PART 17

MT

CONFIDENTIAL FILING

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NHS Expenditure + Efficiency
NHS REVIEW
[IN ATTACHED FOLDER : NHS DRAFT WHITE PAPER].

NATIONAL HEALTH

PART 1 : MAY 1979
PART 17: 20 DEC 1988

Referred to	Date	Referred to	Date	Referred to	Date	Referred to	Date
~~21-12-88~~							
~~4.1.89~~							
~~6.1.89~~							
~~11.1.89~~							
~~17.1.89~~							
~~19.1.89~~ BM							
ENDS 12/88							

PREM 19/2343

HMSO Dd8953031 6/88 C60 GP2265 CCN13412 (3932)

PART Part 17 ends:-

Chéx to SS Health 23/12/88

PART Part 18 begins:-

PA to DoH 3/1/89

chex.ul/jf/9.22.12.mw

cc P.U.
✓ 16pm

Treasury Chambers, Parliament Street, SW1P 3AG
01-270 3000

23 December 1988

Rt Hon Kenneth Clarke QC MP
Secretary of State for Health
Richmond House
Whitehall
London SW1

Dear Secretary of State,

HEALTH TECHNOLOGY ASSESSMENT

We are all familiar with the rapid pace of change in health technology. It is an international phenomenon, and new technologies have undoubtedly made an important contribution to improved standards of medical care. But it also seems to be a general rule that new technologies cost more than the ones they replace. This makes it all the more important that these developments are properly evaluated, taking into account their costs as well as likely clinical effectiveness.

I have recently come across examples of the work produced by the Office of Technology Assessment in the United States, on the effectiveness and costs of new health technologies. The particular case study I saw covered new treatments for chronic renal disease. I found this an admirably clear and well presented piece of work, helpfully free of jargon and with the minimum of technical explanation.

I am aware that health technology assessment is already carried out in this country, much of it organised and funded by your department. But I wonder if there is scope for a better focus than now exists, particularly on cost effectiveness. I should accordingly be very interested to hear your views on the work and approach of the US Office of Technology Assessment and, more generally, on what plans your department have to improve their assessments of cost effectiveness in this area.

I am copying this letter to the Prime Minister, Peter Walker, Tom King, Malcolm Rifkind, John Major and David Mellor; and to Sir Roy Griffiths, Sir Robin Butler, Professor Griffiths and Mr Whitehead in the No 10 Policy Unit and to Mr Wilson in the Cabinet Office.

Yours sincerely,
Moira Wallace

pp **NIGEL LAWSON**
(Approved by the Chancellor and signed in his absence)

SECRET

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PA

PRIME MINISTER

NHS

Richard has

I attach the papers for the NHS meeting on 5 January which you will want to look at over the Christmas break. The papers are divided into 3 folders. The first contains Richard Wilson's steering brief prepared for Thursday's cancelled meeting but still worth a read since it sets out the order in which to tackle the issues. The other 2 folders follow the order suggested by Richard.

The third folder contains the chapters by the Territorial Ministers. Of these, Wales is the tricky one which goes off in its own direction on a number of issues. You will want to consider whether to tackle each of these individually as Richard Wilson suggests or to tackle Mr. Walker's whole approach head-on as the Policy Unit suggests. The other missing part of the White Paper is the Treasury contribution to chapter 10 on fiscal incentives. This is being prepared in time for the 5 January meeting.

You commented on Paul's timetable note that you saw last night that the White Paper should be better by 5 January meeting. Treasury Ministers have commented on the draft. (Their comments are in folder 2).

Do you wish to annotate the White Paper on the basis that we can minute out during the Christmas break?/
or are you content for your comments to be given at the 5 January meeting?

DM

The main White Paper is very poor in ~~Chap~~ the Foreword & Chapter 1. The Scottish Paper is much better on setting out clearly the general strategy in its opening chapter

DOMINIC MORRIS
23 DECEMBER 1988
MRMABY

SECRET

PRIME MINISTER

NHS REVIEW: TIME-TABLE

Following the cancellation of today's meeting of the NHS Review Group, we need to take stock of the time-table for the completion of the exercise.

We have to fit in two meetings of the Review Group, a meeting of E(A) and approval by Cabinet.

Originally we had proposed that the two meetings of the Group would be on 22 December and 5 January, with clearance by E(A) and Cabinet possibly as early as the week beginning 9 January. That would have allowed publication of the White Paper comfortably before the anniversary of your Panorama interview on 25 January.

The only way I can now see of getting publication before 25 January would be a programme as follows:

- next meeting of the Group as already scheduled on Thursday, 5 January; Yes - the W.P. should be better by that time
- final meeting of the Group on Thursday, 12 January;
- E(A) on Tuesday, 17 January;
- Cabinet on Thursday, 19 January.

But there are two problems with this:

i. Although we now have a workmanlike first draft of the White Paper there are still difficult discussions to complete in the Review Group, both with the territorial Ministers and the Treasury. If we have only a week between the two Review Group meetings, I fear time may be too tight; and a gap of only five days between the last Group meeting and E(A) is also very short.

ii. The Chancellor has particular difficulties in attending a meeting on 12 January - he has the Autumn Statement Debate that afternoon. He has suggested to me that we bring forward the final meeting of the Group to Tuesday, 10 January, but I think that is an unrealistic time-table.

An alternative time-table would be as follows:

- first meeting of the Group on Thursday, 5 January;
- final meeting of the Group on Tuesday, 17 January, which would give time both for re-drafting and a weekend for you to look at the revised papers;
- E(A) on Tuesday, 24 January;
- Cabinet on Thursday, 26 January.

This would of course preclude publication of the White Paper before the Panorama anniversary. But you could still go for publication on Tuesday, 31 January - ie within the 'by the end of January' time-table that Ken Clarke has indicated publicly.

Richard Wilson and I think this latter time-table would be better. Your demarche a few weeks back has been successful in accelerating the work programme and enabling a lot of progress to be made. But the final stages of the exercise are crucial, and will not benefit from being rushed.

Content for us now to plan on the latter time-table, with publication scheduled for 31 January? Yes pls

(I will put the papers that were to have been discussed today in the holiday box. If you then wanted to give any reactions over the New Year weekend, we could pass these out in advance of the 5 January meeting.)

PLC 6.

PAUL GRAY
22 December 1988

EAMAKU

88/474 22 December 1988

SECRETARY OF STATE APPROVES WESTMINSTER AND CHELSEA PROJECT

Kenneth Clarke, Secretary of State for Health has given Approval in Principle for a major new teaching hospital for Westminster and Chelsea.

A new £135 million hospital will be built on the site of St Stephen's Hospital, Fulham. Completion is scheduled for 1992.

Mr Clarke said today:
"This is one of the biggest hospital projects ever approved by Ministers in the history of the health service and will greatly improve health services in this important part of the capital.

"My decision has been made after careful consideration of the strong views made in opposition and support of this project. In giving approval to the new teaching hospital I have also approved the closure of four other hospitals: Westminster, West London, Westminster Children's and St Mary Abbot's. All these have provided excellent health care but they will be replaced by the new hospital and the services will be improved when they are relocated on one site.

"At present maternity services are isolated at the West London, paediatrics at Wesminster Children's and geriatric beds at St. Mary Abbot's. Basing all these at the new hospital will give them the kind of back-up and support services that can only be provided at a District General Hospital.

"It will also enable more efficient use of resources and scarce qualified, specialist staff. The Medical School supports the move to concentrate teaching on two sites, at the new hospital and Charing Cross, rather than three.

"Riverside Health Authority intends to provide a new primary health care centre, at Pimlico and five new nursing homes to replace some of the services now offered by St Mary Abbot's and the Westminster Hospital. The total plan will, I believe, provide the most up-to-date health care available for people in west central London".

The new hospital will have an Accident and Emergency Department capable of dealing with up to 60,000 cases a year. Planned support services include pathology, pharmacy and radiology. The maternity unit will be a regional perinatal centre with a full range of specialist and intensive care for the district and elsewhere in North West Thames.

Operating facilities will include six operating theatres supported by an Intensive Care Unit and a Coronary Care Unit. Day hospital amenities will be provided for the elderly, and mentally ill. An Adult Day Unit will provide two treatment suites and an operating theatre suite. There will also be a five bed Day Unit for children.

Comprehensive out-patients' services will include fracture, orthopaedic, dental, opthalmic, dermatology and ENT clinics and a Drug Dependency Unit.

Great attention has been focussed on staff amenities and there will be accommodation for 250 nurses on site, an occupational health centre and day nursery.

NOTE TO EDITORS

The project ensures that the level of acute services for the population of Riverside will be maintained and provided in new and improved facilities. When the services from a number of different hospitals are rationalised onto one site the district will be able to realise savings of up to £15 million which can then be deployed to improve health services elsewhere in the region.

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media enquiries: Sue Jones 01 210 5224

88/474 22 December 1988

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media enquiries: Sue Jones 01 210 5224

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Treasury Chambers, Parliament Street, SW1P 3AG

The Rt Hon Kenneth Clarke QC MP
Secretary of State for Health
Department of Health
Richmond House
79 Whitehall
London
SW1P 3EB

22nd December 1988

Dear Ken,

NHS REVIEW WHITE PAPER

It may be of assistance to you to have the main comments which the Chancellor and I had intended to make on the first draft, had the meeting arranged for today not been cancelled. My officials will be writing separately to yours with some further detailed drafting points.

In general, we felt the draft was a useful start. But we have some doubts about the way that the main message is presented. There are two general points. First, we need to be quite clear whether we are presenting the reforms as a fundamental change to the system, or as a continuation of the evolution that has taken place over recent years. Both chapter 1 and the opening paragraphs of chapter 12 are ambiguous on this point. Our view is that the proposals amount to fundamental reform and that it would be best to present them as such, particularly after a review which has taken us a year to complete.

Secondly, the draft needs to put patients first. This comes across most clearly in chapter 2, the order of which suggests that running the NHS more like other businesses and giving management the freedom to manage are more important than patient care. We must make it clear that the White Paper is primarily for the benefit of patients, and not primarily for the benefit of NHS managers.

Chapter 1 (Foreword) should begin by explaining why the Review has come about: that it is the consequence of the success of the NHS in meeting people's needs by providing ever more advanced services and treatment to more and more patients. As a result, the service has grown, with more doctors and nurses, more equipment, and so on. The Government has made available large and increasing sums of money to meet the costs. It is this growth which has placed the system under increasing strain and has led many people to question the way the service is organised and delivered. It could then go on, as paragraph 1.3 does, to set out the objective of a more efficient and responsive service.

In general, we think this chapter could be in rather more personalised terms than at present. On a couple of detailed points, if paragraph 1.2 is retained, the second sentence should be split into two unrelated statements, while the third sentence should refer to a service which is mostly free at the point of delivery and financed largely out of taxation.

If these proposals for chapter 1 are accepted, the first 4 paragraphs of chapter 2 (Delivering a better service) could be dropped. We think the final section of this chapter should be brought to the front (and that it should talk about patients, not "customers"). What is now paragraph 2.14 should contain positive proposals for dealing with waiting times, and not end just by saying that the problem remains. At present such proposals are buried in chapter 7. Paragraph 2.15 also deserves more prominence.

We were not sure what was added by paragraphs 2.5-2.7, and, since the message here may be open to misinterpretation, they might best be dropped. Paragraph 2.9, like other parts of the White Paper, gives too much prominence to GP practice budgets since, even if we decide to go ahead with them, they will cover no more than 2% of NHS expenditure, and probably a lot less. The proposals in respect of hospitals are far more important.

We think that chapter 2 should be followed by a new chapter on value for money. We will circulate a draft before the meeting arranged for 5 January.

We are to discuss the substance of chapter 3 (Practice budgets) separately. But irrespective of the outcome of that, it would be better to take this issue after chapters 4-7 on hospitals.

My officials will be giving yours detailed comments on chapters 4-9. I will mention only a few specific points.

a. Is it accurate to refer to "leaner and fitter" regions in chapter 5? The scope for removing functions cost-effectively is not demonstrated in paragraph 5.8, while proposals elsewhere in the White Paper will give them a lot of new tasks.

b. The drafting of chapter 7 needs to be looked at again. At present, it is rather unclear and obscure.

c. I was unclear about the reasons for changing the name of FPCs. Will the proposed new name not cause confusion with the Family Planning Association?

d. I thought the title of chapter 9 "Better decision making" was unfortunate since one of the main proposals involves removing many of our supporters from health authority membership.

Chapter 10 (Working with the private sector) does not seem to contain any proposals which are not made elsewhere, notably in chapter 5. This repetition should be removed.

Chapter 12 (Summary and timetable) should confine itself to just that. The first five paragraphs, if they are to be retained, are really for the Foreword.

I am sending copies of this letter to the Prime Minister, Nigel Lawson, Malcolm Rifkind, Peter Walker, Tom King, David Mellor and Sir Roy Griffiths, and Mr Wilson (Cabinet Office).

Yours Ever,
John

JOHN MAJOR

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COVERING SECRET

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000710

Treasury Chambers, Parliament Street, SW1P 3AG

Dominic Morris Esq
Private Secretary
10 Downing Street
London
SW1

21 December 1988

Dear Dominic

NHS REVIEW MEETING 22 DECEMBER: HC 68 AND 69

... I attach two joint papers by the Chief Secretary and the Secretary of State for Health recording the outcome of their discussions on the FPS and GP practice budgets.

I am copying this to the Private Secretaries to the Chancellor, the Secretaries of State for Health, Scotland, Wales and Northern Ireland, the Minister for Health, Sir Roy Griffiths, Sir Robin Butler and Ian Whitehead (Policy Unit).

Yours

Cathy

MISS C EVANS
Private Secretary

NHS REVIEW: FPS - HEADS OF AGREEMENT

Drug budgets

1. Cash limits to be set for RHAs to be passed on to FPCs, who will set indicative budgets for GPs.

2. Excess expenditure in one year to be recovered by reduction in RHA's cash limit the next (except where specifically agreed).

3. Scheme to be set up on basis of existing information base. Study needed of factors causing legitimate differences in prescribing costs at practitioner level to put in place adequate information systems and control mechanisms.

4. Sanctions against excessive prescribers available in the form of peer review and Service Committee proceedings, but would not in practice be used until improved information base fully operational in 2-3 years time. (Target date for RHAs to become responsible for FPCs is April 1991, following necessary legislation.) In meantime existing pressure for more economical prescribing, through dissemination of information and FPC monitoring, will continue.

Control of GP numbers

1. Legislation to be introduced to obtain powers, to be held in reserve, to control numbers of GPs.

2. Continue to negotiate with GMSC to increase capitation element of remuneration, at expense of Basic Practice Allowance.

3. Geographical variation of Basic Practice Allowance, including abolition in some areas.

GP PRACTICE BUDGETS

Note by the Secretary of State for Health and the Chief Secretary of the Treasury

We have had further lengthy discussions on the principle and practice of GP practice budgets, and have to report to the Group a fundamental difference of view.

2. The Secretary of State believes that practice budgets are an essential ingredient of the review. Their objective is to improve consumer choice, competition and the responsiveness of hospitals to GPs and their patients. Budgets are intended to give substance to the concept of the money following the patient. They will be an attractive part of the package, for both GPs and their patients. They will open up the system to a much greater extent than DHAs' ability to place block contracts with each other will achieve.

3. The Chief Secretary thinks their suggested benefits are illusory: they will not add to the competition between suppliers which is already proposed; and the Group's proposals for funding cross-boundary flows will allow money to follow the patient more readily in future. The budgets would amount to no more than 2% of NHS expenditure, and cannot be represented as a centrepiece of the White Paper. There is a fundamental dilemma, in that, as at present constituted, the budgets would offer an unwise, possibly improper, inducement to divert patients' money to a GP's own income. The Chief Secretary thinks this unsustainable. And he does not see how GPs will be able to exercise control over the budgets when decisions determining expenditure will be taken by hospital doctors.

4. We agree that further work is needed before the White Paper on the following issues:

a. what separation of business and patient funds is needed;

b. incentives for GPs to opt for the scheme;

c. the basis of setting budgets;

d. how to ensure the budget holder has sufficient control over his costs to keep within budget;

e. accounting and audit requirements.

5. The Secretary of State believes that these problems are soluble and feels very strongly that the scheme must be included in the White Paper. The Chief Secretary thinks it would be most unwise to confirm a decision to proceed until it has been demonstrated that the scheme is workable and will achieve its objectives.

21 December 1988

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PRIME MINISTER

NHS MEETING

I attach papers for the NHS meeting in case it is possible for one still to be held this side of the weekend. The papers are divided into three folders. The first, on handling the overall presentation, contains Richard Wilson's suggested steering brief for the meeting. As you will see, he suggests first that you look at the overall presentation of the White Paper then go on to the remaining issues of substance.

The Cabinet Office brief in the second folder records the White Paper's sins of omission or commission relative to what has been agreed earlier by the Group. Also in that folder is a note by the Policy Unit which picks up on the issue of GP budgets as the other remaining issue of substance on which Mr Major and Mr Clark have yet to agree, together with short papers from Mr Major on that issue and the Family Planning Service.

The next folder contains the chapters by the territorial Ministers, together with Cabinet Office and Policy Unit briefs. Of these, the Welsh draft is the tricky one which goes off in its own direction on a number of issues. You will want to consider whether to tackle each of these individually as Richard Wilson suggests or to tackle Mr Walker's whole approach head on, as the Policy Unit suggests.

The other missing part of the White Paper is the Treasury contribution on fiscal incentives. You do not need that this side of Christmas but will want the Chancellor to reassure the Group that it will reflect the decisions agreed in July.

You will want to end the meeting with a look at the timetable. You have achieved your aim of putting the pressure on to get

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the review wrapped up in good time. The question is whether, as Richard Wilson hints, you will want to allow an extra week in the New Year to ensure that the drafting and presentation of the White Paper is absolutely right.

DOMINIC MORRIS
21 December 1988

DASARS

SECRET

SCOTTISH OFFICE
WHITEHALL, LONDON SW1A 2AU

21 December 1988

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

Dear Paul,

NHS REVIEW: WHITE PAPER: SCOTLAND

My Secretary of State has asked me to circulate the attached draft chapter (or section) on Scotland for inclusion in the draft White Paper to be considered on 22 December. I should note that, while he is satisfied with the content, Mr Rifkind intends that the style should be sharpened up in the next draft.

I am copying this letter and enclosure to the Private Secretaries to the Chancellor of the Exchequer, the Secretaries of State for Wales, for Northern Ireland, for Health, the Chief Secretary to the Treasury and the Minister of State (Department of Health); to Sir Roy Griffiths, Professor Griffiths and Mr Whitehead in the No. 10 Policy Unit; and to Richard Wilson in the Cabinet Office.

Yours sincerely,

David.

DAVID CRAWLEY
Private Secretary

NHI356F2.063

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NHS REVIEW WHITE PAPER: DRAFT SCOTTISH CHAPTER (20 DECEMBER)

Introduction

1. Scotland enjoys high standards of health care. The proposals in this White Paper will build on these and on a proud tradition of medical and nursing education. Among the achievements published in "The Scottish Health Service" last November were longer life expectancy; fewer still-births; lower rates of peri-natal and infant mortality; more in-patient, day cases and out-patient attendances; increased numbers of patients receiving renal dialysis, kidney transplant operations, and operations to replace joints and treat cataracts. There has been progress too in reducing in-patient waiting lists, increasing care for the elderly in their homes, raising staff numbers and the level of the health service building programme. Total expenditure in the NHS in Scotland has risen 34% in real terms from £1053 million in 1979-80 to a planned £2683 million in 1989-90.

2. Since 1974 the integration within one organisation of all hospital, community and primary care services has been accepted as appropriate for Scotland, given the scale of the NHS and the distribution of population served by each health board. The wide support which this arrangement commands has been confirmed in the Primary Health Care White Paper (Cm 249). The Government will maintain it as the basis on which to introduce in Scotland the improvements set out in this White Paper.

3. The Government's priorities for the Scottish Health Service were recently set out in the Foreword to the Report "Scottish Health Authorities Review of Priorities for the Eighties and Nineties". These are the priorities to which this Review's proposals for improved delivery of services are addressed. They are:

> Services for old people with dementia, both in-patient care in hospitals and domiciliary care in the community;

Care in the community with particular reference to:-

services for elderly people
services for people with a mental handicap
services for poeple who are mentally ill

Health education, prevention of ill health and health promotion encouraging people to be better informed and to take responsibility for their own health and well-being; and

Services for the younger physically disabled

and better management

At the same time acute hospital services require sufficient resources to maintain their present high standards.

4. The means of achieving further improvements in the efficient delivery of health care set out in this White Paper apply fully to Scotland. Scotland will continue to have a high standard of medical care available to all regardless of income; the benefits of greater patient choice, modernised and improved buildings, and equipment; and a service which is responsive to the needs and wishes of individual patients. The necessary changes can be brought about only by giving staff a more satisfying measure of responsibility coupled with clearer accountability for the results they are expected to produce. This applies not only in hospitals but also in the community and family practitioner services which normally provide the first contact patients have with doctors and nurses.

Putting Patients First

5. Chapter 2 sets out the general objectives for better patient care which lie at the heart of this Review. Health boards have already been asked to shorten waiting lists and reduce the time people have to wait for hospital treatment. The funds available for this purpose have been increased over the past two years and up to £7 million will be available in 1989-90. Health Boards will be asked specifically to ensure that:

- services are planned and delivered with the aim of meeting the wishes of patients;

- patients are always treated as valued customers;

- hospitals and clinics provide appointment times that patients can rely on;

- a higher proportion of outpatients see the appropriate consultant on their first visit, rather than a junior doctor;

- attractive information leaflets are provided telling patients what they need to know when first admitted to hospital, including details of what amenities and extra facilities may be available at an extra charge.

Ministers will be considering further the best way to ensure that Boards seek and act on their "customers'" views in the light of a recent management consultants' report on this subject.

6. Responsiveness to the consumer was also a key element in the Primary Health Care White Paper whose detailed implementation is currently being discussed with the professions concerned. Scottish interests are fully represented in these discussions which will result in measures to give consumers more information about family doctors and services to help them exercise a more informed choice.

