHS Review

MANAGING THE FAMILY PRACTITIONER SERVICES

Note by the Secretary of State for Health

1. This paper addresses three related issues arising from the Group's discussion of budgets for general practice (HC 47):

* the management of contracts with GPs.

* the number of GPs.

* the role and constitution of FPCs.

I am working separately to develop our proposals on GP practice budgets in the light of our discussion.

2. In brief, my proposals are that

i. on prescribing costs, we should

a. pilot an incentive scheme for FPCs on drug spending.

b. enable FPCs to buy in the medical manpower they need to follow up their monitoring.

c. take powers for FPCs to impose financial penalties on GPs who persistently over-prescribe.

ii. we should give a high priority to improving the information available to GPs and FPCs about referral rates and costs, and give FPCs the capacity and powers they need to follow up their monitoring of referral rates.

iii. subject to an assessment of the overall impact of the review on the medical profession, we should take powers to control GP numbers; and should in due course reduce the retirement age from 70 to 65.

What does this mean

iv. we should keep FPCs separate from DHAs, but

a. strengthen their non-executive leadership by changing their composition.

B:DC4.2/36

SECRET

b. introduce a tougher, and better resourced, executive management.

c. make FPCs accountable to Regions.

Medical audit in general practice is dealt with in paper HC 50.

I MANAGEMENT OF CONTRACTS WITH GPs

Context

3. Leaving aside the number of GPs, we have identified two main respects in which further action may be needed to secure greater cost-effectiveness in general medical practice: prescribing habits; and referrals to hospitals. GP practices which opt to have their own budgets will have a strong incentive to act cost-effectively. We must therefore address the position of GPs who are not covered by the practice budget scheme. In my view the right way forward is to build on our existing policy of tightening the GP contracts and giving FPCs the powers and capacity they need to manage the contract effectively.

4. The terms of service of GPs are set out in Regulations. These Regulations, along with the current fees and allowances, constitute the basis of each GP's contract with his or her FPC. The main obligations which the terms of service place on GPs, and the main controls and sanctions which are available to FPCs, are summarised in Appendix A, along with examples of the action we have in hand to extend these obligations and controls following the Primary Care White Paper. The following paragraphs set out how these contractual arrangements can - and should - be used to secure cost-effective prescribing and referrals, and how they will need to be reinforced to make them effective for this purpose.

Prescribing costs

5. We have already discussed the possibility of trying to control prescribing costs through cash limits or "indicative" drug budgets. As I have argued in previous papers, I believe that an approach along these lines would be fraught with political difficulty. There would be potential for 30,000 GPs to protest - and encourage their patients to protest - at the perceived inadequacies of their budgets. We would be bombarded with stories of individual patients deprived of necessary medication by the effects of "cash limits".

6. Some FPCs are already monitoring and advising on prescribing habits, but this function has hitherto been carried out primarily by doctors from the Department's Regional Medical Service (RMS). This approach is relatively limited in scale: the RMS visits practices whose prescribing costs exceed the local average by 25%. But these visits -

which are educational, not punitive - are effective enough to save on average around £10,000 per practice in the first year. We are doubling this RMS activity from 1989-90.

7. We are already intending to ensure that FPCs themselves take a more active role from now on. We should not underestimate the potential impact of this. In particular:

i. the experience of some FPCs which are already active in this field suggests that the essential first step is to educate GPs, for example in the use of practice formularies (short lists of drugs selected on the basis of economy and efficiency); the scope for generic prescribing; or systems for helping GPs to ~~for~~ control and reduce repeat prescriptions. We shall be ensuring that in future all FPCs give a strong local lead in educating GPs, so that no doctor can claim to be ignorant of what can be done to control prescribing costs.

ii. we shall also inform - both GPs themselves, so that they can audit their own prescribing, and FPCs, so that they can monitor the performance of their GPs. And I shall be arranging for the publication of "league tables" of FPC prescribing costs. A description of the new "PACT" information system, appended to HC47, is attached again as Appendix B. Despite strong opposition from the profession, we shall be making this information available to FPCs from next year, and all FPCs will be covered by the system from 1990-91. In anticipation of the impact of this information, and of the related FPC and RMS activity, my PES bid offered savings of £15 million and £20 million in 1989-90 and 1990-91 respectively.

8. As I suggested in HC 47, I believe we should explore the scope for reinforcing these initiatives with some incentives. The scheme I set out in that paper was one in which an FPC could be set a target level of spending on drugs, with a proportion of any savings being returned to them to finance primary care initiatives in their area. Involving the GPs themselves would help to secure their commitment to the scheme. I hope colleagues will agree that I should pilot this proposal with the help of a willing FPC.

make their own back-pocket

9. Effective though I believe they will be, our current plans would still leave FPCs with two important handicaps: a shortage of resources with which to follow up their monitoring; and, since a requirement to prescribe economically does not figure in the contract, a lack of effective sanctions. I propose to overcome these handicaps as follows:

i. for most GPs the most effective response to evidence of over-prescribing will be pressure and advice from their peers. We should therefore give FPCs the medical manpower with which to follow up their monitoring, and not only when costs are 25% or more above the local

average (which is all the RMS is resourced to do). The most practical approach, at least initially, would be to expand the RMS and charge FPCs for the use of RMS doctors. I am confident that the resulting savings would outweigh the manpower costs by a wide margin.

ii. we must enable FPCs to impose financial penalties where GPs persist in over-prescribing. Current Regulations provide only for Local Medical Committees (LMCs), which represent the GPs themselves, to investigate excessive prescribing, at the request of the Secretary of State. This provision is ineffective, and has fallen into disuse. I suggest we seek to amend the Regulations to enable an FPC to investigate on its own initiative and to fine GPs who persistently refuse to curb excessive prescribing. This power would be subject to the normal right of appeal to the Secretary of State. GPs' terms of service would also be amended to require doctors to answer questions from their FPC about their prescribing patterns.

review body — p-related pay

10. I have considered further colleagues' suggestion that we should publish comparative information about the prescribing costs of different GP practices. Aside from the certain opposition of the profession there is a fundamental problem: the evidence - from FPC performance reviews, for example - suggests that at least in some areas patients tend to prefer doctors who are more ready to write a prescription. If this is so, publicity could have precisely the reverse effect of the one we intend. It might be more profitable to experiment with publicity campaigns to educate patients not to put pressure on their doctors to prescribe indiscriminately, although I understand that experience of a campaign of this kind in Northern Ireland is not encouraging.

balls

Referral rates

11. We are less well prepared to tackle referral rates. We lack both information and experience in this field. Medically, inefficient referral patterns are more difficult to spot than excessive prescribing. We need to curb over-referral, but we must also guard against the under-referral of patients who need specialist attention.

12. The essential first step is to improve the information available to both GPs and FPCs. There are a number of useful local initiatives, including examples of GPs keeping records of their own referral rates. But the most important development is a project in East Anglia, based at the RHA and part-funded by the Department. This project is tackling three problems, with extensive co-operation from the Region's GPs:

i. developing an information system to identify the decisions being made. The first phase of the project has shown that it is possible to trace the patient and the

referring doctor using existing data, although some difficulties remain to be resolved. (For example, the GPs referring the patient may or may not be the GP with whom the patient is registered, and it is the latter who tends to be recorded.) The next phase, now in hand, is to develop and program a regional computer system.

ii. developing techniques for linking costs to these decisions. Information about the cost of out-patient work is currently poor. It will be important to develop a system which takes account of case mix, as do diagnosis related groups (DRGs) for in-patient costs. We are planning soon to test through the project the use of an adapted version of "ambulatory visit groups" (AVGs), an out-patient equivalent of DRGs being developed in the USA. Linked systems will be needed to cover in-patient and diagnostic costs, and we shall need to ensure compatibility with the resource management initiative. All this work will also be an essential input to the development of GP practice budgets.

iii. learning more about what constitutes a "good" referral decisions in terms of cost effectiveness. The Region have initiated useful work here, too, for example in encouraging GPs and consultants jointly to draw up "protocols" covering particular conditions such as diabetes. But this approach can be fully effective only when adequate information is in place to support it.

13. Our current estimate is that it will take about two years to reach the point at which the information systems at (i) and (ii) will be fully in place in East Anglia and ready for adoption by other Regions. It might be possible to accelerate this programme given additional resources.

why wait?

14. In the meantime, as for prescribing costs, we must ensure that FPCs will have the capacity and powers to make effective use of referral information when they get it. To this end:

i. FPCs are to contract with independent medical advisers - drawing on academic medicine, the RMS and other sources - to encourage good practice in the referral of patients to hospital. This capacity will be built up steadily over time. Among the other effects of this work should be a reduction in waiting times.

ii. although the approach must be primarily educational, I suggest that FPCs are given powers to impose financial penalties in cases of persistent over- or under-referral, as for over-prescribing. But it will be some time before FPCs have adequately robust criteria against which to use this power.

