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PART 8.

Confidential Filing.

NHS Expenditure and Efficiency.

NATIONAL HEALTH.

Part 1: May 1979.

Part 8: February 1987.

Referred to	Date	Referred to	Date	Referred to	Date	Referred to	Date
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PART 8. ends:-

PAB to DHSS _ 14.10.87

PART 9. begins:-

MS/DHSS to LPC - ?d.

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10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

14 September 1987

SECOND GENERATION MAGNETIC
RESONANCE MACHINES

Thank you for your letter of 10 September enclosing the third monthly report on the above subject. The Prime Minister has noted this.

I am copying this letter to Tim Walker (Department of Trade and Industry) and to John Fairclough (Cabinet Office).

(P. A. BEARPARK)

G. H. Langsdon, Esq.,
Department of Health and Social Security.

-010

COVERING COMMERCIAL IN CONFIDENCE

cc

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY

Telephone 01-407 5522

From the Joint Parliamentary Under Secretary of State

P A Bearpark Esq
Private Secretary
10 Downing Street
LONDON
SW1A 2AA

10 SEP 1987

Dear Andy

SECOND GENERATION MAGNETIC RESONANCE MACHINES

I attach the Third Monthly report on this Subject.

As before I am copying to Tim Walker (Trade and Industry) and John Fairclough (Cabinet Office).

Yours sincerely

Geoff Langsdon

G H LANGSDON
Private Secretary

Prime Minister 4.

COMMERCIAL IN CONFIDENCE

SECOND GENERATION MAGNETIC RESONANCE MACHINES

1. Although this project is being led for Picker from the United States, it is clear that the bulk of the design work is being carried out in this country.

2. Some novel ideas are being explored and it is conceivable that the design will end up with two distinct models, only one of which will have a super-conducting (Oxford Instruments) magnet.

3. Picker, and GEC, maintain that no decision has been made about where the manufacture of these second generation scanners will take place.

DHSS
AUGUST 1987

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY

Telephone 01-407 5522

From the Secretary of State for Social Services

The Rt Hon John Major MP
Chief Secretary to the Treasury
HM Treasury
Parliament Street
LONDON
SW1P 3AG

Prime Minister 2

For the second page.

September 1987

Dear John.

HOSPITAL WAITING LISTS

When I wrote to you on 2 July about this year's survey, I said in respect of the bid then made for the waiting list initiative that I had also asked officials here to estimate the cost of introducing specific and timed objectives for reduction in waiting times. This study has now been completed.

As you know, the time patients have to wait for treatment is one of the major factors by which the public judge the effectiveness of the health service. Persistent and damaging stories about how long people have to wait - at best in pain or discomfort, at worst with increasing disability - undermine our ability to demonstrate our commitment to the NHS. They detract from the real success story that can otherwise be told. The public are looking to us for vigorous action.

The present waiting list initiative is useful and was well received. We expect it to lead to an additional 100,000 patients from the waiting list being treated in 1987/88. Its limitation is that £50 million over two years is insufficient to achieve a reduction in waiting times than can be sustained in future years. It is, of course, waiting times that matter most.

At my request officials first examined the possibility of a three-year rolling programme intended to result in no patient waiting more than 6 months for treatment. That would have attractions and would certainly not be perceived by the public as too ambitious. We have concluded that this would be impracticable because increases in surgical activity of the extent required could not be achieved in

E.R.

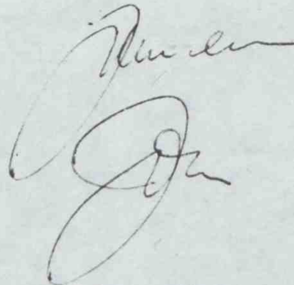
the short term. I am therefore proposing a less ambitious but I believe attainable target for the health service which we believe can be met within existing medical and nursing staffing constraints. This is that health authorities should be required to offer treatment to all patients within a year, this target to be achieved by March 1990. As a first step Regions would agree with districts (and report to the Department on) specific targets for achievement in 1988/89 for reducing the number of patients waiting over 1 year.

We estimate that the costs of adopting this modest target would be some £5 million in 1988/89 over and above the £25 million already agreed. For 1989/90 the cost would be £64 million, and for 1990/91 about £70 million. The figures for these two later years subsume the amounts bid for in my letter of 2 July. My officials will be writing to yours to explain the basis of these calculations.

There is considerable scope in this initiative for the health service to make cost effective use of the private sector and other available facilities. For 1988/89 I would propose that the additional £5 million should be available to health authorities only for projects that will make use of facilities outside the district, whether they be in the private sector, service hospitals, or in other districts. (We would, of course, monitor closely to ensure that the private sector was in fact competing on an equal basis with other health districts and that there would be no hidden subsidies.) This will have the advantage of giving an impetus to internal markets within the health service and overcome some of the more acute nursing shortages. The side effects of a controlled experiment of this sort could be extremely beneficial.

Colleagues will look to us for early action on this front. If we are to make an early impact, health authorities need as much time as possible to plan. I wish, therefore, to announce the new scheme, and the additional funding, as soon as possible and preferably at the Party Conference where both the Party and the public at large will be looking for us to give a further lead on this issue.

I am copying this letter to the Prime Minister, the Lord President, the Secretaries of State for Scotland, Wales and Northern Ireland and to Sir Robert Armstrong.



JOHN MOORE

Prime Minister 4

Ref. A087/2550

MR WICKS

— In attached folder.

Official History of the Health Services Since the War

In your minute of 22 June 1987 in which you conveyed to us the Prime Minister's agreement that Dr Charles Webster should be invited to write the second and final volume of the Official History of the Health Services since the War, you said that the Prime Minister had asked to see a copy of the first volume.

2. Volume 1 has now gone to HMSO for printing. A copy of the text in this somewhat raw state is enclosed for the Prime Minister to see. Publication is expected in June/July 1988 in time for the 40th Anniversary of the National Health Service.

3. All Official Histories contain the statement that:

"The author has been given full access to official documents. He alone is responsible for the statements made and the views expressed."

4. In each case however the text is "cleared" by the Departments to whose records the author has had access, in this case, the Department of Health and Social Security, Scottish Home and Health Department, Welsh Office and Treasury. Their comments were taken into account when this final draft was prepared for publication.

Trevor Woolley

T A WOOLLEY

8 September 1987

File SL

MR. BLACKWELL

NHS - THE WAY FORWARD

The Prime Minister has seen your paper of 11 August. She has read this carefully, and was grateful for it, though she has not made any specific comments upon it. She is, however, looking forward to the later paper promised in the final paragraph.

MARK ADDISON

24 August 1987

SLH/34

10 DOWNING STREET

Prime Minister

Unless you wish to take this Policy Unit paper on the NHS on holiday I suggest I put it in a weekend box when you get back.

AB

Thank you — I look forward to the next paper. MT

Yes please MT 11/8.

CF.

— Pse put in w/end box after return

AB 12/8.

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PRIME MINISTER 11 August 1987

NHS - THE WAY FORWARD

What the last election showed was that it is possible to increase NHS spending massively and still suffer political unpopularity for poor services and "cuts". Despite the Government's efforts to improve the efficiency of the NHS and the significant increase in resources it received, the voters remained unconvinced that the Government had a genuine commitment to a first class health service.

Given the growing demands on the health service - from new treatments, more sophisticated medical technology and a longer living elderly population - unrestrained by prices charged to the customer, simply adding more money in pursuit of the same policies is unlikely to produce any better public reaction by 1991. As Sir Bryan Thwaites argues in his lecture "The NHS: the End of the Rainbow?":"It is unrealistic to suppose that society as a whole will be willing to subscribe, year on year through its taxes, the additional sums necessary to keep resources in sight of expectations."

We need therefore to find new ways of tackling the key issues. These are:

1 How can we get a better return out of the huge level of resources already invested in the NHS?

2 How can we reconcile rising expectations of health care provision with affordable public funding?

3 How can we improve the Government's political credit for its record in health care?

This paper is a preliminary examination of the NHS in the

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light of these questions. It raises the major problems and offers some tentative suggestions as to how they might be tackled politically. It does no more than that -- and we shall return to the thornier and more fundamental points in a later paper.

THE NHS FRAMEWORK

Before considering policy options, however, we should reflect on the basic principles of the NHS. For it is these - not some particular administrative structure - which the public regards as vital and/or threatened by this Government's philosophy.

Yet there has been remarkably little research into public opinion - a gap well worth filling. In the meantime, our assumption is that the key attributes so far as the public are concerned are:

- a comprehensive service primarily for accident/illness treatment (rather than preventative or community care);

  this to be achieved through both primary and secondary care;

  with high quality medical treatment available on need on an equal basis to all - regardless of income.

If we are right, quite far-reaching changes in structure and funding can be considered so long as the electorate can be reassured that those key principles are maintained. But any changes which threaten those principles would be much more difficult to sustain politically.

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AN EVOLUTIONARY APPROACH

Some writers on health care argue that the only solution is to shift the NHS onto the US model of a combination of private health insurance and private hospital management groups. They base their argument on:

-- The need to raise increasing resources for the NHS, which are unlikely to be met by the taxpayer, to bring Britain's share of GNP taken by health spending from its present 6 per cent to the 9 per cent more typical of advanced industrial countries.

-- The need to balance supply and demand in health by some form of pricing.

-- And the benefits in efficiency and service from customer-based competition.

There are, however, a number of difficulties with this approach. To begin with, it is not clear that the higher level of health spending elsewhere necessarily provides more health care as opposed to higher cost health provision -- resulting from higher input costs and less severe cost control. Nor that there is a general shortfall of health provision in the UK currently -- except in the sense, described by Bryan Thwaites, that provision is always likely to fall below ever-growing expectations.

Over and above these theoretical objections, we do not consider it to be practical at this stage to consider reforms which would require the wholesale abandonment of traditional NHS principles. Our own proposals here are based on a more gradualist approach that would capture many of the benefits

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of markets while leaving open the long-term structure of health funding. We would compare them to our present educational policy.

IMPROVING EFFICIENCY

Getting better value out of the resources committed to the NHS is crucial. Although the Government has maintained pressure for efficiency, the available evidence (mostly anecdotal) suggests there are wide variations in cost within the NHS and less efficient management in the NHS than in comparable private sector hospitals. To tackle this, we recommend:

1 Increase Competition

Whatever management structure or systems are imposed, a non-competitive health care system is unlikely to have the unremitting stimulus required for improved efficiency and lower costs. Once accounting systems can provide information about relative costs, we should look for ways of introducing competition between different public sector hospitals and, ultimately, between public and private sector hospitals.

How can this be done? Well, already patients can be directed by their GPs to hospitals and consultants outside their own district health authority. This doesn't happen often and it is actively discouraged by most DHA's and, still more, by RHA's. Furthermore, information on the performance of particular hospitals and individual consultants, which GPs and patients need to make such choices, is not available (although the DHSS is gathering such information to enable DHAs to improve their performance). Above all, because resources within the NHS are distributed by a central bureaucracy in accordance

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with RAWP principles of geographical egalitarianism, there is an obvious limit to the ability of patients to move for treatment to "popular" hospitals and consultants.

There is an obvious next step if an effective, competitive market is to be encouraged. District health authorities can simply be reimbursed for each out of area patient they treat, at an appropriate rate. They would then be free to seek to attract additional patients where they were able to provide the treatment within the standard cost. To preserve control of the total NHS budget, the health authority covering the area where the patient lives - which would otherwise have born the cost directly - would then transfer payment from its budget to the other district. To avoid too large a transitional dislocation, the expansion in any district may need to be limited to - say - 10 per cent increase in any one year. Ultimately, however, popular facilities would be able to expand at the expense of less popular facilities. As in the current education proposals, this would make a practical reality of customer choice - with patients able to shop around to get the best service or shortest waiting time.

Such a system could be "management-driven" as well as "patient-driven." Where the local hospital could not provide the treatment cost effectively - or where a neighbouring district could provide it at much lower cost - there would also be an incentive for the district to either improve their own cost or "buy" treatments from the neighbouring district. Similarly, they could choose to contract out certain operations to private hospitals where these were able to provide a cheaper option - in fact the more enterprising districts already do this. This would be difficult to combine with the current practice of RAWP, but it is fully consistent with its underlying principle. Namely, it would equalise resources available to spend on

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the people rather than on the facilities in different districts.

If this also resulted in more NHS patients using private sector facilities, it might over time become politically feasible to consider handing over the management of existing NHS hospitals to private management (although with the patients still funded by the NHS). Ultimately, the NHS could change to being purely a funding organisation, with provision of treatment to NHS patients provided by any number of competing health care providers -- again, on similar lines to our policy on education.

Such a model has considerable attractions. It would provide direct incentives for improved efficiency, allow greater customer (and GP) choice and accommodate a gradual shift towards private sector health management.

From the patient's standpoint, however, a possible barrier is the problem of creating long travel times for relatives and post-operative care if patients are treated at hospitals some distance away from their home. This may be a problem in some cases. But many treatments require a relatively short stay, where this should not be a serious inconvenience. The average length of stay is declining. And where patients have themselves chosen early treatment away from home (as opposed to being sent away by the DHA), they are unlikely to feel any sense of grievance.

Furthermore, there is some evidence that the historic trend to consolidate hospital facilities in a few, large and geographically distant hospitals may have been overdone. Due to managerial inefficiencies, the optimum hospital size may be reached at only 2-300 beds, and we could therefore get more competition by allowing a network of smaller hospitals to develop. In addition, if a large group of patients from one area were treated in a

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neighbouring district, it would then be possible to lay on special, low cost coach/minicab transport for both patients and relatives.

Another objection might be that an ultimate separation of the "insurance fund" from health care provision could lead to an escalation of costs, as in the US. However, the US experience reflects the fact that only a few insurance companies conducted their relationship with health care providers in order to control the costs. What we are proposing is a much more active bargaining process, more similar to the new US "HMO" model.

2 Tackle producer power directly

To reduce costs in NHS facilities will ultimately require bringing the producer interests, particularly doctors, under control. Although district managers now have nominal responsibility for cost, in reality almost all the important decisions are under the control of consultants. They decide on medical grounds how long patients should stay and what equipment, supplies, medicines should be supplied. At present, these consultants have very little information about their costs, and no incentives to keep them under control. What incentives there are can often be perverse. For instance, a long waiting list creates a demand for a consultant's services by private patients. And a consultant's lifetime tenure makes it very difficult for district managers to exert much influence where he is unsympathetic to the manager's problems.