Central Management of the Health Service in Scotland

7. Following the successful introduction of general management at health board level, the Government's aim is to develop and strengthen the general manager's rôle. This will be done by delegating decision-making for operational matters to the maximum possible extent; with Ministers retaining full responsibility for strategic policy and for ensuring cost-effective use of public money. Delegation downward must be matched by accountability upward. General Managers are already formally accountable for the spending of their Boards. Building on existing monitoring of progress, the Government will introduce an Annual Round of Accountability Reviews and Target-Setting at which each health board will discuss with the Department the Board's performance over the past year and agree targets for the coming year.

8. The central management of the health service in Scotland will continue to rest with the Scottish Home and Health Department, reporting to the Minister for Education and Health and the Secretary of State. But the Government is considering ways of strengthening this central management and supervisory role.

9. The Scottish Health Service Policy Board will however be abolished. Recent experience has shown that the Board has not fulfilled its original purpose. The broad issues of policy can be dealt with more effectively by Ministers directly, seeking advice as necessary, through meetings with representatives of Health Boards and other bodies and through the work of the Scottish Health Service Planning Council.

10. The Government have, however, reviewed the Planning Council machinery for obtaining and disseminating advice on best practice for health service management and clinical care. Following consultation they have concluded that the Planning Council needs to be refashioned to tackle the changing needs of the Health Service. The Secretary of State has therefore decided to replace it with a statutory Advisory Council consisting of individuals who will provide a range of skills and experience and include representation from health service management, the professions, the universities, the private health sector, the staff and other related interests. It will advise the Secretary of State as requested, on the exercise of his Health functions. The Council will also, with his agreement, give advice on good practice to Health Boards, and those delivering health services. Further details of the composition of the new Council and of related advisory bodies for individual health professions will be announced and the necessary legislation prepared in due course.

Future of SHARE

11. Money for the current expenditure of the health service in Scotland, is distributed to the 15 health boards according to a Scottish Health Authorities Revenue Equalisation formula (SHARE). It measures the relative needs of the different areas by weightings for the age and sex structure of the population and its morbidity (as indicated by standardised mortality rates).

12. The Government intend to simplfy the SHARE formula by removing central adjustments for cross-boundary flows. In future "the money will follow the patient", so that wherever patients are examined, tested or treated the board where the patient resides will pay for the work done by the board where the work is carried out. SHARE allocations will continue to reflect relative needs, based on each board's population structure and morbidity, but without any element to take account of work imported or exported across the boundary between boards.

13. This arrangement will require prices to be set for a wide range of hospital and laboratory procedures. To begin with, an indicative tariff, based, for acute hospital procedures, upon the classification of such procedures into diagnosis-related groups (DRGs), may be set centrally but in due course it will be for providers to set their own prices along business lines. The Government will consult interested bodies during 1989 about what modifications to SHARE can be introduced in 1990-1991.

14. Considerable further investment in computers and information technology will be needed in nearly all units to produce patient-based, DRG-classified cost information accurately. Once an accurate information base is provided it may be possible to move away from the SHARE formula altogether and to reimburse providers entirely on the basis of work done rather than needs forecast.

Structure and Role of Health Boards

15. With the introduction of general management the rôle of health boards is changing and their membership should reflect, in size and composition, the kind of changes that are occurring. It will be appropriate for the General Manager to sit on the board alongside a number of external non-executive directors, under the Board's chairman. Such a board might be somewhat smaller than the present range of 14-22 members. The Government will be consulting interested bodies about the details of any such change.

16. Greater emphasis on the rôle of health boards in commissioning, contracting for, and purchasing services from providers (rather than, as now, supplying most services at their own hand) will make it particularly

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valuable to have non-executive directors on boards with business skills and experience.

17. The Government believe that the more active management of the family practitioner services originally proposed in the White Paper "Promoting Better Health" and developed in this White Paper can be carried forward in Scotland by the health boards retaining their responsibility for both the hospital and community health programme and the family practitioner services. The boards will, however, have to adjust their arrangements for managing these services to bring about the changes in accountability and consumer choice proposed in this White Paper.

Self-Governing Hospital Trusts

18. Chapter 4 has set out the Government's proposals for self-governing hospital trusts. The proposals are also relevant to Scotland's interests. In the absence of a regional tier in the Scottish health service, the Scottish Home and Health Department will take responsibility for guiding and supporting hospitals which meet the criteria and are interested towards achieving self-government. Some 30 Scottish hospitals might be regarded as potential candidates in the longer term. But subject to legislation, [two] Scottish major acute hospitals might attain self-governing status by [1992]. The Government will consult interested parties on the criteria for setting up a trust, on the responsibilities of trusts and on the arrangements for managing the process of transition.

Medical Audit

19. The proposals in chapter [ ] for medical audit are fundamental to the principles of the Review. Managers and practitioners need comprehensive and credible outcome data on the treatment of patients in order to assess what they are achieving. A pilot study into avoidable factors in anaesthetic and surgical deaths is proceeding in the Lothian Health Board area, but experience in Lothian over recent years demonstrates how clinicians, in cooperation with one another and with general management, can examine the effectiveness of clinical care and take steps to improve their own performance.

20. In the primary care sector the continuing development of the General Practice Administration System for Scotland (G-PASS) of micro-computer software, issued free to general practitioners, will supply better information about the outcomes of patients' treatment. The software is now in use by general practitioners in all areas. Over a third of practices in Scotland use it to assist with repeat prescribing, patient administration, morbidity recording, call-and-recall of patients for screening or inoculation, as well as audit and research. The next step is to extend G-PASS to all practitioners; and to make sure it fits in easily to the information systems being developed for the hospital service.

GP Practice Budgets

21. The rationale for general practitioners exercising a greater degree of financial responsibility for the total health care of their patients applies with equal force in Scotland. The opportunity of GP practice budgets as discussed in Chapter will therefore be available in Scotland. By virtue of their unified responsibility for family practitioner services as well as hospital services, Health Boards should be well placed to operate such a scheme but they will need adequate information systems for the purpose, as will the GPs. Scottish general practitioners opting for practice budgets will have to demonstrate to the Health Board their capability to manage them. There will be a right of appeal to the Secretary of State against rejection or withdrawal. Those practices which obtain budgets will have the same scope for flexibility between financial years as indicated in Chapter .

22. Taking the criteria indicated above in Chapter , about 60 practices in Scotland will be eligible to opt for GP budgets. This represents 5% of all practices, a lower proportion than in England since list sizes are smaller on average because of the more scattered population. Subject to suitable arrangements being devised with the Health Boards in whose areas they occur, the Government would like to see a number of group practices with GP practice budgets by 1992.

23. An essential ingredient both of clinical audit as applied to general practitioners and of GP budgets will be the feedback of information about prescribing practice and hospital referrals. Machinery already exists for

investigating alleged cases of excessive prescribing and the Government proposes to improve its effectiveness [and extend it to cover referrals as well]. Subject to consultation with the professions, it is proposed that responsibility for conducting these investigations should remain firmly with the appropriate general practitioner committee of the Health Board but consulting the Area Medical Committee for its view on each case rather than using that Committee as its agent for conducting the investigation. By this means a more obviously impartial judgement of each case should be obtained.

24. The emphasis in Chapter on the increased extent to which a general medical practitioner's income will be derived from capitation fees will be reflected in the remuneration of practitioners in Scotland to encourage them to offer a service which will attract patients to their list. The Government appreciates that there will be limitations on that process in the less populated areas, and will consider further the arrangements for these areas. [Fuller detail of how GP practice budgets would be expected to operate in Scottish circumstances will be set out in the discussion document which the Secretary of State will publish as part of the implementation of the Review.]

External Audit

25. The statutory audit of the health boards and other health authorities in Scotland is the responsibility of the Secretary of State. Hitherto the audit has been conducted entirely by the Scottish Office Audit Unit which is not part of the Scottish Home and Health Department but is answerable to the Secretary of State. Recently the audit of two of the health boards has been contracted out to commercial auditors. Both in-house and commercial auditors in the health care field are devoting an increasing proportion of their time to value for money audit in addition to their routine certification audit duties. The Secretary of State has reviewed these arrangements. While he has concluded that they are still appropriate for the present configuration of the health service in Scotland, he would welcome comments on the establishment of statutory audit arrangements which do not form an integral part of the Scottish Office.

The Private Sector

26. Scotland's growing private health sector has 7,000 beds. Most of them give nursing and convalescent care to frail elderly people. In fact, a third of Scotland's long-stay beds are in the private sector. Health Boards already draw on this resource - nearly [1,000] nursing home places are taken by National Health Service patients. Many other residents have their fees paid through Social Security funds. Good nursing homes offer the very elderly - a fast growing group - congenial surroundings, nursing care and a choice of location. The Government expect them to play a big part in our services for the very elderly and, with that in mind, have just made new regulations, to be backed shortly by guidelines of good practice, to promote standards of care.

27. More Scots are looking to the private sector for the diagnosis and treatment of their health problems. The Government want to make this an option for NHS patients too. Over the last year, private hospitals have worked closely with the NHS to tackle waiting lists for operations like hip surgery and this kind of cooperation should continue and expand. With the introduction of GP practice budgets, general practitioners in Scotland should be able to choose, if they wish, to buy operations for their NHS patients directly from private hospitals [or from self governing NHS hospitals]. The results should be shorter waiting lists for operations, and more choice for patients.

28. Medical procedures, like renal dialysis, could also benefit from private sector involvement, and Health Boards in Scotland are already looking at how private companies might help them to provide more, and more convenient, dialysis places.

Concluding Comment

29. [To be drafted]

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PRIME MINISTER

21 December 1988

NHS WHITE PAPER: FIRST DRAFT

CHAPTERS ON SCOTLAND, WALES AND NORTHERN IRELAND

The regional contributions are mixed. Scotland's contribution is too long and general but at least it does focus on the importance of putting patients first and it notes the value of self-governing hospitals and GP budgets. The Welsh paper is extremely tentative and, surprisingly, looks forward to its own full corporate strategy for the NHS in Wales which will be published in 1992. The Northern Ireland paper focusses on management reorganisation only. Actual benefits for patients appear to be minimal.

One worrying theme is emerging from these papers. Self-governing hospitals are only envisaged in areas where there are significant cross-border flows. Consequently, very few self-governing hospitals are anticipated in the less populated territorials.

This is the principle I disagree with

This viewpoint should be tackled head on. Self-governing hospitals could still thrive without significant cross-border flows. Pay flexibility and responsibility over capital will encourage more entrepreneurial management. It is crucial that the three regions set their targets much higher.

The Welsh Paper is of particular concern. The Welsh Office is trying to distance itself from the Review by announcing its intention to present its own strategy review. This is unacceptable: if the Review is to carry credibility with the public it must be seen to benefit the country as a whole. Also the commitment behind self-governance and GP budgets is

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almost non-existent. And paragraph 4 vii inappropriately refers to the need for resolving the community care issue and argues for merging FPCs and DHAs. This paragraph should be excluded.

Extensive redrafting will be required of each paper to bring out the following points which I believe are fundamental:

- Brief summary of past successes. ✓
- The need for change. ✓
- The impact of the reforms on the region (this needs to be more upbeat - especially on self-governing hospitals and GP budgets).
- Summary of main structural changes.

Ian Whitehead

IAN WHITEHEAD

SECRET

PRIME MINISTER

21 DECEMBER 1988

WHITE PAPER: FIRST DRAFT

Overall, this is a good first draft of the White Paper. The theme of improving patient service by devolving responsibility down the line is clearly presented. And GP practice budgets and self-governing hospitals rightly take centre stage in the paper. Chapter 12 gives an excellent summary of the main reforms and benefits.

But there are a number of significant problem areas that will need to be tackled:

- Some chapters are too wordy, require more punch and will need to display greater conviction behind the reforms.

- The rationale behind the changes needs to be more clearly stated (Chapter 2).

- It is essential that more work is done on GP budgets (Chapter 3).

- The distinction between self-governing hospitals (Chapter 4) and DHA-managed hospitals (Chapter 5) should be brought out more clearly.

- The proposed procedure for the medical audit of GP practices is too vague (Chapter 8).

- The draft white paper - and many review papers before it - lack real conviction behind the central role and authority of the NHS Management Board (Chapter 9).

Also, a final decision is required on the proposed tax relief for health insurance payments by the elderly (Chapter 10).

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Chapter 2: Delivering a better service

There needs to be a clearer delineation between the sections on 'the business of caring' (Para 2.5) and 'customer care' (Para 2.13). The similarity of the titles fuels this confusion. Also, the waiting list problem is mentioned after the main reforms have been listed. We need to explain the necessity for the changes before they are discussed in Para 2.8 onwards.

Chapter 3: GP Practice Budgets

The Treasury has reached an impasse with the Department of Health. First, they do not believe in the overall concept of GP budgets. In particular, they remain unconvinced that the benefits outweigh the risk of higher costs. Second, they do not accept that the scheme is workable. I agree with the second point but not the first.

It is essential that the Treasury is not permitted to water down the introduction of GP budgets for a number of reasons:

1. Most of the proposed changes are several steps removed from the patient. They will take time to bite. On the other hand, GP budgets will give patients a greater say.

2. GP budgets will help break the monopoly of districts operating as buyers. Cosy arrangements between districts and hospitals would be challenged.

3. If GP budgets become more limited in scope, their impact will be marginal.

4. The risk of a major increase in expenditure is slight. If all large practices - with over 11,000 patients -

opted out, the total budget for these GPs would be no more than £400 million.

The benefit of GP budgets should outweigh the risks. But the Treasury is right to question the workability of the scheme as proposed by DoH. I have two major concerns:

First, bureaucracy could start burgeoning like a banyan tree. Para 3.12 states:

> 'The Government believes that the fairest and least cumbersome approach is for GP practices within the scheme to negotiate their budgets with the relevant DHA, which will in turn need to consult the practices FPC'.

These tripartite discussions will be a recipe for confusion. Allocation to GP practices should be based upon the same formula as the allocation to the district.

Second, the day-to-day operation of the GP budgets is still unclear - in particular the role of virement in Para 3.9. In my previous note, I suggested that we should treat the GP budget like a 'client account' in a firm of solicitors. The bank balance would be segregated from other GP practice money.

In this way, the operation of the budget is well defined and the benefits are clear. Expenditure could be incurred by the GP practice as follows:

(1) A fee to cover the management and other costs of participating in the scheme (as in Para 3.20).

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(2) Payment for elective surgery from DHA-run hospitals, self-governing hospitals or the private sector.

(3) Payments for minor surgery carried out in the GP practice.

(4) A performance bonus would be paid to each GP (examined in more detail below).

(5) Savings would be retained as a reserve for future years - up to a maximum.

(6) Any surplus would be returned to the Region to be used to offset any shortfalls in other practices or to improve other services.

Many have criticised the concept of a bonus on the basis that GPs will be encouraged to underprovide. Ken Clarke prefers to camouflage the bonus by enabling GPs to plough back 50% of any surplus into improving their practices and offering more and better services to their patients (Para 3.18). Most people will see through this guise as a back-handed payment to the GP.

The political arguments would be countered by making it clear that performance payments will also depend on the result of medical audit and financial audit. More importantly, performance payments will only be paid if GPs pay a surplus back to the Region. This money will be used to improve services elsewhere.

Chapter 4: Self-Governing Hospitals

Para 4.5 — Hospital Trusts

Not in their capacity as councillors

Could local authorities councillors be members of the governing board of a Hospital Trust?

Para 4.14 — Employment of staff

This paragraph states:

'But Hospital Trusts will be free, by agreement with their staff, either to continue to follow national pay agreements or to adopt partly or wholly different arrangements.'

The phrase 'by agreement with their staff' should be taken out. In practice, management would negotiate with staff but we should not state this implicitly.

Para 4.17 — Borrowing capital

As agreed in the last meeting, this paragraph will need to state that Hospital Trusts will have to bid for a proportion of the annual financing limit.

Para 4.20 — Achieving self-government

The first paragraph rightly states that hospitals should have to meet only a few essential conditions to achieve

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self-governing status. So far so good. But the paragraph then goes on to list too many essential conditions.

Chapter 5: Managing the Hospital Service

Para 5.3 Introduction

It should be made clear that DHA-managed hospitals will not have the same flexibility as self-governing hospitals. The statement 'but the Government believes that the same principles should be applied in all hospitals' is unclear and inaccurate.

Para 5.17-18 Cross-border flow will not increase without a strong information technology base.

But I am still sceptical as to whether a nationwide Resource Management Initiative is the best way forward. Local Management should be the driving force behind the introduction of information systems, not central management. The role of the centre is to set minimum criteria and to allocate resources and then to monitor results.

Kenneth Clarke should be asked to report on the results of the RMI so far.

Chapter 6: The Work of Hospital Consultants

Para 6.17 Will consultants still be able to appeal to the Secretary of State? The phrase 'should normally lead to concluding an appeal within nine months of the dismissal' is vague.

Chapter 7: Funding Hospital Services

Figure 7:1 — Graph of Regions distances from RAWP revenue targets.

This looks like a Department of Transport plan for future roadbuilding! It is incomprehensible. The graph should be simplified or perhaps excluded completely.

Para 7.13 — Allocation to DHAs

Kenneth Clarke will need to clarify the meaning of the statement 'such changes must be carefully managed over a period of time'. Will this be RAWP 2?

Para 7.28 — Funding specialist services

The paper proposes 'central funds will cover the fixed costs of the units providing these services with the variable costs covered by contract funding from buyers'.

This will be extremely difficult to operate in practice. What is the exact dividing line between fixed costs and variable costs? Will there be a temptation to abuse the system?

Surely, districts should be responsible for buying specialist services, including fixed and variable costs of managing the services. Why should this system be any different to other health services?

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Chapter 8: Managing the Family Practitioner Services

Para 8.4 Medical Audit

The proposals for medical audit should be tightened up. I have two main concerns.

First, less detailed medical records is no excuse for weaker audit procedures. A central audit procedure - not mentioned in the paper - should be to send a circular by post to patients on the GPs list, eliciting the patients' own views on the quality of service provided by the GP (in confidence).

Second, the effectiveness of the proposed self-audit is unclear. What does self-audit mean? As part of a GPs contract, they should be willing to spend a few days a year on audit in other practices.

Para 8.7 Capitation Fees

This paragraph states that average remuneration of GPs accounted for by capitation fees will be increased 'from 46% to 60%, as soon as possible'.

This is very tentative. Could it be changed to '46% to at least 75%'?

Para 8.18 Composition of FPCs

If we have to keep FPCs separated from DHAs the proposed number of members on an FPC (12) should not exceed that proposed for a DHA (11). Could we limit FPC membership to 10 or 11 members?

Chapter 9: Better Decision-Making

Para 9.6 Composition of health authorities

What does the phrase ' the executive members, who will be co-opted by the non-executive members' actually mean? Co-opted members are usually additional to the core board.

Para 9.9 Central Management of the NHS

One comment is particularly worrying in this paragraph 'The government proposes however to streamline management arrangements with the Department by giving the Board a clear role in major strategic issues'. This statement is extremely unclear.

Surely, the NHS Management Board should be given a clear mandate to manage the health service, not merely to 'deal with day-to-day operational matters' as suggested in this section. The Board should report direct to the Secretary of State, not via a Policy Board, as suggested. I have no doubt that such a Policy Board would be controlled by officials. This would be a recipe for

failure. The NHS Management Board would not gain any real authority and strong business leaders will continue to be unattracted to work in such a confused environment.

Chapter 10: Working with the Private Sector

This chapter will need a lot more attention. It is tentative and poorly written.

Para 10.8 Competitive Tendering

This paragraph stresses the wider scope for competitive tendering, beyond non-clinical support services. But it is far too vague. Specific examples should be given, such as pathology testing and drug management. Also, it should highlight the enormous scope for additional non-clinical support services, as the CBI report shows (Appendix).

Tax relief on health insurance premium in respect of for the elderly

This issue must be finally resolved in the meeting. The arguments for and against tax relief have been well aired. Tax relief would give an immediate stimulus to the private sector. But the actual benefits are difficult to estimate.

On balance, I believe we should incorporate this fiscal stimulus, provided it is also available for families willing to contribute towards the cost of insurance premiums for their elderly parents. This will help diffuse the political problem that we are only giving tax relief to the rich elderly.

K

Chapter 11: Health services in Scotland, Wales and Northern Ireland.

These papers have just been received. Comments will follow later.

Ian Whitehead

IAN WHITEHEAD

Extract from - Report of the CBI - The Competitive Advantage. Appendix.

Extending competition

51 The CBI Task Force agrees with the Treasury's conclusions[18] that:

- the prime objective of competitive tendering should be value for money;
- *all* activities should be examined to assess the scope for competition;
- managers should account for decisions to stay in-house;
- value for money does not always mean the lowest tenders.

52 Though there is now a much greater appreciation of commercial realities in the public sector, the Task Force does not believe this has developed sufficient momentum to carry forward the extension of competition on the scale required. Legislation has so far been the most effective method of extending competition and, while it would be preferable to proceed by co-operation rather than coercion, regrettably this must still be the main way forward. But the approach taken will need to vary between different areas of Government, and the co-operation of individual managers will be an important factor in ensuring success.

The National Health Service

53 At present no central initiative is planned to extend competitive tendering to other activities in the NHS. The three ancillary services at present subject to competition make up only 28% of non-medical support expenditure in hospitals and community care. (Table 9). Services not so far covered include: portering, security, medical records, building maintenance and grounds and garden maintenance. In addition, it is not clear what proportion of capital expenditure, which includes the professional support services of architecture, quantity

[18] 'Using Private Enterprise in Government', HM Treasury, 1986

Table 9
Total spending on hospital and community care services in England, 1986/87

		£ million
Patient care services		6,485
of which:		
Medical, nursing, and dental staff services	4,640	
Supplies, equipment, and services	871	
Medical and para-medical support services	974	
General services		2,902
of which:		
Administration	622	
Medical records	115	
Training and education	58	
Catering	361	
Domestic/cleaning	377	
Laundry	151	
Portering	63	
Linen services	121	
Transport	43	
Estate management:		
engineering maintenance	282	
energy and utility services	264	
building maintenance	153	
ground and gardens	22	
general estate expenses	164	
Miscellaneous	86	
Additional administration costs		435
Capital expenditure		937
Total spending		10,759

Source: Health Authority Annual Accounts, National Summary 1986-7

surveying and law, is open to competition. Consistent application of the principle of competition demands that professional services also be subject to the discipline of specification and outside competition.