B:DC4.2/36

Relationship to practice budgets

15. I am confident that the measures outlined in paragraphs 7-14 will be not only effective in themselves but also more than sufficient to avoid giving large GP practices a disincentive to opt for their own budgets. Without going into detailed aspects of practice budgets, which I have been asked to work up separately, it may be helpful to make three further points:

i. the main incentives for a practice to take its own budget are that it

- enables them to back their choices with money, and
- opens up the possibility of generating funds for their practice through virement.

In both respects it offers the potential for attracting more patients. All these incentives apply whether or not other practices are brought under effective pressure to curb prescribing and referral costs.

ii. if practice budgets are calculated in the way I proposed in HC 47 only practices which beat the average, or believe they can do so, will have an incentive to opt into the scheme. This in turn means that practices which would like to join the scheme will have an incentive to beat the average first.

iii. colleagues have questioned my proposal in HC 47 that practices opting for a hospital service budget should have the option of having a drug budget too. The logic of this proposal is that, if drug budgets were a compulsory element of the scheme, practices which would like a hospital service budget but do not (at least yet) beat the prescribing costs average would be deterred altogether. I believe this logic holds good, and that we should proceed accordingly. I would rather they at least began with a hospital services budget to get them into the scheme. They would then have a strong incentive to bring down their prescribing costs so that they could safely opt for a drugs budget and thereby increase their scope for virement. (They might choose to vire into drug spending, of course, where they judged this more cost-effective than using hospital services.)

II CONTROLLING GP NUMBERS

16. Recruitment into general practice is buoyant. The number of GPs in Great Britain has increased by nearly 20% over the past decade, to nearly 30,000. The increase in the year to October 1987 was 1.8%. In 1987 the average GP had less than 2,000 patients on his list, compared with nearly 2,300 in

1977. There is a strong demand to fill practice vacancies even in traditionally unattractive areas. Excluding the cost of drugs and hospital referrals, but including practice expenses, the average GP costs the Exchequer £56,000.

17. Aside from the normal immigration controls, the Government has no power to restrict the entry of suitably qualified doctors to general practice. The only "de facto" control is that exercised by the statutory Medical Practices Committee (MPC), which regulates the geographical distribution of GPs. Under present arrangements a doctor who wishes to set up in practice in an area with an average list size of 2,100 patients or less must apply to the MPC for admission to the relevant FPC's "Medical List". The power to change this criterion to a different average list size rests with the MPC itself. The MPC is empowered to refuse an application from a suitably qualified doctor only where the number of doctors in the area is "already adequate".

18. Controlling the total number of GPs would require primary legislation. I continue to see some difficulties in this. Limiting the number of independent practitioners (small businesses, in effect) is arguably inconsistent with our general approach to freeing trade restrictions (although we have done it for pharmacists); and public reaction to limiting the number of GPs might well be unfavourable. It would be opposed by the profession, whose declared aim is an average list size of 1,700 (although in private many would see controlling the numbers as helping to maintain their incomes). Abolishing the MPC, or substantially constraining its role, would also be strongly contested by the profession.

19. For these reasons I suggest we defer a final decision until we are in a position to assess the reaction of the profession to the review package as a whole. Subject to that, I agree in principle that we should legislate to take the necessary powers.

20. I shall give further thought to how these controls should work and to the nature of the powers we shall need, so that we are ready with detailed proposals when the White Paper is published. I see two basic approaches, each operating within a ceiling - set by Government - for the total number of GPs in any one year:

i. we could empower the Secretary of State to direct the MPC - or a successor body - as to the manner in which, and criteria on which, it exercises its existing functions.

ii. allocations within the ceiling could be made to FPCs, either directly by the Department or, preferably, by Regions. The MPC would be abolished.

21. The main advantage of option (i) is that it distances Government from potentially contentious allocation decisions. It could work well if we changed the composition of the MPC, or replaced it altogether, to remove its current domination by the profession. On the other hand option (ii) arguably makes more management sense because it enables allocations to Regions and FPCs to be directly related to other priorities and resource allocation decisions. I should like to give a little more thought to this.

22. As we discussed at our last meeting it will be important to ensure that we do not deter good, young doctors from entering general practice. I shall need to give further thought to this, too. The best approach might be

i. to reduce from 70 to 65 the retirement age for GPs which we are introducing through the Health and Medicines Bill, this reduction to take effect when the new manpower controls are established.

ii. to ensure that, when filling single-handed practice vacancies, FPCs give priority to younger doctors who are keen to work as members of primary health care teams.

I am looking at ways in which FPCs could have more influence over the filling of vacancies in partnerships.

III THE ROLE AND CONSTITUTION OF FPCs

Need for change

23. There is a clear need to strengthen the management of the FPS. In particular, we must

* complete the substantial body of changes set out in the White Paper, including the implementation of legislation.

* secure much more effective local management of contracts with independent practitioners. Appendix A outlines some of what is involved for GPs (and GPs with their own budgets will, of course, remain in contract with FPCs and subject to the same basic terms of service).

* implement effectively the measures proposed in parts I and II of this paper.

24. The key management changes we need are

i. a strong, non-executive leadership devoted specifically to the management of the FPS locally.

ii. tougher, and better resourced, executive management of the FPS.

iii. firmer monitoring and accountability of local FPS management.

My proposals under these three heads are set out more fully in paragraphs 27-32 below.

Merger with DHAs

25. The changes in paragraph 24 will be needed whether or not FPCs are merged with DHAs. DHAs could not simply absorb either these new management tasks or the existing administrative functions of FPCs, and they would lack the experience which FPCs have been building up since 1985.

26. I remain of the view, therefore, that we should not merge FPCs with DHAs, for the reasons I gave in HC 41. In short:

i. I believe we can inject competition into the NHS more effectively by keeping "customers" and "suppliers" separate and by ensuring that the interests of hospitals do not dominate those of primary care. This is still more true if we are to develop GP practice budgets.

ii. merger could easily be portrayed as indicative of a Government which does not know its mind. FPS and hospital administration were merged from 1974 until 1985, following the 1974 reorganisation. It was this Government which detached them again, not least because we judged that health authorities did not have a good track record in their administration of the FPS. Since 1985 there has been real progress towards more effective management.

iii. if the introduction of general management into the hospital and community health services is included in the reckoning, merging FPCs with DHAs would be the fourth administrative upheaval within a decade. Of 90 FPCs, 56 relate to more than one District and 17 cover part or all of at least four Districts. Further reorganisation would tend to divert effort away from more important objectives.

iv. there would be significant costs - in additional computers, in reorganising FPC registers and in additional staff - but only minimal financial savings because the bulk of the work undertaken by FPCs would continue as before.

Composition of FPCs

27. FPCs currently consist of 15 members from the professions and 15 lay members. All the members are appointed by the Secretary of State. The professional members are drawn from Local Representative Committee (LRC) nominees. Four of the

lay members are drawn from DHA nominees, and a further four from local authority nominees. The Chairman may or may not be lay - we have been steadily reducing the proportion of chairmen drawn from the contractor professions - but the professional members tend to dominate the proceedings.

28. Not surprisingly, some Committees regard the support of the contractors as more important than service to the customers. There is a general tendency to shrink from proper enforcement of the contracts, and I see changing the constitution of FPCs as essential to strengthening the management of the FPS. There will be strong opposition from the contractor professions, particularly the doctors, but I believe we should face this.

29. I propose that the composition of FPCs should in future be as follows:

i. there should be no more than, say, 12 members in total.

ii. there should be a lay chairman, appointed by the Secretary of State.

iii. there should be a clear minority of professional members - one from each of the four contractor professions. The professional members could be nominated by anyone but would be appointed by the RHA.

iv. the chief executive (paragraph 31 below) should always be a member of the committee. (There are no equivalents of the other executive members I propose for DHAs - see HC52.)

v. the remaining members - all lay - would be appointed by the RHA and chosen for their experience and personal qualities. No places would be reserved for DHA or local authority nominees.

vi. the currently extensive sub-committee structure should be radically slimmed down, and many decisions currently taken by sub-committees devolved to officers. The reduced size of the membership should then suffice.

Executive management

30. The typical FPC has about 50 staff, most of whom are engaged in the routine work of paying practitioners and maintaining records. Computerisation has enabled staff savings to be made and released resources for strengthening middle management. But this is not enough.