To remedy these problems, we need, first, financial information that would provide detailed cost performance by a doctor for specific treatments and allow cost comparisons with the same treatment by other doctors. Next, we must create the right incentives. Even though moves in this direction are likely to provoke a major

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campaign by the medical profession, a consultant's lifetime tenure must be replaced by a fixed-term contract linked to performance. It would, however, be difficult to place this contract under the control of non-medical district management. District managers simply do not possess the necessary authority in relation to consultants. Instead, we might consider instituting a mixed medical/administrative review board to which the district manager could make a report. Unlike existing reviews by the medical organisations, which focus purely on medical standards, this would also look at efficiency performance measures.

In these circumstamces, the manager would then have greater influence over doctors in discussing how costs - e.g. treatment, equipment, or number of staff in the operating theatre - might be reduced without medical risk. Management would also have more influence over priorities - providing a balance to the consultant's inclination to pursue medically interesting cases at the expense of mundane priorities (which nonetheless can greatly improve the quality of life enjoyed by ordinary patients) .

We should also consider bringing local GPs under the same management as consultants, with fixed term, renewable contracts. GP performance - particularly in the rate of referrals to hospital consultants and the casualty department - can have a major impact on overall costs and waiting lists. Between 1978 and 1986, the increase in FPC expenditure, unplanned and fortuitous, was nearly double that of the hospital and community services. And GPs' performances can vary alarmingly. Local management needs the mechanism to remove rogue elephants.

Equally, we need to confront the nursing interests which are pushing for ever more qualified and higher paid nursing staff. Nursing is not one job, but several jobs.

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Many jobs currently performed by highly-trained nurses could be transferred to less qualified auxiliary staff. We need to re-examine the whole question of task specialisation, to use expensive nurses more effectively and to reduce hospital staffing shortages and costs.

3 Slim the management hierarchy

While we should shy away from any further, disruptive major re-organisation of the NHS, we need to increase the opportunity for local management initiative and enterprise. That means slimming down the bureaucracy at the top and clarifying its role. If the district is to be the front line management unit, regional staff should be only a fraction of those required at district level - with a minimal performance review and policy making group at national level. The current structure seems at first sight to be top heavy at regional and national level, resulting in far too much detailed interference in local decisions - with a consequent loss of speed and sharpness in decision making.

What we now need is to remove the clutter from the current structure - cutting down the size and power of regional boards. To help implement this and to restore authority at district level, we should consider reconstituting Regional Boards to include the Chairman of the District Health Authorities in the region.

4 Extend best practice

Given the wide variation in performance between one district and another, we need to accelerate the transfer of best practice. We propose establishing a small review/audit team - comprising both medical and management representatives - which would examine the performance of

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individual districts and present management with a set of recommendations for upgrading performance. Pilot schemes for trying out reforms should also be attempted more often.

Since in many districts the key factor blocking efficiency improvements appear to be the conduct of 'rogue' consultants, such an external review would strengthen management's hand in bringing difficult consultants into line. Reviews of medical performance are at present conducted by the relevant group - consultants are reviewed by consultants, nurses by nurses, etc. It might shine a brighter light in dark corners if the professional bodies were to cooperate in sending joint teams to review into a particular hospital.

In addition we should encourage districts to take advantage of the distilled best practice available through "off the shelf" systems and management packages from US service companies - which have developed to help US hospitals to bring their costs under control. Companies such as Service Master and American Hospital Supplies have shown that they can often dramatically reduce costs when given a subcontract opportunity.

MATCHING EXPECTATIONS AND RESOURCES

We need to consider ways of both bringing new resources into health care, and setting reasonable expectations for what the NHS can deliver.

1 Encourage private funding for non-core activities

While we believe the public regards the NHS as primarily providing treatment in case of sickness or accident, an increasing part of the NHS budget now goes on preventive care and care for the elderly. Both of these are areas

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where we could increase private provision to reduce the call on NHS resources.

Preventative health screening might thus be provided through employer schemes - which a number of companies already run. It is clearly in the interests of both companies and their employees to develop such schemes and unions should have no difficulty in accepting - indeed demanding - such benefits for their members. We should review whether more generous tax treatment could encourage their development. At first glance, tax relief for employers' preventive health schemes are less likely to provoke political resistance than other forms of fiscal incentive for private health. And, once widely and successfully operating, such relief could be extended - both to those not in work via individual tax relief and to cover other forms of private health provision.

Residential care for the elderly is also a growing NHS cost. We could encourage private provision for such care by introducing a charging system, offset through the benefit system for those without resources to pay. The measures taken to increase the proportion of pensioners with personal and occupational pensions schemes should raise pensioner income and make it increasingly feasible for many to provide for themselves through savings and pension income if they need residential care.

2 Identifying NHS tax contributions

If health care is regarded as a consumer good, it is perfectly healthy for individuals to wish to spend more on the health service as their incomes rise. Most, however, have relatively little idea how much of their income does currently go on health care support.

At present, the income from national insurance

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contributions provides only 13% of NHS resources.
We should consider separating this out from NICS to have a clear "health insurance contribution" charge on every pay slip. This would emphasise the contribution principle and also make it possible to raise expenditure on health care - where there was popular demand to do so - without raising the basic rate of income tax. (Indeed, there might be political advantages in raising the NIC contribution at some point in the next 2-3 years explicitly to pay for the increasing NHS budget, at the same time as holding or reducing income tax.)

Ultimately we might look for some way of restructuring taxation to show the whole of the individual's NHS contribution as a single item (ie both tax and NICS). Separately identifying the health insurance charge in this way would then make it feasible to allow people the option of taking out alternative insurance (ie opting out of the NHS and the health insurance charge). Alternative insurance schemes would be able to negotiate their own terms directly with public and privately NHS hospitals - but would have to be prepared to pick up the investment of costs that might be incurred in the provision of emergency treatment at an NHS or other hospital to which the patient was delivered.

3 Charging for treatment

NHS charges - notably prescription charges - currently raise quite substantial sums. There has long been a good case for a "hotel" charge to cover the food and accommodation costs of hospital treatment with the charge tapering off the longer the patient remained in hospital. Now that most hospital stays are of short duration, the case is even stronger.

This has normally been considered too hot to handle politically. But the recent poll conducted on behalf of the

Public Finance Foundation suggests that there is now a small majority in favour of such charges.

IMPROVING POLITICAL CREDIT

1 Waiting Lists

Waiting lists are clearly the most obvious aspect of the health service where any Government's record can be attacked through the use of selective examples. So long as we do not have widespread payment at point of treatment, waiting lists are bound to form a rationing mechanism - and even the most efficient hospital would need some minimum waiting list under any circumstances in order to operate an efficient throughput of patients. It is, among other things, a primitive appointments system.

Furthermore, waiting lists statistics are currently distorted by many factors. They include individuals who have been offered a bed but chose not to take the appointment. They also include patients whom consultants add to their list without any intention of treating in the near term. And the size of the queue in itself is no indication of the speed of throughput.

The waiting list political problem could be deflated, however, by:

- classifying treatments into three or four priority categories - ranging from the painful/life threatening to the purely cosmetic;

- publicising both a target performance (eg 80% offered a bed within one month) and a guaranteed maximum waiting time to be offered a bed for each class of priority;

- patients who reach the maximum waiting time would then

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be offered treatment by another consultant, another district or - if necessary - in private facilities if they could not be accommodated by the consultant on whose list they were waiting. NHS use of the private sector for the purpose of cutting down the waiting list would be positively popular.

Since waiting lists are currently the property of consultants, district management has only limited ability to influence the lists in their district. The existence of a guarantee would, however, give them the ability to intervene to offer the patient alternative options - and the political problem of waiting lists could be completely defused if it could be guaranteed that no-one need wait longer than the specified time for an urgent operation.

2 Tackling nursing shortages

The problem caused by nursing shortages are another area where the Government can be easily criticised. Sub-dividing the nurse's job as proposed above would be one way of getting round the growing difficulty of nurse recruitment. In addition, we will have to bite the bullet on providing much greater differentials to attract nurses into areas where there are currently shortages - notably inner London and certain specialties.

3 Improving customer handling

Customer contact is a key part of the image for any consumer organisation. Yet NHS reception areas are typically atrocious, and run on the principle of keeping the patient waiting as long as necessary to ensure that the doctor is efficiently used.

It would be a worthwhile investment to simply smarten up reception areas, and both train receptionists and provide

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them with modern systems that would allow them to handle appointments more efficiently and courteously.

In addition we could improve the comfort and friendliness of NHS hospitals by allowing much greater opportunity for commercial services to be provided on site - ranging from fruit/drink stalls, books and newspapers, tapes and cassette players for hire, hairdressers and a range of other facilities that one would normally expect to find in hotels. Equally one could provide premium items on menus for those who preferred to pay for a greater choice in meals.

4 Provide an annual report

Given the amount of money that the average taxpayer is spending on the NHS, we should provide a regular vehicle for the NHS to report back on its successs story. This could take the form of both a written report in advertisements/leaflets, and a more exciting, popular version presented through an annual series of TV commercials. (This could also have an important effect on raising staff morale)

5 Clarify role of private sector

Finally, to avoid being accused of lack of commitment to the NHS because of its support for the private health sector, the Government needs to take steps to explain more fully the role of the private health sector. In particular, the fact that the maintenance of a privately funded health sector makes available to the NHS the services of many top class consultants and facilities which might otherwise not be available in this country. Expanding use of private sector facilities in a sub-contract role to the NHS would be another way of diffusing antagonism to private health by giving more and

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more people contact with the use of privately funded facilities.

Conclusion

This paper offers some ideas for reforming the NHS in ways that will improve the service without undermining public confidence in the Government's intentions. We will explore some of them in greater detail in a later paper. It would be useful to have a general idea of which reforms are thought practicable and worth pursuing -- and which not.

J.O'S.
p.p. Norman Blackwell. John O'Sullivan.

CONFIDENTIAL

NAT HEALTH: Expenditure PT8

fire DTJ

10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

MR FAIRCLOUGH

SECOND GENERATION MAGNETIC RESONANCE MACHINES

The Prime Minister has seen your minute to me of 7 August which she has noted without comment.

M E ADDISON

11 August 1987

GH

Prime Minister

For information.

MEA 10/8

W0112

PS/PRIME MINISTER

7 August 1987

SECOND GENERATION MAGNETIC RESONANCE MACHINES

I was sufficiently concerned at the second monthly report (Langsdon's undated letter to Andy Bearpark) to make some further investigations. There is a strong risk that this technology, in which the UK once held a very strong position, will be lost to us, and our overall position in medical equipment weakened.

2. As you will know, Picker was a US company before it was taken over by GEC, and it still has an American chief executive and headquarters in Cleveland, Ohio. This is where the preliminary work on the TQ magnetic resonance project is being done. GEC is now merging its medical equipment interests with those of Philips, which has its main base in continental Europe. The risk is that, in the merger, R & D activities will polarise between these two bases, with the UK left in the cold. To counteract that, the UK's position needs to be built up before the merger by locating a major R & D project here, for which TQ is the obvious candidate. I understand that DHSS officials have made strong representations to this effect to GEC management, who appear to be sympathetic but reluctant to direct the management of their subsidiary.

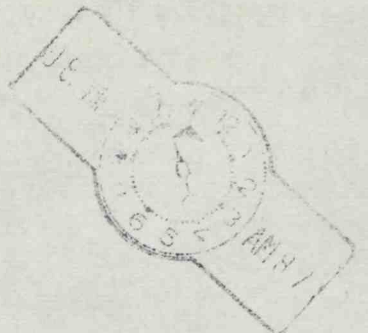
3. I intend to reinforce this message when I visit GEC on 13 August, but I consider that it would be very valuable if the Prime Minister could take advantage of any contacts with GEC management to do likewise.

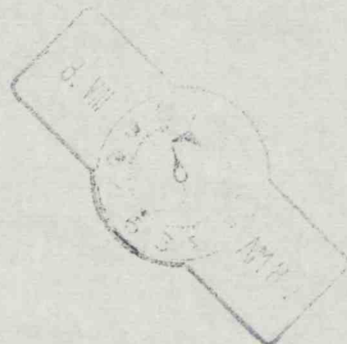
4. I am copying this minute to Sir Robert Armstrong and Tim Walker (DTI).

JWF

JOHN W FAIRCLOUGH

NAT HEALTH: Expenditure PT8.





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5

SUBJECT
CC MASTER

NOTE FOR THE RECORD - DN to see

POLICY ON THE NHS

The Prime Minister had a three-quarter hour discussion today with the Secretary of State for Social Services about future policy on the NHS.

The Secretary of State said that he hoped to have a longer talk with the Prime Minister in September about his plans for the NHS, but now wanted to outline his preliminary thinking. He believed that the Service's short term problem was that it was trapped in a structure which stimulated its one million employees to complain. They saw that their reward was conditioned by the strength and volume of their complaints. The Service needed to be persuaded it had a success story to tell. For the short term, he proposed to tackle this in the following ways:

(i) there should be a three year communication strategy so that the Service's employees and the public were aware of its success;

(ii) the problems of nurse supply in London and in the acute sector needed to be tackled. He had some ideas for helping the problem of nurses' accommodation;

(iii) the perennial problem of waiting lists needed continued attention.

Such initiatives would need small amounts of money if he was to succeed in changing the Service's culture.

For the long term he was concerned about the NHS's failure to become a service dedicated to serving the consumer rather than the producer. An important element was to remove the friction between the public and private health sectors.

The Prime Minister said that the need was to find a different way of rewarding hospitals. Their money should come from the treatment of patients, not the existence of the hospital itself. Doctors' income should be determined by their work and output and thus be in proportion to their effort and achievement. She did not agree that tax relief for contributions to private medical insurance was the right way forward, especially since the Chancellor of the Exchequer had, rightly, reduced the number of tax reliefs available. She was not convinced that the Department were using their waiting list money efficiently. She had been told that Moorfields Eye Hospital had been given waiting list money even though it had no waiting lists. It therefore had to resort to writing around to other hospitals to find patients. She was convinced that the RAWP process should come to an end.

Turning to social security benefits, the Secretary of State said that he believed there were two main tasks. First, he wanted to see whether it was possible to eradicate some of the benefits; he was unconvinced that the child benefit "Churn" was justified. Second, he wanted people to understand the realities behind the financing of their pension. The problem, hopefully a declining one, was the group of people who had only one pension. For the rest of the population, debate should be focussed so as to persuade them of what the State could and should provide.

Finally, the Secretary of State referred to the problem in the benefit offices, particularly those in the inner cities. They should play an important part in breaking the cycle of welfare dependency and the client state. But their culture needed to change. This could only be achieved if their conditions were improved. The Prime Minister suggested that she might meet some of those involved in the more difficult benefit offices, for example at a party here.

N.L.W.