54 If competition were extended to all general non-medical services and cost reductions of a similar proportion to those on ancillary services are achieved, the savings would be worth over £350 million. The non-front-line medical services, such as pathology, cervical and cytology screening centres, pharmacies, radiology and radiography departments have also been put forward as candidates for competition. Including these areas could make possible a further £300 million of savings. There is also potential for competition in some clinical services.

55 In view of this great potential, the Task Force recommends that, each year, the NHS central administration should select a range of services which could be opened to competition. These could be piloted in, say, 10 different Health Authorities, which *volunteer* to open the particular services to competitive tendering or contracting out. With successful pilot schemes in existence, compulsory tendering of all authorities would be the logical next step. This step by step approach would utilise the co-operation of local management and alert managers to potential problems and pitfalls. Closer monitoring of competitive tendering will be needed and the Task Force therefore believes that the plan to cease collection of the costs of contracts and the savings on them is a mistake.

Central Government

56 Outside the NHS, the main problem facing central directives is the differing nature of departments' operations. The major 'common-denominator' services of catering, cleaning, security and maintenance have already been designated for compulsory tendering. The Task Force notes the slow progress in tendering for security services and the lack of data on which to assess the proportion of maintenance expenditure which is subject to competition.

57 The Task Force therefore recommends that the principal responsibility for choosing the specific areas to which competition is to be extended should rest with individual departments. Nevertheless, an increasing proportion of running costs should be subject to competition each year and these targets should be set by the Treasury with the aim of covering the majority of all departmental expenditure as soon as is practically possible.

58 Individual departments should develop a 'competitive position', laying out the progress of competitive tendering within their own budget. This should be published as a chapter in the department's Annual Expenditure Report, which will replace Volume II of the Public Expenditure White Paper in January 1989. The 'competitive position' should include:

- the extent of expenditure under different functions which is subject to competitive tendering, plus a target for the next three years;
- an assessment of the savings from competitive tendering, together with an estimate of the costs of the tendering exercise, highlighting any gaps in the market where private sector tenders were not forthcoming;
- properly audited budget out-turns for successful in-house providers compared with their budgeted bids;
- an analysis of the quality of service, drawing on customer survey work and the department's monitoring procedures. The criteria applied should be the same for both in-house provision and private contractors.

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NHS REVIEW

Outstanding Points from Ministerial Group

Other than on capital and pay

Self-governing hospitals

Use of the existing power to set up Special Health Authorities was 'worth considering as a first step' (15th meeting).

The application of end-year flexibility to self-governing hospitals remained to be settled, but there was a strong case for it (15th meeting).

Proposal that representatives of the local community should be on hospital boards 'needed further thought' (13th meeting).

GP practice budgets

Secretary of State to 'revise and develop' his proposals for GP practice budgets in the light of the discussion at the 13th meeting.

Two particular points mentioned in this connection at 13th meeting:

a. There was scope for the inclusion of expenditure on accidents and emergencies.

b. The proposals on overspending and underspending should be 'developed' in the light of the need to ensure that the system was simple and workable.

HC 51, on managing the FPS, said that the Secretary of State was working up separately his proposals on detailed aspects of GP practice budgets.

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Effect of top slicing on GP practice budgets 'needed clarification' (13th meeting). This may drop in view of later developments on top slicing.

Other FPS questions

Secretary of State to prepare a note about timetable for getting information about the proper level of referrals and prescribing, and basing budgets on it (15th meeting).

Secretary of State to 'consider what could be done' on providing incentives to GPs (15th meeting).

Audit

Secretary of State to check that arrangements already agreed would expand Audit Commission's role to cover FPS as well as hospitals (15th meeting).

Reconstituting Health Authorities

'Further thought to be given' to case for giving RHAs guidelines for the exercise of their power to appoint members of DHAs (14th meeting).

Private Sector

The possibility of Government action to ensure that the private sector had adequate medical standards 'should be further considered' (14th meeting).

Number of consultants

HC 49 proposed using some performance funding to provide for more consultant posts. This was also mentioned in HC 58. The proposal was not discussed by the group.

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PRIME MINISTER

NHS REVIEW: DRAFT WHITE PAPER
[HC67: Paper by the Secretary of State for Health]

1. This is a workmanlike first draft but it will need quite a lot of sprucing up before it is ready for publication. You may wish to concentrate on the main points of substance, rather than a line-by-line analysis. Particular points on each chapter are set out below.

CHAPTER 1: FOREWORD

2. The main question on the foreword is whether it strikes the right note and is substantial enough. More than any other part of the White Paper it needs to catch attention. You may feel that the present text, although making roughly the right sort of points, does so without much conviction. You will wish to invite views on this. One possibility might be to say rather more sharply not only that the Government is committed to preserving the NHS and the good things about it but also that there are weaknesses on it, as many patients know, which the Government is determined to put right. Some of the material at the beginning of Chapter 2 might also be brought into the Foreword to demonstrate the Government's commitment to the NHS. There is also the question who should sign the foreword: a decision on this will be needed fairly shortly.

CHAPTER 2: DELIVERING A BETTER SERVICE

3. This is the key chapter which should establish from the outset the rationale for the reforms and how they are all designed ultimately to result in a better service for patients. You may wish to comment on the following:

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1. benefit to patients. You confirmed on 24 November that the White Paper should include a package of practical improvements in the NHS of direct benefit to patients. The White Paper is however rather tentative, with the main description tucked away in paragraph 2.15, beginning "The practical improvements that may often be needed include..." You may feel that these points should be brought forward in the chapter and put more convincingly;

ii. changing doctors. There is no reference in this chapter to improving the procedure for allowing patients to change their GPs although there are proposals in paragraph 8.29. You may want to suggest that there should be some mention of them in this chapter;

iii. waiting lists. The passage on waiting lists in paragraph 2.14 says rather lamely that the problem of waiting lists remains, even though paragraphs 7.31 and 7.32 deal more fully with the position. Here again, the chapter might be strengthened;

iv. Value-for-Money. Improving the NHS is not only a question of making the NHS more businesslike, but also of getting better value for money for the huge sums poured into it. It is not reasonable to expect the taxpayer endlessly to provide more money without some assurance that present expenditure is being properly used. There is no flavour of this in the present text. You may wish to consider whether there should be.

CHAPTER 3: GP PRACTICE BUDGETS

4. This is the chapter with which the Treasury seem likely to be in most disagreement. The central point must be to ensure that the Department of Health have a scheme which will work and that they know the answers to the main questions which are likely to be raised. Points which you may want to test out include the following:

i. accident and emergencies. The Group asked Mr Clarke on 17 October to consider the scope for experimenting with the inclusion of expenditure on accidents and emergencies in budgets. You may wish to ask Mr Clarke what conclusion he has come to;

ii. overspending and underspending. The Group asked Mr Clarke on 17 October to devise simple and workable arrangements for dealing with overspends and underspends. The arrangements outlined in paragraph 3.19 have square brackets round the key numbers. You may wish to ask whether this is backed up with detailed proposals. Is Mr Clarke satisfied that there is no danger of GPs lining their own pockets at the expense of patient care, under the arrangements for ploughing back underspends into the practice? You may wish to ask what will be done about auditing GP practices.

iii. drugs. The text accurately reflects the decision that GP practices which opt to have their own budgets should have a further choice as to whether or not to include prescribing costs in their budget (paragraph 3.10). It has now been decided that all GP practices should have indicative drug budgets. You may wish to ask whether this further option should therefore be dropped. Would it not be better to include prescribing costs in the budgets of all practices which choose to have them?

iv. negotiating budgets. The draft proposes that GP budgets should be settled by a process of negotiation between the practice in question, the Regional Health Authority and the Family Practitioner Committee. This could be a lengthy process, particularly if the FPC wanted to give the practice as small a budget as possible (as they would have every incentive to do). And it would be difficult for the GPs in the practice to know whether they wanted to apply for their own budgets if they had no idea how much money

they were going to get. You may wish to ask whether it is really right to rule out a straightforward formula for setting the budget, so that everyone knew where they stood;

v. aim. The draft says that the Government aims to encourage a substantial number of GP practices to apply to manage their own budgets with effect from April 1991 (paragraph 3.21). Mr Clarke will be asked how many he has in mind. You may wish to ask him what he will say.

CHAPTER 4: SELF-GOVERNING HOSPITALS

5. This chapter explains the Government's proposals on self-governing hospitals. Much of its content has already been thoroughly discussed by the Group. You may wish to concentrate on the following:

i. composition of the board (paragraph 4.5). The Secretary of State was asked to give further thought to a proposal that representatives of the local community should be on the boards of self-governing hospitals. The draft proposes that "at least two" of the five non-executive members should be drawn from the community, for example from the League of Friends, and that they should be appointed by the Regional Health Authority (unlike the other non-executives who will be appointed by the Secretary of State). None will be an employee of the hospital or health authority, or trade union with employees in the NHS or a major contractor or supplier. You may wish to ask why the list of exclusions does not extend to local authorities and all trades unions;

ii. accident and emergency. You may wish the draft to reassure readers that very urgent treatment, for example for accidents, will continue to be available from the nearest hospital. Paragraph 4.10 mentions that the point will be covered in Chapter 7. Should it be covered in this Chapter?

iii. number of self-governing hospitals. The Government will be pressed on how many self-governing hospitals it expects to set up. You may therefore wish there to be a clear and unequivocal commitment on this point. The nearest to this in this chapter is in paragraph 4.23 which refers to the establishment of Trusts. You may wish to ask Mr Clarke what he will say when he is asked how many he has in mind.

iv. role of the regions. There is a reference to the Regional Health Authorities "establishing the precise range of services and facilities" for which self-governing hospitals will be responsible (paragraph 4.22). You may wish to probe what lies behind this. The paragraph refers to RHAs putting forward the formal applications for self-government: is it the intention that they should be the only source of formal applications?

v. closures. The White Paper rules out self-governing status for any hospital which the Secretary of State believes should be closed (paragraph 4.20). You may wish to consider whether this negative note is the right one to strike.

CHAPTER 5: MANAGING THE HOSPITAL SERVICE

6. This chapter brings together a variety of important issues to do with the management of the NHS. The role of the NHS Management Board, slimming down the Regions, devolving management responsibility to hospitals, making better use of staff, introducing information systems, improving pay negotiations, changing the rules on capital (public and private) and extending the role of the Audit Commission: all of these are dealt with here, mostly quite briefly. You might raise the following:

i. accountability to Parliament. At the last meeting you asked that the White Paper should remove from Ministers responsibility for answering detailed questions about pay in

Parliament. Mr Clarke said that this would require legislation and that any reduction in accountability would be controversial. The point was not resolved.

You may wish to consider returning to this important issue in the context of paragraph 5.2. The role of Government is not only to set objectives and priorities, but also to decide how much money the nation can afford for the NHS, to provide financial disciplines to make sure that it is well spent and to monitor performance. Within that framework it is the job of managers to manage. You may wish to discuss whether this should be embodied in legislation. The reference in paragraph 9.8 to Ministers being "fully accountable" to Parliament is also relevant. It seems to imply continuation of the present arrangements;

ii. Resource Management Initiative (paragraphs 5.16 to 5.19). The draft commits the Government to pressing on with the centrally driven RMI, with the aim of extending it to all 260 acute hospitals by the end of 1991/92. In parallel, there will be "regional information strategies" (paragraph 5.19) prepared by May 1989 which will cover all 260 hospitals by March 1993. You may wish to ask how these timetables fit in with the arrangements for setting up self-governing hospitals. Might it not be better to let the hospitals get on quickly with whatever information systems they think they need?

iii. pay. The section on pay is headed "Pay flexibility" but begins with the statement that the Government remains committed to a central framework for pay determination in the NHS (paragraph 5.21) and puts the main paragraph on flexibility, paragraph 5.24, in square brackets. There are no doubt important sensitivities on this. But you may wish to consider whether the text gets the balance right. Does there need to be such a resounding commitment to central negotiation?

CHAPTER 6: THE WORK OF HOSPITAL CONSULTANTS

7. This chapter mainly sets out the decisions taken by the Group on hospital consultants, but you will wish to probe two points where these decisions have been modified:

i. distinction awards. The fourth inset in paragraph 6.20 says that new or increased distinction awards should be pensionable only if a consultant continues working in the NHS for at least three years. The proposal agreed by the Group (set out for example in Mr Clarke's letter of 21 November to the Chancellor) was that awards should only be payable if the consultant continued working for three years. This seems a significant change and you will wish to question it;

ii. eligibility for distinction awards. The first inset in paragraph 6.20 says, as agreed by the Group, that 'C' distinction awards will be replaced by performance related pay, for which eligibility will be jointly decided by general managers and senior doctors. It also refers to "a small number of exceptions" for consultants whose jobs have only a limited management content. We understand that Mr Clarke has in mind medical school staff for example. The reference to exceptions may be justified but it has not been put to the Group before and you may wish to ask about it.

8. There is also an important point on consultants' remuneration. Mr Clarke proposed, and the Group agreed, that where a consultant worked only X sessions a week for the NHS he should be paid only X/11ths of a full-time salary. This is not mentioned. We understand that Mr Clarke may say that it is covered by the general reference to the consultants' job description in paragraph 6.13. But such flexibility in pay arrangements for full-time consultants is unusual, and you might ask whether it would be better to say explicitly that the Government intends to make more use of it.

9. There is also one point on audit. The Group agreed that there should be provision for joint enquiries covering both medical and

management audit in cases where both types of issue are involved. This does not seem to be mentioned and you may wish to ask about its absence.

CHAPTER 7: FUNDING HOSPITAL SERVICES

10. This chapter sets out the new arrangements for funding hospital services, and in the main follows what the Group has agreed. You may however wish to raise the following.

i. RAWP. There appears to be a change in the new system to replace RAWP for allocation to RHAs. HC58, which was agreed by the Group, mentioned a differential of 3% in favour of the Thames regions (paragraph 12). You might ask why the White Paper (paragraph 7.8) now mentions 2%, given that even a 3% differential would have meant losses for the northern Thames regions.

ii. Allocations to districts. No timetable is given in paragraph 7.13 for the new method of allocation to districts. Instead the Government is to discuss implementation with RHAs. This may be right and is not contrary to earlier decisions by the Group, but you may wish to be satisfied that there is no needless uncertainty.

iii. Contracts between buyers and providers. This chapter goes into some detail on the forms of contracts between buyers and hospitals. Paragraph 7.18 for example says that contracts for core services will be based on fixed payments, and paragraph 7.22 that those for elective surgery will be "cost and volume" contracts, with some buying on a case by case basis. You may wish to ask whether it is necessary to go mnto this degree of detail before consultation, when other important topics have been dealt with relatively briefly.

iv. Waiting times. The Group earlier said that the White Paper should give some detail on how a reduction in the waiting list for operations would be achieved. You may wish to consider whether paragraph 7.31 gives enough detail on this important topic.

v. Appointment of more consultants. The draft proposes a scheme for increasing consultant numbers (paragraph 7.32). This was originally the Chancellor's idea but no final decision about it was ever taken. You may wish to confirm that the Group agree to its insertion in the White Paper.

CHAPTER 8. MANAGING THE FAMILY PRACTITIONER SERVICES

11. On medical audit, the White Paper does not contain a clear statement that management, in the form of the FPC, should have access to the general results of medical audits of GPs. The Group attached importance to such access in the case of medical audit in hospitals, and a reference appears in paragraph 6.8. You might ask whether there should be a similarly explicit reference to management access in the case of audit of GPs. Other points which might be raised are:

i. GPs' Pay. Paragraph 8.7 mentions the decision to increase the capitation element in GPs' pay so as to exert downward pressure on numbers. A firm target of 60% is however new and you will wish to consider whether you are content with it. Mr Clarke may want to reconsider it following his meeting yesterday with Mr Major;

ii. control of drugs. The last two sentences of paragraph 8.11 say that the new controls over prescribing costs will do no more than moderate their rise. You may wish to ask whether the White Paper really needs to accept further increases in public expenditure in this area;

iii. change of name. The White Paper also contains (paragraph 8.18) the new proposal that FPCs should be re-named Family Practitioner Authorities. You might ask whether this change of name is necessary.

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CHAPTER 9: BETTER DECISION-MAKING

12. This rather thin chapter deals with the reconstitution of health authorities and the new arrangements for the NHS Management Board. You might raise the following:

i. local authorities. There is a reference in square brackets to consulting local authorities about the appointment of members of District Health Authorities (paragraph 9.6, sixth indent). You will wish to consider whether this should be in;

ii. guidelines for RHAs. On a minor point, Mr Clarke was asked at the 14th meeting to consider further whether to give guidelines to RHAs about how they exercised their power to appoint members of DHAs. You might want to ask what conclusion he has come to;

iii. NHS Management Board. The draft firmly restates the responsibility of Ministers for directing and controlling the NHS. The Secretary of State will chair a Policy Board; the new Chief Executive will run the Management Board. You may wish to ask about membership of the latter. The present Management Board has considerable representation from the Department of Health: will this continue? If there is to be a clear separation between responsibility for strategy and responsibility for management, should not the role of the Department be to concentrate on strategy, and keep out of management?

CHAPTER 10: WORKING WITH THE PRIVATE SECTOR

13. This chapter seems very thin. Two points arise:

i. can it be strengthened? You may wish to ask Mr Clarke to consider whether it could be made more specific. For instance, the Group has agreed that the Government should encourage local initiatives on competitive tendering for such clinical services as pathology: is there any reason why this cannot be mentioned specifically?

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ii. tax. The weakness of the chapter makes it all the more important to include some reference to the decisions on tax agreed in July. The Chancellor may still be considering coming back to you on them: we do not know. You may simply wish to ask him where the Treasury passage is, and how he plans to handle the announcement. The best course might be a Parliamentary Answer by the Chancellor in parallel with publication of the White Paper which would include a short passage on what is proposed.

CHAPTER 11: HEALTH SERVICES IN SCOTLAND, WALES AND NORTHERN IRELAND

14. See separate brief.

CHAPTER 12: SUMMARY AND TIMETABLE FOR CHANGE

15. It may be best to come back to this chapter when the rest of the White Paper has been polished. It is not completely clear what purpose the chapter serves. In particular the introduction appears to duplicate the foreword and some of the early chapters; and the timetable seems sketchy (eg it makes no reference to the Audit Commission or medical audit, or to the new funding arrangements). You may wish to ask Mr Clarke to have another look at it.

RTJW

R T J WILSON
Cabinet Office
21 December 1988

SECRET

P 03315

PRIME MINISTER

NHS REVIEW

WHITE PAPER: FIRST DRAFT

[HC67: paper by the Secretary of State for Health]

1. Before discussing the White Paper, you may wish to begin by asking Mr Clarke to report the outcome of his discussions with the Chief Secretary on the Family Practitioner Service. We understand that the two Ministers will be circulating later today joint notes, not yet seen, covering:

i. indicative drug budgets for GPs on which they are now agreed;

ii. controls over GP numbers on which they are also agreed;

iii. budgets for large GP practices on which they are not agreed. The Treasury still have reservations about both principle and practicability.

2. Next, you may wish to consider the text of the draft White Paper. It is a first draft, and will need quite a bit of polishing and sprucing up - preferably with a professional touch - before being ready for publication. The best approach at this stage may be to avoid detailed line-by-line discussion but concentrate on:

i. general presentation. In particular you may wish to consider whether the text brings out adequately and convincingly the main themes and rationale for the reform, especially the benefit to patients;

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ii. substance. You will wish to be satisfied that the text accurately reflects the Group's decisions and thinking and that nothing important has been left out. We will provide you with a brief which draws out particular points which you may wish to consider, chapter by chapter. You may find it helpful to have the attached checklist of outstanding points which the Group remitted to Mr Clarke at various meetings;

iii. missing passages. There are two important passages missing from the text. One is the Treasury contribution on tax relief in chapter 10.8: it is conceivable that the Chancellor may wish to come back to you on the decisions taken in July. The other is Chapter 11 on Scotland, Wales and Northern Ireland: the three Secretaries of State are circulating their contributions separately (Scotland not yet received).

now available. PRCG.

3. More generally on the White Paper, you may wish to ask Mr Clarke about his plans on presentation. Particular points are:

i. title. We do not know what titles Mr Clarke has in mind. If you wanted to suggest some, possibilities might be:

Serving the patient
A better NHS
A better service for patients.

ii. cover and illustrations. These will now need to be brought forward rapidly;

iii. other publications. You may wish to ask what other publications Mr Clarke plans to issue at the same time as the White Paper. We understand that he is preparing to issue one or more 'popular' versions of the White Paper. The text also refers in paragraph 6.7 to the simultaneous publication of a consultation document on medical audit. Will all these other documents be ready? Are there any others?

Consultation document on medical audit

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iv. speeches and visits. Mr Clarke is probably planning a concerted campaign of speeches and/or visits to accompany publication of the White Paper. You may wish to ask about his plans.

4. Finally, there is the timetable. This is as follows:

Thursday 5 January	-	a further meeting of the Group is pencilled into your diary.
Friday 6 January	-	Mr Clarke circulates the White Paper to E(A).
Tuesday 10 January	-	we have arranged a meeting of E(A).
Thursday 12 January	-	discussion in Cabinet.
Tuesday 17 January	-	publication of White Paper.

This timetable is very tight. In particular it means that the Group will have relatively little chance to make a further contribution to the drafting of the White Paper at its meeting on 5 January, since Mr Clarke will have to circulate it to E(A) the next day. (If you wanted to allow another week, it would still be possible to publish the White Paper before the anniversary of your interview on Panorama.)

RTJW.

R T J WILSON
Cabinet Office
21 December 1988

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P 03318

PRIME MINISTER

NHS REVIEW
TREATMENT OF SCOTLAND, WALES AND NORTHERN IRELAND IN WHITE PAPER

Mr Walker, Mr Rifkind and Mr King have circulated draft sections on their territories. In considering them the Group will want to ensure that there is reasonable consistency of both style and substance.

TREATMENT IN WHITE PAPER

2. The first question to decide is how the material on Scotland, Wales and Northern Ireland should be organised. The three possibilities are:

i. no separate treatment for the territories, but where there are differences the insertion of suitable references in the subject chapters;

ii. a separate section in a UK White Paper;

iii. separate White Papers on each of the territories.

The argument against i. is that many of the detailed differences between the territories would considerably complicate drafting and presentation. The argument against iii. is that it goes too far towards recognising Scotland, Wales and Northern Ireland as different. Mr Clarke's outline, and the contributions from the territorial Ministers, therefore assume separate sections in a UK White Paper. Subject to the discussion, you may wish to endorse that.