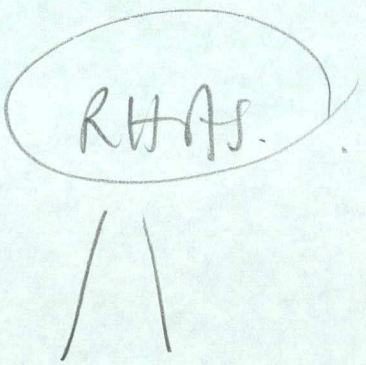
31. I believe we must now appoint new chief executives to all FPCs, by open competition. The salaries offered will need to be good enough to attract quality managers from both inside

and outside the NHS. Essentially the same level of administrative support should remain, with the chief executive supplying the drive and managing the many changes that will be needed. I estimate the costs at around £3 million a year.

Accountability

32. Since April 1985 the 90 English FPCs have reported direct to the Department. Although a good deal has been achieved by way of setting objectives for the Committees and giving them a sense of direction, it is impossible to monitor all FPCs as closely as we would like. As they take on new responsibilities it will be necessary to assess their performance more regularly. I therefore believe that FPCs should be made managerially accountable to RHAs, who would carry out much more frequent performance reviews than the four-yearly formal reviews carried out by the Department now. This relatively modest addition to the functions of Regions will be more than offset by the overall slimming down I propose in HC52.

November 1988



APPENDIX A

GENERAL PRACTITIONERS' CONTRACTS

The contract with the FPC

1. GPs are independent contractors. Their contract with the FPC is governed by Regulations which include their terms of service. The main obligations placed on the GP are:

- to render to his patients all necessary and appropriate personal medical service.
- to do so in suitable surgery premises or at the patient's home.
- to refer the patient to other parts of the NHS if necessary.
- to prescribe whatever medicines are necessary.
- to provide 24-hour cover either personally or through a deputising service.
- to provide (if he so contracts) maternity services, contraceptive services, cervical cytology and vaccination and immunisation.

Controls and disciplinary procedures

2. FPCs have the following powers

- to refer a complaint about unsatisfactory treatment to a Service Committee. This is set up by the FPC under lay chairmanship with, additionally, three GPs and three other lay people.
- to receive and act on recommendations from the Service Committee as to whether or not there has been a breach of the GP's terms of service.
- to fine the GP if he is in breach, subject to the Secretary of State's agreement. Fines of £500-£1000 are not uncommon. There is a procedure for the GP to appeal to the Secretary of State.
- to refer more serious cases (eg repeated breaches) to the NHS Tribunal, which is a statutory body with an independent chairman appointed by the Lord Chancellor; and to remove a GP from the FPC's list if so instructed by the Secretary of State in the light of the NHS Tribunal's decision. This is also subject to an appeals procedure.

B:DC4.2/36

Additionally, an FPC can refer a case to the General Medical Council, which can remove a GP from the Medical Register and therefore from the right to practise altogether.

3. An FPC can also

- check that premises are up to standard and, if not, withhold reimbursement of rent and rates.
- withhold fees or allowances if the specified conditions are not satisfied.
- approve consultation hours.
- approve and oversee use of deputising services.

Current plans to tackle weaknesses

4. The weaknesses of these arrangements are

- poor leadership in some FPCs.
- domination of FPCs by the professions.
- limited FPC resources to take necessary follow up action.
- lack of specific requirements in the terms of service (eg. no reference to health promotion).
- patients ill informed of rights and service availability; patients' expectation are low.
- inadequate flow of information about GPs' activities.
- the complaints procedure is cumbersome and insufficiently consumer friendly.
- quality of care is not monitored.

5. Following the Primary Care White Paper, the Government intends to:

how? ll

- make the remuneration system performance related.
- increase competition and consumer power through better information about local services and greater emphasis on capitation fees.
- cash limit and target expenditure on premises improvements and practice team staff on those premises and practice teams where the need is greatest.
- retire elderly doctors.

- enhance the role of FPCs and their management.
- make GPs' terms of service more specific.
- streamline the complaints procedure.

6. In addition, FPCs will be required to:

- submit service development plans for improving services where most needed.
- set targets for GPs in receipt of vaccination and immunisation and cervical cytology fees.
- monitor performance of GPs using outcome measures, performance indicators and consumer surveys.
- exercise leadership in improving the cost effectiveness of prescribing.
- in due course apply similar arrangements to hospital referrals.
- exercise more vigorously their powers to inspect records.
- use existing Service Committee and Tribunal powers to raise and maintain standards.

APPENDIX B

GP PRESCRIBING - INFORMATION PROVIDED TO PRACTICES

The Prescription Pricing Authority has developed a 3-level reporting system based on data taken from prescriptions dispensed by community pharmacists (shortly to be extended to dispensing doctors):

* Level 1 reports are sent quarterly to each GP practice and within 3 months of the period measured. Each report compares the practice prescribing costs (calculated at list price) with the FPC average and the national average. It also compares the prescribing pattern with the FPC average in each of the 6 highest-cost drug categories (e.g. cardiovascular). The report gives information on the prescribing of individual GPs within the practice and about generic prescribing habits.

* Level 2 reports are sent automatically within a week of the level 1 report to practices whose costs exceed their FPC average by 25% or more and to those whose costs in any of the 6 major cost categories exceed the FPC average by 75%. Level 2 reports are sufficiently detailed to identify areas of high cost down to individual drugs. Tables show how individual GPs stand in relation to the practice as a whole, and how practices stand in relation to the FPC overall, in terms of

    - numbers of items prescribed
    - total cost (at list prices)
    - average cost per item

* Level 3 reports are available on request for those wishing to carry out a detailed audit. It provides a full catalogue of items prescribed. Analyses of prescribing can be provided in terms of

- overall pattern
- 6 major cost groups
- all other drug groups
- appliance and dressings
- other preparations

2. The system is under continuing review. A leaflet explaining its methods and purposes has been sent by the Department to all GPs and group practices.

HC 53

SECRET

Copy No:

HC 53

NHS Review

A BETTER SERVICE TO PATIENTS

Note by the Secretary of State for Health

Introduction

1. We are agreed that, in presenting the outcome of the review to the public, we shall need to be ready with a convincing package of expected benefits to patients and to the public generally consistent with the impact on doctors and managers.

2. I propose to deal with this in three ways:

first, by presenting our proposals throughout in the White Paper in a way which brings out the patient's perspective and underlines the improvements being made for the benefit of patients. I will also emphasise that while much of our work has concentrated on financial and managerial issues, underlying this is our objective of securing a better service by giving patients and their GPs a greater say in where they will be treated and by encouraging greater competition in the provision of services.

second, by a package of measures to improve both service to patients and the quality of clinical care.

third, by a number of initiatives to emphasise our aim of improving health as well as the treatment of those who need care.

3. In summary, my key proposals on the second and third points are:

i. a national initiative to put better service to patients at the top of the agenda. The key to this will be a quality assurance programme in every District.

ii. specific proposals for making the service more personal, including proposals on waiting times for outpatients' departments and for diagnosis and treatment.

iii. much better information provided by hospitals, e.g. leaflets, better telephone service, periodic reporting to the public.

iv. more emphasis on the quality of clinical care through better information about clinical outcomes, medical audit and monitoring of health outcomes.

B:D6.32/1

SECRET

v. an action plan on quality assurance programmes.

vi. a major training initiative to back up these plans.

vii. a new acute sector advisory service to monitor the quality of service in acute hospitals.

viii. a focus on better health, through more public awareness, monitoring health, measuring the outcome of health services and a new initiative to encourage health promotion and disease prevention.

ix. one element of this focus would be the development of a portfolio of health indicators.

A national initiative

4. There is already a lot of good work going on in the field. A number of Regions, notably Trent and Wessex, have set up comprehensive programmes aimed at improving the quality of service to patients. We now need a national initiative to ensure that every health authority puts the issue at the top of the agenda.

5. The key to change is to get a quality assurance programme up and running in every District. The objectives of each programme will be:

i. to treat people as people by giving a more personal service and offering them a wider choice of amenities,

ii. to inform and consult people so that they are less daunted by hospitals and feel they can have a say about the way services are delivered to them,

iii. to maintain and improve the quality of clinical treatment that patients receive by encouraging professionals to review systematically their procedures and the clinical outcomes.

6. The review offers us the ideal opportunity to launch such an initiative. But we should not overplay the role of central Government. We need above all to change the attitudes and commmitment of the people working in the NHS, and the experience of large private corporations has shown that this takes time and resources in education and training. Any national initiative must also be flexible enough to accommodate a potentially enormous range of local initiatives. I therefore envisage the programme being driven by local management with the full involvement of the professions.

Making the service more personal

7. The most visible impact of a district programme on the public will be in making services more personal. Some health authorities are already alive to the need to change both their image and their practices, but this attitude should be the norm and not the exception.