N.L. WICKS
28 July 1987

DCA CBF

bc BG

10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

28 July 1987

NURSING IN LONDON STUDY

The Prime Minister has seen your Secretary of State's minute of 25 July about the nursing in London study. She has commented that the Government must be in a position to respond to the report at the same time it is published.

On a small point, you are no doubt following up a difficulty identified at the time of the discussion of the last review body reports, that London Weighting falls within the remit of the Whitley Council rather than the nurses review body. This is an anomaly which needs to be tackled if the review body is to move towards recommending greater regional variation in pay.

(D.R. NORGROVE)

Miss Jane McKessack,
Department of Health and Social Security.

COBG

Prime Minister 2
Despite the delay, the Government must have a response to make at the same time the report is published.
JEW 27/7.

I agree

PRIME MINISTER

NURSING IN LONDON STUDY

FILE ON DLP

You asked for an account of the position on this study.

In the early part of 1986 there was a good deal of publicity about nurse staffing problems in London. Health Authorities were reporting recruitment and retention difficulties, particularly in Inner London.

Since our information about this area was mostly anecdotal, the NHS Management Board commissioned a study to establish the nature and extent of the problems and reasons for them. The target date for reporting back to the Board was Spring 1987. The review was conducted from October 1986 to January 1987 by postal questionnaire to the 35 Health Authorities in the Greater London area. It was overseen by a DHSS/NHS steering group.

Despite the high level of cooperation from the Health Authorities, the initial responses needed further work because of incompatability between different sets of local data. After the Election, the Management Board, under Tony Newton's Chairmanship, considered the report on 6 July.

The report shows increasing difficulties in recruiting and retaining nursing staff. Between 1984 and 1986 overall average vacancy levels have gone up in Inner London from 13 per cent to 16 per cent compared with a current average of about 6 per cent in the rest of England. Most areas of the hospital service in London have increasing difficulty in filling posts for qualified staff. There are particular problems in the acute sector and in the more specialised and high technology areas such as intensive care, theatres and hospital midwifery. In the long-stay sector problem areas are shown in the

mental illness, mental handicap and geriatric fields. Community nursing levels in some districts are low. Many of these vacanices are inhibiting the development of priority services. Recruitment to basic nurse training is also falling below the desired levels.

The main reasons given by Health Authorities for these problems are pay, the high cost of living (especially housing) and the poor state of much NHS residential accommodation.

We want to publish the report as soon as possible. At present it is being revised to take account of a number of presentational points and more up to date statistics which will be available shortly. A more significant factor is that there is no doubt that publication will lead to demands for action. Timing of publication will need to be carefully considered in relation to wider plans for dealing with nursing shortages. I am considering these as a matter of urgency. (My preliminary view is that the most likely areas for action are London weighting, upgrading of NHS residential accommodation in the Thames Regions and geographically targeted recruitment publicity aimed particularly at getting nurses back into nursing.)

Taking this into account, it seems unlikely that I will be in a position to publish before early autumn.

This should be part of the remit of the review board, as you earlier asked.
JBr

JM.

25 July 1987

J M

NAT HEALTH
EXPENDITURE
PT ✓

PRIME MINISTER

You are meeting Mr. Moore on Tuesday at 1130, at his request, to discuss some ideas he has for the future policy of his Department.

I believe that at the meeting he wants to talk particularly about future NHS policy. He may provide a note of his ideas on Monday. You may wish to see as background the notes of your discussions with his predecessor on longer term policy towards the NHS, together with the record of your discussion at the Dinner with the Regional Health Chairmen.

We are arranging a meeting on the Social Fund for later in the week, probably Thursday.

N.L.W.

N.L. WICKS
24 July 1987

SLH/34

GA

COVERING COMMERCIAL IN CONFIDENCE

cc BG

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY

Telephone 01-407 5522

From the Joint Parliamentary Under Secretary of State

P A Bearpark Esq
Private Secretary
10 Downing Street
LONDON
SW1A 2AA

Prime Minister[2]

17 JUL 1987

Dear Andy

SECOND GENERATION MAGNETIC RESONANCE MACHINES

I attach the Second Monthly report on this Subject.

As before I am copying to Tim Walker (Trade and Industry) and John Fairclough (Cabinet Office).

Yours sincerely
Geoff Langsdon

G H LANGSDON
PRIVATE SECRETARY

CN/9730p

COMMERCIAL - IN CONFIDENCE

SECOND GENERATION MAGNETIC RESONANCE MACHINES

1. The development of the low-cost magnetic resonance scanner for general purpose imaging is now known within Picker as the TQ project. Work at the moment is going on on the gathering of market intelligence and the development of a requirement specification for this scanner.

2. GEC management repeat that decisions to go ahead with the project and on its location depend on the outcome of their negotiations with Philips and repeat their determination to protect the UK interest. Nevertheless, the TQ project leader is based in the United States and there is evidence that that is where this preliminary work is centred.

3. The Government interest in this project and our concern that it should be carried out mainly in the UK is being emphasised to GEC top management.

DHSS
PROCUREMENT DIRECTORATE

July 1987

Prime Minister [2]

A lot of work in hand, but the proof of the pudding will be whether the patient gets better treatment.

N.L.W. (S.)

Ref. A087/2071

MR WICKS

National Health Service Management Board

When the Prime Minister agreed by your minute of 10 December 1986 that a Grade 3 post should be retained under the Director of Operations for Personnel on the National Health Service Management Board, she asked that she should be given in, say, about six months time a report on what had been achieved in the National Health Service since the changes in management were made earlier this year.

2. I now enclose a report of what has been achieved in the National Health Service personnel field. In forwarding it, Mr France has said that the report demonstrates that the pace of change has increased sharply in the last year and that they now have in hand a major programme of work which is fully stretching the capacity of both the Department of Health and Social Security, the National Health Service Management Board and the capacity of the Health Authorities.

RTA

ROBERT ARMSTRONG

13 July 1987

REPORT BY NHS PERSONNEL DIRECTORATE

ACHIEVEMENTS IN THE NHS PERSONNEL FIELD

The Griffiths report made wide-ranging recommendations on personnel matters. These are reproduced in Annex A. The task of implementing them was given major impetus by the appointment as Personnel Director of Mr Len Peach on secondment from IBM with effect from 4 November 1985. It had however begun before that. The present report includes action begun before November 1985.

The Griffiths report had wider personnel implications than were reflected in its specific recommendations in two major respects - the need to create and train a cadre of general managers (GMs) and the need to adapt the organisation to the new management style. The present report reflects that.

The Griffiths report recognised that its recommendations would take several years to implement. In a sense implementation will never be complete since the process of change and improvement should be continuous. First stage action has however been completed on some recommendations. Action is in hand on all the others.

Following is a synopsis of achievements and progress to date. Further detail is given in Annex B.

A. Personnel organisation and staffing

1. New functions absorbed without increase in staffing.
2. NHS Training Authority brought within Personnel Directorate.
3. Consultation and joint working with NHS management improved.
4. Progress made on improving NHS personnel function.

B. General personnel policy

1. Comprehensive review of conditions of service begun.
2. Interim Working Party report received on development of an integrated personnel policy.
3. Two Working Parties established on equality of opportunity. Model policy for ethnic minorities about to be published.

C. General management

1. 816 GMs recruited from wide range of backgrounds. Low turnover.
2. Revolutionary employment package for GMs implemented.
3. Similar package devised for senior managers.

D. Management development

1. New and successful General Management Trainee Scheme established.
2. Major training programme carried out for GMs and for clinicians involved in management.
3. Individual performance review system established.
4. Management education and development strategy published for implementation by Authorities.
5. Study of learning needs of District General Managers completed and published.
6. Measures in hand to change personnel management culture in NHS.

E. Manpower planning, utilisation and supply

1. Range of steps taken to improve manpower planning and utilisation.
2. Improvements in hospital medical career structure agreed in principle.
3. Review in progress of medical manpower supply and demand.
4. Joint Working Party established to review disciplinary procedures for hospital doctors.
5. System under discussion to ensure that doctors fully meet contractual obligations.
6. Major communications programme undertaken to improve Authorities' performance on nurse staffing.
7. Proposals published for major changes in training of nurses and support workers.
8. Feasibility study in hand of extended use of YTS for nurse recruitment.
9. Training capacity increased for paramedical professions.

F. Pay

1. Review Bodies have accepted Personnel Directorate advice on balance of awards.
2. Successful negotiations for non-Review Body sector, 1984-86.
3. Major programme launched to reform pay systems. Major new deals negotiated and introduced for ancillary, ambulance and maintenance staff. Market-related changes introduced for IT and Finance staff.
4. Proposals developed for other groups, notably administrative and clerical and nursing.

G. Communications

1. Bi-monthly management bulletin introduced.
2. Other steps taken to improve management and staff communications.

NHS Personnel Directorate
July 1987

Main Griffiths personnel recommendations and key to relevant achievements

Recommendation	Relevant achievements
The Personnel Director's main responsibilities should include:	
- to co-ordinate the NHS management evidence to the Review Bodies and to organise the management sides and objectives in the Whitley pay negotiations for bodies not covered by the Review Bodies, after full consultation within the NHS;	A3, F
- to review the remuneration system and conditions of service for management so as to overcome the lack of incentive in the present system and the inability of Chairmen to reward merit or take action on ineffective performance;	C2 & 3
- to ensure with line management that a policy for performance appraisal and career development operates, from the Unit to the centre, to meet both the aspirations of staff and the management needs of the service;	D3
- to assess how far the management training of different staff groups, including clinicians, meets the needs of the Service and to stimulate the provision of appropriate training courses, inside and outside the NHS;	D2, 4 & 5
- to review procedures for appointments, dismissal, grievance and appeal; identify any conditions of service which are not cost effective in management terms; and secure the maximum devolution of responsibility for such matters;	B1 & 2
- to carry forward the DHSS work, stimulated by the Management Inquiry, in determining optimum nurse manpower levels in various types of Unit, having regard to the needs of the local situation and the maintenance of professional standards, so that Regional and District Chairmen can re-examine fundamentally each Unit's nursing levels;	E1 & 6
- to secure reviews of manpower levels in other staff groups.	E1 & 3
The NHS Management Board should control directly the work of the NHS Training Authority.	A2
The Personnel Director [should] ensure that formal structures of communication and informal means of consultation are established to secure the full commitment and involvement of staff.	G
The Personnel Director [should] lead a review of Whitley agreements, pay structures, terms and conditions of service etc., examining each to ascertain whether greater devolution is possible.	B1 & 2
Devolution in personnel matters will imply a strengthening of the personnel function at each level and its close support of line management. The most important development to be achieved is one of morale and attitudes: this will be done by the line management leadership, and the perceived professional competence of the Personnel Director and an injection of enthusiasm and pride in the quality of personnel service provided.	A4, D6

Recommendation	Relevant achievements
Line managers need to accept their responsibility for their staff and will require better training in personnel matters. This is only part of the general upgrading of the quality of management which the NHS requires. As in any process of change, there will be a need to take staff along in a positive sense, by top-class communications and training. There must be incentives for staff, through proper reward for performance and career prospects. The sanction of removing the inefficient performer must also be more easily available than at present, though always as a last resort.	D & G
Senior managers, in particular, must be given proper incentives, by way of greater opportunities for career progression, both through to the new NHS centre and also out of their primary professionalism.	D1, 3 & 4

ANNEX B
(Note: numbering of items corresponds with main report)

A Personnel organisation and staffing

1. In the years before 1983 DHSS had deliberately divested itself of many personnel functions, including non-professional training (by setting up the NHS Training Authority) and manpower planning (by establishing a central function within the NHS). Its NHS Personnel group had been cut down to little more than a pay and industrial relations function. It has been necessary to recreate a proper personnel function.

   The following main changes have been made:

   - at the request of the NHS the central manpower planning function has been taken back into the Department
   - a new Personnel Development Branch has been established
   - the Department has substantially expanded its activity on professional, particularly nurse, training
   - these changes have been staffed by a 10 per cent reduction in pay and industrial relations staff, through tighter management, wider use of information technology, discontinuation of low priority work and greater delegation to Regional Health Authorities (RHAs).

   The staffing of the Personnel Division has been broadened by the secondment of two principals from the NHS.

2. The NHS Training Authority's outside Chairman has been replaced by Mr Len Peach in his capacity as Personnel Director.

3. Consultation and joint working arrangements with NHS management have been substantially strengthened.

4. There is a need to strengthen the personnel function in the NHS and to improve its status. This is necessarily a gradual process on which a start has been made. Most Authorities now have an integrated personnel department, where previously medical and nursing personnel were separate, and have elevated their Director of Personnel to management board level. A review of personnel staffing is in hand.

B General personnel policy

1. A comprehensive review of conditions of service is being conducted, by an officer seconded from the NHS for the purpose.

2. A joint Personnel Directorate/NHS Working Party was established in 1986 to prepare an integrated personnel policy designed to optimise the total employment package in the interests of effective management and of staff recruitment and retention. Its interim report is being considered by the NHS Management Board (NHSMB) for possible publication.

3. Working parties on equal opportunities for women and for ethnic minorities have been established. The latter is about to publish a model policy.

C. General management

1. Health Authorities, under central supervision, have completed the recruitment of General Managers (GMs) at Region (14), District (191) and Unit (611) levels. These include 127 clinicians, 75 nurses, and 95 appointments from outside the NHS.

   Turnover has been small. 13 GMs have left, including 2 for higher paid jobs in the private sector. Most of the rest had proved unsatisfactory in one way or another, including a few outsiders who publicly blamed the NHS for not allowing them enough freedom of action.

2. In 1986 a radical new employment package was introduced for GMs, including the abolition of incremental scales, a measure of controlled local variability in basic pay rates, performance-related pay and rolling short term contracts. GMs' pay and conditions have been taken out of negotiation and are now determined by Ministers on the advice of the NHSMB and RHA Chairmen.

3. A similar package for about 1,200 other senior managers awaits Ministers' authority to implement.

D. Management development

1. A new General Management Trainee Scheme has been introduced, for graduate recruits and in-service candidates. The first intake was in 1986. The scheme has proved highly competitive.

2. A major programme of training for GMs was undertaken in 1985 and 1986.

There has been a substantial increase in training for clinicians currently or prospectively involved in management. The NHS Training Authority (NHSTA) has published a discussion document on clinicians in management.

3. In 1986 the Department and the NHSTA jointly published a Staff Appraisal Scheme ("individual performance review") for general application in the NHS, and a Performance-Related Pay Scheme for General Managers (see Section C2). A key objective of the system is to achieve clarity about individual goals and responsibility for achieving them, and to assess and reward their achievement. A major familiarisation programme was undertaken for Authority Chairmen and GMs, followed by a series of training events. Nearly all GMs are now covered by the system, and the appraisal scheme is being spread to other staff.