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3. There is still a choice between one Chapter covering all three territories, and three chapters, one for each. Mr Clarke's outline assumes only one chapter, and you may feel that for the territories to have three chapters out of 14 would be to give them disproportionate importance.

4. If however, there is to be only one chapter covering all three territories, the Scottish section at least seems too long. It alone contains 29 paragraphs, compared with around 20-30 paragraphs for each of the other chapters. The Welsh chapter is also rather long by this standard. In any rewriting, you might set a target of around 10 paragraphs for each of the territorial sections.

WALES

5. The two biggest initiatives in the White Paper are self-governing hospitals and GP practice budgets. The draft Welsh section mentions both, but without enthusiasm.

i. On self-governing hospitals, it says that "it may be possible" for some to become self-governing "in due course" where this is compatible with the need to provide adequate services (paragraph 4i). Mr Walker argues that there is less scope for competition in Wales than in England, and this is probably right. But you may wish to ask if there could be a more positive tone in the section on self-governing hospitals and whether a more definite timetable for a move towards self-government could be set, if only for a small number. The Scottish section has such a timetable.

ii. On GP practice budgets, the section says that they will be extended to Wales as various initiatives take effect, including the provision of information about waiting lists and costs by 1992 (paragraph 4v). The English chapter says that the Government hopes a "substantial number" of GP practices will apply to join the scheme by April 1991. You may wish to ask if there could be a similar timetable for Wales.

6. Paragraph 4(iii) promises to publish a "wider programme of quality assurance" in Wales in 1989. The group rejected a rather similar proposal for England, and you may wish to ask Mr Walker more of what he has in mind here.

7. Paragraph 4(vii) says that there are "strong arguments" in Wales for bringing together the hospitals and FPS "under common management and leadership". Merger of FPCs and DHAs has of course been rejected for England, although FPCs will become answerable to RHAs. You may wish to ask Mr Clarke's view on this reference in the Welsh section.

8. Paragraph (vii) also says that the Welsh Secretary is considering Sir Roy Griffiths' report on community care. The White Paper will not of course contain any proposals in this area and the Griffiths report is not otherwise mentioned. You may wish to ask if the group see any disadvantage in mentioning this subject in the Welsh section.

SCOTLAND

9. Mr Rifkind's references to the two major initiatives of self-governing hospitals and GP practice budgets are more positive than Mr Walker's, but you may wish to ask two questions about GP practice budgets:

i. The draft says that the Government would like to see a number of group practices with GP budgets by 1992 (paragraph 22). For England the target is a substantial number by 1991. Accepting that fewer practices will be eligible in Scotland because list sizes are smaller, why should the timetable for the first practice budgets be slower in Scotland than in England?

ii. The draft refers (paragraph 24) to the special problems of the less populated areas in Scotland and promises a special discussion document on implementation in Scotland. You will wish to be satisfied that this separate treatment for Scotland is desirable.

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10. The proposals for Scotland are however more obviously different where they deal with management organisations. There are some references in the draft which might be questioned:

a. Paragraph 8 says that the Government is "considering ways of strengthening the central management and supervisory role" of the Scottish Home and Health Department. This seems at odds with the English policy of taking the Government out of management.

b. Paragraph 9 says that the Scottish Health Policy Board will be abolished, whereas Mr Walker intends to keep the Health Policy Board in Wales (paragraph 3 of the Welsh section).

c. Mr Rifkind proposes (paragraph 10) to set up a new quango, a statutory Advisory Council, to advise the Secretary of State on the exercise of his health functions.

11. You will probably not want to get involved in the details of the Scottish structure, but you may want to ensure that it will reflect the basic distinction, settled for England, between strategy, which is decided by Government and management, with which Government will not interfere. In England there will be a two-tier board to reflect this distinction. Why not in Scotland?

12. Paragraph 15 is also less definite than the corresponding English chapter (Chapter 9) about the composition of the Boards of the Health Authorities. It leaves the number of members open and promises, unlike the English chapter, to consult outside bodies about the "details". You might wish to probe this apparent difference between England and Scotland.

13. Paragraph 25 says that the audit of the health authorities in Scotland will continue in the main to be the responsibility of the Scottish Office, although the Secretary of State would welcome comments on establishing separate statutory arrangements. You may wish to ask whether the Treasury are content.

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NORTHERN IRELAND

14. The draft section on Northern Ireland gives rise to fewer questions. But paragraph 10.12 says that, while District Council nominees will no longer save on the health boards, they "will be given a stronger voice in an advisory and consultative capacity". There will be new advisory Committees with representatives from the District Councils. Mr King referred to this proposal in his minute to you of 14 December, and believes it to be justified by the special difficulties of encouraging local democracy in Northern Ireland. But you may wish to probe an arrangement which gives local authorities a stronger voice, even though only in an advisory capacity, might be used as a precedent in Great Britain

RTJW.

R T J WILSON
Cabinet Office
21 December 1988

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Copy 29 of 17

cc R Wilson

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FROM THE PRIVATE SECRETARY
TO THE SECRETARY OF STATE
FOR WALES

20 December 1988

Dear Paul.

NHS REVIEW: WHITE PAPER: WALES

My Secretary of State has asked me to circulate the attached draft chapter/section on Wales for inclusion in the draft White Paper to be considered on 22 December.

I am copying this letter and enclosure to the Private Secretaries to the Chancellor of the Exchequer, the Secretary of State for Northern Ireland, the Secretary of State for Health, the Secretary of State for Scotland, the Chief Secretary to the Treasury, and the Minister of State (Department of Health); to Sir Roy Griffiths, Professor Griffiths and Mr Whitehead in the No 10 Policy Unit; and to Richard Wilson in the Cabinet Office.

Yours ever.

S R WILLIAMS

Paul Gray Esq
Private Secretary
10 Downing Street
SW1

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DRAFT OF WELSH CHAPTER FOR NHS REVIEW WHITE PAPER

Introduction

1. There are distinctive health care needs and circumstances in Wales. This [Chapter/Section] describes these and the proposed programme of action for the Principality.

2. There is no regional health authority in Wales. Some of the functions of the regional health authorities in England - such as the holding of medical consultants' contracts - are the responsibility of district health authorities in the Principality. Others are carried out on authorities' behalf by the Welsh Health Common Services Authority (WHCSA), and there is the special remit of the Health Promotion Authority for Wales, which works in co-operation with the DHAs and other interests, to ensure that ill health is prevented and better health promoted.

3. Other regional functions, such as determining the capacity, location and funding of regional services (such as renal dialysis), resource allocation, regional manpower planning, and strategic investment in information systems and technologies, are the direct responsibility of the NHS Directorate. The NHS in Wales works under the strategic direction of the Health Policy Board, which is chaired by the Secretary of State. An Executive Committee of the Board is led by the Director of the NHS in Wales and is responsible for carrying into effect the decisions of the Board. The Director is also the Chairman of WHCSA. These arrangements, which were introduced following the NHS management inquiry of 1983, have proved their worth and will continue. They will be focussed to ensure the delivery of the programme of action described in this [Chapter/Section]. A full corporate strategy for the NHS in Wales will be published in 1992.

Putting the patient first: the programme for action

4. i. Increased autonomy for hospitals - The introduction of general management at all levels of the NHS in Wales has already brought a significantly improved focus on quality of care

/and cost

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and cost effectiveness. Unit general managers have been appointed to run hospital and community services at local level and given clear responsibility, working in co-operation with medical, nursing and professional staffs, for budgets and results. Wales is in the vanguard of the UK-wide drive to introduce the information systems and technologies which are needed to show what medical treatments cost.

There are 17 major acute hospitals in Wales, ie with 250 or more beds, but only three of these are within five miles of each other and the scope for direct competition is more limited than in some other parts of the United Kingdom. Many of these hospitals serve widely dispersed populations and are, in effect, monopoly suppliers of hospital care. This limits the extent to which they can become self-governing. Nonetheless, there is a need to continue to develop their managerial autonomy and to place direct responsibility on hospital managements and clinical staffs for the services they provide. These major hospitals - and increasingly other hospitals and management units in Wales - will move as quickly as possible to a position where they are, in effect, contracted to provide a given level, range and quality of services. As a result of this process, it may be possible for some hospitals to become self-governing in due course, where they show clearly their capacity to become independent of their district health authorities, and where this is fully compatible with the authorities' continuing need to provide an adequate range and depth of services for their local populations.

ii. An open market in health care - These changes in the management of hospitals will take place against a wider background of the creation of an open market in health care.

Private sector hospital care is relatively poorly developed in Wales, with just 215 in-patient beds. And there are just 52 pay beds in NHS hospitals. These facilities will need to expand to increase patient choice.

/Health authorities

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Health authorities in Wales have begun to purchase private sector care where this represents the best deal for patients. These initiatives will be built on to lead a sustained drive to reduce waiting times. Special consideration will be given to the establishment of a central treatment centre or centres to ensure the rapid turn-round of cases, with direct referrals by GPs for key disabling conditions where waiting times are too long, such as hip and knee replacements, cataracts, varicose veins and hernias.

The drive to open up the market in health care for the benefit of patients will be supported and encouraged by the changes in the way in which resources are allocated. Detailed proposals, based on the movement of money with the patient, will be the subject of consultation, so that hospitals which are efficient and effective, and attract more work, get the resources they need.

iii. Assuring quality of care - The Welsh Office will work jointly with the other UK Health Departments and the professions to introduce as rapidly as possible a comprehensive system of medical audit. There will be close working with the professions and the representative bodies in Wales to build on the work which has already been done, for instance to develop protocols for particular treatments. The proposals for a wider programme of quality assurance, covering acute care and other services, will be published in 1989. These will include better ways to take account of patients' views in the development of services.

iv. Closer involvement of doctors in management - Wales is well advanced in developing the role of clinicians in management, in particular through the pilot resource management project and the development of costings for individual treatments. This work will be accelerated, so that the information systems to enable doctors to work with general managers and ensure the most cost-effective use of resources are in place throughout Wales by 1992.

/Developing

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v. Developing the role of the GP - The NHS in Wales has taken the lead in securing the closer involvement of GPs in the planning and development of hospital services, through an experiment under which the decisions of GPs about where patients receive hospital treatment will be reflected in the DHA's planning and budgeting. The results will be used to extend the influence of GPs in such decisions across Wales.

There is already a sustained drive to equip GPs with the management systems and technologies they need to make effective referrals to hospital services. The central elements are information about waiting lists, waiting times and the costs of treatment. This programme will be accelerated so that by 1992 all GPs in Wales have up-to-date information on which to base their decisions. As these initiatives take effect, and as GPs are able to demonstrate their management capacity in these new ways, the programme to enable GPs to hold budgets for their expenditure, and those of key areas of hospital services, will be extended to Wales.

vi. Promoting better health - There is far too much avoidable illness and premature death in Wales. Levels of coronary heart disease, strokes and most forms of cancer are significantly higher in Wales than on average in the United Kingdom. A sustained drive to tackle these problems is central to the future of a prosperous Wales. The Secretary of State has set up the Health Promotion Authority for Wales to lead this drive, building on the success of Heartbeat Wales. Detailed proposals for action will be published later this year.

figures?

vii. The health authorities - Health authority memberships will be reconstructed with the creation of new style boards on which the non-executive members, including the Chairman, will be appointed by the Secretary of State. There will be a strong emphasis in these appointments on leadership and top level management qualities. The Secretary of State

/will continue

will continue to appoint one member to each authority in Wales as a representative of the University of Wales College of Medicine. The executive directors of the board will include the district general manager and the medical, nursing and finance directors. The non-executive directors will form a majority.

The new boards will sharpen the focus on the delivery of cost-effective services and the quality of care, through the development of the DHA's role as enablers and purchasers of services, rather than simply as direct providers.

There are strong arguments, in the circumstances of Wales, to bring the hospital and community services (currently the responsibility of the district health authorities) and the family practitioner services (currently the responsibility of the FPCs) under common management and leadership. The Secretary of State will publish proposals for the future management of these services in the light of his wider consideration of future arrangements for the development of community care, which he is considering in the light of Sir Roy Griffiths' report on the public financing of community care in England.

viii. The consumer voice - There are 22 community health councils (CHCs) in Wales. Their memberships come from the voluntary sector, the local authorities, and by direct appointment by the Secretary of State. In the light of the new style boards of DHAs, there is a strong case for there being one CHC for each DHA area, to represent the consumer voice in a clear and more focussed way. The Secretary of State will publish proposals along these lines for consultation.

ix. All of these proposals are aimed to secure better patient care and to see that the maximum benefit is obtained from the large resources that will be available. To help authorities achieve targets for cost improvement programmes and the generation of income, a value for money unit will be set up under the NHS Directorate.

From: THE PRIVATE SECRETARY

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cc R Wilson a-f

NORTHERN IRELAND OFFICE
WHITEHALL
LONDON SW1A 2AZ

Paul Gray Esq
10 Downing Street
LONDON
SW1

20 December 1988

Dear Paul

NHS REVIEW

I attach a draft section on Northern Ireland to Chapter 10 of the White Paper.

The draft does not recap the conclusions of the White Paper. It only addresses distinctive Northern Ireland issues, which largely reflect the contents of my Secretary of State's recent minute to the Prime Minister.

The draft section has been prepared without sight of the full draft White Paper. It may therefore be necessary to amend it when the full text is available. In particular my Secretary of State would wish to ensure, as far as possible, the contributions from Scotland, Wales and Northern Ireland are broadly consistent in terms of both content and length.

I am copying this letter and enclosures to Alex Allan, Andy McKeown, David Crawley, Stephen Williams, Carys Evans, Mary Grafton, Sir Roy Griffiths in the Department of Health, Professor Griffiths and Mr Whitehead in the No. 10 Policy Unit and to Mr Wilson in the Cabinet Office.

Yours sincerely

Mike Maxwell

M T H MAXWELL

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CHAPTER 10: HEALTH SERVICE IN SCOTLAND, WALES AND NORTHERN IRELAND

NORTHERN IRELAND

Introduction

10.1 The Government is determined to provide in Northern Ireland cost-effective health services responsive to the needs of patients. It intends the more productive use of resources to speed up the achievement of the objectives in its regional strategy. These are to encourage people to improve their own health, to streamline acute hospital services and to develop care in the community.

10.2 In Northern Ireland, health and personal social services are managed by four Health and Social Services Boards. The Department of Health and Social Services is responsible at regional level for policy, strategic planning and resource allocation. These arrangements have brought real advantages to the joint planning and delivery of services. The Government intends to build upon these by further improving the quality of care and concentrating on management performance.

10.3 As elsewhere in the United Kingdom, service to the customer will be enhanced and competition encouraged. Customers will be informed by the publication of guides to the services available in individual hospitals and GP practices, including such details as expected waiting times for first appointments, diagnostic tests and inpatient treatment, and the availability of optional extras. Better co-ordination of hospital and community services will also

result in a higher quality of individual care. The Government's principal objective is to show real improvements in service for every patient. The Department also calls the Boards to account for their plans and expenditure.

More Effective Management

10.4 There have been General Managers in the Boards at area level since 1985, while Units are still managed by Unit of Management Groups. Boards have recently completed detailed management audits which show that further decision making should be pushed down to the local level.

10.5 The Government believes that management at local level would now support, and to be fully effective requires, the appointment of Unit General Managers in major acute hospitals. These complex institutions increasingly need a management focus capable of securing the co-operation and support of the various professional groups on whom the successful implementation of effective change depends. Similarly, within the psychiatric field the process of change from institutional to community care needs more effective leadership. Community services, including the social services, are delivered on a highly localised basis. Their management therefore does not face the same problems as occur in large and complex institutions. No change will be made in their management in advance of decisions on the organisation of community care nationally.

10.6 Boards will now be asked to review their structures and to submit proposals on these lines.

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10.7 The Government welcomes the increasing willingness of hospital consultants to assume managerial responsibility. The Government is providing financial and technical support for resources management initiatives under way at the Royal Victoria and Tyrone County Hospitals, and wishes to see such systems spread across all the major hospitals. The Government will continue to support a programme of computerisation in general practice, which will also contribute to more cost-effective services.

Self Governing Hospitals

10.8 The introduction of Unit General Managers in major acute hospitals will facilitate progress towards self-governing status for a small number of hospitals. Since self-governing hospital will have to compete for business, only hospitals in the Belfast area are likely to be candidates for self-governing status. The same conditions for self-governing status will apply as elsewhere in the United Kingdom. This will include an effective management structure, involving senior professional staff. Improved information systems for both management and clinical purposes will be required. Self-governing hospitals will continue to provide basic services to their local population with appropriate linkages to services in the community. They will also undertake necessary teaching and research activities. Effective safeguards will prevent any self-governing hospital abusing its position as monopoly supplier.

10.9 Meanwhile the Government believes that the management of the major Belfast teaching hospitals requires to be brought together and strengthen to ensure their complementary

working. It therefore supports proposals for a unified management structure for these hospitals within the Eastern Board.

GP Practice Budgets and Service

10.10 There are few GP practices in Northern Ireland large enough to opt for a practice budget. Nonetheless the Government is keen to explore the potential for opting-out including the need for better information systems. Training programmes will be developed for GP practices which wish to opt out.

10.11 In parallel, the Government will continue with its existing initiatives to improve primary care services in the Province. These include the greater involvement of GPs in the delivery of co-ordinated community health and social services and more cost-effective and economical prescribing.

Membership of Health and Social Services Boards

10.12 Boards will be reconstituted as management bodies on similar lines to NHS authorities in Great Britain. District Council nominees will no longer serve on the Boards, but will be given a stronger voice in an advisory and consultative capacity. The present District Committees have a limited remit and a highly localised focus. The Government intends to replace them by a Committee relating to each Board, with stronger advisory and consultative powers and representation from District Councils and voluntary interests.

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Financial Management

10.13 The Government intends to replace the present PARR formula for the allocation of revenue resources by a simpler capitation-based formula, as in Great Britain. The adoption of the new formula will require better and more timely information on the extent and cost of treating patients from other Boards' areas.

10.14 The Government intends to strengthen existing arrangements for the external audit of the health and personal social services, including the greater use of the private sector.

CONFIDENTIAL

From: R T J Wilson
20 December 1988

P 03314

MR BEARPARK

NHS REVIEW

1. I understand that Mr Clarke and Mr Major are now both of the view that a meeting tomorrow afternoon is not necessary. They have had a lengthy meeting today on outstanding NHS issues and, I gather, will be circulating two notes in the course of tomorrow.

2. The first will set out the substantial agreement which the two Ministers have reached on outstanding issues on the Family Practitioner Service. In particular, they have come to an agreement on indicative drug budgets for GPs which will include a clear policing mechanism to deal with those GPs who overspend their budgets. And they have also devised an approach on controlling GP numbers which puts an increasing emphasis on the capitation element in GP remuneration. The Secretary of State would take reserve powers to control numbers but the aim would be to move to a position where practice allowances were eventually targeted on those areas where they were most needed (eg inner cities) and GPs would otherwise be primarily rewarded through their basic capitation. All this is hearsay but, if it is correct, is a significant advance.

3. The second note will deal with budgets for large GP practices on which there is clearly still disagreement between Mr Clarke and the Treasury. I gather (from the Treasury) that at today's discussion Mr Clarke acknowledged that more work still needed to be done on a number of practical issues which the Treasury raised. One key aspect is propriety and the need to

ensure that GPs are not able to line their own pockets at the expense of patient care. But here again I think it would be sensible to wait and see what the note says.

5. The Prime Minister may wish to begin the meeting on Thursday with, say, twenty minutes or half an hour on these points and we will brief accordingly. But in the meantime you may wish to consider cancelling tomorrow's provisional meeting which Mr Clarke and Mr Major do not think is needed.

RTJW

R T J WILSON

file

PRIME MINISTER

Richard Wilson's note reports the outcome of this afternoon's meeting between Mr. Clarke and John Major. They have made significant progress on the Family Practitioner Service issues though there is still some further thinking to be done on budgets for large GP practices.

We had pencilled in an extra meeting of the Group for tomorrow afternoon, in case there were still major outstanding policy issues. You will see that Ken Clark and John Major do not now think that tomorrow's meeting is needed. Richard Wilson shares that view.

Content for us to cancel? Yes

If we can get the papers across in time you could use tomorrow afternoon's slot to read up in advance of Thursday's main meeting since you have a fairly full set of engagements tomorrow night. We have set aside 2 hours on Thursday for the meeting.

Patricia D. Parker
Diary clerk.

D. C. B. MORRIS

20 DECEMBER 1988

MRMABL

Seen by PM

[redacted]

DEPARTMENT OF HEALTH ~~AND SOCIAL SECURITY~~

Richmond House, 79 Whitehall, London SW1A 2NS

Telephone 01-210 3000

a-Liii

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

COVERING SECRET

Paul Gray Esq
10 Downing Street
LONDON
SW1

20 December 1988

Dear Paul

NHS REVIEW

I attach a draft of the White Paper for discussion at Thursday's meeting of the Ministerial Group.

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

Yours

Andy

A J McKEON

SECRET

Copy No: 1

HC67

NHS Review

WHITE PAPER: FIRST DRAFT

1. Attached for the Ministerial Group's consideration on 22 December is a first draft of the White Paper, together with the current outline.

2. The draft includes revised versions of the three chapters circulated by the Secretary of State for Health under cover of HC62. The only chapter missing is that on health services in Scotland, Wales and Northern Ireland: the Health Departments concerned are circulating their contributions separately.

20 December 1988

Dept. of Health

B:DC7.10/40

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WHITE PAPER: SUGGESTED OUTLINE

Chapter 1: Foreword

Chapter 2: Delivering a better service

Chapter 3: GP practice budgets

Chapter 4: Self-governing hospitals

Chapter 5: Managing the hospital service

Chapter 6: The work of hospital consultants

Chapter 7: Funding hospital services

Chapter 8: Managing the family practitioner services

Chapter 9: Better decision making

Chapter 10: Working with the private sector

Chapter 11: Health services in Scotland, Wales and Northern Ireland

Chapter 12: Summary and timetable for change

B:DC7.7/40

SECRET

Draft (20.12.88)

CHAPTER 1: FOREWORD

1.1 This White Paper explains how the Government plans to reform, strengthen and revitalize the National Health Service to make it fit for the 1990s and beyond.