8. I have considered whether we should set specific targets from the centre for improving customer service, but it would not be easy to monitor and risks crowding out other worthwhile, local initiatives. In the White Paper we can however give examples of the kind of improvements we expect to see health authorities introducing. I have in mind:

i. ensuring that all the patients are properly welcomed to the clinic or ward,

ii. providing facilities for patients, or their relatives who are distressed, to recover or be counselled in private,

iii. ensuring that a full range of optional extras are available for patients who are willing to pay an extra charge. These could include more elaborate meals, colour TVs, hairdressing services and so on.

9. Considerable irritation and inconvenience is also caused when, having arrived for an appointment in a clinic or an outpatients' department, a patient is kept waiting to see the doctor for long periods without any explanation or apology. A more personal service would tackle this, too. I would expect all health authorities to review their appointments procedures, to make sure that every patient is given a specific appointment time and, as far as possible, is seen within a reasonable period of that time; in Peterborough, for example, all patients are expected to have been seen within 20 minutes of their appointment time. Where there are unavoidable delays, patients should be given an apology and told what has gone wrong.

Waiting times

10. The White Paper will also need to deal with the more intractable problem of long waiting times for diagnosis and treatment. We shall also need to draw out the ways in which our proposals for greater competition and moving money with the patient will serve the objective of reducing waiting times. Our current national waiting list initiative, our proposals for rolling it forward in 1989/90 - for which resources have already been earmarked - and my proposals on "performance funding" (HC 49), can be presented as interim solutions until the full effects of our proposals work through.

Information

11. I also want to see a much better flow of information between hospitals and their customers. Again, there are a number of basic rules which I would expect all health authorities to follow, such as:

i. sending all prospective hospital patients a leaflet telling them what they need to know about coming into hospital - how to get there, what to bring, and other relevant information. Brighton have produced some very attractive and informative booklets,

ii. making sure that telephone calls are answered promptly by the hospital switchboard. This is a good example of a basic improvement where targets can be set and progress monitored.

12. Further, I expect all health authorities to keep their customers informed about past performance and future plans through periodic reports, annual meetings open to the public and regular publicity in the local media.

Improving the quality of clinical care

13. Quality assurance programmes are not just about improving hotel and support services. These are important - and highly visible to patients - but all health authorities should be satisfying themselves that they have adequate mechanisms in place for monitoring and improving the quality of clinical care. In the past, this has been inhibited by the absence of a reliable information base and the technology which enables the complex range of clinical and personal data to be processed quickly at ward level. We are now well on the way to overcoming these problems and have more "computer literate" doctors and nurses wanting to develop this aspect of care.

14. My separate paper on medical audit (HC 50) suggests how we can ensure that every doctor is involved in securing high-quality cost-effective clinical care. The same principles apply to all the professional groups. Nurses, for example, are leading a number of initiatives for improving standards of care. The acceleration of the Resource Management Initiative will provide an added stimulus and context for the developing quality assurance on a national scale.

15. Health authorities must also be able to focus on areas of particular concern. Monitoring the health of the local population will continue to be a key role of all DHAs. Health authorities will need to satisfy themselves that what they are buying offers not only value for money but also a high quality service which is effective in improving the health of its resident population. In this regard, the work currently under way to devise better measures of health outcomes (para 27-28

below) will be particularly valuable. Health authorities must also learn to listen to their customers, and surveys must be an integral part of the district's monitoring role.

Implementing quality assurance programmes

16. We cannot rely solely on exhortation to ensure that all health authorities introduce a quality assurance programme. Following the publication of the White Paper, I suggest that all health authorities should be required to draw up plans in 1989/90 for implementation from 1990/91. Progress on preparation and delivery will be monitored through the performance review process. I propose to consolidate this by including improvements to quality of service and clinical care as one of the criteria against which general managers' performance will be assessed. I also believe that the increased competition that will result from our other proposals will act as a spur to a systematic improvement in quality.

Costs

17. Quality assurance programmes themselves need not cost a great deal to introduce. In Wessex, for example, the initial work is costing about £0.75m a year, excluding training costs. But a major training initiative is also vital. British Airways, for example, invested £25 million over 3 years to retrain their 40,000 staff. Given the size of the NHS, even a basic training programme would cost at least £10m a year in the first two years that the programme was launched. We are therefore talking of £20 million a year over 2 years to launch a comprehensive quality assurance initiative.

An acute sector advisory service

18. I have also given some thought to whether we should establish a national body to monitor the quality of services in acute hospitals. A number of the organisations who have made submissions to the review have advocated some form of hospital inspectorate, and the Social Services Committee endorsed the idea in their report on the future of the NHS. We shall therefore need to be ready to give our views when the White Paper is published, even if we do not make specific proposals ourselves.

19. A monitoring body could take various forms. I am not proposing an organisation that is independent of Government and could develop into yet another lobby for more resources. For this reason, I have rejected the models adopted in the United States and Canada under which an independent body formally accredits hospitals against a set of national quality standards. I am however attracted to the idea of an advisory body that is ultimately answerable to Ministers but whose main function is to offer a source of independent advice to local management on a consultancy basis.

20. The model I have in mind is akin to the existing NHS Health Advisory Service (HAS). The HAS was established in 1970. It is professionally led and monitors, on my behalf, the provision of services for the mentally ill and the elderly. An acute sector advisory service might similarly consist of a small, central group of staff with perhaps a doctor as its director. For each visit it would appoint a multi-disciplinary team drawing on a group of practising professionals who could command the respect of colleagues. The membership of the team would of course need to reflect the nature of the service being reviewed. The inspectorate would be self-financed mainly through fees from health authorities and hospitals being visited.

21. I have considered the option of extending the remit of the existing HAS into the acute hospital sector, but I have concluded that acute hospital services are sufficiently different to merit a separate body. More importantly, unlike the HAS which sets its own programmes, I see the acute sector advisory service as essentially a tool of local management, with the bulk of its work programme being determined in the early stages by Regions and later by Districts. It would also be available to - but would not be imposed upon - self-governing hospitals. There may however be occasions where difficulties arise of sufficient importance for Ministers to ask the service to investigate a particular area of work or a particular hospital. As with HAS reports, the new advisory service's reports should be published. Not to do so risks charges of excessive secrecy.

22. The concern of the advisory body would be mainly the quality of clinical services. It would in some circumstances be an imposed peer review. Thus when a local manager, unhappy at the quality or performance of a particular specialty, called in the advisory body, the key part of their visit would be the review of local professional work by other doctors in that specialty. In this way, it would complement the other work being undertaken in the hospital either in the context of value for money initiatives or as part of a medical audit programme. The multi-disciplinary composition of the team and its independent status would however enable it to take a wider view of service provision, including the targets and priorities that a hospital had set itself and to act as an outside stimulus to change.

23. The follow up to an advisory report would in the first instance be the responsibility of local management, who would need to have regard to the wider resource and policy implications. But an adverse report would also be picked up by the RHA as part of the performance review process. Failure to take action on a report would be one of the criteria against which the general manager's performance was assessed. At national level, advisory reports would be one of the sources of information against which regional performance was assessed.

24. I believe that an initiative of this kind would be widely welcomed. The UK is one of the few countries not to have some

form of national body that is capable of assessing the quality of acute hospital services. My proposals do not go as far as some have argued, not least because we must avoid a heavy-handed, bureaucratic approach. But they would help to reassure the public and the professions that the review is not simply about value for money, and, in my judgement, are the minimum we can put forward in the White Paper.

Better Health

25. I have dealt so far with the scope for improving services for patients who need treatment. We must also do more to reduce the numbers who do need treatment. I propose to focus on four developments in the White Paper:

First, building on our successful efforts to convince people that by taking sensible measures e.g. on diet, exercise, smoking and alcohol they can help to improve their own health.

Second, improving our ability to monitor health and to identify areas of concern e.g. adverse changes in the patterns of disease so that we can respond to them effectively and in good time.

Third, measuring the outcome of health services.

Fourth, developing new initiatives to prevent illness and to promote health.

26. Public awareness Our emphasis here should be on providing better information so that people can make their own choices. This will be consistent with our emphasis elsewhere on the importance of choice.

27. Monitoring health Following discussions between my predecessor and the Chancellor, my officials have agreed with Treasury officials the basis for developing a portfolio of health indicators, which will be published regularly. The indicators will enable us to chart improvements in health and to identify potential areas of concern. We would also, if we so wished, be able to quantify what we wanted to achieve e.g. a reduction in alcohol misuse.

28. Measuring outcome of health services The health indicators will also enable us to provide data for the first time on the benefits to quality of life by treatment in the NHS. In so doing, we shall be able to set out much more clearly the beneficial impact of our NHS funding. This will enable us for example to put into proper perspective the issue of those waiting for treatment as compared to those already successfully cured.