4. Also in 1986 the NHSTA published a general management education and development strategy, which is now being implemented by Authorities.

5. The NHSTA has funded a two year research project to identify the learning needs of existing and future District General Managers. Its findings are being widely disseminated.

6. An important requirement of more effective management is to improve the personnel management performance of a wide range of managers. This is partly a matter of training. It is also a matter of culture change. The Personnel Director has devoted considerable time to a programme of visits, conferences and speeches designed to bring this about.

E. Manpower planning, utilisation and supply

1. A range of steps has been taken to improve manpower planning and utilisation, for example:

(i) Central action - general

A range of manpower performance indicators has been published for Authorities' use, as part of a wider package of NHS performance indicators.

A number of techniques have been tested and published for assessing nurse manpower needs.

A major review of the present skill mix in nursing was published in 1986, as a basis for further work by Authorities.

Reviews of staffing patterns and utilisation, including skill mix, are being conducted in a range of occupations, both centrally and locally.

Steps are being taken to improve manpower and personnel information, building on the major developments in NHS information systems and technology following the Korner report.

(ii) Action by Health Authorities - general

Under strong central pressure Health Authorities are steadily improving their manpower planning and relating it more effectively to service planning. This has resulted in the identification of some significant problems of balancing supply with likely demand, which Authorities are now tackling, on a centrally prescribed regional self-sufficiency basis.

The national performance review system includes regular reviews of action being taken by Authorities to improve the planning and use of manpower, including the application of the techniques etc referred to in Section (i) above.

(iii) Medical staff

2. Following discussions with professional and NHS management representatives, a major consultative document on the hospital medical staffing structure was published in July 1986. The Department is now negotiating its implementation with the profession. It aims to achieve a proper balance between training and career grades, both to improve the quality of patient care and to give doctors a reasonable expectation of career progression.

3. The Advisory Committee on Medical Manpower Planning began work in October 1986 on a review of its 1985 report on medical manpower supply and demand over the next 20-30 years. Its report is targetted for the end of 1987.

4. A joint working party has just begun a review of disciplinary procedures for hospital doctors and dentists.

5. The Department is discussing with the medical profession the introduction of a system of peer review to ensure that hospital doctors fully meet their contractual commitments to the NHS.

(iv) Nursing staff

6. The NHS faces substantial staffing problems in the 1990s because of the reduction in the number of school leavers and increasing competition from other employers. This competition is already biting hard in London and the South East. A range of measures is being planned, designed to

- use staff better, including cost-effective use of unqualified support staff
- reduce wastage
- extend the recruitment base
- attract staff back after career breaks.

The Personnel Directorate has mounted a major communications programme to secure action by Health Authorities, where it is for them. Their progress is being regularly checked through the performance review system and by other less formal means.

7. Pr[illegible]ssional training is the responsibility of independent statutory bodies. The relevant bodies recently produced revised proposals for radical changes in nurse training. Whilst still not as we should like them, these reflected much behind-the-scenes influence by the Personnel Directorate to secure greater realism and relevance to service needs. The proposals are now out for consultation.

Simultaneously we are consulting on our own proposals for a new-style support worker grade.

8. In February 1987 a feasibility study was launched into the use of two-year YTS as a mode of entry both to the support worker grade and to qualified nurse training. Both the support worker grade and the YTS study could have wider application than nursing.

(v) Paramedical staff

9. Training capacity has been increased in a number of paramedical professions, particularly occupational therapy, where it is a proven supply constraint.

F. Pay

1. The Personnel Directorate has had the task of giving evidence to the two NHS Review Bodies and implementing Ministers' decisions on their reports. While recommended pay levels have been high, the Review Bodies have, for the most part, weighted their recommendations in the way suggested in our evidence - eg, in 1987, towards newly qualified nurses whose wastage is high.

2. In the negotiated sector general settlement levels have been achieved, without industrial action, which have been very low in relation to settlement levels generally: 4.5 per cent in 1984, 4.7 per cent in 1985 and 6 per cent in 1986. The negotiating success has been such that selective steps are now having to be taken to alleviate growing recruitment and retention problems.

3. The Personnel Directorate has embarked upon a programme of reform of pay systems designed to allow local managers to use staff more effectively, respond to local labour markets and recognise the worth of individual employees. Major achievements so far are:

General Managers

See Section C2.

Ancillary (manual) staff

In 1986, as part of a radical revision of the grading and pay structure, negotiation of generic grade discriptions breaking down traditional occupational demarcations. Also improved differentials for supervisors.

Ambulance staff

In 1986, a new grading and pay structure allowing more flexible use of staff, inter alia by consolidating most bonus, overtime and other plussages into basic salary; and encouraging advanced training in emergency treatment and care at Authorities' discretion.

Maintenance staff

In 1987, a new grading and pay structure, achieved with ACAS help after threats of industrial action against our proposals. This severed the long established pay link with the Electrical Contracting Industry, replaced an outdated bonus scheme by new and tougher work standards to be achieved in return for a high day rate, and introduced multi-skilling for electrical, plumbing and engineering staff.

Information Technology staff

In 1987, a "first ever" agreement to regional negotiation of allowances to reflect differing recruitment and retention problems.

Finance staff

In 1986, as an aid to recruitment and retention, introduction of new and more flexible grading definitions allowing Authorities to award higher grades to recognise the contribution of the individual.

4. Proposals have been prepared, for negotiation in 1987 if feasible, for a radical revision of the structure for administrative and clerical staff on lines which we hope to extend to all white collar staff in due course. This will allow for controlled local variation in pay within a nationally negotiated framework. Local management would be able to adjust pay to reflect local labour markets, different local job structures, and individual job worth including the contribution of the individual.

   Work is well advanced on a new grading and pay structure for nurses involved directly with patient care, to reflect historic and prospective changes in nursing care and to provide better career structures and more flexible reward systems. It is hoped to negotiate this structure with the Staff Side in time for it to be priced by the Review Body in its next report.

   Work has also begun on reviews for the professions allied to medicine, pharmacists and speech therapists.

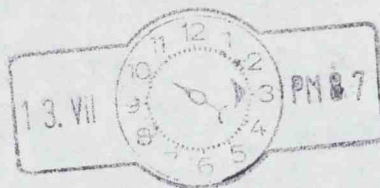
G. Communications

1. Since July 1986, the NHSMB has published a bi-monthly Management Bulletin designed to keep senior NHS managers informed of Management Board thinking and plans, and to share sound ideas and good practice among managers.

2. A pilot study of management communications within one Region has just been concluded. Its findings are now being implemented and extended to other Regions.

   Health Authorities are being encouraged to use briefing groups and other mechanisms such as staff newspapers to improve the flow of information downwards on a regular basis through the hospital and community health service.

   At the centre, an electronic mail system is being introduced to provide a fast link with Health Authorities, to speed the flow of communications with GMs and their staff.



NAT HEALTH: Exp. + Eff. pt 7.

10 DOWNING STREET

From the Principal Private Secretary

SIR ROBERT ARMSTRONG

OFFICIAL HISTORY OF THE HEALTH SERVICES SINCE THE WAR

The Prime Minister has seen your minute of 18 June in which you seek approval for Dr. Charles Webster, of the Wellcome Unit for the History of Medicine, to write a second and final volume of the history of the National Health Service.

The Prime Minister is content for this second volume to be written in the way that you suggest.

The Prime Minister has asked whether she could see the first volume of this series.

N. L. WICKS

22 June 1987

Nor GR cc B9

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY

Telephone 01-407 5522

From the Secretary of State for Social Services

N L Wicks Esq CBE
Principal Private Secretary
10 Downing Street
LONDON
SW1A 2AA

22 June 1987

Dear Nigel,

Thank you for your letter of 19 June attaching Mr David Skidmore's letter of 11 June to the Prime Minister about future NHS policy in the light of the General Election campaign.

My Secretary of State has seen Mr Skidmore's letter and is anxious to have the opportunity to discuss it personally with Mr Skidmore. My Secretary of State suggests that there would not be a need to trouble the Prime Minister with involvement in such an initial meeting. If this approach is acceptable, you might wish to put a reply to the Prime Minister on the line of:

> "Thank you for your letter of 11 June. It is a refreshing and penetrating analysis of an area where the way forward is by no means easy. John Moore has seen your letter and would be very interested in a personal discussion with you of the ideas you have put forward. John Moore's office will be in touch with you to arrange such a meeting."

Yours sincerely,

Geoffrey Podger

G J F Podger
Private Secretary

Prime Minister
Agree to the preparation of the second volume of the Official History of the Health Service?
N.L.W. 19.6

Yes - May
I see the first volume
MT

Ref. A087/1749

MR WICKS

Official History of the Health Services since the War

Dr Charles Webster, of the Wellcome Unit for the History of Medicine, has, since 1978, been writing the Official History of the Health Services since the War. The first volume, "History of the National Health Service before 1957: Problems of Health Care", is about to go to HMSO for publication. The purpose of this minute is to seek the Prime Minister's approval to proceed with preparation of the second volume.

2. When Dr Webster was appointed as Official Historian to produce this work, it was on the basis of a synopsis, which had been approved by the Committee of Privy Counsellors for Official Histories (PCH), covering the period to 1974. Early on in his appointment Dr Webster took the view, which was accepted, that such a synopsis would encompass too much for a single volume history and that the first volume should cover the Health Service after the war, taking the story up to the mid-fifties. There was at that time no commitment on either side to a second volume.

3. The present policy on histories of peacetime events is to support the preparation of four at any one time. The completion of the first volume of Dr Webster's work leaves us with one "berth" free. For practical reasons, such as the problems of reconvening PCH to consider alternatives, but also, and mainly, because I believe that an Official History of this importance ought not to be left incomplete, I recommend the commissioning of the second and final volume. Dr Webster would be willing to undertake the work.

RTAABD

4. I mentioned earlier that the original end date for the National Health Service History was 1974. Dr Webster believes that it would now be logical to cover the period up to 1978/79 to include the Royal Commission and the subsequent election of the Conservative Administration, leaving developments since that time for future historians.

5. I should be grateful to know whether the Prime Minister would be content for me to make the necessary arrangements for Dr Webster, whose work is well regarded by those who have seen it in draft form, to write the second and final volume to complete this Official History. The Department of Health and Social Security, who consulted Mr Fowler, the Scottish Office and the Welsh Office, all of whose records are involved, would be content with the proposal.

RTA

ROBERT ARMSTRONG

18 June 1987

RTAABD

R 11/6.

F. DAVID SKIDMORE
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11/6/87.

Dear Nigel,

I enclose a letter for the P.M. about the implications for the NHS management in the future which result from the campaign 'lessons'.

With best wishes

Yours

David.

COVERING COMMERCIAL IN CONFIDENCE

ic/7450p/3

DEPARTMENT OF HEALTH & SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY

Telephone 01-407 5522

From the Joint Parliamentary Under Secretary of State

P A Bearpark Esq
Private Secretary
10 Downing Street
LONDON
SW1A 2AA

20 May 1987

Dear Andy

SECOND GENERATION MAGNETIC RESONANCE MACHINES

In your letter of 13 April you asked that the Prime Minister receive short monthly notes on the progress of this issue. I attach the first of these.

I am copying this to Tim Walker (Department of Trade and Industry) and John Fairclough (Cabinet Office).

Yours Ever

Geoff

G H LANGSDON
Private Secretary

ENC

js/7450p/4

SECOND GENERATION MAGNETIC RESONANCE MACHINES

1. The development of a low-cost magnetic resonance imaging (MRI) scanner has been authorised by Picker. It is understood that this involves a new design of Oxford magnet and that an agreement will be made for co-operation between Oxford Instruments and Picker. No formal agreement has yet been reached.

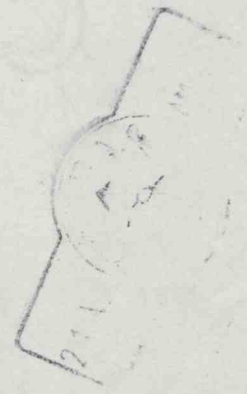
2. No decision has yet been made about the location of the development and manufacture of the low-cost unit and we are assured that it cannot be made until the Picker-Philips negotiations are more advanced. However, there are signs that more work will go to America than was expected. Picker have recently decided that a low-cost unit is wanted by the US market and this appears to have changed their approach to this development.

3. As Picker and Philips negotiate, the picture is confused and Picker are unable or unwilling to provide details, at present, of the development programme. GEC management assure us that the position of the UK will be protected.

May 1987

DHSS

NATHEALTH Expend + Efficiency PL8



LOR

cc DHSS

10 DOWNING STREET

LONDON SW1A 2AA

THE PRIME MINISTER

12 May 1987

Dear Tony,

Thank you for your letter of 16 April about NHS capital construction procedures and the scheme which is serving as a "test-bed" for your procedures. Should the scheme prove as successful as we all hope, we will certainly wish to apply the lessons elsewhere.

I understand that the Department of Health wrote to the Regional General Manager some weeks ago indicating willingness to see the scheme delegated. The present position is that the region is now urgently assessing your team's proposals to try to ensure that these are compatible with the overall strategy plans for the redevelopment of the Royal Sussex County Hospital and the proposed new hospital at Holmes Avenue. Once compatibility has been established, the regional and district authorities will be able to consider the matter formally and, I hope, to agree that the scheme should be delegated as suggested. I have asked Tony Newton to keep me informed of developments.

Yours ever

Margaret

Lord Trafford.

SRW

GR NT.

5.R.

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY
Telephone 01-407 5522

From the Minister for Health

Andy Bearpark Esq
Private Secretary
10 Downing Street

8th May 1987.

Dear Andy,

I enclose a draft reply for the Prime Minister's signature to the letter from Lord Trafford.

You may find it helpful to have some more detail on the assessment work the region is urgently carrying out. Lord Trafford's plans were originally for 84 beds. He is now proposing a 168 bed unit. This obviously raises a number of significant new issues, both in relation to the site itself and to the 'knock-on' effects on the overall district strategy, including the plans for a new hospital at Hove.

All involved have however been asked to undertake the necessary consideration quickly and constructively and the Minister for Health will be kept informed of progress.

Yours sincerely,

Jenny Harper

MISS J M HARPER
Private Secretary

KW/DNo.28

NHS: Expenditure & Efficiency PT8

DRAFT LETTER: PRIME MINISTER TO LORD TRAFFORD

LO4 AD

Thank you for your letter of 16 April about NHS capital construction procedures and the scheme which ~~it~~ is ~~proposed to delegate from region to district to~~ serv[ing] as a "test-bed" for your procedures. Should the scheme prove as successful as we all hope, we ~~should of course~~ [will certainly] wish to apply the lessons elsewhere.