1.2 Underlying everything we propose is a simple aim - a service that puts patients first. To achieve that, we must build on all that is best in the NHS, while standing by the principles on which it was founded. Our Health Service must continue to be available to all, regardless of income, free at the point of delivery, and financed out of general taxation. The society it serves today, however, is very different from that of the 1940s when it was created. Nowadays, we all quite rightly expect better service, higher quality, more choice. It is to those ends that this White Paper is directed.

1.3 To deliver the highest standards of care that we all want the NHS must be run more efficiently. In this respect, it is just like other businesses. Like them, it will benefit from stronger and more flexible management. The spur of competition will sharpen its performance. The quality of its service will be improved if it listens to what its customers want. Greater efficiency is the key to a better, more caring service for patients.

1.4 Change on the scale we propose is never easy. Nor will it happen overnight, for we must be certain that the new, modern NHS has strong and secure foundations. It will require huge effort and commitment from management and staff. I am confident that those who serve the NHS will make that commitment on behalf of those who use it.

Draft (20.12.88)

CHAPTER 2: DELIVERING A BETTER SERVICE

Introduction

2.1 The NHS has an enviable record of success. Since it was established in 1948 it has played a major part in improving the nation's health. Immunisation and vaccination have virtually wiped out previously common diseases such as diphtheria and poliomyelitis. Perinatal mortality has fallen by three-quarters since 1948, and maternal mortality is down to 5% of its 1948 level. Medical advances have meant that people not only live longer but can enjoy a better quality of life. Transplant surgery, for example, is now commonplace, and it has become possible to carry out hip replacements for people in their seventies and eighties. The introduction of antibiotics has revolutionised the treatment of many diseases.

2.2 The NHS itself has grown out of all recognition. Its total gross expenditure in the UK has increased from £433 million in 1949 to nearly £24 billion in 1988/89, a fourfold increase in real terms. In England and Wales the number of hospital doctors and dentists has grown from 12,000 in 1949 to 40,000 in 1986, and the number of nurses and midwives from 147,000 to 403,000. NHS staff now care for nearly 4 million more in-patient cases than their counterparts in 1949.

2.3. Progress has been even faster in recent years. The service is treating 1½ million more in-patients, 4 million more out-patients and over half a million more day cases than it was a mere ten years ago. Improved productivity and a substantial increase in the money provided by Government have made this huge stride forward possible. The NHS now employs 15,000 more doctors and dentists and 70,000 more nurses than it did in 1978.

2.4 But although medical advance has been spectacular since 1948, the organisation that provides that care has not developed at the same rate. That is why the Government announced early in 1988 that it was undertaking a thorough review of the NHS. This announcement has in turn stimulated a wide-ranging debate. Many people share the Government's view that now is the time to bring the Health Service up to date.

The business of caring

2.5 Experience shows that direct, central government intervention and control is not the most effective way of delivering the services that customers want. By the same token, it is not the best way to deliver services for patients. It is essential that those whose job it is to meet the changing needs and wishes of those patients have the authority, flexibility and incentive to innovate and adapt.

2.6 Whilst remaining unique, the NHS must be run more like other businesses. The best businesses are geared to putting their customers first. They also know that their customers will get a proper service only if the unseen parts of the organisation are working well - if resources are properly managed; if talented people are found and given their head; if everyone working for the organisation is encouraged to give of their best, and rewarded for doing so.

2.7 Making the NHS more business-like will not make it less caring. It will mean that it can deliver better care and more care to more people than every before.

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Competition and choice

Scottish paper

2.8 Doctors, nurses, managers and others who work in the NHS are committed to improving services for patients, and know how to do so. But they are often held back by the rigid way in which the service is presently organised and financed. The Government intends to free up the system by introducing more competition and more choice.

2.9 The most fundamental reforms proposed in this White Paper are directed to this end. In particular:

* large GP practices will be able to apply to have their own budgets for buying a range of services direct from hospitals. This will enable GPs and their patients to back their own choices with money, and the size of each practice's budget will depend on how many patients its GPs attract. GPs will be encouraged to compete for patients by offering better services. Hospitals will be encouraged to compete for the custom of GPs.

* hospitals will be given much more responsibility for running their own affairs. Major hospitals will be able to apply for self-governing status within the NHS. This means that they will be free, for example, to set the rates of pay of their own staff and, within annual financing limits, to borrow capital. They will be free to sell their services to other parts of the NHS, to the private sector and to patients. Because they will have an incentive to attract more patients, they will want to make sure that the service they offer is what their patients are looking for.

* funding arrangements will be changed so that each health authority's duty will be to buy the best service it can

from its own hospitals, from other authorities' hospitals, from self-governing hospitals or from the private sector. Hospitals will be free to sell their services to different health authorities. In this way money will in future go more directly to where the work is done best. At present a hospital or service which becomes more efficient and could treat more patients may be prevented from doing so by its budgetary limits. At the same time, one which is failing to deliver is still paid its share of NHS resources. Any exercise of choice by patients and their GPs is thereby made less effective. The Government's proposals will change this.

2.10 These and related reforms are set out fully in chapters 3,4 and 7. They represent a shift of power and responsibility to people whose job it is, at local level, to advise patients, to provide services to them, or to fund services for them. By placing the patient centre-stage, they will improve the standard of service he or she receives.

Giving management the freedom to manage

2.11 In recent years the Government has given a high priority to strengthening the management of the NHS, most importantly through the introduction of general management following a report by Sir Roy Griffiths in 1983. The reforms outlined in paragraph 2.9 will build on this progress and take it further. It will become all the more important that objectives for improving services, and responsibilities for achieving those objectives, are clear; and that money is not spent ineffectively or inefficiently when it could be used to buy more or better services. Achieving objectives through the efficient use of resources is the job of management. Local managers in particular must be both freer and better equipped to do that job.

2.12 Chapters 5,6,8 and 9 propose a range of important changes to strengthen local management. They will build on the introduction of general management, and on the proposals for the better management of the family practitioner services (FPS) set out in "Promoting Better Health" (Cm 249). Among the most important aims behind these changes are:

* ensuring that hospital consultants - whose decisions effectively commit substantial sums of money - are involved in the management of hospitals; are directly responsible and accountable for their own use of resources; and are encouraged to use those resources more effectively.

* ensuring that GPs too take greater responsibility for their use of resources, and are in more effective competition with each other.

* introducing new arrangements for the effective monitoring of medical care by doctors themselves.

* providing the audit support which management needs, through a stronger and more independent source of financial and value-for-money audit.

* improving the information available to local managers, enabling them in turn to make their budgeting and monitoring more accurate, sensitive and timely.

* contracting out more functions which do not have to be undertaken by health authority staff and which could be provided cost effectively by the private sector.

* constraining the rate of growth in drug prescribing costs.

* turning District and Regional Health Authorities and Family Practitioner Committees into tighter, more effective management bodies.

* restructuring the national management of the service to provide for a corporate management team which is freer to manage the service within policy objectives and financial targets set for it by Government.

Customer care

2.13 All these reforms will in time improve the quality of the service that the NHS is able to offer those who use it. The quality of the Service's medical, nursing and other care is widely recognised as excellent, but there are other changes which will make a real difference to the day-to-day services which patients receive.

2.14 Many people are still having to wait too long for treatment, and still have little if any choice over the time and place at which treatment is given. The Government has already done much to tackle this problem. Over the past two years, for example, an additional £55 million has been spent on reducing waiting lists and waiting times, allowing over 200,000 patients to be treated. A half of all waiting list patients are now admitted from the list in five weeks or less. But the problem remains.

2.15 The service provided by a hospital is still too often impersonal, inflexible and unnecessarily stressful. Patients should be treated much more like valued customers. The practical improvements that may often be needed include:

* appointments systems which give people individual appointment times which they can rely on. Waits of two or three hours in out-patient clinics are unacceptable.

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* quiet and pleasant waiting and other public areas, with proper facilities for parents with children, for counselling worried patients or relatives, and so on.

* clear information leaflets about the facilities available and what patients need to know when they come into hospital.

* once someone is in the hospital, clear and sensitive explanations of what is happening: on practical matters, such as where to go and who to see; and on clinical matters, such as the nature of an illness and its proposed treatment.

* clearer, easier and more sensitive procedures for making suggestions and, if necessary, complaints.

* rapid notification of the results of diagnostic tests.

* a wider range of optional extras and amenities for patients who are prepared to pay for them - a choice of meals, single rooms, personal telephones, TVs and so on.

2.16 The Government has prepared detailed proposals for making the NHS more sensitive to the needs of patients, more efficient in the use of resources and better able to provide high quality care. The chapters which follow set out these proposals in full.

→ * making it easier to charge your family practitioner

Draft (20.12.88)

CHAPTER 3: GP PRACTICE BUDGETS

Introduction

3.1 The service offered by the family GP is one of the greatest strengths of the NHS. On average, people visit their GP between four and five times a year. For most it is their first port of call if they are feeling unwell.

3.2 Of those who go into hospital some may go or be taken there direct, for example in an emergency. More usually, people who need hospital services - consultation with a specialist, diagnostic tests, or even immediate admission as an in-patient - are referred by their GP. Some 5 million new out-patients a year are seen by a hospital doctor on referral from a GP, and about a third will subsequently be admitted to hospital for in-patient treatment.

3.3 The GP is each patient's key adviser. He or she is best qualified to advise on whether or not someone needs to go to hospital, on which hospitals offer the best service, and on who are the best specialists to consult. The GP - acting on behalf of patients - is the gatekeeper to the NHS as a whole.

3.4 GPs, in this role of broker or go-between, hold the key to giving patients a greater say, and above all to improving the quality of the services they receive. Their special relationship with both patients and hospitals make GPs uniquely placed to improve patients' choice of good quality services. But there are three main obstacles to further progress:

* there is at the moment no real incentive for NHS hospitals and their consultants to look on GPs as valued consumers whose patients' custom they have to win.

* the present system of funding hospitals effectively penalises success. It may take years for a hospital that provides a good service and attracts more patients to receive the extra resources it needs to cope with increased demand. As a result, waiting lists grow and waiting times lengthen in good, successful hospitals.

* there is no real incentive for GPs to offer their patients a choice where one is available.

3.5 As a result, there is too little choice and competition in the system. Just as in any other business, the quality of the service to the customer - in this case, the patient - suffers accordingly.

3.6 Building on the strong foundations of the family doctor service, the Government will introduce a new scheme which, by extending competition, will help ensure that patients receive the best available care. In future, the Government wants to see money flowing with the patient, so that the practices and hospitals which attract the most custom will receive the most money. GPs will compete for patients. Hospitals will compete to win the custom for which GPs are responsible. For the first time, both GPs and hospitals will have a real incentive to put patients first. The Government believes that this reform will deliver better care for patients, shorter waiting times, and better value for money for the NHS - which in turn will lead to more care for more people.

3.7 The Government also believes that the scheme will be attractive to the many GPs who are keen to improve the services they offer. It will enable the practices which take part to influence directly the way in which money is used to provide services for their patients. It will give them scope to plough back savings into their practice. General practice will become a still more satisfying job.

How practice budgets will work

3.8 At the start of the new scheme, GP practices with lists of at least 11,000 patients (see paragraph 3.11) - will be able if they wish to apply to hold their own budgets for buying a defined range of hospital services. They will be free to buy from either NHS or private sector hospitals. The size of each practice's budget will depend primarily on the number of patients on the practice's list. There will be three categories of hospital services for which GPs within the scheme will be able to control their own budgets and buy services from the hospital or hospitals of their choice:

* outpatient services, including associated diagnostic and treatment costs. With the exception of expensive out-patient treatment which has to be provided on a hospital site - radiotherapy, for example - continuing out-patient treatment will be included.

* a defined group of in-patient and day case treatments, such as hip replacements and cataract removals, for which there may be some choice over the time and place of treatment. The inclusion of this category will make it easier for GPs to offer shorter waiting times to patients who are willing to travel. The Government will consult on the precise list of treatments to be covered.

* diagnostic tests, such as X-ray examinations and pathology tests, which are undertaken by hospitals at the direct request of GPs.

3.9 In addition, the Government intends the scheme to cover three important aspects of the services provided by GPs themselves:

* the 70% of practice (team) staff costs which is directly reimbursed to GP practices at present and which will be cash-limited under the Health and Medicines Act 1988. The inclusion of staff costs within the budget will, for example, encourage practices to consider whether to employ additional nursing or other staff and instead make less use of out-patient services.

* improvements to practice premises. The assistance available to GPs in improvement grants and under the cost rent scheme will also be cash-limited under the 1988 Act. Its inclusion within the scheme will add a small but useful element of budgetary flexibility.

* prescribing costs. Chapter 8 sets out the Government's proposals for setting indicative drug budgets for GPs generally. GPs within the practice budget scheme will be able to draw on the budgets allocated to RHAs for prescribing costs generally.

3.10 Participation in the scheme will be voluntary, and practices which have joined the scheme will be free to leave it again if they wish. All practice budgets will cover the specified range of hospital services, together with practice team staff and improvements to practice premises. Practices within the scheme will be able to choose whether or not to include prescribing costs in their budget. Although the different elements within the budget will be calculated or negotiated in

different ways - as set out in paragraphs 3.12-15 below - the result will be a single budget. The practice will be free to spend the money as it wishes within the scope of the scheme.

3.11 Practice budgets will need to be large enough to cope with fluctuations in demand for what will sometimes be expensive treatments. A hip operation, for example, may cost in excess of £2,000. The Government proposes that at the outset of the scheme participation should be limited to practices with lists of at least 11,000 patients, which is twice the national average. This should ensure that participating practices will have annual budgets in the region of £300,000 or more, excluding prescribing costs. On this basis over 1,000 practices will be eligible in the UK, which is nine per cent of all practices covering between them about a quarter of the population. The Government will consider relaxing the 11,000 patient minimum for practices which are prepared to include prescribing costs in their budgets. The Government will also consider relaxing the limitation generally if experience shows that budgets for 11,000 patients are more than large enough to allow for the necessary flexibility.

Negotiation of budgets

3.12 Chapter 8 sets out the Government's proposals for managing the family practitioner services, and suggests that in future RHAs should be responsible for allocating funds to FPCs as well as to DHAs. Practice budgets cannot be settled by a simple formula. That would be too inflexible. They will therefore need to be negotiated. The Government believes that the fairest and least cumbersome approach is for GP practices within the scheme to negotiate their budgets with the relevant RHA, which will in turn need to consult the practice's FPC. The FPC will continue to hold the GPs' contracts and be responsible for monitoring expenditure against the budget.

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Hospital services

3.13 The hospital services element in the budget will be settled by RHA alongside its responsibility for funding DHAs as proposed in chapter 7. This element will be taken out of the revenue allocation which the RHA itself receives from the Government for hospital and community health services. Each practice's share will be settled by reference to the number of patients on their list, weighted for the same population characteristics as are proposed in chapter 7 for allocations to Districts, and taking account of the practice's current referral rates. The RHA will then make corresponding adjustments to the relevant District allocations. The Government will be discussing with interested parties how best to ensure that the hospital service element of practice budgets is fairly assessed, and that adequate information is available to all concerned for this purpose.

Practice team staff and improvements to premises

3.14 A different approach will be needed to settling that element of the practice's budget which will be attributable to the costs of practice team staff and premises improvements. The Government expects that the budget for the practice's first year in the scheme will be based on the current costs of the practice team's staff, together with the practice's due share of the money available to the FPC for premises improvements. The practice could then receive its due share of any additional cash allocated to the FPC for these purposes. The Government will consider whether more detailed guidance is needed in the light of its discussions with interested parties.

Drugs

3.15 The prescribing costs element in a practice budget, where the practice has opted to include it, will need to be found from within the overall drug budget allocated to the RHA in accordance

with the proposals set out in chapter 8. The RHA will not be free to offer an amount in excess of the average level of spending which would be expected from the practice concerned, [assessed as described in chapter 8], but will be able to agree to any figure at or below that level. This element of each practice budget will need to be renegotiated periodically, and adjusted annually in the meantime in line with forecast increases in prescribing costs.

The management of practice budgets

Buying hospital services

3.16 Where costs are to some extent under the direct control of the practice itself, as with practice team staff and premises improvements, GPs should have relatively little difficulty in keeping within budget. But the costs incurred by hospitals in treating patients referred by the GPs are not within the GP's own control. It is essential that practices are able to limit their total expenditure, without denying services to their patients, where a hospital fails to control its costs. It is also important that practices manage their budgets in a way which enables them to negotiate the best deals they can.

3.17 To this end, practices within the scheme will need to make full use of the range of methods of buying hospital services described in chapter 7. To cover initial referrals for an out-patient appointment, for example, a practice will need to negotiate fixed-price contracts for an agreed range of services to all patients referred, so that any patient who needs the advice of a specialist can be sure of getting it. On the other hand, practices will also want to hold some money back, to keep open the possibility of buying services at marginal cost where hospitals have spare capacity to offer in the course of the year. GPs themselves will be responsible for deciding the best mix of budgeting and contractual arrangements for their practices, but

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the Government will ensure that ideas and experience are widely disseminated. — calculated on the same basis

Scope for flexibility

3.18 Practices within the scheme will be well placed to generate savings within their budgets. The Government intends that they should be free to spend up to 50% of any such savings as they wish, with the balance reverting to the RHA. This flexibility will allow them to plough money back into improving their practices and offering more and better services to their patients.

3.19 The Government recognises that practices may run into budgetary problems during the year, not necessarily through any fault of their own. It will be important to ensure that urgent treatment is still available to patients in such circumstances. The Government therefore intends to allow practices within the scheme to overspend by up to [5]% in any one year, but on the basis that this is contained within the RHA's overall cash limit and that any overspending is recouped in the following year. If a practice overspends in excess of [5]%, or persistently overspends at a lower level, the FPC will initiate a thorough audit, including a review by other doctors of any medical judgements which seem to be causing budgetary problems. An overspend in excess of [5]% for two years in succession will result in a practice losing the right to hold its own budgets.

Are there figures backed up by detailed proposals

Management costs

3.20 The Government proposes that each practice's budget should include a fee to cover the management and other costs of participating in the scheme.

Implementation

3.21 The Secretary of State will publish shortly a discussion document which develops in more detail the proposals set out in this chapter, as a basis for discussion with interested parties. The Government's aim is to encourage a substantial number of GP practices to apply to manage their own budgets with effect from April 1991, with more practices joining the scheme in subsequent years. In the meantime the Government will seek the necessary powers to enable GP practices to buy hospital services in the ways proposed. It will also encourage and invest in the development of the information systems which will be needed to support the calculation of budgets, the pricing and costing of hospital services to GPs, and the monitoring of prescribing costs.

3.22 The Government will look to RHAs and FPCs to give a positive lead in guiding and supporting GP practices which are interested in joining the scheme. The decision on any application will rest with the relevant RHA in each case, subject to a right of appeal to the Secretary of State. In reaching its decision the RHA will need to consider two main factors: first, the ability of the practice to manage its budget effectively, for example its practice management capacity, its technology and its access to hospital information; and, secondly, the GPs' commitment to, and policies for, the management of a collective budget which may affect their individual decisions.

3.23 The Government believes that the introduction of this practice budget scheme will bring substantial benefits to patients, building on the developments already in hand following its earlier White Paper on primary health care ("Promoting Better Health", Cm 249). In particular, people who live close enough to a practice within the scheme will be able to choose their GP partly in the light of the practice's policies and performance in buying hospital services. GPs will be encouraged to give more

information to their patients, and successful practices will attract more income through capitation fees. Hospitals and hospital consultants will be encouraged to compete with each other to attract the custom of GPs and the funds which will flow with the patients. The scheme will inject much of the choice, flexibility and competitiveness of private sector medicine into the security of a mainly tax-funded NHS.

Draft (20.12.88)

CHAPTER 4: SELF-GOVERNING HOSPITALS

Introduction

4.1 There are currently over 320 major acute hospitals in the UK - "major" defined as having more than 250 beds. This chapter sets out the Government's proposals for enabling as many of these hospitals as are willing and able to do so to run their own affairs.

4.2 Major acute hospitals are substantial businesses. Even the smallest of the management units which currently run these hospitals may have revenue budgets in excess of £10 million a year. The largest may have budgets in excess of £30 million.

4.3 It is already a central plank of Government policy to push down decision making to local, operational level. Some of the larger acute hospitals now have substantial responsibilities delegated to them for running their own affairs. The Government intends to take this process a significant stage further by providing for a new, self-governing status within the NHS.

4.4 The Government believes that greater independence for hospitals will encourage a stronger sense of local ownership and pride, building on the enormous fund of goodwill that exists in local communities. It will stimulate the commitment and harness the skills of those who are directly responsible for providing services. Supported by a funding system in which successful hospitals can flourish, it will encourage local initiative and greater competition. All this in turn will ensure a better deal

for the public, improving the choice and quality of the services offered and the efficiency with which those services are delivered.

Hospital Trusts

4.5 The powers and responsibilities of each self-governing hospital will need to be formally vested in a board of management. The Government will bring forward legislation enabling the Secretary of State to establish such boards, to be known as Hospital Trusts. The Government proposes that Hospital Trusts should be constituted as follows:

* each should have ten members, five executive and five non-executive, and in addition a non-executive chairman.

* the chairman should be appointed by the Secretary of State.

* of the non-executive members at least two should be drawn from the local community, for example from hospital Leagues of Friends and similar organisations. These two "community" members should be appointed by the Regional Health Authority (RHA). The remaining three non-executive members should be appointed by the Secretary of State on the advice of the chairman. All the non-executive members should be chosen for the contribution they can make to effective management of the hospital. None should be an employee of a health authority or hospital, of a trade union with members who work in the NHS, or of a major contractor or other hospital supplier. For teaching hospitals, the non-executive members will need to include a representative of the relevant medical school.

* the general manager, as chief executive, should be appointed by the non-executive members.

* the remaining four executive directors should include a medical director, the senior nurse manager and a finance director.

4.6 Hospital Trusts will assume all the powers and responsibilities previously exercised by the hospital's health authority. Specifically, they will be empowered by statute to employ staff; to enter into contracts both to provide services themselves and to buy in services and supplies from others; and to generate income within the scope set by the Health and Medicines Act 1988.

Funding and accountability

4.7 A self-governing hospital will ~~need to generate~~ income by ~~selling its services~~. ~~The main buyers will be~~ health authorities. Other buyers will include GP practices with their own budgets, private patients or their insurance companies, and perhaps other self-governing hospitals. This form of funding will be an opportunity for growth and a stimulus to better performance.