29. Health promotion and disease prevention. I propose to take a major new initiative with Regional Health Authorities to encourage the development of new ideas in this field. The aim

will be to build on local enthusiasm, as has been successfully done with the Welsh campaign "Heartbeat Wales" and the English campaign "Look After Your Heart". There are two main elements:

First, and more important, incentives for developing new initiatives in disease prevention and health promotion, e.g. the detection of congenital deafness and treatment of undisclosed high blood pressure as well as new health education programmes. These would be funded from regional allocations by agreement with Regional Chairmen.

Second, prizes for those who have already run successful disease prevention or health promotion campaigns. The prizes would be funded privately by charitable foundations (I already have one potential backer) or leading local firms.

We would be able to link this initiative to the development of new health outcome indicators, since these would help us to identify areas where incentives were most needed. The amount of money involved, particularly in the prizes would be small. But it should provide very good value. It will also help us to respond to public concern that we do not pay as much attention to the prevention of disease as to its cure.

B:D6.32/1

HC 54

SECRET

Copy No: 2

HC 54

NHS Review

THE PUBLIC AND PRIVATE SECTORS

Note by the Secretary of State for Health

1. This note

* assesses the impact of the review on the distinction between public and private health care; and

* makes specific proposals for carrying forward the competitive tendering of pathology and radiology services.

2. In summary, the key elements are:

i. blurring the distinction between public and private sectors.

ii. enabling the private sector to trade and compete freely and on a fair basis.

iii. extension of competitive tendering, to the clinical as well as non clinical field.

Blurring the distinction

3. One of the key objectives of the review has been to blur the distinction between the private and public sectors in health care. Taken together, many of the reforms we are planning will achieve this in the most effective way possible: by helping the private sector to trade and compete freely with the public sector.

4. In presenting our conclusions, especially to those who are looking to the review for a boost to private health care provision, I suggest we emphasise three points in particular:

(i) we are building in strong incentives for health authorities and, especially where they have their own budgets, GPs to look to private as well as public sector providers for the best available deals, especially in elective acute services.

SECRET

(ii)we are breaking the monolith of public provision by enabling self-governing hospitals to operate much more like private sector hospitals, but within the public sector.

(iii)we are "levelling the playing field" so that public and private sector hospitals can compete on equal terms.

5. My discussions with the Chief Secretary on charging for capital are particularly relevant to (iii). More generally, we must ensure that the new funding arrangements set out in HC49 are developed in a way which does not build in significant advantages or disadvantages to NHS providers - in terms of training costs, for example.

6. There are two other changes which would help further to blur the distinction:

(i) easing the constraints on the access of public sector providers to private capital. This too I am discussing separately with the Chief Secretary.

(ii)making progress towards the competitive tendering of pathology and radiology. The remainder of this note makes specific proposals to this end.

Competitive tendering

7. We have made good progress in recent years in the competitive tendering of non-clinical support services. My paper on reconstituting health authorities (HC52) suggests that we accelerate the contracting out of other non-clinical functions at Regional level. For clinical services generally, and elective surgery in particular, the new funding arrangements we propose will themselves generate more competition.

8. As we have acknowledged, the main outstanding area to address is the potential for competitive tendering of clinical support services, particularly pathology and radiology. We must not overlook the importance of excessive demand from clinicians for diagnostic tests, whether or not these tests have been contracted out: we must continue to tackle this through the resource management initiative, and medical audit will also be relevant. But that need not prevent us from addressing the need for competitive tendering. My proposal here, which I outlined in an earlier paper, is that we proceed by fostering local initiatives.

9. There is clear scope for competitive tendering of pathology and radiology, for example to reap the full benefits of economies of scale and to make the most effective use of expensive capital equipment. The routine processing of samples in chemical pathology is one example. There is considerable scope for the

B:D5.30/5(DC4)

private sector to respond. But there are also legitimate professional concerns: that we must secure proper quality control; and that clinicians do not lose their ready access to the expert advice of pathologists and radiologists.

10. In the light of these concerns the profession have been assured, for example in a letter from John Moore to the Royal College of Pathologists last November, that we have no plans for a "central initiative" in this field. But initiatives by individual health authorities are not ruled out, as long as the views of the profession are taken into account.

11. It should not be difficult to foster local initiatives of this kind, and to learn from early experience how best to meet the profession's proper concerns. This is the course I recommend. If colleagues agree I shall draw up and implement an action plan along these lines. The White Paper will need to be drafted in terms which leave the way open but which are also consistent with the assurances the profession have been given.

November 1988

B:D5.30/5(DC4)

SECRET

Copy No. 2

HC 55

NHS Review

PROFESSIONAL AND EMPLOYMENT PRACTICES

Note by the Secretary of State for Health

1. This note responds to the Group's wish for a paper on "restrictive practices", which I have interpreted broadly to cover professional and employment practices generally in the NHS. It concentrates on doctors, nurses and the "professions supplementary to medicine" (physiotherapists, radiographers, chiropodists and so on).

2. In my judgement the most important requirement in this field is to tackle the rigidities caused by professional boundaries. The paper deals mainly with this issue, but also with employment practices. I have not addressed directly activities such as advertising and "price fixing", which are subject to wider legislation on fair trading which we should be ready to invoke as necessary; nor the scope for local flexibility on pay, which DH and the Treasury are to discuss further. The specific possibility of employing consultants on short-term contracts to reduce waiting lists is addressed in my paper on "Funding Issues" (HC 49).

3. In brief, I propose

(i) a major - but rapid and well-focused - inquiry into the best use of professional resources in the NHS.

(ii) reform of the national conditions of service of NHS staff, in the interests of greater flexibility.

(iii) further action on the efficient use of nursing staff.

I PROFESSIONAL BOUNDARIES

4. A note summarising the statutory framework for the main professions covered by this paper is at Appendix A. The health care professions are by definition self-regulating, setting their own standards for entry and training and thereby defining the scope of their work. As a result rigid professional boundaries have tended to grow up, both between the different professions and between professional and non-professional staff.

5. The problems are probably most serious where medical, nursing and social services are available in people's homes, aggravating the risk of the same patient being seen by

SECRET

different professionals for similar purposes. In hospitals too the existence of distinct professional roles can inhibit the deployment of less skilled staff and the use of one profession rather than another (such as the use of nurses or midwives to carry out tasks traditionally associated with doctors).

6. Any action in this area will need to take account of the following:

i. The NHS is a very large employer of (particularly female) school leavers with a reasonable level of academic qualification (5 GCSEs or more). This group is declining quickly in numbers and will continue to do so until the middle 1990s. There will be little recovery before the end of the century.

ii. It will be necessary to eliminate any unnecessary restrictions on entry to professional training, and to maximise recruitment from older age groups. It will also be essential to develop more flexible training patterns which allow non-professional staff to progress into professional training, and more flexible working practices.

iii. The "skill mix" between professional and non-professional staff needs further research to establish the optimum mix of staff in different circumstances.

iv. In community settings in particular the respective roles of different professional groups need review. This may mean identifying more positively those staff who have a primary diagnostic, caring or therapeutic role and those who, in effect, act more as consultants to patients' families and to other health care staff.

v. We need to explore to the full the scope for shared education and training.

Action in hand

7. Some small progress - no more - has been made on inter-professional issues. But a good deal of useful, collaborative work is under way with the professions to tackle the problem of boundaries between professional and non-professional staff.

8. Some examples are set out in Appendix B. A great deal of progress is being made with the nursing profession in the context of Project 2000, and also, for example, with occupational therapists and clinical phychologists. Others, such as physiotherapists and radiographers, are being more cautious, although constructive discussions are in hand. The spread of clinical budgets will put increasing pressure on the professions themselves to find more flexible ways of using staff; and some changes will be forced by demographic constraints on recruitment, even if the results are sometimes

less than ideal. (A higher ratio of non-professional to professional staff is not necessarily either more cost-effective or in the interests of the patient; but nor are traditional role boundaries.

An inquiry

9. It will be important to maintain the momentum of these developments. Where we can make progress through collaboration between management and the professions we should do so. But much of our work so far has been opportunistic, and hence piecemeal. And progress is uneven.

10. The climate is right for a major, objective examination of professional boundaries. Many of the health professions are becoming more receptive to change as they recognise the likely impact of labour market developments in the 1990s. The Government has set the tone in other fields, most recently on the legal profession (although the parallel here is not exact): there could be no suggestion that the health professions were being unfairly singled out in our drive for greater flexibility.

11. We must proceed carefully nonetheless. For example, any legislative attempt either to curtail current restrictions on rights to practise or to redraw the boundaries around and between professions would be exceptionally contentious and fraught with definitional difficulties. Whether we need to legislate or not the ground must be carefully prepared.