I understand that the Department of Health wrote to the Regional General Manager some weeks ago indicating willingness to see the scheme delegated. The present position is that the region is now urgently assessing your team's proposals to try to ensure that these are compatible with the overall strategy plans for the redevelopment of the Royal Sussex County Hospital and the proposed new hospital at Holmes Avenue. Once compatibility has been established, the regional and district authorities will be able to consider the matter formally and, I hope, to agree that the scheme should be delegated as suggested. I have asked Tony Newton to keep me informed of developments.

I ~~wish the project every success.~~

MARGARET THATCHER

ECL

10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

Ack 24 April 1987

I attach a copy of a letter to the Prime Minister from Sir Anthony Trafford.

I should be grateful if you could provide a draft reply to Sir Anthony for the Prime Minister's signature, to reach me by Friday 8 May please.

P.A. BEARPARK

Craig Muir, Esq.,
Department of Health and Social Security.

From: SIR ANTHONY TRAFFORD, F.R.C.P.

103 THE DRIVE
HOVE
SUSSEX
Tel: (0273) 731567

CCBG

16th April 1987

The Rt. Hon. Mrs Margaret Thatcher, MP, FRS,
10 Downing Street
London SW1

24/4 pps

My dear Prime Minister,

I thought you might like to have a follow-up to our meeting on February 17th on the subject of the Hospital Capital Building programme.

(1) Planning Cycle

It is true, as the DHSS said, that there were two editions of Capricode but the second included the Option Appraisal system which although of value in theory does increase the delays. It is true, however, that the DHSS can expedite planning procedures if they wish and they have also raised the threshold of expenditure allowed to local initiative.

(2) Procurement Cycle

The basic weakness here remains the same which is that cost control is not introduced in the earliest stages though lip service is paid to the concept. This means that the planning cycle and the early part of the procurement cycle are deprived of the discipline of elemental analysis and thus, at the very earliest stages, can start to come off the rails.

(3) Prime Minister's 'Experiment'

This has not quite worked out as you recommended but some progress has been made, firstly in speeding up the planning part of the exercise and secondly in the DHSS waiving part of the close control and feedback

Continued over.../2

mechanisms which would also cause delay. Such concessions which are, of course, only 'one-off' but should really apply all over the country, may reduce by one or two years the completion of this relatively small building, but I still think it is of considerable interest that within the six weeks you mentioned, our own team, without bureaucratic restraints, was able to provide a full outline plan of precisely how, where, at what stages and at what times and at what cost this could all be done, whereas nothing much had come from the official project teams in the same period. No doubt they will take advantage of what we have passed on to them and this may speed things up.

It was most kind of you to take such an interest in the detail of the hospital programme as well as the particular local delays. I fear, however, that only the necessary reform of the Health Service as a whole will actually enable effective reform of the capital programme to take place.

Best wishes, Yours ever

Tony.

NATHGAITH : Expenditure PT8

File

bc: BG

10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary 13 April 1987

SECOND GENERATION MAGNETIC RESONANCE MACHINES

The Prime Minister has noted the contents of the brief enclosed with your recent letter to Nigel Wicks. She has asked to see short monthly notes informing her of progress on this issue. I should be grateful if you would arrange to prepare and submit these.

I am copying this letter to Tim Walker (Department of Trade and Industry) and John Fairclough (Cabinet Office).

P. A. Bearpark

G. H. Langsdon, Esq.,
Parliamentary Under Secretary of State's Office,
Department of Health and Social Security.

PRIME MINISTER

THE HEALTH DIVIDE

You saw the New Statesman article last week which challenges the conclusions of the "health divide" that health inequalities were widespread.

The Independent today carries a piece to mark the publication of the research on which the New Statesman article was based. You may like to cast an eye over this. The DHSS are looking at the piece of work, and will be letting us have a note on it.

The gist of Dr. Le Grand's argument is that since 1921 changes in the average age of death suggest that:

(i) all groups are getting healthier;

(ii) the gap between the groups is narrowing.

The second point is a flat contradiction of the health divide's conclusions, and indeed a line which DHSS have been giving us for Questions.

Obviously interpreting the statistics in this area is an extraordinarily difficult thing to do. I hope the DHSS's note will throw some light on it.

Le Grand's work does not seem to say much about the trends over the last 8 years. The DHSS conclusion that there is nothing to substantiate the Le Grand claim that life expectancy for manual workers has actually fallen in that period, still holds good.

MEA

10 April, 1987.

JD3AXI

2

RPS/P80

PRIME MINISTER

SECOND GENERATION MAGNETIC RESONANCE MACHINES

The note from DHSS (Flag A) below reports on the state of play of the development of the second generation magnetic resonance imaging (MRI) machine. You will recall that Robin Butler had drawn to your attention Donald Longmore's fear that we were slipping behind in this technology because of the failure to develop a machine suitable for cardio-vascular purposes. (The backgrond is in my minute at Flag B).

The DHSS note confirms that MRI as a technique for cardio-vascular diagnosis has not yet moved outside the research environment. The more important priority is to develop a lower cost RI scanner which would make the technique more widely available in the NHS as well as overseas. DTI and DHSS are encouraging Picker (GEC) and Oxford Instruments to coopérate to develop the low cost magnets necessary.

N.L.W. Please keep me informed (monthly) on progress

MT

NLW

10 April, 1987.

JD3AXM

COMMERCIAL IN CONFIDENCE

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY

Telephone 01-407 5522

G.T.N. 2915

From the Joint Parliamentary Under Secretary of State

N L Wicks Esq
Principal Private Secretary
10 Downing Street
London SW1A 2AA

R 2/4

Dear Mr Wicks

SECOND GENERATION MAGNETIC RESONANCE MACHINES

You wrote to Geoffrey Podger on 16 March asking for a short note for the Prime Minister on this subject.

I attach a note which has been agreed by Ministers here and in DTI.

with PM 11/4

I am copying this to the recipients of your letter.

Yours sincerely,

Gwen Walsh

PP: G H LANGSDON
Private Secretary

10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

30 March 1987

The Prime Minister has seen your Minister's letter to her of 27 March, and the report by officials on Sir Anthony Trafford's proposals, which was attached.

She is content for your Minister to authorise the project on the fast-track basis proposed by Sir Anthony, subject to the points set out in your Minister's letter.

MARK ADDISON

Mike O'Connor, Esq.,
Department of Health and Social Security.

010

CC: BG

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY
Telephone 01-407 5522

From the Minister for Health

Prime Minister (1)
Content that Mr. Newton should authorise the project?
MEA 27/3

Yes 27.3.87.

Rt Hon Margaret Thatcher MP
Prime Minister
10 Downing Street
LONDON
SW1A 2AA

Dear Margaret,

Following the meeting with Sir Anthony Trafford on 17 February you asked me to explore urgently his ideas on the NHS capital programme and to report to you within six weeks. I attach my officials' report to me and would propose, with your agreement, to authorise the project on the fast-track basis proposed by Sir Anthony, subject only to the necessary approval procedure and the establishment of technical feasibility.

As you will see from the report, the principal risk of further delay arises from the process of consultation on the closures associated with the proposed new building; but we will, of course, seek to keep these to the absolute minimum.

I am also enclosing a background note giving fuller information about the NHS capital programme and health building procedures.

Yours ever,

Tony

TONY NEWTON

KW/DNo.8

NHS CAPITAL CONSTRUCTION PROGRAMME: SIR ANTHONY TRAFFORD'S PROPOSALS

Introduction

1. The Prime Minister met Sir Anthony Trafford on 17 February 1987 to discuss Sir Anthony's views on the management of the NHS capital programme. The Prime Minister summed up by suggesting that a proposed 84-bedded hospital block at the Royal Sussex County Hospital might be used as a test-bed for Sir Anthony's alternative procedures. The Prime Minister called for a progress report within six weeks.

2. Details of the NHS capital construction programme and procedures (Capricode), including various recent changes and relaxations, are set out in an annexed background note. The following comments relate directly to the question of the 84-bed unit.

PROPOSED 84-BED UNIT AT BRIGHTON: A TEST-CASE FOR SIR ANTHONY'S PROCEDURES

3. Sir Anthony contrasted NHS procedures with private sector practice. In the private sector a manager would typically be given a budget, and then allowed freedom to secure the best possible "deal" on accommodation, time and cost within this budget. The NHS building procurement process is service-led, and therefore involves the building up initially of a schedule of accommodation to be provided, each item in the schedule having a separate, fixed cost-allowance. This approach, Sir Anthony suggested, effectively dictated the design solution, ruling our alternative approaches which might be quicker and cheaper.

4. The Department's Director of Health Building met Sir Anthony, together with the Regional and District General Managers, on 6 March to discuss the suggestion that the proposed 84-bed unit might be used as test-case for Sir Anthony's procedures. The Director explained how the existing NHS procedures can be adapted and applied in a way that closely mirrors commercial practice. The Regional General Manager confirmed that the necessary capital could be made available and that the revenue consequences of bringing the 84-bed unit on stream earlier than expected could be contained. It was agreed that the Department will authorise the region to delegate this scheme to the District on a "hands off" basis, providing only that two conditions relating to public accountability can be met, viz;

(1) That these must still be a clear and comprehensive Capricode Stage 1 (Approval in Principle) submission, which will need to be approved by the Secretary of State and the Chief Secretary.

(2) That it must be demonstrated that it is technically feasible for the 84-bed unit to be built in isolation from other developments on the Royal Sussex County site. This also means that the region must prepare, before the district is set free to go ahead, a full and satisfactory site Development Control Plan.

5. The first of these provisos is necessary because the 84-bed block is an integral part of an impending £40m district-wide capital investment programme. The second proviso arises out of the very congested nature of the Royal Sussex County site; there is an interaction between the 84-bed block and the other works which are scheduled for this site - most especially the proposed extensions to the tower block and the proposed new operating theatres. It must be demonstrated that the contract for the 84-bed block can sensibly stand alone and be managed at district level alongside the other parallel contracts being managed by the region.

Timing

6. At the Department's request, the region has already initiated work on a site Development Control Plan which will demonstrate whether or not the contract for the 84-bed block can be separated from the contracts for the other schemes on this site. The answer should be known within 4-5 weeks. The region's present timetable envisages the overall Brighton Stage 1 (AIP) submission coming forward to the Department during the autumn of 1987. The Department's view is that this process might be accelerated, although there is a limit imposed by the need to allow 3 months for the formal public consultations associated with the closure of the Brighton General Hospital and two other smaller hospitals (integral parts of the package). If these closures are contested we have, additionally, to allow up to 2 months for the formal reference of the issue to Ministers by the regional authority. This means that the AIP submission, accompanied if necessary by the closure submission, is unlikely to reach Ministers before November or December 1987. Providing that the submission is technically sound, and that the option appraisal (which is central to the submission) stands up to scrutiny, the Department and the Treasury would aim to clear it within 5 weeks. This means that the District would be free to take over the 84-bed project and to run it on a "fast-track" basis independently of the region, and in accordance with Sir Anthony's suggestions, by the end of this year or early in 1988.

"Fast-track" possibilities

7. As indicated, the Department's Director of Health Building has explained to Sir Anthony how the existing NHS Capricode procedures can be used in a way that closely mirrors commercial practice. Specifically, there is no reason why, once the initial Capricode Stage 1 (Approval in Principle) has been granted, Brighton should not adopt a "fast-track" approach, bringing forward the detailed design work and the preparation of production drawings so that these activities proceed in parallel with work on the preceding Capricode stages. This approach, especially when coupled with one of the new 'unconventional contracting' possibilities, would be virtually indistinguishable from private sector methods.

Nucleus

8. As a separate but related issue, discussions about the possibility of using Nucleus for the 84-bed block are currently under way with the district. If Nucleus is feasible (space will determine this) and if the district adopt Nucleus (they, as customers, will decide), there could be further savings in both time and cost. There is also a possibility that slightly more accommodation than the intended 84 beds could be made available for the same cost within the development. If Nucleus is adopted, it would be possible - once a satisfactory overall Development Control Plan has been agreed - for the district to initiate the design process on an "at risk" basis in advance of approval of the AIP submission. The Department's Health Building Directorate has offered Brighton exactly the same help and support that it would give to any region adopting Nucleus for the first time.

SUMMARY

1. The Department accepts the suggestion that the district should design and build the 84-bed unit on a "fast-track" basis, in accordance with Sir Anthony's proposals, subject only to approval in principle of the overall plan for Brighton, and demonstration of technical feasibility.

2. Work on technical feasibility is in hand and should be completed in 4/5 weeks. The region will be encouraged to speed up the preparation of the AIP submission to DHSS and Treasury Ministers.

3. The possibility of securing even greater time and cost-savings by using Nucleus is being investigated. Decision will be for the district; the technical feasibility of using Nucleus will also be established within 4/5 weeks.

BACKGROUND NOTE

THE NHS CAPITAL PROGRAMME AND HEALTH BUILDING PROCEDURES

Capital allocations

1. NHS capital allocations have risen steadily since 1979. In cash terms the increase (including land sales proceeds) is from £407m in 1979/80 to £925m in 1986/7. In real terms (86/87 prices) the increase has been from £650m to £925. Construction industry prices have been relatively stable since 1980 and tenders have been increasingly competitive. This has meant that NHS capital allocations, to the extent that they have been used to fund capital construction projects, have been even more productive than the figures suggest.

NHS capital expenditure and capital programme

2. About 25% of NHS capital expenditure relates to non-building items such as motor vehicles, computers and equipment. The remaining 75% funds the NHS capital construction programme. All new building works and/or upgrading schemes costing more than £15,000 are regarded as capital expenditure. The capital construction programme therefore includes a great variety of minor works as well as the major schemes. The division between major schemes (over £1m) and minor works varies between regions, but it normally ranges between 70:30 and 50:50.

3. The capital programme currently includes over 400 schemes, each costing in excess of £1m, at various stages of planning, design and construction. Of these about 110 are planned for completion within the next 3 years. The capital cost of the schemes in the programme, including fees and equipment, is about £3bn.

Role of DHSS

4. The DHSS neither builds nor designs hospitals. Following a major review of the Department's works function in 1985, Ministers defined the Department's role as:

(a) determining strategic policies and setting key objectives for the NHS works and property functions.

(b) monitoring health authorities' performance and ensuring compliance with key policies and objectives.

(c) supporting the NHS by producing cost-effective guidance in selected areas.

(d) dealing at government level with statutory and regulatory issues.