4.8 It will be an opportunity for growth because the money will ~~flow to where~~ the patients ~~are going~~. If a hospital attracts more patients it will get more income. A successful hospital will then be able to invest in providing still more and better services.

4.9 The funding arrangements will be a stimulus to better performance for two reasons. First, they will inject an element of competition. There will not always be an alternative provider of, say, local accident and emergency services. But for some services - and in some areas for many services - the hospital

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will be at risk of losing business if it does not meet the needs of its customers. Secondly, the hospital's contracts will need to spell out clearly what is required of it, in terms of both price and quality, by those who entrust patients to its care.

4.10 Each Hospital Trust's line of accountability will be through these contracts. The consequences of a failure to meet the terms of a contract - potential loss of future business, for example, or renegotiation of the contract - will be for the buyer to settle. The arrangements set out in chapter [7] will ensure that patients who are in need of urgent treatment are not turned away from a hospital simply because their treatment is not, or may not be, covered by a contract with that hospital.

4.11 Each Health Department's Accounting Officer will have an overall stewardship responsibility for the use made by self-governing hospitals of public funds. But the Accounting Officer will not be accountable for each individual hospital. The Secretary of State will need specific powers for use in reserve to prevent any self-governing hospital with anything near to a local monopoly of service provision from exploiting its position, for example by charging high prices for its services.

Freedom and responsibility

4.12 The Government proposes to give Hospital Trusts a range of powers and freedoms which are not, and will not be, available to health authorities generally. The Government believes that greater freedom for self-governing hospitals will create more scope for competition, diversity and innovation within the NHS. Greater freedom for their leadership will stimulate greater enterprise and commitment, which will in turn improve services for patients. Self-governing hospitals will be a novel part of a system of hospital care alongside health authority-managed and private sector hospitals, and will increase the range of choice available to patients and their GPs.

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Employment of staff

4.13 The Government intends that Hospital Trusts should be free to employ whatever staff they consider necessary, irrespective of any manpower controls which may apply to health authorities. The only exception should be junior doctors' posts, which will continue to need the approval of the relevant Royal College for training purposes. The Government sees it as particularly important that Trusts should employ their own consultants. Where consultants work also for other NHS hospitals or in the private sector, a Trust will need to employ them on a part time basis consistent with their commitment to the Trust's hospital.

4.14 The Government also intends that Hospital Trusts should be free to settle the pay and conditions of their staff, including doctors, nurses and others covered by national pay review bodies. They will not be able to alter unilaterally the existing contracts of employment of staff transferred from the relevant health authority to the self-governing hospital. But Hospital Trusts will be free, by agreement with their staff, either to continue to follow national pay agreements or to adopt partly or wholly different arrangements.

4.15 It will be important to ensure that this freedom does not simply generate higher pay costs which are passed on to the health authorities which buy the hospital's services. Health authority funding will continue to be cash-limited, and this will place authorities under a strong incentive to secure value for money through their contracts. Performance-related contracts of employment will similarly provide strong incentives for hospital managers to improve the quantity and quality of the services on offer. Competition with other hospitals, where it is effective, should also constrain costs.

Ownership of assets

4.16 The Government intends that Hospital Trusts should be constituted as public corporations. On this basis each hospital's assets will be vested in its Trust, as follows:

* the Trust will be free to use the hospital's assets to provide health care, in accordance with stated purposes laid down by the Secretary of State when self-governing status is granted.

* the Trust will be free to dispose of its assets, subject only to a reserve power for the Secretary of State to intervene if a disposal would be against the public interest.

* when it is established, the Trust will be given an interest-bearing debt equal to the value of its initial assets. The effect of this will be consistent with that of the new capital charging system proposed in chapter 5.

* the Trust will be free to retain surpluses and to build up reserves with which to improve services and finance investment. It will also be free to manage any temporary deficits, but will be required to break even taking one year with another.

* the Trust's operations will be subject to independent audit by the Audit Commission in accordance with the proposals in chapter 5. The National Audit Office will have right of access to papers relating to the accounts and audit of self-governing hospitals, and will be able to include self-governing hospitals in their value for money studies.

* the hospital's assets will revert to the ownership of the Secretary of State if for any reason the Trust is wound up.

Borrowing capital

4.17 As public corporations Hospital Trusts will also be free to borrow, either from the Government or from commercial sources, within an annual financing limit. The Government will seek limited, reserve powers for the Secretary of State to use if this freedom is being abused or if the Trust is getting into difficulties. The annual financing limit will be set each year by the Secretary of State following the Government's Public Expenditure Survey. Borrowing from the Government will be from the funds voted by Parliament for the NHS. Hospital Trusts will have to service their loans from their income, just as other NHS hospitals will be charged for their capital under the Government's proposals in chapter 5.

Achieving self-government

4.18 The Government will lay down a simple, flexible process for establishing a Hospital Trust. A hospital has no definable constituency equivalent to, for example, the parents of children attending a school. It will therefore be open to a variety of interests either to initiate the process or to respond to any initiative taken by the Secretary of State. These interests could include the DHA, the hospital management team, a group of staff, or people from the local community who are active in the hospital's support.

4.19 Similarly, the Government is not proposing a rigid definition of what a "hospital" should be for the purposes of self-government. For example, it will often be sensible for two

neighbouring hospitals to combine, or for a hospital to retain its existing obligations to run a range of community-based services.

4.20 The Government intends that hospitals should have to meet only a few essential conditions to achieve self-governing status. It has two main criteria in mind. First, management must have the skills and capacity to run the business, including strong and effective leadership, sufficient financial expertise and adequate information systems. Secondly, senior professional staff, especially consultants, must be involved in the management of the hospital, and there should be a comprehensive system of medical audit along the lines proposed in chapter 6. The Secretary of State will also need to satisfy himself that self-governing status is not being sought simply as an alternative to an unpalatable, but necessary, closure.

4.21 The Government will look to RHAs to play an active part in guiding and supporting hospitals which can be expected to meet these criteria and are interested in achieving self-government. In each case the Secretary of State will need to satisfy himself at an early stage that there is a good prospect of being able to approve the creation of a new Hospital Trust. With the advice of the RHA, he will also need to identify a "shadow" chairman who can act for the hospital in preparing the ground.

4.22 The RHA will be responsible for establishing the precise range of services and facilities for which the proposed Trusts will be responsible; for ensuring that the proposal to seek self-governing status is given adequate publicity locally; and for preparing and submitting a formal application to the Secretary of State. No-one will have the right to veto such an application.

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Implementation

4.23 The Government believes that self-governing hospitals have a major role to play in improving services to patients. It will therefore encourage as many major acute hospitals as possible to seek self-governing status as Hospital Trusts. The Government's aim is to establish a substantial number of Trusts with effect from April 1991, in the wake of the necessary legislation. The experience gained will then inform the process of establishing more Trusts in later years.

4.24 In the meantime the Government (and RHAs) will take the initiative, ~~with the help of RHAs,~~ in identifying suitable candidates for self-government and encouraging them to seek and prepare for self-governing status. The Secretary of State will be publishing shortly a more detailed document which will form a basis for discussion with interested parties. The aim will be to ensure that the hospitals concerned make productive use of the next two years by building up their capacity to run their own affairs effectively and by securing the maximum devolution of management responsibility from their DHAs. Self-government will then be - as it should be - a natural step forward from devolved management ~~within the present structure.~~ further.

4.25 The establishment of self-governing hospitals will mean a substantial change in the responsibilities of the DHAs which were previously responsible for their management. The Government does not believe that this implies a wholesale reorganisation of the NHS. But as more and more proposals come forward for establishing Hospital Trusts, RHAs will consider the viability of existing DHAs and, if appropriate, propose mergers of neighbouring Districts. The implications for the role of DHAs are set out more fully in chapters 7 and 9.

The logic is to merge with the P.P.B's.

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Draft (20.12.88)

CHAPTER 5: MANAGING THE HOSPITAL SERVICE

Introduction

5.1 With an annual budget now well in excess of £20 billion, the NHS is one of the UK's biggest businesses. It is also its largest employer with over a million staff.

5.2 The way in which this money is spent cannot sensibly be dictated in detail from Whitehall by Ministers or by civil servants. The Government's main task must be to set a national framework of objectives and priorities. Management must then be allowed to get on with the task of managing, while remaining accountable to the centre for its delivery of the Government's objectives.

5.3 Managers need to be properly equipped if they are to do their job effectively. This means having greater control over and better information about their use of resources. In particular, they must have more control over pay, and also over the use of capital which is their main investment tool. The Government's plans for self-governing hospitals will ensure that their managers are free to manage in this way. But the Government believes that the same principles should be applied in all hospitals. This chapter sets out its proposals for achieving this.

5.4 These are not new objectives. Since taking office, much of the Government's policy has been aimed at strengthening the management of the hospital service and improving its performance through the better use of resources. In any organisation that is as large and complex as the NHS, the full

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effects of better management take time to work through. But since a comprehensive system of general management has been introduced at all levels of the service, progress has been made towards:

* the establishment of a more effective planning and review process from Department to region and region to district and unit, through which national and local priorities can be identified more clearly;

* the introduction of a single focus for decision-making and, through the setting of objectives for individual managers backed at the most senior levels by performance related pay, the translation of national regional and local policies into specific management tasks;

* closer working relationships between managers and professional colleagues, particularly in the use of resources;

* the creation of a stronger foundation of better information, with a programme which will extend the information base into clerical as well as management areas;

* competitive tendering for support services;

* increasing the scope for health authorities to generate their own income.

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5.5 The tauter approach to management has contributed to increased activity levels, taking advantage of falling lengths of stay and other clinical developments; and, since 1983, a marked fall in unit costs. It has further produced additional revenues of over £1 billion from cash releasing cost improvements and land sales since 1985.

5.6 Following the introduction of general management, the Government is committed to pushing down as much decision making as possible to the local level. Under its proposals some hospitals , with or without associated community health units, will be able to move towards full self-government. Chapter 4 sets out how this will work. But all hospitals and other management units will be expected to carry more direct responsibility for running their affairs. This will need to be within an agreed framework of objectives and resources, to ensure that a comprehensive service is provided within the financial limits laid down by the Government.

Leaner and fitter regions

5.7 The NHS Management Board could not directly exercise effective authority over the current 190 DHAs which have a total expenditure of over [£15] billion ([£20] billion with Family Practitioner services). RHAs will therefore continue to play a major role in the chain of accountability from the centre to the local level by ensuring that Government policies are properly carried out within their regions. To be effective they will need to concentrate their efforts on their essential tasks, which are:

* maintaining oversight of the performance of the health services and of the improvement of the health of the people within the region;

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* setting challenging performance targets/standards for Districts, comparing and monitoring the outcome;

* establishing a framework for service development on a regional or inter district basis to make best use of scarce or expensive resources;

* relating national funding provision to individual district requirements;

* establishing regional manpower requirements including a recruitment and training policy;

* ensuring that adequate facilities are available for clinical teaching and research;

* ensuring coordination of hospital services and primary care at the local level.

In future, RHAs will also have a key role to play in managing the wider programme of changes that are set out in the White Paper.

5.8 In addition, historically RHAs have provided a range of operational and management services to their districts. These range from distribution centres, ambulance and blood transfusion services which could not be provided economically in every district, through to legal, information and management services which districts have been able to draw upon as required. Following the introduction of general management and the re-organisation of regional headquarters, many RHAs have reviewed the provision of these services. As a result, some services have been streamlined, delegated to districts or contracted out to the private sector. There remains, however, a wide variation in the size of each region's operations and the Government believes that there is

still considerable scope for reductions in the number of staff directly employed by RHAs. Each RHA will therefore be asked to review the provision of its regionally managed services and submit plans, with expected cost savings, for Ministerial approval.

A stronger role for hospitals

5.9 District Health Authorities (DHAs) currently carry out a mixture of strategic and operational functions. On the one hand they implement Ministerial policies including securing an overall range of services, setting and monitoring standards, and maintaining financial control; on the other, they provide operational services such as information technology and the day to day management of the estate.

5.10 Through a new system of funding described in Chapter 7, the Government wants to distinguish more clearly between the different - and sometimes conflicting - roles of health authorities and hospitals as the "purchasers" and "providers" of services. In particular, specialist operational functions should lie as far as possible at the unit level with hospitals.

5.11 The Government does not intend to specify the precise details of devolution to hospitals since such a list would not make sense everywhere. Instead it will expect Regional Health Authorities (RHAs) to achieve a significant measure of devolution from the DHAs to units. Targets will be set to monitor change. The touchstone will be that operational functions should be devolved to unit level unless there is an overwhelming case for retention at district.

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5.12 The pace of change will need to take account of the scarcity of skills in key disciplines such as finance, information and personnel. But it will be necessary to ensure that proper priority is given to increasing unit capacity and that the inability of units to be self sufficient in specialist functions does not necessarily hold back the drive towards devolution. A clear distinction will need to be made between functions which should properly be retained at district level for functional or economic reasons and those which may temporarily need to be provided by districts as a service to units.

Better use of staff

5.13 In a staff intensive organisation like the NHS, one of the keys to successful management is the effective management of human resources. Chapter 6 includes proposals for ensuring that managers are able to deploy consultants in the most effective way. It is however the nurses who represent the largest single group of professional staff in the NHS and who are responsible for delivering direct patient care around the clock.

5.14 There have been many developments in recent years on the better use of nursing staff. These have included research into and experiment with different mixes of skills and grades; improved methodologies to assess the demand for nursing staff to deliver a given level of service; development of rostering systems to match available staff to workload more accurately; action to eliminate over-long shift overlaps; better nurse management information systems; and the use of 5-day wards.

5.15 The Government has concluded that there is room for more progress at local level. The Government has already endorsed the need to provide non-professional support staff to nurses with a better training. It will be necessary to re-examine all areas of work to identify the most cost-effective use of professional skills, which may, in a number of areas involve a reappraisal of traditional patterns and practices. Examples include the substitution of nurses for junior doctors in some casualty department duties and the use of clerical rather than nursing staff in receptionist work. There is scope also with other professions, some of which, such as physiotherapists, speech therapists and chiropodists, make little use of non-professional helpers.

Better information

5.16 The Government recognises that managers and professional staff need good information if they are to make the best use of the resources that are available to them. The Government has made considerable progress in developing better information systems in hospitals, but there remain some important limitations. In particular, there is at present only a limited capacity to link information about the diagnosis of patients and the cost of treatment. Neither is the information always as timely or reliable as it should be. The greater competition which the Government is proposing in the provision of services should stimulate managers to generate improved information more quickly. But the Government also recognises that national action will be needed if all hospitals are to have adequate information systems up and running within an agreed timetable.

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5.17 A key part of the Government's strategy will be to secure further improvements in cost information. The Government believes that the best way of delivering this is by extending and accelerating the existing Resource Management Initiative (RMI). The RMI is being piloted in selected health authorities and is intended to provide a complete picture of the resources used by hospital patients. It draws on basic data that are already available from existing operations systems such as the Patient Administration System (PAS), and from pathology and radiology departments. These data are not however at present generally integrated to provide a total picture of the cost of treating patients. The other key feature of the RMI is that doctors, nurses and other professional staff have been directly involved in its development. This should ensure that the new systems are actively used for the benefit of patients.

5.18 The Government therefore proposes to extend the RMI to a further 20 acute hospital units in 1989/90 with the aim of building up coverage to 260 acute units by the end of 1991/92. It is an ambitious timetable and some of the information generated may be less precise than that which has been released in the existing pilot projects. The Government believes however that, by using the experience gained from the current exercise, it will be possible to generate cost information that vastly improves what is currently available to managers and in which professional colleagues can have confidence. The Government will be discussing its proposals in detail with representatives of the professions who have been involved in the development of the new information systems.

5.19 The Government remains committed to the production of regional information strategies by May 1989 running in parallel with the RMI. This wider information strategy will involve improving or introducing modern information systems to support both the clinical and administrative functions in hospitals. It will generate up-to-date information for managers and will enable more efficient use to be made of valuable staff resources. Few hospitals will start from the same point, and it will be essential to make the best use of the limited number of skilled information systems staff, both within the NHS and outside it. Three pilot sites will be launched in 1989/90, building up gradually to cover 260 sites by March 1993.

Pay flexibility

5.20 In addition to giving managers the tools with which to manage, the Government wants to give them greater control over the resources for which they are responsible. Pay accounts for over 70 per cent of all NHS expenditure. Getting pay wrong can therefore have serious effects on expenditure on the one hand, and on the availability of staff on the other.

5.21 The Government remains committed to a central framework for pay determination in the NHS. It does not believe that unrestricted local bidding and bargaining would be in the interests of the patient or the taxpayer. However the Government's objective is to move towards a system of broad pay ranges, centrally negotiated, with freedom of action for local managers in matching market forces and rewarding individual performance. With such freedom, individual hospitals will be better able to tailor their services to meet the health needs of the public they serve.

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5.22 There is at present no geographical variation of pay (other than London weighting) for doctors. The Nurses Pay Review Body, in its 1988 reports, recommended London supplements to be paid in addition to London weighting to nurses and the professions allied to medicine, and these were introduced from 1 April 1988. The Government has now asked the Review Body to look at the case for discretionary payments to nurses to help with particular local staff shortages and nurse management problems.

5.23 The established performance pay arrangements applying to general managers and other top managers have recently been extended to senior and middle managers lower down the scale. The extended arrangements, unlike the original ones, include an explicit market flexibility element for posts at these levels.

[5.24 Negotiations are already under way to introduce ~~market~~ flexibility into the administrative and clerical pay scales. This will be based upon a main pay spine, with management having latitude to supplement points on the national pay spine, to reflect market pressures.]

Capital

5.25 Managers should also be able to make the most flexible use of their physical resources. Capital in the NHS is treated for the most part as a "free good". Once an investment has been made, whether in land, buildings or equipment, no further revenue charges arise from the continuing use of these capital assets. In the private sector, for example, there would be interest and repayments to be met. This means that investment decisions tend to favour capital-intensive solutions, rather than forming a balanced, cost-effective package. It is difficult to make valid comparisons of efficiency between different parts of the NHS

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as no amount is taken of capital costs. It also means that it is impossible to compare the public and private sectors, in terms of overall cost-effectiveness, since the former takes no account of the cost of using assets, while the latter has to do so.

5.26 The Government therefore proposes to introduce a new system for accounting for capital in the NHS which will give managers more flexibility in the deployment of this key resource. In essence this will involve a system of charges for the use of capital assets, reflecting private sector practices of accounting for interest and depreciation. The Government's intention is to balance, overall, the increased revenue allocations to health authorities which would be needed to meet capital charges, with the income to the capital programme which such charges would represent.

5.27 Funds for capital investment will continue to be financed by the Exchequer, and allocated by RHAs from the overall capital programme. There will therefore continue to be strategic oversight of capital planning, within an overall cash limit. But a charging mechanism will ensure that managers have the appropriate financial measures available in taking decisions on capital deployment, and will reward those authorities which use their assets to best advantage.

5.28 The capital expenditure limits above which projects have to be referred up to the Department or the Treasury for approval will be increased. From now on schemes with a capital cost of over £15m (previously £10m) will be referred to Treasury for approval. Schemes costing over £10m (previously £5m) will be referred to the Department of Health. These increases will be a welcome step forward in speeding up investment approvals and giving health service managers greater freedom over key resource decisions.

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Private capital

5.29 As health authorities become more business-like in their approach to the provision of services, and to the use of the resources at their disposal, they are increasingly looking at the scope for involving private sector capital. Examples include joint ventures where the NHS provides land, and a developer puts up a building, or where a major capital-intensive service is contracted out to the private sector. The Government must maintain overall constraints on the use of resources, including capital from whatever source, within the public sector. And these resources should be used in the most cost-effective way. For these reasons Districts cannot have unfettered access to private capital.

5.30 But the Government recognises too that joint ventures with the private sector, and other income generation schemes, should be encouraged wherever possible. Competitive tendering needs to be developed further in the NHS, and treating the contractor's capital investment as if it were public expenditure can work against this aim. There should also be scope for more flexibility for an authority to work with a private developer to achieve a net saving. All these examples involve the use of, or access to, private capital, and the Government is determined that authorities should have the maximum freedom in this area, consistent with value for money and the proper use and control of public expenditure.

[Could put this section in private sector chapter]

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Audit

5.31 Currently, the statutory audit of health authorities' accounts is carried out by the Department of Health, using, to a limited extent, private firms of accountants under contract. Greater freedom over the use of resources brings with it greater responsibility for ensuring that resources are used in the most efficient and effective way. Through the annual review process, health authorities will continue to be accountable to Ministers for their use of resources. But, because of the huge sums of money involved, Ministers need an independent source of advice whose reports will be published and therefore available to Parliament and the public.

5.32 The Government has decided that the Audit Commission is best equipped to fulfil this role for the NHS, including self-governing hospitals, GP practice budgets and Family Practitioner Committee spending. It is currently responsible for the audit of local authorities in England and Wales and reports on this to the Secretary of State for the Environment. It has considerable experience and expertise in areas of work closely related to that of health authorities. In particular, it is accustomed to working in multi-disciplinary teams with professionals looking at the professional aspects of services. This would be an important part of its new role in the health service.

5.33 The Housing and Local Government Bill [currently before Parliament] includes a provision which will enable the Audit Commission to undertake audit work in the NHS under contract to the Secretary of State for Health. This will develop the experience of the Audit Commission, and enable its staff to start to work with the DH officials currently responsible for NHS audit. The Government proposes to bring forward further legislation formally establishing the Audit Commission as the NHS auditor, reporting to the Secretary of State for Health.

5.34 The role of the National Audit Office will remain unchanged. As an Officer of Parliament, the Comptroller and Auditor General will continue to report on the use of voted funds, and to certify the aggregated accounts of the NHS, drawing upon the individual health authorities audits of the Audit Commission.

Draft (20.12.88)

CHAPTER 6: THE WORK OF HOSPITAL CONSULTANTS

Introduction

6.1 The NHS employs over 45,000 hospital doctors, of whom 16,000 are Consultants. The reforms proposed by the Government in this White Paper will make it easier for Consultants and their colleagues to get on with the job of treating patients. The greater autonomy for hospitals proposed in chapters 4 and 5 will remove unnecessary controls. The new funding arrangements set out in chapters 3 and 7 will help Consultants to treat more patients. The expansion of the "resource management initiative" outlined in chapter 5 will give them budgetary and information systems more sensitively tuned to medical needs.