12. If colleagues agree I propose to set up a small inquiry team consisting of, say, 3 or 4 lay people of suitable standing. Any attempt to make the team respresentative of the professions themselves would be impossibly cumbersome, but the inquiry could and should take evidence from all the relevant professional bodies, as well as from NHS management and other interested parties. It would be desirable to secure commitment to the inquiry's proposals from at least some of the professions involved.

13. It would be important to ensure that the inquiry was not seen as a crude attempt to "de-skill" health care but as an objective scrutiny of problems and solutions. Its task would be to examine, from first principles, the mix of professionally qualified and other staff required to deliver a given level of service safely and economically. It would be asked to take into account the labour market circumstances and other factors summarised in paragraph 5. Most importantly, its terms of reference should focus on how to make the best use of professional resources in the interests of patient care.

14. The inquiry should be free to make both general recommendations and recommendations which are specific to individual professions. It would need to examine

- supply, training and education.

- personnel, employment and working practices.

- the substitution of technology or capital for labour.

- changes in the culture of the service and in professional attitudes.

- the consequences of the inquiry's proposals for patterns of service delivery.

- the management, financial and information implications.

15. We would need to guard against two, potentially serious, risks: first, that the sheer range of issues and professional interests would lead the inquiry to lack a clear focus; and, secondly, that the useful work already in hand would be stalled whilst the inquiry took place. To avoid these dangers I would propose asking the team to

i. take account of the wide range of projects already under way - as exemplified in Appendix B.

ii. let me have early proposals - within, say, two or three months - as to the issues on which they wished to focus their attention. I could then agree with them a more specific remit and timetable for the main part of their work. There might be advantage in seeking an early report on some issues and allowing more time for others; subject to that, the team might be asked to complete its work by, say, the end of 1989.

iii. concentrate not on producing a comprehensive and detailed report but on identifying areas where insufficient progress is being made and recommending solutions.

16. If colleagues are content with this proposal I shall work up the detailed arrangements - and try to identify a Chairman - so that we can move forward quickly after the publication of the White Paper.

II EMPLOYMENT PRACTICES

Terms and conditions of service

17. I suggest that the White Paper should also signal an intention to give managers greater flexibility to determine the conditions of service of NHS staff, which are currently determined mainly by national negotiation in the Whitley Councils. My proposals for self-governing hospitals envisage that these hospitals will be wholly removed from Whitley constraints. Leaving aside the issue of pay flexibility, that

still leaves room for the present detailed and prescriptive agreements on conditions of service to be replaced by arrangements which give health authorities generally scope for greater flexibility.

18. Following a recommendation of the Griffiths Inquiry, the Department last year commissioned a radical review of conditions of service by a seconded NHS personnel specialist. His report is due by the end of the year and will provide the basis for a programme of reform. I propose that the White Paper should state our intention to carry through these reforms. To do so it will be necessary to amend the relevant Regulations, which at present severely restrict our scope for progress other than by negotiations through established machinery.

Efficient use of nursing staff

19. At our last meeting the Group also raised the issue of working patterns in nursing.

20. The NHS Management Board has devoted considerable effort recently to improving health authorities' capacity to plan the demand for nursing staff. Most authorities now use one of a number of recommended methodologies.

21. Staff must also be deployed and used to best advantage. A whole range of measures is needed here, from reducing wastage and absenteeism to restructuring the workforce to produce taut, effective management structures and the best possible grade mix. Some of the relevant work in hand is among that referred to in Appendix B. As soon as the initial pay assimilation process is completed I shall be taking steps to ensure that authorities use the restructuring opportunities created by the new clinical grading structure.

22. An area particularly needing attention is matching staffing levels more closely to workloads. This includes the elimination of shift overlaps which are not justified by peaks in activity levels. Authorities are beginning to use computerised work scheduling systems, and the resource management initiative will give these a considerable boost. Progress is not, however, dependent on information systems, and while some authorities have made good progress others still lag behind.

23. I am considering how to give greater focus and impetus to the considerable range of work which is going on in this whole field. I should be happy to bring forward proposals for inclusion in the White Paper if colleagues agree that that would be appropriate.

November 1988

B:DC2.7/6

APPENDIX A

THE STATUTORY FRAMEWORK

Professional self-regulation

1. The statutory framework for doctors, nurses and the professions supplementary to medicine is founded on the principle of self-regulation. For some at least of these professions the activities of the statutory and/or professional bodies may encompass, among other things:

(a) maintaining a register of qualified members - only those on the register may practise the profession.

(b) protecting the profession's title.

(c) establishing codes of professional conduct and removing members from the register in the event of breaches of the code or unfitness to practise.

(d) controlling entry standards for, the content and length of - and sometimes the numbers in - training,

(e) through a combination of (a),(c) and (d), determining the role of the profession, including the role of non-professional support staff.

(f) determining staffing and other criteria for suitable clinical placements during training.

(g) specifying mandatory refresher training.

Doctors

The General Medical Council

2. The General Medical Council is an independent statutory body whose constitution and functions are regulated by the Medical Act 1983. The general duty of the Council is to protect the public and uphold the reputation of the profession. Specifically its duties cover registration; standards of education and experience; standards of professional conduct and medical ethics; and professional discipline.

3. The Council consists of 97 members, of whom 50 are directly elected by registered practitioners, 34 appointed by universities with medical schools and by the Royal Colleges, and 13 (including 11 lay members) nominated by the Privy Council. It elects a President from among its members.

The Royal Colleges

4. There are seven English Royal Colleges (Surgeons, Physicians, Psychiatrists, Radiologists, Pathologists, Obstetricians and Gynaecologists, and General Practitioners), each established by Royal Charter. Together with similar bodies covering other specialties (such as the Faculties of Anaesthetists and Community Medicine), they have the general aim of promoting standards of excellence in their respective specialties, for example by providing courses, promoting research and publishing reports. In practice they control the standards and content of specialist training, by conferring post-graduate qualifications (diplomas, memberships and fellowships) and through a system of regular inspection of all junior medical posts. In these ways they have considerable power to shape specialist practice. There is machinery for co-ordinating College views, but it is weak.

Nursing

The United Kingdom Central Council for Nursing, Midwifery and Health Visiting

5. The United Kingdom Central Council is an independent, statutory body set up by the Nurses, Midwives and Health Visitors Act 1979. The Council's functions cover registration; standards of training and professional conduct; and professional discipline. Each of the four National Boards (see below) nominates seven members, and 17 are appointed by the Secretary of State. The Council elects its own Chairman.

The National Boards

6. Four National Boards - for England, Scotland, Wales and Northern Ireland - have been set up under section 6 of the 1979 Act. The job of each Board is to ensure that pre-qualification training courses are provided and examinations held, and that the courses meet the requirements of the Central Council as to their content and standard. The Boards also carry out preliminary investigations of cases of alleged misconduct. The majority of the members of the Boards are directly elected by members of the professions, the remainder being appointed by the Secretary of State. A majority of appointed members are nurses, midwives or health visitors appointed to ensure that all branches of the profession are adequately represented. The Boards elect their own Chairmen.

Professions Supplementary to Medicine

7. Machinery for the state registration of a range of health professions was set up under the Professions Supplementary to Medicine Act 1960. The seven professions currently within scope of the Act are chiropodists, dietitians, medical laboratory scientific officers, occupational therapists, orthoptists,

physiotherapists and radiographers. State registration under the Act is a pre-requisite for employment in the NHS.

8. There is a separate Board for each profession, whose membership is drawn mainly from that profession, and which is responsible for maintaining the register and for the regulation of professional education and conduct. The Boards approve courses, curricula and institutions as suitable to lead to state registration in their respective disciplines. In the majority of the professions the qualification so approved is the diploma of the professional body concerned.

9. The Boards are supervised and co-ordinated by a Council for Professions Supplementary to Medicine. The Council may comment on, but not veto, the Board's recommendations, which are submitted to the Privy Council for approval. The Health Ministers appoint either directly or indirectly (by advice to the Privy Council) seven of the Council's 21 members and its Chairman. A further seven members are appointed by, and represent, the individual Registration Boards. Most of the remaining members are appointed by medical colleges.