5. The Department's guidance is restricted to:

(a) Health Building Notes and associated cost allowances. These specify space, environmental and safety standards together with building costs against which performance can be monitored.

(b) The Nucleus standard design solution, which enables authorities or their professional consultants to design a modern hospital on the basis of a series of standard "templates". Designs are always individual, but the standard data and the systematic approach save time and reduce costs. Authorities are free to decide whether or not to use the Nucleus system, but the take-up has been excellent. 27 Nucleus schemes have been completed and another 88 are under way; this makes Nucleus the world's largest and most successful standardised hospital design system. Capital and fee savings to date are estimated at £32m.

<u>Regional and District health authorities</u>

6. The design and construction of health buildings is delegated to regional and district health authorities. Until 1985 district health authorities were only responsible for minor upgrading and refurbishment works. Following the works review in 1985, the limit for delegation was raised to £1/4m. At the region's discretion this limit may be increased to £5m or more. Authorities' performance is monitored by the Department via the CONCISE computerised information system. Regional health authorities make regular information returns to CONCISE at fixed points throughout the planning, design and construction phases of all schemes costing in excess of £1m.

<u>Capricode</u>

7. Regional and district health authorities are required to regulate all their health building in accordance with procedures embodied in Capricode. These procedures, revised and streamlined in 1986, follow a series of interconnected steps through which any well-managed project - private or public sector - will pass, viz:

Stage 1: Approval in Principle AIP

Stage 2: Budget Cost (where a specific cost limit is set)

Stage 3: Design

Stage 4: Tender and conntract

Stage 5: Construction

Stage 6: Commissioning

Stage 7: Evaluation

8. The aim of Capricode is to ensure that the scheme fits the service requirements, that it is the option which represents the best possible value for money, that it proceeds in clear, well defined stages, and that it is built to time and cost. Key decisions must be taken in sequence, but some overlapping of stages is possible.

9. The NHS Capricode procurement process begins with the determination of functional content rather than with the establishment of a budget limit. This is because the content of an NHS capital construction project is directly linked to, and determined by, the strategic plan for service delivery. The first priority is to decide, on the basis of planned levels of service, what facilities are required. For capital planning purposes this decision translates into specific requirements in terms of functional content and, thence, accomodation. It follows that the setting of the budget cost limit for a particular scheme will always follow rather than precede the determination of functional content. That said, the determination of content and the setting of the budget cost limit in no way dictate the design solution or the procurement options. Within the requirement for a specific content and a budget cost, designers are free - and are expected - to explore alternative possibilities before finalising their design.

Capricode approvals

10. Approval of Capricode Stage 1 (AIP) submissions for schemes below £5m is delegated to regions. Approval for schemes costing between £5m and £10m rests with the DHSS, schemes over £10m go to the Treasury, and schemes in excess of £25m have to be approved personally by the Secretary of State for Social Services and the Chief Secretary of the Treasury (one of the Ibbs recommendations). Authorities are now self-certifying in respect of all stages after Capricode Stage 1.

11. Where a scheme below one of the AIP approval thresholds is an integral part of a wider scheme with a total cost exceeding an approval threshold, it is treated as if it were the wider scheme.

Project managers

12. The revised Capricode requires every project to have a single, identifiable project manager who will be personally responsible for keeping the project to time and cost. (Thereby fulfilling another of the Ibbs recommendations).

Performance

13. In the mid and late 1970s a number of major NHS schemes, the most notorious being the Liverpool teaching hospital, were subject to major time and overruns which led to justified PAC criticism.

14. Various measures have been taken to improve performance. These include building in smaller, discrete phases; revised Departmental guidance; the development of Nucleus; the strict application of Capricode; and the introduction of tighter monitoring.

15. The combined effect of these measures has been to bring cost and time overruns down to very low levels indeed. A survey of 36 schemes undertaken for the Efficiency Unit in 1985 showed that average time overruns had been reduced to 4.4% and cost overruns to only 1.8% . These figures compare well with other public and private sector organisations.

Privatisation

16. Health authorities' capital construction programmes are 100% privatised in respect of construction works: there is no direct building. Design work for regionally controlled schemes is approximately 70% privatised and 30% in-house. In-house design work is required to be fully-costed and it must be tested against the cost of employing outside consultants.

Competitive tendering for design work

17. Following the Monopolies and Mergers Commission's conclusion in 1977 that architects and surveyors scale fees operated against the public interest, and following PAC recommendations in 1982, the Department now requires there to be fee-competition for all projects costing in excess of £5m (in-house teams must compete against outside consultants), and is currently considering reducing this threshold to £1m. For smaller schemes authorities are encouraged to seek to negotiate reductions in outside consultants' standard scale fees.

Unconventional contracting

18. Health authorities have traditionally used their own or outside professional consultants to design and supervise the

construction of major health building schemes. Last year the Department removed any constraint on the use of so-called "unconventional contracting". Authorities may, if they wish, follow the common commercial practice of employing one major contractor on a design and build basis, or they may engage a firm of management contractors to oversee the project as a whole. There are no restrictions on the use, where appropriate, of system building techniques involving factory pre-fabrication.

DHSS Health Building Directorate
March 1987

COMMERCIAL IN CONFIDENCE

DCA

10 DOWNING STREET

LONDON SW1A 2AA

From the Principal Private Secretary

16 March 1987

Dear Geoffrey,

SECOND GENERATION MAGNETIC RESONANCE MACHINES

The Prime Minister understands that the development of second generation magnetic resonance machines has reached an important stage and that there is a real risk that Britain, which pioneered much of NMR technology, is in danger of losing its position in the market. Some argue that in these circumstances priority should be given to developing a cardio-vascular machine while others believe it more important to devote limited resources to a machine which will bring NMR into routine clinical practice.

The Prime Minister has heard that Oxford Instruments have recently entered into some collaboration with GEC's Picker subsidiary to develop a second generation machine, but their efforts may be inhibited somewhat, not so much by lack of financial resources, but by difficulties in recruiting sufficient skilled manpower. Last year's ACARD report on medical equipment, which highlighted some of the problems which NHS purchasing practices create for industry, may be relevant here in indicating some of the problems which might face the Oxford/Picker venture in selling new machines assuming they can develop a technologically satisfactory product.

BF The Prime Minister would be grateful if you could let her have a short note on the position reached in the development of second generation NMR machines and on your Department's progress in dealing with the problems highlighted in ACARD's report on medical equipment, especially insofar as they have any relevance to the second generation of NMR machines. You will, no doubt, need to consult the DTI.

I am sending copies of this letter to Tim Walker (Department of Trade and Industry), and John Fairclough (Chief Scientific Adviser).

Yours sincerely

Nigel Wicks

(N.L. WICKS)

Geoffrey Podger, Esq.,
Department of Health and Social Security.

COMMERCIAL IN CONFIDENCE

4

SECRET

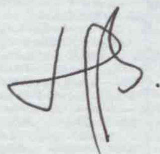
SECRET

MR WICKS 16 March 1987

A AGAINST B IN THE COURT OF APPEAL

Further to your minute of 16 March, we accept your point concerning the Attorney General. However, we are much struck by a sentence in the third paragraph of your minute which states "Of course DHSS can exercise some informal pressure on the authority to drop or modify their case". We suggest that you might in turn put some pressure on the DHSS along these lines. The policy point remains that the public are likely to see a coach and horses being sent through our Government policy of openness on this topic. Furthermore, the practicalities remain that although the News of the World may be restrained from producing this information, there is firstly every chance that the foreign press unrestrained may produce this information, and secondly, bearing in mind that the News of the World has already printed some information yesterday, they may well print more regardless of the injunction.

We conclude that from the policy angle there is everything to be gained and very little to be lost by reaching accommodation with the News of the World as soon as possible.



HARTLEY BOOTH

SECRET

NAT. HEALTH : Expenditure PT 8

File NFJ 3

PROFESSOR GRIFFITHS

cc Mr Booth

A v B IN THE COURT OF APPEAL

As I told you on Friday evening, I held back Hartley Booth's minute of 13 March until I had made some further investigations.

The Permanent Secretary at the DHSS tells me that the District Health Authority concerned have successfully sought an injunction against the News of the World to prevent them making public information from medical records. The medical records have fallen into the hands of the News of the World through unauthorised means. The burden of the case is not about aids, but about confidentiality of medical records. Further I am told that the thrust of the evidence of the Government's Medical Adviser was in support of the principle that medical records should be kept confidential and not disclosed without proper authority. What the Chief Medical Adviser said about aids in his evidence was, I am told, rather by the way.

I understand too that the Government have no formal locus in this case. The District Health Authority concerned have brought the case on their own authority and are a legally distinct entity from HMG. Of course, DHSS can exercise some informal pressure on the Authority to drop or modify their case, for example, to permit the News of the World to publish only the existence of the doctors, without disclosing their names. But the department will, I think, be unwilling to seek to override the judgment of an Authority in a matter like this where questions of professional conduct - keeping medical records confidential - are involved.

Hartley Booth suggests that the Attorney General should be informed of the position. I must say that I see some

difficulty here. The information has, I understand, come to the Policy Unit directly from the News of the World. That newspaper is, if I understand the position right, in breach of the undertaking which it has given the Court of Appeal. I am no lawyer, but this looks to me rather like as if the newspaper has committed some contempt of court. In such circumstances there is a certain oddity, to say the least, of No.10 contacting the Attorney General with information which has come to us through a contempt of court. I do not know what the Attorney would do. He might feel that he had to report the contempt to the court. I do not know where that would lead us.

I am very loath to engage the Prime Minister in this matter.

N.L.W.

N.L. Wicks

16 March 1987

2

Not submitted with Policy Group's ...

SECRET

PRIME MINISTER 13 March 1987

A v B heard today in Court of Appeal

This case is likely to cause a big scandal unless urgent steps are taken to avert trouble.

1. Two GPs have AIDS.

2. This information reached the News of the World.

3. An action was commenced in the High Court by the District Health Authority to restrain the News of the World from publishing the fact of the existence of these Doctors.

4. The Government became further involved through its Chief Medical Officer, Sir Donald Acheson, who gave written evidence that the GPs could not pass AIDS to patients. This evidence was critical today in the Court deciding against the News of the World.

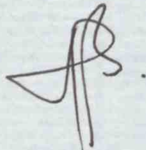
5. The News of the World have offered to publish only the existence of the doctors not their names. This was rejected.

6. Further Appeal to the Lords is likely. Even if AIDS cannot be passed to patients by doctors we believe (a) the public should not be denied this information (b) if (or when) the public is told they will be understandably angry with the Government for suppressing the information.

Conclusions: We recommend the Attorney General should be informed and in any event that urgent consideration be given

SECRET

to allowing a settlement of this case along the lines of the News of the World's offer (in 5 above).



HARTLEY BOOTH

Footnote: We note that parties to this case are subject to a further injunction not to discuss this case. Whether the News of the World broke this injunction by speaking to a Minister who informed us or whether we are a party through the District Health Authority is a moot point.

B

PRIME MINISTER

SECOND GENERATION MAGNETIC RESONANCE MACHINES

19.2.87

You will be interested in Robin Butler's letter attached about correspondence between Donald Longmore and Geoffrey Pattie concerning difficulties in developing a second generation of NMR machines.

Mr. Longmore's essential point is that if Britain is to remain competitive in this technology, we must produce second generation machines. He argues that Oxford Instruments and GEC's Picker subsidiary are being dilatory in developing a second generation machine. He proposes, as the top priority, a crash programme to develop a cardio-vascular machine with lesser priority for a cheap general purpose magnetic resonance machine. Oxford and GEC should bear a substantial part of the development costs, though some Government contribution is needed.

I asked John Fairclough to find out what was going on. He tells me the following:

(i) Oxford Instruments have always recognised that, as others master NMR technology, they will have to surrender a market share. They are trying to do this in a controlled way (for example by licensing their technology) while moving on to new frontiers of technology.

(ii) The next important step in medical NMR - one which is technologically demanding - is production of cheaper and easier to use machines which will bring NMR into routine clinical practice.

(iii) It is less obvious that Mr. Longmore's top priority - a cardio-vascular machine - will provide a commercially attractive market. The more likely route is for general purpose medical NMRs, perhaps

featuring cardio-vascular application packages. Mr. Longmore's ambition - a machine cheap enough to be sold in very large numbers for general cardio-vascular screening - requires a further large reduction in cost over what is obtained in the next generation.

(iv) Since Robin wrote, Picker and Oxford agreed, on 20 February, to collaborate on the development of a new generation machine. Their inhibition had, I understand, been lack of resources - not so much money, but skilled manpower. Both companies have had other commercial projects they judged of higher priority. (This is not a case of not devoting enough resources to R & D; both GEC and Oxford have a good reputation here.)

It looks as if matters have moved in a more satisfactory direction since Robin wrote with the two companies now in active cooperation. It remains to be seen whether that collaboration is sufficiently active for the development to be pushed through with enough determination and resources (especially skilled manpower) to produce the second generation of machines before the foreign competition. There is not much the Government can do here; it is a matter for the companies. A later problem will be whether the product will find a receptive home market. John Fairclough tells me that last year's ACARD report on medical equipment highlighted some of the problems which the NHS's purchasing practices create for industry. DHSS are aware of the problems here and are trying to bring about improvements.

I think some Prime Ministerial interest might concentrate minds here. If you agree, I will write to DHSS and DTI expressing your interest in:

(i) the development of second generation NMR machines; and

(ii) DHSS's progress in dealing with the problems highlighted in ACARD's Report on Medical equipment.

Agree?

This aspect of NHS purchasing was raised (by me) at the ~~Regional~~ Regional Chairmen's dinner at No 10. I hope they are doing something about it.

N.L.W

N.L. WICKS
13 March 1987

Yes

EL3BVO

NAT HEALTH

EXPENDITURE

PT V

COMMERCIAL IN CONFIDENCE

A

D R A F T

SECOND GENERATION MAGNETIC RESONANCE MACHINES

Since the UK began to produce Magnetic Resonance Imaging (MRI) in 1983 all the major international suppliers of medical imaging equipment have developed MRI products for the world market. Picker, the major UK manufacturer, is still among the top three or four manufacturers world-wide and is well placed to maintain that position with the current model, the 2055 HP, which is a high performance system capable of being further upgraded as new techniques develop.

Whilst some people are advocating the application of MRI techniques in cardiovascular screening but the reality is that MRI as a technique for cardiovascular diagnosis has not yet moved outside the research environment. Considerably more research and clincial evaluation will be necessary before the development of a specialised MRI scanner for cardiovascular screening can be justified. Picker are well placed to assess the commercial possibilities of such a system.