6.2 Consultants must be as free as possible to do their job. But treating patients means spending money. The taxpayer has to find this money for the NHS, and expects management to use it efficiently and to good effect. The decisions taken by Consultants are critical to the way in which the money is used. It is therefore important to ensure that Consultants are properly accountable for the consequences of these decisions.

6.3 This chapter sets out the Government's proposals for striking a proper balance between two legitimate pressures: the professional responsibilities and rewards of the individual consultant; and the responsibility of managers (whether or not they are medically qualified) to ensure that the money available for hospitals buys the best possible service.

Medical audit

6.4 A patient's primary concern is to be given an accurate diagnosis and then receive effective treatment. The quality of medical care available to NHS patients is obviously of central importance. Within the next two years, the Government would like to see all hospital doctors taking part in medical audit - a systematic, critical analysis of the quality of medical care, including the procedures used for diagnosis and treatment, the use of resources, and the resulting outcome for the patient.

6.5 Medical audit is essentially a professional matter, a means of ensuring that the quality of medical work meets acceptable standards through peer review of medical practice. It necessarily requires both specialised knowledge of current medical practice and access to medical records. It must also be developed and implemented with care. Medicine is an inexact science, often lacking generally accepted measures of the benefits to patients from different techniques and services. Medical audit must not discourage doctors from taking on difficult but essential clinical work.

6.6 The Government welcomes the initiatives which the medical profession is already taking, both nationally and locally, to foster the development of medical audit, and aims to work with the profession to build on what has been achieved. For example, the Secretary of State for Health has asked the statutory Standing Medical Advisory Committee to consider and report on how the quality of medical care can best be improved by means of medical audit, and on the development of indicators of clinical outcome. The Government will also encourage all the Royal Colleges to make participation in medical audit a condition of a hospital unit being allowed to train junior doctors.

6.7 Management too has a responsibility to ensure that medical audit becomes firmly established, especially at local level. The Government is publishing alongside this White Paper a document which sets out in more detail, as a basis for consultation with the profession, its proposals for securing effective framework for medical audit in all NHS hospitals by April 1991. The Government's approach is based firmly on the principle that the quality of medical work should be reviewed by a doctor's peers, whilst recognising also that management itself is responsible for ensuring that resources are used in the best interests of patients.

6.8 The Government's main proposals are as follows:

* every Consultant should participate in a form of medical audit agreed locally between management and the profession.

* the system should be medically led, with a local medical audit advisory committee chaired by a senior clinician.

* District management should be responsible for ensuring that an effective system of medical audit is in place, and also that the work of each medical team is reviewed at whatever regular, frequent intervals are agreed locally.

* peer review findings should be confidential, but the general results of medical audit should be available to management locally and the lessons learned published more widely.

* management should be able to initiate an independent professional audit, for example where there is cause

to question the quality or cost-effectiveness of a service.

6.9 The Government also proposes that a hospital should have an effective system of medical audit before it can be granted self-governing status. By the same token, District Health Authorities (DHAs) will be asked to ensure that effective medical audit is in place before they sign a contract with a self-governing hospital or with a hospital in the private sector.

6.10 The Government recognises that medical audit is not cost-free. It needs a significant investment of time by doctors themselves, and adequate support to ensure that the necessary information is available. The Government is confident that this investment will prove worthwhile by further improving the quality of service to NHS patients.

Managing the Consultant's contract

6.11 Most hospital services are the responsibility of DHAs. But, with the exception of those working in Teaching Districts, Consultants' contracts of employment are held by Regional Health Authorities (RHAs). This has tended to cause confusion about the nature of a consultant's accountability to local management and the DHA. It has also tended to leave unclear what a District can and should expect of its Consultants.

6.12 The Government believes that it is unacceptable for local management to have little authority or influence over those who are in practice responsible for committing most of the hospital service's resources. This does not mean moving consultants' contracts from RHAs to DHAs, which would cause unnecessary disruption. The Government proposes instead to ensure that each DHA acts as its RHA's agent in agreeing with

consultants the scope and arrangement of their NHS duties in each hospital.

6.13 The key to this is that every consultant should have a fuller job description than is commonly the case at present, covering their responsibility and accountability both for the quality of their work and for their use of resources. These job descriptions, which will be subject to annual review, will be an essential tool for managing all consultants' contracts. They will need to be sufficiently detailed, for example as to the number of outpatient clinics which a Consultant is expected to hold, to enable District management to monitor whether Consultants are fulfilling their contractual obligations.

6.14 DHAs will be asked to agree a job description along these lines with each of their Consultants. They will need to do so in a way which preserves both the freedom of Consultants to take clinical decisions within the boundaries of accepted professional standards and their 24-hour responsibility for their patients. The Government will discuss with the medical profession nationally how best to implement this, including a suitable national framework for Consultants' job descriptions.

6.15 There is currently no provision for District management to take a full and formal part in the appointment of a Consultant. Consultant appointments are recommended by mainly professional Advisory Appointment Committees, whose primary consideration is the professional suitability of the candidate. The Government will seek to amend the Appointment of Consultants Regulations to enable District General Managers to take part directly in the appointments procedure. Professional suitability will and should remain a major criterion, but the general manager will be able to ensure that the chosen candidate is also willing and able to meet the managerial requirements of the post.

6.16 The Government intends to complement these changes by improving the present disciplinary procedures for Consultants. These procedures are at present cumbersome and inflexible. They have recently been reviewed by a Joint Working Party of the Health Departments and the profession, established by the Government in 1987. The Working Party has made a number of valuable recommendations. The Government will now open negotiations with the profession on the basis of the Working Party's report, which will be published.

6.17 The Government sets particular store by two of the changes which the Working Party suggests. The first is the introduction of new, local procedures for dealing with circumstances which warrant disciplinary action short of dismissal. The second concerns the unique right of a Consultant dismissed by his employer to appeal to the Secretary of State against his dismissal. This can be a time-consuming and costly process, the prospect of which may deter management from embarking on dismissal proceedings in the first place. The Government therefore welcomes the Working Party's proposal for a timetable which should normally lead to concluding an appeal within nine months of the dismissal.

Reform of distinction awards

6.18 Some 35% of Consultants are currently in receipt of a distinction award. This takes the form of a superannuable increase in salary at one of four levels. There are currently some 3,900 'C' awards (£6,260), 1700 'B' awards (£14,200), 700 'A' awards (£24,850) and nearly 200 'A'+ awards (£33,720). Distinction awards are intended to reward clinical excellence, and are payable until retirement. The normal pattern is for progression through the levels of awards. New and increased

awards are given on the advice of an independent professional committee.

6.19 The distinction awards scheme was introduced in 1948, and has remained substantially unchanged since then. In their 1988 report (Cm 358), the Review Body on Doctors' and Dentists' Remuneration suggested that expenditure on the scheme should result as far as possible in a benefit to the NHS, as well as rewarding doctors for their individual efforts. The Government agrees. It believes that the nature and administration of the scheme should now be changed, with two main objectives in view: to reflect the wider responsibilities of Consultants for the effective use of resources, and not only the clinical merit of their work; and to ensure that the scheme offers Consultants stronger incentives to maintain and improve their contribution to local services.

6.20 Taking into account the specific suggestions made by the Review Body, the Government proposes to open discussions with the medical profession nationally with the following changes in mind:

* leaving unaffected the rights of existing award holders, to replace 'C' awards with performance-related pay of equal value for those consultants who demonstrate not only their clinical skills but also a commitment to the management and development of the service. The Government proposes that general managers and senior doctors should decide jointly which consultants should be rewarded in this way. There will be a small number of exceptions, to meet the circumstances of Consultants whose jobs include only a limited management content.

Medical schools
staff ?

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* for the future, to restrict progression to the remaining three levels of award to those consultants who have earned performance related pay. The Government proposes that these higher awards should, as now, reward clinical excellence, but that there should be a stronger general management influence on the choice of award holders.

* to make new or increased awards, including performance-related pay, reviewable every five years.

* to make new or increased awards pensionable only if a consultant continues working in the NHS for at least three years. The Government believes that this will meet the criticism of the Review Body that awards given to those approaching retirement, with the additional pension benefits entailed, can hardly be said to be in the best interests of the Service.

Payable

Payable

New consultants?

bii

Draft (20.12.88)

CHAPTER 7: FUNDING HOSPITAL SERVICES

Introduction

7.1 Hospital services must be funded in a way that encourages more competition and more choice, two of the elements at the heart of the Government's proposals for a better health service. To do this a simpler way of allocating funds to health authorities is needed. So is a new method of funding those hospitals which continue to be run by health authorities.

7.2 At present a hospital or service which becomes more efficient and could treat more patients may be prevented from doing so by its budgetary limits. One which is failing to deliver may still be funded at the same level, despite its relative inefficiency. The Government is determined to change this. It believes that the key to doing so is to move towards a system in which health authorities are funded not for the services they provide but for the population they serve. The job of health authorities will then be to buy the best services they can for their - and their GPs' - patients, and hospitals will have to compete much more for their business.

7.3 This chapter sets out the Government's proposals for achieving these objectives.

Funding health authorities

The present system

7.4 Since 1977, money has been allocated to Regional Health Authorities (RHAs) on the basis of a formula which identifies

target shares for each Region. The formula is known as RAWP (Resource Allocation Working Party). It is based on the size and expected growth of each Region's population, and also a range of other factors including the proportion of elderly people, the relative health of the population and the extent to which patients cross Regional boundaries for hospital treatment. Each year, when making financial allocations to Regions, the Government decides how far actual allocations should move towards the target shares. When the formula was introduced most Regions were significantly above or below their RAWP target. Now 11 of the 14 are within 3% of it. [The changes since 1979-80 are shown in figure 7.1.]

7.5 At District Health Authority (DHA) level, distances from RAWP target are greater. The extent to which RHAs rely on the RAWP formula when allocating funds to Districts tends to vary from Region to Region. In recent years growth money has usually been allocated on the basis of planned service developments - for example, to enable a new hospital to open - rather than by a simple application of the formula.

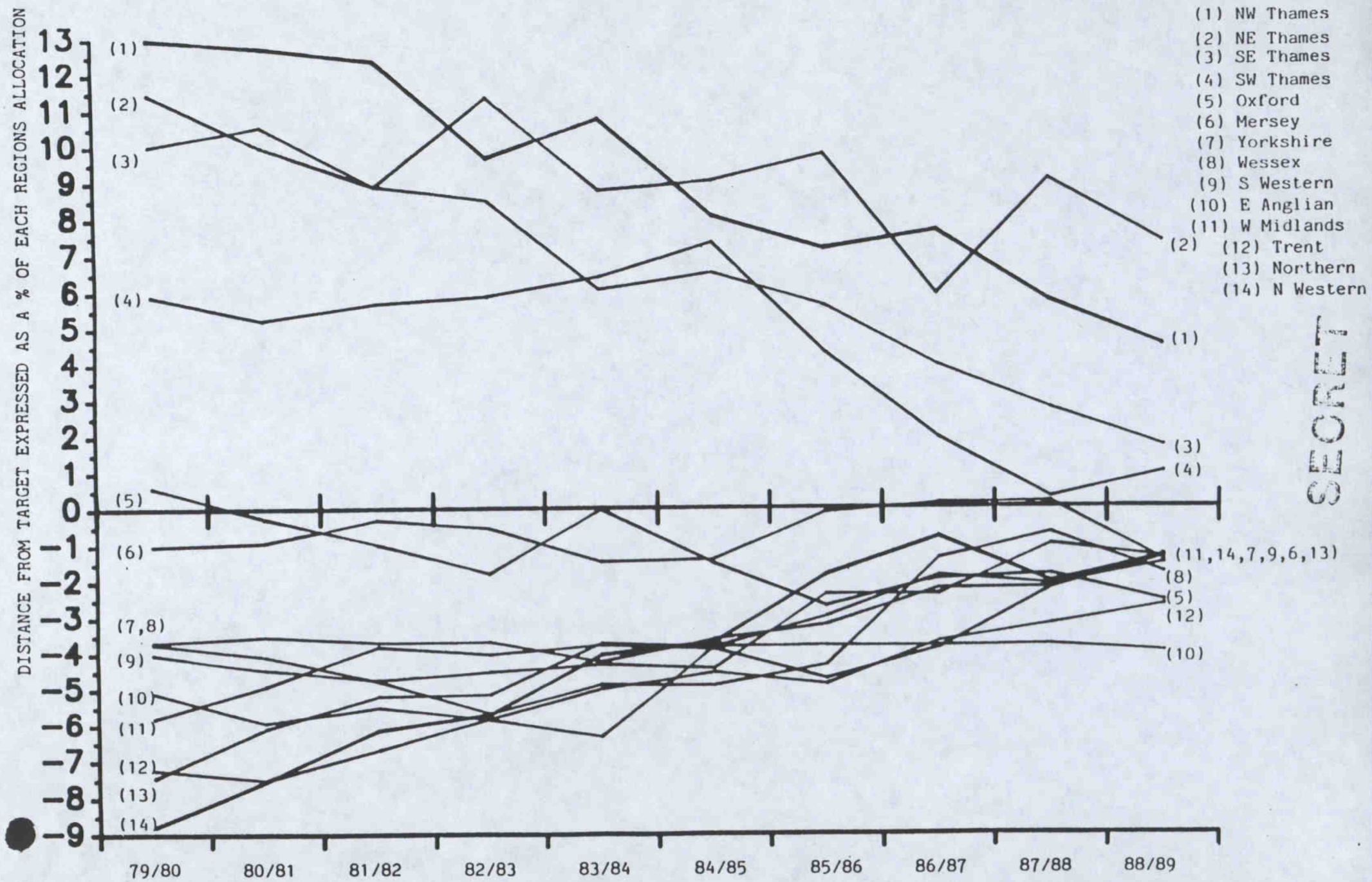
7.6 There is no direct relationship between the amount of money a District is allocated and the number of patients its hospitals are treating. This is partly because the movement of patients across Regional boundaries is reflected only retrospectively in the formula. Further, these adjustments affect only target, not actual, allocations, and may be based on forecasts which are not borne out in practice. Even significant changes in such "cross-boundary flows", therefore, may have little impact on the amount of money actually allocated.

A new approach

7.7 The Government proposes to simplify the arrangements for allocating funds to RHAs and DHAs. The underlying principles

FIGURE 7.1

REGIONS DISTANCES FROM RAWP REVENUE TARGETS



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to be applied are the same in both cases. The Government recognises the need for a transitional period, which will be longer at District than at Regional level.

Allocations to RHAs

7.8 Regions will be funded, on a weighted capitation basis, to buy services for their resident populations. The allocations will reflect, as now, the number of elderly people and the health of the population. The Thames Regions will receive a slightly higher level of funding - some two per cent higher per head of population than the rest - in recognition of the particular problems of providing services in the densely populated and high cost south east.

I thought recognised

3% extensive losses for Thames regions.

7.9 Funding Regions on the basis of their resident populations will leave them to pay each other directly for cross-boundary flows. Starting in April 1989, RHAs will be asked to begin work on agreeing the cost of these flows in preparation for funding on the basis of resident populations from April 1990. The present arrangements for funding cross-boundary flows will cease from that date. As a result, Regions will be paid much more quickly and in full for the work they do for other Regions.

7.10 It is the Government's aim to move over a two year period, starting in April 1990, to Regional allocations calculated on a weighted capitation basis. The transition to the new system will therefore be completed by April 1992. There will be no separate "targets": the move to weighted capitation removes the need to calculate target shares to which allocations should be moving.

7.11 These arrangements will replace the use of the RAWP formula.

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Allocations to DHAs

7.12 RHAs will continue to be responsible for allocating funds to DHAs. At present Districts are funded mainly according to where hospitals happen to be located. In future Districts, like Regions, will be left to pay each other directly for cross-boundary flows. A start to the process depends on improved information at the hospital and District level about population, the movement of patients and the costs of different treatments. The Government expects some DHAs to be in a position to pay each other directly for services provided from April 1991. Other authorities, drawing on the experience gained, will be expected to complete the process by April 1994.

7.13 Even after adjusting for the effects of cross-boundary flows on allocations, the differences between current levels of funding and those implied by a weighted capitation approach are much larger at District than at Regional level. Residents in Districts with relatively extensive hospital provision tend to use services more intensively than might be expected simply on the basis of the numbers of elderly people and the health of the population. While it is the Government's aim that Districts should in due course be funded on broadly the same basis as Regions, it recognises that an immediate switch would in some cases involve substantial changes in the money available to buy services for their resident population. Such changes must be carefully managed over a ~~period of time~~ workload. The Government will discuss with RHAs the detailed implementation of these proposals.

Funding hospital services

7.14 The present system of funding Districts for their hospital provision leaves the relationship between workload and funding obscure and indirect. Hospitals are funded as

much because they are there as for the work they do or how effectively they do it. As a result, there are only limited incentives for them to satisfy the needs and preferences of patients or to take on additional work by improving productivity. They may even be penalised for their efficiency if they treat more patients than planned for and, as a result, have to close beds to stay within their budget.

7.15 As the new arrangements described so far in this chapter become established, each DHA's duty will be to buy the best service it can from its own hospitals, from other authorities' hospitals, from self-governing hospitals or from the private sector. Hospitals for their part will be free to sell their services to different health authorities. In this way money will in future go more directly to where the work is done best.

"Core" services

7.16 It will be essential to ensure that patients needing urgent treatment continue to receive it. Services to which patients need guaranteed immediate access where necessary can be divided into five broad categories:

* accident and emergency (A and E) departments.

* services for patients who need immediate admission to hospital from an A and E department, for example a significant proportion of general surgery.

* services for other patients who need immediate admission, such as most general medicine and a substantial proportion of hospital geriatric and psychiatric services.

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* out-patient and other support services which are needed in support of the first three categories, either on site or immediately available.

* public health, community based services and other hospital services which need to be provided on a local basis either as a matter of policy e.g. services for the elderly or the mentally ill, or practicability, e.g. district nursing and health visiting.

7.17 Where these core services are provided by a hospital which continues to be managed directly by its DHA, they will be funded through a management budget. The scope for competition may be limited but, through management budgets, a DHA can set clear targets for the quantity and quality of the hospital's services, and can then assess the hospital's performance against these targets. As better cost information becomes available, Districts will be able to refine and improve their planning and monitoring.

7.18 Where core services are bought in from a self-governing hospital, or from a directly managed hospital in a neighbouring District, it will need to be on the basis of an annually negotiated contract. Under this arrangement hospitals will provide an agreed range of services, for a fixed payment, to all patients referred or admitted. The fixed payment means that DHAs know how much they will spend, and the risk of increases in cost or volume is borne by the hospital. Contracts of this kind will need to be negotiated carefully because of the substantial volume of potential business involved and the need for hospitals to take account of variations in the costs of treating different conditions. Current costs and workload will provide a baseline from which to work.

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7.19 Hospitals will need to budget, on the basis of experience, for the treatment of patients who are not covered by an annual contract or by their own districts' management budgets. The costs of treatment will be reimbursed directly by each patient's own DHA. Core services must be provided without any question as to where the money is coming from.

Other services

7.20 Where patients and their GPs may be able to exercise some choice over when and where treatment is provided, it becomes possible for Districts to buy services in a more flexible way. This in turn widens the scope for switching money to where the best services - for example, the shortest waiting times - are on offer.

7.21 The precise range of services which could be funded in this way will tend to vary according to the accessibility of different hospitals. There are broadly three categories:

* those procedures or treatments which are currently provided in most Districts but for which patients may be prepared to travel if a better service is available elsewhere. These treatments are in the main surgical acute operations, such as hernias and hip replacements, which make up the bulk of waiting lists.

* services which are not currently provided in every District, such as ear, nose and throat (ENT), ophthalmology and oral surgery, and which some Districts will therefore need to buy in.

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* other services for which patients may wish to exercise choice as to location, for example some long-stay care for elderly people.

7.22 The Government envisages that most of these services will be bought in under a "cost and volume" contract. The number of cases to be treated would be specified within a range, with payments on the basis of work done above the minimum. This arrangement would cover most in-patient and day case treatment. The minimum payment assures the hospital of a contribution towards its fixed costs, whilst the maximum volume makes it easier for the hospital to offer shorter waiting times.

7.23 DHAs may also want to keep back a relatively limited budget for buying services on a case by case basis, at a price quoted by the hospital. This could not be a normal basis of funding, since it gives hospitals no guarantee of income and would leave Districts to bear the risk of unexpected costs within their cash-limited allocations. Used judiciously, however, it opens up the scope for buying services at marginal costs as hospitals try to use spare capacity.

7.24 The Government believes it essential that DHAs use this greater flexibility in funding hospitals to offer more choice to patients. This in turn means involving GPs far more in key decisions. When they place contracts, DHAs will need to take full account of the existing referral patterns of GPs in their Districts. They will also need to discuss with GPs the desirability of changing those patterns, whether on grounds of cost or quality of the services provided. GPs for their part will want to make sure that their views about the quality of care, and about shorter waiting times for out-patient appointments and in-patient treatments, are reflected in a DHA's contracts. GPs who take part in the practice budget

scheme set out in chapter 3 will be taking these decisions for themselves.

7.25 At present an increasing number of hospitals are declining to accept referrals from GPs for patients who are not resident in the District. The Government's proposals will overcome this difficulty by enabling the patient's own DHA to pay directly for the services required. DHAs will need to allow for referrals by GPs to hospitals with whom no contracts have been placed, keeping in reserve some funding for this purpose based on previous referral patterns and discussion with the GPs themselves.

7.26 For these new arrangements to work well, GPs and their patients will need to be well informed about the choices on offer. The Government is putting further work in hand on two fronts to assist this. First, it will be seeking to improve the information available to GPs about their referral patterns. Information of this kind will be needed anyway for the practice budget scheme. Secondly, it will be exploring how best to develop and publish indicators of hospital performance which cover the quality as well as the efficiency of the services provided.

Funding specialist services

7.27 Districts cannot be self sufficient in all services. Specialist services can be divided into two broad categories:

* supra-regional services - these are designated and protected with central funding by the Secretary of State for Health. They include heart and liver transplants and neo-natal and infant cardiac surgery.

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* Regional and supra-district services - these are designated by RHAs and may include ophthalmology, ENT, neurosurgery, neo-natal care and radiotherapy.