APPENDIX B

PROFESSIONAL BOUNDARIES

1. A substantial programme of action is either planned or in hand concerning the boundaries of professional practice in health care, both between professions and between professionals and their non-professional support staff. Among this work is the following:-

a. Project 2000. The Government's acceptance in principle of the Project 2000 reforms of nurse education and training depends on developing the role of non-professionally qualified support workers to nurses and the possibility of progression from support work into professional training. The UK Central Council has work in hand to identify vocational qualifications, as well as academic qualifications which might satisfy the entry criteria to nurse training; and is also looking at alternative entry procedures for potential mature students.

b. Nursing. Following up a current, small-scale study at the University of Warwick on skill mix within the acute ward team, concentrating on the role of ward clerks, the University has been commissioned to undertake a major two year study of cost-effectiveness and skill mix within nursing.

c. Nursing and technicians in high technology care. A short study of possible overlap between the roles of nurses and technicians in high technology care has been completed. This identified overlap in many areas of work. We plan to follow this up shortly with a larger study which will encompass the deployment and training implications of these findings.

d. Occupational therapy. A report on skill mix and manpower requirements for occupational therapy in the NHS and local authorities is expected by autumn 1989. This work will form part of a longer term project which will continue with a review of competencies and training requirements.

e. Physiotherapy. A study of workload measurement and supply is in hand. This work is expected to lead on to an examination of skill mix.

f. Clinical psychology. We are planning a study to identify common or core skills; to determine the levels of staff and skill mix required; and to examine both the possibility of introducing supporting staff and the feasibility of delegating tasks to, or sharing them with, other groups.

g. Pathology. A recent report on pathology service staffing has suggested that there is scope for greater use of non-graduate laboratory assistants.

h. Speech therapy. We are funding a study of skill mix in speech therapy, and in particular the role of speech therapy helpers.

i. Shared training. Examples of current initiatives include significant progress towards shared training between nurses and social workers in the field of mental handicap, and a joint working party of the Royal College of Nursing, the College of Occupational Therapists and the Chartered Society of Physiotherapy on the scope for joint working, including shared training, between the three professions.

2. Action is also in hand on nurse prescribing. Outside the hospital service the ability to prescribe and/or supply drugs and medicines is limited to preparations ordered by a medical or dental practitioner. The Cumberlege Report on Community Nursing recognised that in practice community nursing staff were frequently operating in circumstances that required them to supply a limited range of preparations to patients with whom they were in direct contact. The Report recommended that nurses should be able to prescribe and/or supply a limited list of preparations, and also, in carefully defined circumstances, to control and vary drug dosage.

3. The Government has made clear its general support for this recommendation. The Department has established a small working group, including all the professional interests involved, to examine the professional and ethical issues. These issues range from the nature of prescribing and the appropriate categories of nurse to engage in it, through the types of items which might be covered and the financial and legal consequences. There are related questions of security, training and personal liability. The Group expects to complete its work by June 1989.

4. The Group will confine itself essentially to the Cumberlege recommendation, which was limited in scope. The consultation exercise which followed Cumberlege gave the other professions the opportunity to voice their concerns, but it was recognised that to a large extent the recommendation would regularise existing practice and opposition from other professions was limited. Any attempt to go further would be fiercely resisted. Primary legislation may nonetheless be needed to achieve the necessary changes.

ANNEX A

figures for in-patients, for out-patients, and for operations. May I also point out that the Government have increased the proportion of the GNP spent on the National Health Service from 4·8 per cent. under the last Labour Government to 5·5 per cent. Not only has the GNP gone up but the proportion spent has also gone up in real terms. Other countries are able to devote more to health care services because more is contributed privately, both from private insurance and from families' pockets. If the doctors think what they have written, they must be very thankful that there is not a Labour Government in power.

Mr. Kinnock: In the 40-year history of the National Health Service the presidents of the royal colleges have never found if necessary to speak to any Government in the terms that they have spoken to the Prime Minister's Government. Can she not learn from that, or from the evidence of patients, nurses and other professions in the National Health Service? When Mr. Ian Todd, the president of the Royal College of Surgeons said:

"Managers are telling surgeons to do less work to balance the books."

does she not recognise that she is responsible for setting lives against sums? What will she do about it?

The Prime Minister *rose——[Interruption.]*

Mr. Speaker: Order. How can the Prime Minister possibly answer with all this noise going on?

Mr. Foulkes: You, Mr. Speaker, are like a Pakistani umpire.

Mr. Speaker: The hon. Gentleman should withdraw that remark at once.

Mr. Foulkes: I withdraw it, Mr. Speaker.

The Prime Minister: In the 40 years of the NHS there have never been more patients treated, whether as in-patients or out-patients. There have never been more accident and emergency cases treated. There have never been more heart bypass operations or hip replacements — *[Interruption.]* Of course hon. Gentlemen will interrupt because they cannot bear to hear the facts.

There are more cataract operations, more bone marrow transplants, more kidney transplants, more cervical smear tests, more people treated for kidney transplants and for chronic renal failure. — *[Interruption.]* Opposition Members will shout because they cannot bear the fact that the Government have a far better record than they have ever had. With regard to the future, if the Leader of the the Opposition had listened to me earlier he would have heard that next year spending on the NHS will increase by £1·1 billion. I mentioned that figure because I have heard Labour Members on the radio suggesting that an extra £200 million would do the task. Next year there will be an extra £1·1 billion—five times as much.

Mr. Riddick: Bearing in mind that the demands for health care are never-ending and the fact that private spending on health care in this country is among the lowest in Western Europe, does my right hon. Friend believe that the time has come to introduce tax relief for individuals who take out health care insurance?

The Prime Minister: No. It is more important to leave people to make their own decisions about what they do with their money rather than increasing reliefs for a particular sort of expenditure.

Q2. **Mr. Allen McKay:** To ask the Prime Minister if she will list her official engagements for Thursday 10 December.

The Prime Minister: I refer the hon. Gentleman to the reply that I gave some moments ago.

Mr. McKay: Irrespective of the statistics that the Prime Minister throws out and irrespective of the light attitude she has adopted towards the statement from the Royal College of Surgeons, will she take notice of the National Association of Health Authorities, which reported that the hospital service is £200 million underfunded? Will she give an assurance to the House that the much needed increase in nurses' pay will not have to be found from the existing area health budgets?

The Prime Minister: The hon. Gentleman has given the figure of £200 million which I mentioned earlier. I have already told him that next year the increase going to the NHS will be £1·1 billion. I remind the hon. Gentleman that the previous Labour Government slashed the NHS programme. They cut new hospitals by one third, cut capital spending for two years running and, having supported a strike against patients, presided over an increase in waiting lists of 250,000, to record levels under Labour.

Mr. Heddle: On the matter of those employed in the Health Service, nurses in particular, and the community charge, will my right hon. Friend confirm that among the options she and her right hon. Friends considered as a replacement for the present unfair and outdated system, was capital valuation coupled with a local income tax? Does she agree that that would bring hardship and chaos to every individual and their families and that the Labour party, whose policy it is, is discredited for having pursued it?

The Prime Minister: Capital valuation would have been infinitely worse than even the present basis of valuation. A local tax, similar to a local income tax, would put an even heavier burden on those people who pay income tax and would mean that the amount they had to pay would be greatly in excess of a community charge.

Q3. **Mr. Nellist:** To ask the Prime Minister if she will list her official engagements for Thursday 10 December.

The Prime Minister: I refer the hon. Gentleman to the reply that I gave some moments ago.

Mr. Nellist: Instead of burying her head in 10-year-old NHS statistics and repeating them like a cracked record, what would the Prime Minister say to Adrian Woolford, a seven-year-old Coventry lad, who has waited two years for a heart operation? What would she say to the parents of Chintu Kumar, a one-day-old baby, who died after a 100-mile dash from Coventry to Liverpool because half of Birmingham children's hospital beds were closed? What would she say to the parents of dozens of kids in the midlands who, tomorrow night, will meet midlands Members about the crisis? She might be able to buy her health and the health of her kids, but our families cannot. Does she not care?

The Prime Minister: Let me assure the hon. Gentleman that the statistics that I give are not out of date but are updated. The number of bypass operations, cataract operations and many other operations that are now performed on children could not have been performed 10

chex.rm/mw/75

SECRET

FROM: MISS M P WALLACE
DATE: 12 December 1988

MPW
BT CST
12/12

PS/CHIEF SECRETARY

cc Paymaster General
Sir P Middleton
Sir T Burns
Mr Anson
Mr Phillips
Miss Peirson
Mr Richardson
Mr L Watts
Mrs Butler
Mr Parsonage
Mr MacAuslan
Mr Sussex
Mr Saunders
Mr Griffiths
Mr Call

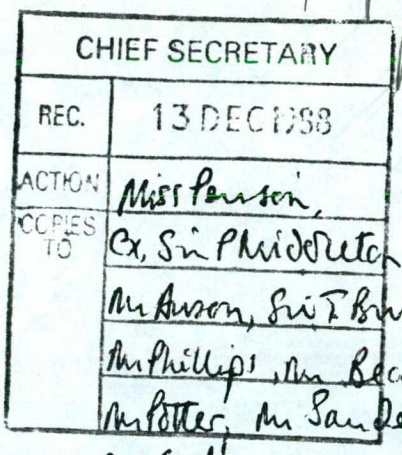
NHS REVIEW: SELF-GOVERNING HOSPITALS

The Chancellor has seen Mr Griffiths' minute of 9 December.