The development of a lower cost MRI scanner, which would make the technique more widely available in the NHS as well as overseas, is seen as a much more important development. The cost of the magnet in an MRI scanner represents about 50 per cent of the cost of the system. The development of low cost magnets is therefore crucial. Both the DTI and DHSS have held discussions with Picker and Oxford Instruments, the magnet manufacturers, and have encouraged them to co-operate as far as possible in their separate development activities.

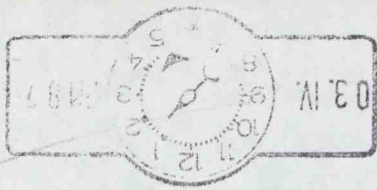
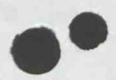
DTI are considering a proposal from Oxford for support of their magnet development programme, which includes work on magnets suitable for lower cost MRI scanners.

Picker are aware that the DTI are prepared to consider a proposal for assistance from them. Recent changes in the Picker management have delayed their preparation of a proposal.

Within the industry there is certainly awareness of the need to develop a low cost MRI scanner for the world market and all manufacturers of MRI scanners are believed to be working towards this end although no really low cost equipment is yet available. The ACARD Report laid particular emphasis on the need for option appraisal in NHS purchasing and for more equipment evaluation to support such appraisals. Guidance on option appraisal has been drafted and is with the NHS for comment. Clinical evaluation of MRI is being carried out at a number of centres in the UK under the auspices of a DHSS/MRC Co-ordinating Committee. A further report on the clinical utility of MRI will be issued from this Committee around the middle of this year.

An essential element of equipment evaluation is the ability to make objective measurements of equipment characteristics which can be related to clinical performance. This is particularly difficult in the case of MRI equipment but a DHSS R & D project to develop such methods is now well advanced. It will shortly be possible to make effective performance measurements on first generation MRI scanners and these methods will be applicable to second generation MRI scanners when they become available.

The ACARD Report also recommended that a mechanism should be set up to co-ordinate the R & D programmes of the various government bodies supporting work in the medical equipment field. Liaison meetings are now being held regularly between DHSS, DTI, SERC and MRC to correlate their activities in this field.


NAT HEALTH: Exped. + Efficiency: PT8


CC DC BI APB MEA

McCOLL REPORT

With permission, Mr Speaker, I wish to make a Statement on the Government's response to the McColl Report on the Artificial Limb and Appliance Services. As the House will know, these important services are administered directly by my Department and the Working Party were invited to consider them and to make recommendations for the improvement of efficiency and patient care. I am most grateful to the members of the Working Party for the comprehensive and dedicated manner in which they tackled this task.

The Report made wide ranging and detailed recommendations, concerning the organisation and management of the services; the nature of the Contracts for the supply of limbs; the quality of the limb fitting services; and the desirability of closer links between the full range of Hospital, Community Care and Local Authority services. Action has been taken already to implement many of the Recommendation.

We have strengthened substantially the top management of the Limb and Appliance services by appointing a General Manager to head a specialist Disablement Services Division; supported by a new Director of Operations, and a new Director of Procurement from the NHS.

We now propose to extend the principle of general management throughout the Limb and Appliance Service in order to implement the far reaching changes we envisage. We intend to re-organise the Service into regions with boundaries that are co-terminous with those of the NHS. Each region will be headed by a senior manager responsible for the entire Limb and Appliance Service in that area. We are also, as I told the House on 17 February, improving the range of wheelchairs that are provided. Pilot projects to improve transport arrangements for patients are under way and improved management systems are already in place.

We believe the quality of limb fitting by prosthetists is vital to patient welfare. The McColl Report was critical of the level and quality of prosthetic training. We agree that it should be improved. We wish to see professional training and the status of prosthetists upgraded. We have therefore established a Joint Working Party with the Limb Industry and the Orthotic and Prosthetic Training and Education Council (OPTEC) to review speedily the present arrangements for prosthetic training and to make recommendations for improvement. We have already received an interim report from the Working Party and expect a final report within three months - I shall report further to the House when this is received. I anticipate that implementation of any recommendations will make provision both for initial training leading to a qualification and subsequent in-service training.

We also agree with the McColl Report that we should seek improved contracts for the supply of artificial limbs. We are therefore, pressing the limb industry to agree to new contractual arrangements that will increase competition and encourage a quicker and more flexible service. Discussions with this aim in mind are continuing and we attach great importance to this principle.

Mr Speaker, One of the most important conclusions of the McColl Working Party was that it would be inappropriate for the Limb and Appliance services to remain under the direct control of the DHSS. I wish to make clear that we accept that recommendation and propose to act on it.

We have therefore decided to establish an interim management board, in the form of a Special Health Authority, with effect from 1 July this year. The Authority will be accountable directly to me. I am delighted to announce that my noble Friend The Lord Holderness has agreed to be Chairman of the new Authority. My Noble Friend is a distinguished former Member of this House and has a long and proven record of commitment to disabled people. I have no doubt that he will be an excellent Chairman.

We envisage the Board will have about eight members and their names will be announced shortly following further consultation with the Chairman. We shall of course also have regard to the provisions of the Disabled Persons (Representation and Consultation) Act in appointing board members. However, the House may care to know that I have already invited Professor Ian McColl, Chairman of the McColl Working Party to join the Board as Vice Chairman so that the views and knowledge of the Working Party will be readily available. I am delighted to report that Professor McColl has accepted and I know this view is shared by my noble Friend..

The McColl Report identified an imperative need for stronger links with the occupational therapy, physiotherapy and rehabilitation services offered by the NHS. We agree with this recommendation. To achieve this aim in the interests of patient care we have concluded that, in the longer term, the right organisational framework for the Limb and Appliance Service would be alongside these services within the Regional and District HAs. This is also the view of the recent report on disability published by the Royal College of Physicians.

Clearly, however, this is a far-reaching change which cannot in our view be carried into effect immediately. The process of transition will need very careful management to safeguard the interests of all involved - whether patients or staff. We shall expect the new Authority to complete this task in time for integration to take place on 1st April 1991. The instrument establishing the Authority will set this as the end date.

The new Authority will have a threefold responsibility: to oversee the planning for the eventual transfer of the services; to build upon the improvements already under way; and to run the service for this transitional period. It will have power to appoint its own senior staff. The SHA will be given its own budget for 1987-88 and planning figures for the two following years. Special arrangements will be made to safeguard the level of funding available throughout the period of the SHA's life and for a period after integration with Health Authorities. The Authority will also be charged with devising safeguards to ensure that continuity of the services is maintained following integration.

Staff who are currently employed in the Service will be invited to work for the new Authority. Their existing terms and conditions will apply and the Authority will be required to ensure that their interests are protected. Discussions with Trade Unions and staff will begin today.

The authority will be responsible for the whole of the artificial limb service, for the wheelchair service and for the provision of appliances to war pensioners. The Government are committed to ensuring that the status of war pensioners continues to be recognised. We will ensure that the new Authority reflects that commitment. Decisions on the future of the artificial eye service will be taken when the current review of the service is complete but this may also be added to the SHA's responsibilities. The Departmental Vehicle schemes will remain directly administered by the DHSS.

Mr Speaker, the decisions I have announced today represent the most far reaching changes in the Artificial Limb and Appliances Service since its inception. They follow the recommendations of the Working Party. They meet the aspirations of disabled people and I am confident they will improve the services available to them. I believe it is right to end the uncertainty of recent years.

The Government look forward to working with the new Authority to build a better future for the patients they will serve.

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY

Telephone 01-407 5522

From the Minister of State for Social Security and the Disabled

Please find enclosed a preliminary draft of a statement that John Major intends to make to the House next week on the subject of the McColl Report and the Government's intended action on it.

SARAH LLOYD-WILLIAMS
Assistant Private Secretary

6 March 1987

cc Miss J MacNaughton, Private Secretary to the Lord President of the Council
Ms Alison Smith, Private Secretary to the Leader of the House
Mr M E Addison, Private Secretary to the Prime Minister
Mr R S B Gordon, Private Secretary to the Secretary of State, Scotland
Mr Colin Williams, Private Secretary to the Secretary of State, Wales
Miss J Rutter, Private Secretary to the Chief Secretary
Mr M MacLean, Private Secretary to the Chief Whip
Mr B Calderwood
Mr C Muir
Mrs Rookes
Mr Langsdon

MG3554p

McCOLL REPORT - PRELIMINARY DRAFT STATEMENT

With permission, Mr Speaker, I wish to make a Statement on the Government's response to the McColl Report on the Artificial Limb and Appliance Services. As the House will know, these important services are administered directly by my Department and the Working Party were invited to consider these and make recommendations for the improvement of efficiency and patient care.

The McColl Report made wide ranging and detailed recommendations, concerning the organisation and management of the services; the nature of the Contracts for the supply of limbs; the quality of the limb fitting services; and the desirability of closer links between the full range of Hospital, Community Care and Local Authority services. Action has been taken already to implement much of the Report.

We have strengthened substantially the top management of the ALAC services by appointing a General Manager to head a specialist Disablement Services Division; with a new Director of Operations, and a Director of Procurement from the NHS.

We now propose to extend general management through the ALAC organisation to enable local management to implement the far reaching changes we envisage for the services. We are also, as I told the House on 17 February, improving the range of wheelchairs that are provided. Pilot projects to improve transport arrangements for patients are under way and improved management systems are already in place.

The McColl Committee were critical of the level and quality of prosthetic training. We agree that it should be improved. We have therefore established a Joint Working Party with the Limb Industry and the Orthotic and Prosthetic Training and Education Council (OPTEC) to review speedily the present arrangements for prosthetic training and to make recommendations for improvement. We believe the quality of limb fitting is vital to patient welfare. We have now received an interim report from the Group and expect a final report within three months - I shall report further to the House when this is received.

We also agree with the Committee that we should seek improved contracts with the industry for the supply of limbs. We are therefore, pressing the limb industry to agree to new contractual arrangements to increase competition and encourage a quicker and more flexible service. Discussion with this aim in mind are continuing and we attach great importance to this principle.

One of the major conclusions of the McColl Working Party was that it would be inappropriate for the ALAC services to remain under the direct control of the DHSS. I wish to make clear that we accept that recommendation and propose to act on it.

We have therefore decided to establish an interim management board, in the form of a Special Health Authority, with effect from 1 July this year. I am delighted to announce that the Rt Hon the Lord Holderness has agreed to be Chairman of the new Authority. Lord Holderness is a distinguished former Member of the House and has a long record of service to the disabled. We envisage the Board of the SHA will have about eight members and their names will be announced following further consultations with the Chairman. However, the House may care to know that I have already invited Professor Ian McColl, Chairman of the McColl Committee, to join the Board as Vice Chairman so that the views and knowledge of the Working Party will be readily available to the SHA. I am delighted to say that Professor McColl has accepted.

The McColl Report identified an imperative need for stronger links with the occupational therapy, physiotherapy and rehabilitation services offered by the NHS. We agree with this recommendation. To achieve this aim in the interests of patient care we have concluded that, in the longer term, the right organisational framework for the ALAC would be alongside these services within the Regional and District HAs.

Clearly, however, this is a far-reaching change which cannot in our view be carried into effect immediately. The process of transition will need very careful management to safeguard the interests of all involved with the ALAC services - whether patients or staff. We shall expect the new Authority to complete this task in time for integration to take place on 1 April 1990. (?1991). The instrument establishing the Authority will therefore also set an end date for the Authority of 31 March 1990.

The new Authority will have a threefold responsibility: to oversee the planning for the transfer of the services to existing [Regional and District] Health Authorities; to continue the improvements already under way; and to run the ALAC services for this transitional period. The SHA will be given its own budget for 1987-88 and planning figures for the two following years. Special arrangements will be made to safeguard the level of funding available throughout the period of the SHA's life and for a period after integration with [Regional and District] Health Authorities. It will have authority to appoint its own senior staff on contract.

The Authority will also be charged with divising safeguards to ensure that continuity of the services is maintained without disruption or diminutions.

Staff who are currently employed in the ALAC service will be invited to work in the service for the new Authority. Their existing terms and conditions of service will apply and the Authority will be required to ensure that their interests are safeguarded.

The authority will be responsible for the whole of the artificial limb service, for the wheelchair service and for the provision of appliances to war pensioners. The Government are committed to ensuring that the status of war pensioners continues to be recognised, and we will ensure that the new Authority reflects that commitment. Decisions on the future of the artificial eye service will be taken when the current review of the service is complete but this may also be added to the SHA's responsibilities. The Departmental Vehicle schemes will remain directly administered by the DHSS.

Mr Speaker, I believe the changes I have announced today represent the most far reaching changes in the Artificial Limb and Wheelchair Service for many years. I am confident they will improve the services available to disabled people. I believe it is right to end the uncertainty of recent years.

The Government look forward to working with the new Authority and their excellent staff to build a better future for the patients they will serve.

NAT HEALTH: Expenditure.

CONFIDENTIAL

PRIME MINISTER

PRESCRIPTION CHARGES

I now understand that Mr. Fowler is inclined to postpone his statement until after the Truro by election. He is giving a Press Conference tomorrow in Truro and appearing on Question Time on Thursday. He feels that to make a statement today would put the announcement firmly in the context of Truro.

It now seems however that if the statement is postponed it will have to be made on 16 March, the day before the Budget. This would give a golden opportunity to Mr. Kinnock to attack the Budget on the grounds that the tax cuts are being paid for by undermining the health service and so on.

Mr. Fowler has a good story to tell on prescription charges, particularly taken with the announcement on needles for diabetics.

May I say to Mr. Fowler's office that your strong view is that the statement should be made today?

That would be much better than 16th March.

DN

David Norgrove

If that date it will dominate the Budget

MT

3 March 1987

CF

W0451

MR WICKS 3 March 1987

SECOND GENERATION NMR MACHINES

You asked for advice on Robin Butler's letter about the development of second generation medical NMR machines. I have not consulted DTI, but I have consulted DHSS, who played a very active part in getting medical NMR off the ground in the UK and are still strongly involved.

2. The background is that Oxford Instruments have dominated the production of magnets for medical NMR. They have done this by being "suppliers to the trade", selling their magnets to virtually all producers of NMR scanners, a very important, but not dominant, one being the GEC subsidiary Picker. Oxford Instruments are still a relatively small company, whose success has been built on having a technology lead. They have always recognised that as others master any given technology they will have to surrender market share; their strategy has been to do this in a controlled way (for example, by licensing their technology), whilst moving on to the new frontier of technology. We are seeing this process in medical NMR.