2. He has noted the awkwardness set out in Mr Griffiths' paragraph 3, namely that GGE and the planning total will increase if we turn self-governing hospitals into public corporations and require them to pay interest charges on originating debt. However in his view this effect, although awkward, should not be decisive.

MOIRA WALLACE

CONFIDENTIAL



PRIME MINISTER

12/12/88.

AUDIT OF THE NATIONAL HEALTH SERVICE

In a recent meeting of your Ministerial group on the review of the National Health Service (NHS) you asked Kenneth Clarke for a note on the possibilities for using this session's Housing and Local Government Bill to provide for the Audit Commission to take over the external audit of the NHS. In the event, it proved most convenient for me to take a meeting last Tuesday on this issue with Kenneth Clarke, Nicholas Ridley, John Major and Ian Grist. This minute, which I have agreed with them, reports the conclusions that we reached.

First, we agreed that if any provisions on NHS audit were to be included in Nicholas Ridley's Bill, it would not be practicable to do it entirely by way of Government amendment during the Bill's passage. Some minimum provision would, therefore, have to be ready for the Bill's introduction at the end of January, ie, shortly after the likely publication of the NHS White Paper. It would not be possible to prepare a fully worked-up set of NHS audit provisions on that timetable, but we were also clear that there were considerable objections to the idea of promoting a general power that would simply enable the Audit Commission's role within the public sector to be expanded. We, therefore, concluded that the only practical compromise would be a paving provision authorising the Audit Commission to undertake some audit and value for money work in the NHS field, so as to enable them to build up experience and prepare to assume the full role that they would be given when the main NHS review legislation came forward in a later session. In principle it would be possible for such a paving provision to be expanded at Committee to embrace the full legislation required for the transfer of the NHS audit to the Audit Commission, but the problems that even a paving provision could create, as discussed below, would be greatly magnified by such a move and we concluded that it was not practicable. A paving provision of this kind should be fairly short, and Nicholas Ridley is prepared for it to be included in his Bill. Given the importance of the topic in your review group's thinking, Kenneth Clarke and John Major would ideally have wanted the Audit Commission to be given the full powers in the present session. Failing that possibility, they view the paving provision as the bare minimum that should be done on the issue in 1988-89.

The inclusion of a paving provision of this kind would require a reference to the NHS in the Bill's long title and it would clearly enlarge the scope of the Bill in a way that made it vulnerable to some amendment on NHS issues. It is impossible to predict quite how far that vulnerability might extend beyond the immediate areas of efficiency audit and value for money, as a great deal would depend on the ingenuity and determination of the Opposition. If, for example, the NHS review were to link funding with performance and efficiency, and the Opposition were determined to debate those issues on Nicholas Ridley's Bill, then they could probably find a way to do so. There is, therefore, an unavoidable risk that Nicholas's Bill could be used as an additional vehicle for debating the NHS review in a way that might be difficult to contain. Kenneth Clarke and John Major both feel that this is unlikely to happen. They see the extension of the Audit Commission's remit as an essentially technical matter that is unlikely to attract a great deal of attention, especially if it is tucked away towards the end of a very long Bill on local government matters and only debated some time after the review has been widely discussed. So far as the carriage of Nicholas's Bill itself is concerned, it is clearly unwelcome to have to contemplate a completely new kind of extension of a major Bill that is already starting very late. In my own view, it would be too optimistic to assume that the Opposition would entirely refrain from exploiting the inclusion of NHS material, and I believe that expanding the Bill in this way would be bound to add to the difficulties of managing it. The fact that the Bill is almost certain to be guillotined is not the end of the story. I know that Nicholas is anxious that the inclusion of NHS material should not be allowed to have much impact on the Bill's timetable, but I am afraid that I cannot guarantee that. Nevertheless, if it is decided to include this material, then I am confident that we can bring the Bill to Royal Assent, albeit at the possible cost of limiting our room for manoeuvre in other parts of the programme.

I think it follows from this that, although I see the business management aspects as quite important, they are not the decisive factor. The essential thing is the assessment of the threat that a paving provision in Nicholas's Bill might present to the overall presentation of the NHS review proposals during the first half of next year. The majority of the colleagues at my meeting this week were confident about this, and I hope that this minute will provide you with a basis for reaching a decision on the point.

Finally, if it is decided to include this provision in the Bill, Nicholas Ridley wondered whether the most effective way of playing it down as an essentially technical issue might be for him to make a speech on audit issues in early January, praising the Audit Commission's performance and announcing the intention of extending their role into the NHS as a pragmatic and sensible next step. He believes that, notwithstanding the proposal's subsequent inclusion in the health review White Paper, such a speech would

helpfully set the measure in the context of making fuller use of a body which has proved its effectiveness. I know that Nicholas would welcome your views on this suggestion should you decide that the paving power should be included in his Bill as introduced.

I am sending copies of this minute to Nicholas Ridley, Kenneth Clarke, John Major, Ian Grist, and to Sir Robin Butler.

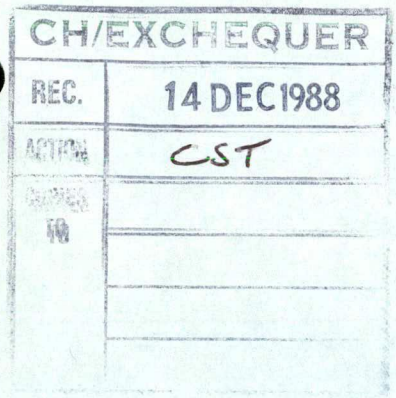
P.P.

JW

12.12.88

CONFIDENTIAL

MP



✓ 14/12

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

14 December 1988

Dear Alison,

AUDIT OF THE NATIONAL HEALTH SERVICE

The Prime Minister was grateful for the Lord President's minute of 12 December. She is content for a paving provision to be included in the Housing and Local Government Bill on the lines set out. She also thinks it would be helpful for the Secretary of State for the Environment to make a speech on audit issues in early January along the lines proposed.

I am copying this letter to Stephen Williams (Welsh Office), Roger Bright (Department of the Environment), Flora Goldhill (Department of Health), Carys Evans (Chief Secretary's Office), Alex Allan (HM Treasury), David Crawley (Scottish Office), Mike Maxwell (Northern Ireland Office) and Trevor Woolley (Cabinet Office).

Yours,
Paul

(PAUL GRAY)

Ms. Alison Smith,
Lord President's Office.

CONFIDENTIAL

Bourn

CONFIDENTIAL

FROM: J. ANSON
19th December, 1988.

MISS PEIRSON

c.c. Chancellor
Chief Secretary
Sir P. Middleton
Sir T. Burns
Sir A. Wilson
Mr. Phillips
Mr. Beastall
Mr. Potter
Mr. Saunders
Mr. Call

AUDIT OF THE NATIONAL HEALTH SERVICE

This is just to place on record developments on this during the last few days.

2. One of the points which the C&AG originally put to me was that he ought at some stage to put the Chairman of the PAC in the picture. When he came over on 18th November, I told him that there was no hurry because the proposal to use the Audit Commission would be announced as part of the NHS Review, which would anyway not be until some time after the Christmas Recess.

3. The Prime Minister has now agreed, however, with the suggestion that Mr. Ridley should foreshadow this proposal in a speech on audit issues in early January. I discussed this with Mr. France and (in Sir Terence Heiser's absence) with Mr. Osborn (DOE). We agreed that it would be a great pity if, after all our careful sapping and mining, a speech by Mr. Ridley were to provoke an unfavourable off-the-cuff comment by Mr. Sheldon before Mr. Bourn had been able to brief him. If Mr. Sheldon took up an unfavourable position it would then be difficult for him, or the rest of the PAC, to nod the thing through. Mr. Ridley does not at present have an obvious slot for the speech, and in the absence of himself and his entourage in China last week it was not possible to settle when it would be made. The Prime Minister did however agree that it would be in

"early January", and DOE could not rule out the possibility that the only convenient time might turn out to be during the Recess.

4. I discussed this with the Chief Secretary at the end of last week, and in the circumstances he agreed that the safest course was now to allow Mr. Bourn to brief Mr. Sheldon. Mr. Sheldon is of course a Privy Counsellor, and is used to receiving confidential information as PAC Chairman. I have accordingly spoken to Mr. Bourn and advised him that the proposal might be unveiled in a Ministerial speech early in January, and that he could brief Mr. Sheldon informally before the Recess. This should of course be on the basis that the information should be treated as confidential until it was made public by Ministers. Mr. Bourn thanked me for this information and said that he would talk to Mr. Sheldon, and would let me know his reaction.

5. I have told Mr. France that I have done this, and will tell Mr. Osborn as soon as I can get hold of him. I have already emphasised to Mr. Osborn the importance of clearing the speech with us and others concerned.

J. ANSON