3. Most observers would agree that the next important step in medical NMR, and one which will be technologically demanding, is indeed to produce cheaper and easier to use machines which will bring NMR into routine clinical practice. Despite Mr. Longmore's enthusiasm for his own specialism, it is less obvious that there is a commercially attractive market for a machine aimed specifically at cardio-vascular applications, though general purpose machines may well feature cardio-vascular applications packages. In particular, in other contexts Mr Longmore has apparently envisaged a machine cheap enough to be sold in very large numbers for general screening for cardio-vascular disease; this would require a further large reduction in cost over what appears attainable in the next generation.

4. DHSS have been discussing the development of a new generation machine with both Picker and Oxford Instruments for some time. At a meeting on 20 February at GEC headquarters, involving both companies and DHSS, the two companies agreed to go ahead with this development in collaboration. (Oxford in particular may be sensitive about precisely what is said in public about its relationship with Picker, given its need to appear to treat all its customers reasonably even-handedly.) This is reasonably satisfactory, though it would of course have been nice if the development could have been initiated earlier. The problem for both companies (but especially Picker) has I understand been resources, and particularly skilled manpower. Both have had other commercial projects they judged of higher priority. In the case of Picker, they have recently introduced a new very high performance range of machines, and have devoted their main technical efforts to curing some teething troubles with those machines. I understand also that Lord Weinstock is himself very keen on this project, but has met resistance from staff lower down who have had to cope with the resource problem.

5. Both the companies concerned have high R & D spending, unlike much of the medical equipment industry, and cannot fairly be criticised for lack of commitment to the future. Whether they made the right commercial judgements about priorities on this occasion, time will tell. Now that they have committed themselves to the project, I see no need for immediate Government action, though gentle encouragement would do no harm at all. The more serious problem is whether, when the product is launched, it will find a receptive home market. Last year's ACARD report on medical equipment highlighted some of the problems which the NHS's purchasing practices create for industry. DHSS understand and support most of the changes that need to take place, but they will not be easy to push through, and any encouragement that the Prime Minister can give Mr Fowler and his colleagues, perhaps referring specifically to the new generation of NMR, would be welcome.

John

JOHN W FAIRCLOUGH
Chief Scientific Adviser

P.S. I met Weinstock by coincidence & he tells me he is unhappy with progress of the Picker - OI arrangement!

SECRET

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY

Telephone 01-407 5522

From the Secretary of State for Social Services

The Rt Hon John MacGregor OBE MP
Chief Secretary to the Treasury
HM Treasury
Parliament Street
LONDON
SW1P 3AG

26th February 1987

Prime Minister 2
DRN 27/2

Dear John,

PRESCRIPTION CHARGES AND DIABETICS' SYRINGES

As you will know, we agreed during the PES round to secure a further £10 million from prescription charges in 1987/88, which entails an increase in the charge from £2.20 to £2.40 per item. It is in practice only possible to make changes at the beginning of the financial year, which in this case means 1 April. To achieve this, the necessary order must be laid by 11 March at the latest.

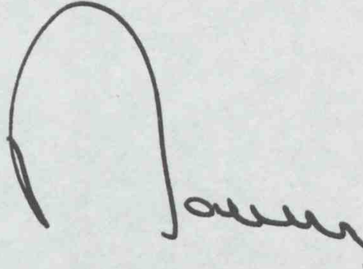
Although I would, of course, ideally prefer to make such an announcement at a less sensitive time, I see no alternative if we are to deliver our PES commitment. I therefore propose that it should be made as soon as possible and have provisionally arranged for a statement on 2 March. It is not essential that the statement should be made on Monday but I see no point in delaying the announcement.

I should add that there are very strong arguments for prescription charges. The charges provide significant revenue and with the increase will raise some £150 million annually. At the same time, there are very extensive exemptions from the charges which result in 75 per cent of all prescription items dispensed being without charge. Special season tickets are also available to limit the outlay of those who are not exempt but need frequent prescriptions. Finally, the increase we are proposing in prescription charges is in line with the increase in cost of the drugs covered by prescriptions over the last financial year.

E.R.

I propose at the same time that we should announce our intention to make disposable syringes available on prescription to diabetics. This, of course, will be very much welcomed and should assist in countering any criticism on the increase in prescription charges.

I am copying this letter to the Prime Minister, the Secretaries of State for Wales, Northern Ireland and Scotland, the Chancellor of the Duchy of Lancaster, the Chief Whip and to Sir Robert Armstrong.



NORMAN FOWLER

PRIME MINISTER

NHS PRESCRIPTION CHARGES

Mr. Fowler intends to announce on Monday a 20p increase in the basic £2.20 prescription charge.

He intends to announce at the same time that needles will be made available to diabetics on prescription (though presumably many diabetics may be exempt) and certain changes to the rules on charges for private patients.

His draft statement has not yet arrived here, but should come down to you at Chequers tomorrow.

DAVID NORGROVE

26 February 1987

ECL/29

CONFIDENTIAL

PRIME MINISTER

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DAVID NORGROVE
26 February 1987

ECL/29

CONFIDENTIAL

Mr faxed to Chequers 26/2

PRIME MINISTER

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DRN

DAVID NORGROVE
26 February 1987

ECL/29

CONFIDENTIAL

NMR machines
3/3

file

(07)

10 DOWNING STREET

From the Principal Private Secretary

MR. JOHN FAIRCLOUGH

CABINET OFFICE

Robin Butler, my predecessor here, has sent me the papers attached about the problems which have arisen in developing the second generation NMR machines.

Before I put these papers to the Prime Minister I should be grateful if you could let me have a note on the issues raised. Is there a serious problem? Where and why does it arise? Is there anything that Government can do to help facilitate a solution?

If you feel it necessary to consult the Department of Trade and Industry, please could you not mention No. 10's interest at this stage nor that Robin Butler has drawn the matter to our attention.

If you could let me have a note within a week, that would be helpful.

N. L. WICKS

24 February 1987

ECL

Cile

10 DOWNING STREET

From the Principal Private Secretary 24 February 1987

Thank you for your letter of 19 February. I am looking into this (without mentioning your name) and will bring the papers to the Prime Minister's attention. I will let you know the outcome.

N. L. WICKS

F. E. R. Butler, Esq., C.V.O.,
H. M. Treasury

NMR

PPS

H M Treasury

Parliament Street London SW1P 3AG

Switchboard 01-233 3000
Direct Dialling 01-233 ....

F E R Butler, CVO
Second Permanent Secretary
Public Expenditure

N. L. Wicks, Esq.,CBE,
10 Downing Street,
LONDON, SW1

19th February, 1987.

Dear Nigel,

The Prime Minister may be interested on personal grounds in the attached letter from Donald Longmore to Geoffrey Pattie. She knows Mr. Longmore and opened his NMR project. I am also enclosing the DTI's (not very helpful) reply, although I should emphasise that Mr. Longmore has stressed that Mr. Pattie has been personally very friendly - he has visited the NMR centre twice - and Mr. Longmore also has a high opinion of his DTI contact, Mark Farry.

I cannot personally verify Donald Longmore's claims, but I suspect that this is a prime example of the "English disease" of failing to exploit a technological advantage. Donald Longmore simply cannot get Arnold Weinstock and Oxford Magnets to get their act together. They meet him and say positive things but nothing seems to happen. Meanwhile the Japanese are putting the ideas into practice. Even so, Donald Longmore claims that he is still technologically ahead.

This has all come my way because Donald Longmore invited me to lunch today to show how he was getting on - and I saw the most amazing moving pictures of circulation of blood through the heart, which Donald Longmore and his team have developed the technology to achieve. Derek Rayner, who has now taken over the chairmanship of the heart charity Corda (which has supported this work), is trying to get Arnold Weinstock moving. I am not suggesting that the Prime Minister does anything, but it would do no harm if she showed that she was watching the progress of the project when she next saw Arnold Weinstock - and Geoffrey Pattie.

Yours ever,

Robin.

F. E. R. BUTLER

DEPARTMENT OF TRADE AND INDUSTRY
1-19 VICTORIA STREET
LONDON SW1H 0ET
Telephone (Direct dialling) 01-215)
GTN 215) 5147
(Switchboard) 01-215 7877

From the Minister of State
for Industry and Information Technology

GEOFFREY PATTIE MP

Donald Longmore Esq
Magnetic Resonance Unit
National Heart and Chest
Hospitals
30 Britten Street
LONDON
SW3 6NN

E3 DEC 1986

30 November 1986

Dear Mr Longmore

MAGNETIC RESONANCE MACHINE EXPORTS

Thank you for your letter of 11 November 1986.

I was very interested in what you said about the world market for magnetic resonance medical systems and what should be done to improve the UK's chances of securing a good slice of that market.

GEC and Oxford Magnets are the UK's front runners in this technology and their views on your proposals are of course of primary importance. May I suggest that you discuss the implications with these companies and with officials from my Department and DHSS. The point of contact here is:-

Mr Mark Farry
Electronics Applications Division
29 Bressenden Place
LONDON
SW1E 5DT

Tel: 01 213 4670

I am copying this letter to the recipients of yours.

Yours sincerely

Geoffrey Pattie

GEOFFREY PATTIE

NO6/NO6AAX

17 1986

MAGNETIC RESONANCE UNIT

NATIONAL HEART AND CHEST HOSPITALS

MR. DONALD LONGMORE FRCS

30 BRITTEN STREET
LONDON SW3 6NN
TEL: 01-351 5773

11 November 1986

Geoffrey Pattie Esq MP
Minister of State for Industry
1 Victoria Street
London SW1H OET

Dear Mr Pattie:

MAGNETIC RESONANCE MACHINE EXPORTS

The United Kingdom has a technical lead in the design of magnets and of magnetic resonance medical systems. It is now set to lose all but a trivial part of the market share. This letter explains how much will be lost if nothing is done and proposes a rescue plan to salvage the industry.

The forecast predicts the Japanese, American and European market for magnetic resonance machines to be $7 billion over the next five years. The other world markets are significant but unknown.

Oxford Magnets used to supply 85% of the world's diagnostic magnets (now 65%). The magnetic resonance machine developed first by EMI, later by GEC and the Hammersmith Hospital gave the United Kingdom a head start. The National Heart and Chest Hospitals Magnetic Resonance Unit has applied magnetic resonance to cardiovascular disease which kills half of us. This development has already created a big new market and will lead to cost effective methods of prevention and

another market.

The USA and Germany are investing heavily in improved versions of the first generation equipment, Japan has set about producing cheap machines, with which to flood the world market.

If Britain is to remain competitive we must produce second generation more advanced, cheaper and more practical clinical machines without further delay.

If nothing is done, the return on Government and private investment will be lost. The efforts of the charity CORDA, British inventive genius and pioneering medicine will all be wasted.

We shall not only lose potential profits if we let others beat us. We shall also lose 4000+ jobs, the frustrated scientists may join the brain drain and Britain will spend over $100 million on imported machines.

Unlike other industries which are beyond hope we could still salvage the situation and avoid throwing away our lead position.

Designs for a new generation of magnets have lain unused for over a year at Oxford, and GEC/Picker have had concepts for new cheaper machines aimed specifically at the diagnosis of cardiovascular disease for even longer. Clinically relevant data processing systems which GEC/Picker could manufacture have been developed here. These overcome the difficulties experienced by non specialist doctors trying to interpret the results of magnetic resonance investigations widening its application.

THE RESCUE PLAN

Following the recent gloomy ACARD report and in the absence of any existing mechanism to co-ordinate the effort required to salvage this industry, I

propose that you and I jointly set up a steering comittee, asking Oxford and GEC to nominate senior representatives to meet with me and DTI urgently to achieve the following:-

i) Setting up immediately a design team of senior scientists from Oxford and GEC, guided by us to draw up the specifications for two versions of the second generation magnetic resonance machine:-

a) The cardiovascular machine. (Top priority)
b) A cheap general purpose magnetic resonance machine.

ii) The necessary development and capital costs. Oxford and GEC should bear a substantial part of these, but Government should contribute to stimulate action both to save the industry and because of its monopolistic control of the home market. About 4 million is needed to ensure a sufficiently guaranteed home market and increase clinical experience necessary to guide the manufacturers.

One possible way of driving the industry might be to generate orders specifying exactly what is required. Two leasing companies are both prepared to purchase a number of present generation machines, say five, to provide machines for training and to provide clinical experience. A buy-back arrangement from Oxford and GEC would allow these to be sold off second-hand when the first five second generation machines are ready to evaluate thus creating ten orders. The leasing and running costs would have to be found. I could probably fund some from soft money.

iii) An independent watchdog body should be set up by us immediately to monitor the efforts of the companies and the clinical unit to make sure that they are kept up to scratch and have sufficient sense of urgency to meet the challenge.

iv) The involvment of every relevant government body and the clinical users to help market the British equipment and to persuade potential customers that there is a credibile backup service in the face of numerically superior and much more sophisticated sales forces from GE, Siemens and the Japanese.

Donald Longmore

Donald Longmore FRCS

cc:

Tony Newton Esq MP DHSS

Lord Weinstock GEC

P Williams Esq Oxford Magnets

Prime Minister [2]

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY

Telephone 01-407 5522

From the Joint Parliamentary Under Secretary of State

MT

The Rt Hon Margaret Thatcher MP
Prime Minister
10 Downing Street
LONDON
SW1

10.2.87

Dear Prime Minister,

THE MAUDSLEY HOSPITAL

In my letter of 7 January I reported on the position and promised to let you know the outcome of my visit to the hospital on 3 February.

What I saw and heard on 3 February confirmed the accuracy of last month's report. The hospital is now clean and provides a generally better environment than at my visit last Summer. Some minor upgrading and redecoration is in progress, and this will make a further improvement. However everyone recognises that the only fully satisfactory way of dealing with the main ward block is to replace it. Work is planned to start on site in May. Morale at the hospital is slowly improving but still has some way to go; the building scheme will obviously help.

I should say that, despite my concerns about some aspects of the Maudsley, I have no reason to doubt the advice I have, that the quality of medical and nursing care is very high. Indeed I was generally impressed by the people I met.

I intend to visit the hospital again in the Summer, to check on progress. In the meantime my officials are working very closely with the hospital management to ensure that the momentum of improvement is maintained.

Yours ever

Jean

THE BARONESS TRUMPINGTON

NAT HEALTH
EXPENDITURE
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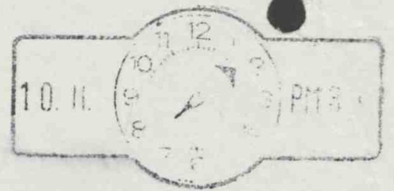

PART 7 ends:-

DRN to NLW 30.1.87

PART 8 begins:-

PUSS/DHSS to PM 10.2.87

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