7.28 The Government intends that most of these services should in future be bought by Districts from their basic allocations. The necessary contracts would cover both direct referrals from the A & E department or GPs and referrals to a specialist consultant from another consultant. The Government recognises, however, that it will be necessary to continue to provide some central funding for the development of supra-regional services. Central funds will cover the fixed costs of the units providing these services with the variable costs covered by contract funding from the buyers. RHAs may decide to adopt a similar approach to the funding of some regional and supra-District services. The Government will discuss with RHAs the detailed application to these services of the new funding arrangements it proposes.

Training and research

7.29 There are some significant overhead costs which hospitals will need to meet but which will not be incurred directly in the provision of services for its customers. The main examples are medical, nurse and other training; and research. The Government proposes that these costs should be met directly, either by central government or by RHAs, and will discuss with RHAs how best to secure this.

7.30 More particularly, the Government remains firmly committed to maintaining the quality of medical education and research. It recognises the complexity and special needs of these areas. Health authorities involved in medical education incur additional costs which will continue to be reflected in the new funding arrangements through an enhanced SIFT (Service

Increment For Teaching). The Government has established an inter-departmental Steering Group on Medical Education to examine the special problems of this area. It will develop its work, and make recommendations in the light of the proposals in this White Paper. It will be a principal task of RHAs to see that appropriate facilities are maintained for teaching and research.

Waiting times

7.31 The Government believes that the new funding arrangements described in this chapter will bring down waiting times for hospital treatment, both through the greater flexibility they offer in moving money to where the work is done and through making maximum waiting times an important feature of contracts and management budgets. DHAs, and GPs within the practice budget scheme, will tend to buy where waiting times are shortest, and hospitals will have a stronger incentive to become more efficient. In the meantime, the Government intends to build on the current waiting list initiative. The central waiting list fund will be targeted at Districts who can show that they can use the extra money effectively. They will be enabled to treat, on a contract basis, patients from that District or elsewhere in the Region who have already waited excessively.

7.32 As a further, immediate measure the Government proposes to introduce a scheme under which a number of additional, permanent Consultant posts can be created over the next two years. These posts will be over and above the 2.2 per cent annual expansion in Consultant numbers to which Regions are already committed. The details of the scheme will be worked out with representatives of the profession and NHS management. In essence it will concentrate on increasing the number of Consultants in those acute specialties which currently have the longest waiting times for treatment. Establishing a new

Consultant post also involves indirect costs, such as nursing and other staff and the provision of equipment. The Government recognises this and will ensure that effective use can be made of the new posts.

Draft (20.12.88)

CHAPTER 8: MANAGING THE FAMILY PRACTITIONER SERVICES

Introduction

8.1 This chapter makes a number of proposals for building on the policies set out in the Government's White Paper on primary health care, "Promoting Better Health" (Cm 249). It does so in four areas: medical audit; competition; prescribing costs; and management. In each case the Government's proposals complement those in the rest of this White Paper by aiming to improve services for patients, both directly and through achieving better value for money.

Medical audit

8.2 Chapter 6 outlines the Government's proposals for ensuring that effective medical audit is established throughout the hospital service over the next two years. Medical audit is no less important in primary care. The quality of the medical care offered by a GP is just as fundamental to patients. Are referrals to hospital always well judged? Are drugs used effectively and efficiently? Does the coverage of clinics, and do clinic times, suit patients? Are relationships between doctors, community nurses and health visitors working satisfactorily? Is night and weekend cover good enough?

8.3 As with the hospital service, the Government intends to work with the medical profession nationally to establish a system of medical audit in general practice. The aim will be to build on the foundations being laid by the profession

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itself, such as the Royal College of General Practitioners' "Quality Initiative". The organisation of medical audit will be less straightforward than in hospitals. Care is delivered in more places; periods of treatment are less well defined; medical records are usually less detailed. But the Government is confident that these are difficulties which can be overcome.

8.4 The Government believes that the following key features will be generally applicable to medical audit in general practice:

* medical audit locally should be based primarily, but not exclusively, on self-audit by GPs and GP practices.

* local practice and procedures should be led, supported and encouraged by a medical audit advisory committee established by each Family Practitioner Committee (FPC).

* each FPC should establish a system for identifying possible indicators of poor quality care, such as emergency admissions to hospital resulting from poor health surveillance or a failure to refer for specialist advice.

* each FPC, in consultation with its GPs, should set up a small unit of doctors and other staff to support and monitor the medical audit procedures of its practices.

* the local advisory committee should guide the work of the medical audit unit and, where necessary, help to arrange an external peer review of a GP or GP practice.

* The F.P.C. should have access to the general results (not particular cases) of medical audit of a G.P.

8.5 The Government recognises that it may take longer than in hospitals to establish a satisfactory approach to medical audit in general practice. The Government will consult the profession and FPC interests on the detail of the approach it has in mind. The Government believes that, once a satisfactory system has been developed, all GPs should be required by their contracts to take part.

Competition

8.6 In "Promoting Better Health", the Government described a range of measures it intended to introduce to "put the patient first". A greater degree of competition was needed to improve services to the public. A better informed public, and a remuneration system geared to consumer demand, were seen as key mechanisms. This White Paper provides an opportunity for the Government to clarify some key objectives.

Capitation fees

8.7 At present, capitation fees form on average 46% of a GP's income. "Promoting Better Health" stated the Government's intention to raise this proportion. The Government remains of the view that GPs will have a stronger incentive to satisfy their patients if a greater proportion of their income is attributable to the number of patients on their lists. The Government intends, therefore, to raise average remuneration accounted for by captitation fees from 46% to 60%, as soon as possible. This will still allow scope for targeted incentive payments, for example for childhood immunisation or cervical cancer screening.

8.8 It will be important to ensure that good, young doctors who wish to enter general practice will find an adequate number of practice vacancies to apply for. The Government proposes to take two further steps to achieve this. First, it

will seek in due course to reduce from 70 to 65 the retirement age for GPs which has been introduced through the Health and Medicines Act 1988. Secondly, it will ensure that, when filling single-handed practice vacancies, FPCs give priority to younger doctors who are keen to work as members of primary health care teams.

Patients as consumers

8.9 The Government also remains of the view that patients must be able to exercise a real choice between GPs. "Promoting Better Health" outlined two particularly important changes to this end. The first is to make patients better informed. [Sentence referring to MMC consideration of doctors' advertising.] The second key change is to enable patients to register with a new doctor without having to go through the present procedure, which requires them first to approach either their existing doctor and FPC. The Government believes that patients should be quite free to choose and change their doctor without hindrance, and will bring forward the necessary amending Regulations as soon as possible.

Prescribing costs

8.10 The drugs bill is the largest single element - 36% - of expenditure on the family practitioner services (FPS), accounting for £1.9 billion in 1987-88. It has grown on average by four per cent a year in real terms over the past 5 years. The Government has taken a number of steps in recent years to contain the rate of growth in drug costs by encouraging more economical prescribing. The introduction of the selected list scheme in 1985 is just one example.

8.11 If unnecessary spending on drugs can be saved, money is released for other aspects of patient care in the NHS. The Government believes that there is more scope for reducing the

rate of growth in prescribing costs without harming patient care. For example, drug spending in different FPCs varies in England from £26 to £40 per head of population. To some extent these variations will reflect differences in population structure and morbidity. But they also reflect varying attitudes to the cost of drugs by doctors who have no direct or personal interest in the cost of the drugs which they charge up to the NHS and the taxpayer when they prescribe them. In the Government's view the time has come to establish a more rigorous approach to securing better value for money. It is extremely unlikely that the drugs bill will fall as important and expensive new drugs are produced steadily by successful research. More must and can be done to prevent the bill rising so quickly

8.12 Accordingly, the Government proposes to establish as soon as practicable - if possible from April 1991 - a new budgeting scheme to encourage economical and cost effective prescribing. Under this scheme FPCs will be given reasonable budgets for their drug spending, based on sensible assumptions about patient needs and prescribing patterns in their area. FPCs will in turn allocate indicative budgets to individual GP practices, and monitor spending in the light of those budgets. The aim will be to put downward pressure on the rate of growth in drug spending in the highest spending practices.

8.13 The Government will consult interested parties on the detailed development and implementation of this scheme, which will include the following main features:

[to be drafted in the light of final decisions on HC63]

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8.14 Before the scheme can work fairly and effectively, adequate information on drug prescribing and costs will be needed. An improved prescribing information system - known as "PACT" - was introduced in August 1988. This provides good quality feedback to doctors about their prescribing, three months after the quarter to which the information relates. FPCs will also have access to this information. The Government recognises that some improvement in the timeliness of this information will be needed. Subject to that, it believes that "PACT" information will form an adequate basis for monitoring expenditure against budgets.

Managing the FPS

8.15 The Government believes that there is a clear need to strengthen further the management of the FPS. "Promoting Better Health" set out a substantial body of changes which have still to be implemented by FPS management. This White Paper includes others. The rest of this chapter sets out the Government's proposals for stronger executive management, for streamlined non-executive leadership, and for firm monitoring and accountability.

Executive management

8.16 The Government proposes to create new chief executive posts in all FPCs, to be filled by open competition. The salaries for these new posts will be set significantly above those of the present FPC administrators, to be attractive to good quality managers from both inside and outside the NHS. FPCs will also need to strengthen their management and administrative skills at every level of the organisation. The main task of the new chief executives will be to supply the drive needed to manage change, working closely with the contractor professions themselves.

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Composition of FPCs

8.17 FPCs currently consist of 15 members from the contractor professions and 15 lay members. The Chairman may be from either group. All the members are appointed by the Secretary of State. The 15 professional members are drawn from nominations made by the professions' local representatives. Four of the lay members are drawn from District Health Authority nominees, and a further four from local authority nominees.

8.18 The Government believes that it is no longer sensible for the management of contracts with practitioners to be the responsibility of bodies on which the professions themselves are so strongly represented. Nor does it believe that a committee with 30 members can lead the management of the FPS as effectively as the changes now envisaged will require. The Government will therefore seek powers to replace FPCs with new bodies, to be known as Family Practitioner Authorities, with the following composition:

No FPA mean Family Practitioner Authority.

* a maximum of 12 members in total.

* a chairman appointed by the Secretary of State.

* three professional members - a doctor, a dentist and a pharmacist - appointed by the Regional Health Authority (RHA).

* a majority of lay members, appointed by the RHA and chosen for their experience and personal qualities.

* the chief executive, appointed by the chairman and lay members.

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8.19 The Government intends that the new Authorities should be freer than FPCs are now to determine their own sub-committee structure, and should be able to co-opt members to the committees as necessary. There is scope for slimming down radically the extensive sub-committee structure which currently applies.

Accountability of FPCs

8.20 Since April 1985, the 90 English FPCs have reported directly to the Department of Health. A good deal has been achieved by way of setting objectives for the Committees. But in the longer term the Government does not believe that it makes practical sense for central government to be so directly involved in local management, or for the Department to be responsible for monitoring the performance of 90 different bodies. This White Paper includes a number of proposals which, for good practical reasons, will give RHAs direct responsibility for FPS matters. The drug budget scheme described earlier in this chapter is one example, and GP practice budgets is another.

8.21 The Government will therefore seek powers to make the new Family Practitioner Authorities accountable to RHAs, and to enable RHAs to monitor and, if necessary, direct the work of these Authorities as they do that of DHAs. This change will have the further, important advantage of bringing responsibility for primary health care and hospital services together at a strategic level. It will then be easier to plan and monitor effectively comprehensive policy initiatives spanning both services, for example in the field of health promotion and disease prevention.

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Draft (20.12.88)

CHAPTER 9: BETTER DECISION-MAKING

Introduction

9.1 Today's health service is a complex, multi-billion pound enterprise. Demand is continually changing and increasing while resources are inevitably limited. The Government recognises the demands that this places on health authority Chairmen and members and is very appreciative of their efforts.

9.2 Chairmen and members will continue to have a vital role in the running of the health service. Indeed, they will need to spearhead the changes that the Government is proposing in the White Paper. To enable them to discharge this role effectively, the Government has decided that authorities should be streamlined. It also recognises the need for the centre to provide authorities with a clear framework of objectives and priorities within which to operate. This chapter sets out its proposals in both areas.

Composition of health authorities

9.3 Regional and District Health Authorities currently comprise a Chairman and between 16 and 19 members. The Chairmen and members of RHAs are appointed by the Secretary of State. The Chairmen of DHAs are also appointed by the Secretary of State, and most of the members are appointed by the relevant RHA. The RHA is required to consult various interests, and must appoint a representative of the appropriate university. Between 4 and 6 of the members of DHAs are directly appointed by relevant local authorities.

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9.4 The Government does not consider that an authority of this size and composition is conducive to effective decision-making . If authorities are to discharge their new responsibilities in a business-like way, they need to be smaller and to provide a single focus for corporate decision-making.

9.5 At district level, the arrangements for appointing members also reinforces a lack of clarity in the role of health authorities. At present they are neither truly representational nor management bodies. This confusion is underlined by the appointment of some members direct by local authorities. The Government believes that members should be appointed on the basis of the skills and experience they can bring to the authority and not according to the constituency which they represent.

9.6 The Government therefore proposes that, with effect from [April 1991]:

* RHAs and DHAs will be reduced from their present 16-19 members to 5 non-executive and 5 executive members plus a non-executive chairman;

* the executive members, who will be co-opted by the non-executive members, will include the General Manager and other senior staff such as the Finance Director, a leading clinician and nurse manager;

* the Secretary of State for Health will continue to be responsible for appointing the Chairmen and [non-executive] members of RHAs and the Chairmen of DHAs;

* RHAs will continue to be responsible for appointing the [non-executive] members of DHAs;

Guidelines?
as to how to appoint

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* non-executive members will be appointed on the basis of the skills and experience they can bring to the authority;

* local authorities will no longer have an automatic right to appoint members to DHAs [~~but will~~ [can] be consulted by RHAs as part of the normal appointments ~~procedure.~~];

Why?

* teaching districts will continue to include a representative of the Medical School;

* [RHAs will include a representative of the FPC Chairmen.]

Community Health Councils

9.7 The interests of the local community will continue to be represented by Community Health Councils (CHCs) which act as a channel for consumer views to health authorities and FPCs.

Central management of the NHS

9.8 Under the proposals set out in this White Paper, the NHS will continue to be largely funded by the Government from tax revenues. Ministers must be fully accountable to Parliament and to the public for the spending of these huge sums of money. ~~and for the services which they finance.~~ The Government therefore believes that a central Management Board for the NHS must be retained within the Department of Health and be under Ministerial direction and control.

Not in detail

9.9 The Government proposes however to streamline management arrangements with the Department by giving the Board a clear role in major strategic issues. In particular:

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* responsibility for the family practitioner services will be brought under the Board. The better integration of primary care and hospital services is an important objective;

* the Management Board will be chaired by the Chief Executive and will deal with ~~day-to-day~~ operational matters under the guidance of [a Policy Board] chaired by the Secretary of State;

* the [Policy Board] will be strengthened by the appointment of non-executive members from the NHS and from the private sector of business;

* the [Policy Board] will replace the former Health Service Supervisory Board.

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CHAPTER 10: WORKING WITH THE PRIVATE SECTOR

Competitive tendering for wider range of services CBI report

10.1. The Government's aim is that there should be a genuine mixed economy in health care to the benefit of all those needing health care, whether in the National Health Service or in the independent health sector. Both the National Health Service and the independent health sector should be able to learn from each other to help each other and to buy and sell services to each other. The greater choice and spur of competition provided by such a mixed economy should make a substantial contribution to achieving the objectives of the Government's proposals for reform.

Scope of independent health sector

10.2. Since 1948 the National Health Service has been complemented by an independent health sector made up of a broad spectrum of private, voluntary and charitable bodies. The independent sector has re-inforced the National Health Service not only in areas such as elective surgery where public provision is universal, but also in areas where NHS coverage is limited. These range from hospices, nursing and convalescent homes to fitness training, screening and chiropody. Its contribution to health care in the UK is now significant:

- 5.25 million people or 9 per cent of the population of the UK are covered by private insurance;

- its acute hospitals in England have 7 per cent of acute beds and treat over 400,000 in patients and day cases a year;

- it carries out 17 per cent of all elective surgery, including 28 per cent of all hip replacements and 19 per cent of all coronary artery by-pass grafts;

- it provides over 90 per cent of all hospice beds and convalescent home places;

- there are over 52,000 beds in nursing homes.

10.3. The advantages brought by the independent sector are that it:

- increases the range of options available to general practitioners and patients and offers the consumer choice;

- contributes, and could contribute more, to the cost effective treatment of NHS patients. It increases the options available to NHS management as well as to individual patients;

- responds flexibly and rapidly to consumer needs, thanks to its diversity.

These advantages can be developed to the benefit of all patients. Just as the private sector has no monopoly of efficency or quality of hotel services, so public provision has no monopoly of caring or the quality of clinical treatment.

Meeting the NHS's needs

10.4. There is already a growing partnership between the NHS and the independent health sector, which provides some 3,000 residential places for mentally ill people and some 7,500 places for mentally handicapped people. In 1986, contractual arrangements between the NHS and independent sector led to over

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26,000 patient treatments at a cost of some £45 million. Many of these are long term contracts. As part of the Government's drive to improve hospital waiting lists, many health authorities have entered short term contracts with private hospitals specifically to treat waiting list cases.

10.5. The Government believes that there is considerable scope for building on these initiatives. Under the proposals set out in Chapter [7] general practitioners and their patients will be able to choose treatment in the private sector for certain conditions if this offers better quality or better value for money than buying NHS services. Similarly, health authorities will continue to be able to buy in services from the private sector if these are not available locally and if they offer a better deal than is available from other NHS hospitals.

Joint Ventures

10.6. Current examples of co-operation between the two sectors include the purchase of expensive equipment or minor captial developments, joint ventures to build day surgery units and the construction of a private hospital on NHS land adjacent to a new NHS hospital. These schemes allow the shared use of expensive facilities and their costs to the benefit of each partner. For instance the private sector has increased its ability to perform day surgery, an area in which it has so far lagged behind the NHS. The NHS has achieved additional treatment of patients and the opportunity to market its own facilities. The Government expects all health authorites to consider the opportunites for co-operative ventures as part of their regular reviews of hospital performance.

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Competitive tendering

10.7 The Government launched a competitive tendering initiative in 1983. By the end of the June 1988, 97% of domestic and laundry services, and 76% of catering services had been put out to tender, generating savings of almost £108 million annually - some 17% of previous costs. Though 85% of contracts have been awarded in-house, it is clear that the spur of external comptetition has produced substantial savings. Together with other NHS acitivities for which competitive tendering has been the established practice (eg estate services and some property maintenance), the total value of NHS services now subject to regular tendering is well in excess of £1 billion annually.

10.8 The Government believes that there is scope for much wider use of competitive tendering, beyond the non-clinical support services which has formed the bulk of tendering so far. This can extend as far as the wholesale "buying in" of treatments for patients from private sector hospitals and clinics, as has proved effective in the Waiting List Initiative. But competitive tendering should not be a "top down" exercise. The Government's objectives of pushing down decision making to the operational level and introducing more competition into the provision of services will greatly increase the opportunities for managers to buy in services from the private sector where this will improve the services to patients.

What?

[Treasury contribution on tax relief]

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CHAPTER 11

SUMMARY AND TIMETABLE FOR CHANGE

Introduction

11.1 Taken together, the proposals in this White Paper represent the most far-reaching reform of the NHS in its forty-year history. They offer new opportunities - and pose new challenges - for GPs, for consultants, for hospital staff, for hospital managers, for regional and district health authorities, and for FPCs. They will mean change at the centre, and change on the ground.

11.2 They will lead to a more modern, more efficient, more caring NHS, better able than ever before to make the most of its formidable resources and the reserves of talent and commitment at its disposal. Their aim is to ensure that the NHS provides a more rewarding environment in which to work, and - most important of all - that it becomes even better at delivering the highest possible standards of care and treatment.

11.3 Although the reforms outlined in this White Paper are designed to make the NHS fundamentally different, in many respects they herald a change of pace and scale rather than a change of direction. Frequently they build on what is already being achieved in some parts of the NHS today; their aim is to spread the benefits of those achievements more widely throughout the service as a whole.

11.4 There is nothing new, for example, in the idea of devolving management responsibility down to local level. What is different is the extent and degree to which that process will in future be taken, and the particular twist it has been given with the development of the concept of self-governing hospitals. Similarly, the drive to extend Medical Audit will be building on well-established principles.

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11.5 What is new, however, is the way in which the Government's policy will work to free up the NHS and give more choice to patients, more choice to GPs, more choice to DHAs as buyers of services. By introducing competition and by rewarding those who offer the best service the Government plans to overcome the "take-it or leave-it" attitude still found too often in the NHS. As a result of those reforms, those who work in the NHS will have to think even more carefully about the needs and wishes of patients.

Summary of proposals

11.6 A single thread runs through all the proposals in this White Paper - the drive for a properly managed health system that will deliver the best quality care - but it will affect different groups connected with the NHS in different ways. The main changes for each major group can be summarised as follows:

i. GPs

- large GP practices will in future be able to opt to hold their own budgets (ch.3);

- money following the patient will mean that GPs referral patterns will have a greater impact on hospital services (ch.x);

- a new system of medical audit will be introduced (ch.x);

- publication of information on the clinical records of hospitals and units will give GPs a better informed choice (ch.x);

ii. Consultants

- will have more responsibility for the management and delivery of hospital services (ch.x);

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- there will be medical audit in all DHAs and SGHs within 2 years (ch.x);

- will be affected by new criteria for distinction awards (ch.x);

- will have a greater say in the way their hospitals are run as a result of devolution of managerial responsibility and the establishment of new self-governing hospitals (ch.x);

- will be affected by the introduction of GP budgets and money following the patient (ch.x).

iii. Managers

- will be affected by the abolition of RAWP and the introduction of funding to HAs on a weighted capitation basis (ch.x);

- will be affected by the devolution of managerial responsibility to hospitals and the introduction of self-governing status (ch.x);

- will be affected by the increased involvement of consultants in the management of hospitals (ch.x);

- more competitive tendering (ch.x);

- external audit by the Audit Commission;

- a smaller NHSMB with more non-executive directors from outside the Health Service. The Executive Committee will be chaired by the Chief Executive, and the HSSB will be abolished (ch.x);

- DHAs will become primarily buyers of services (ch.x).

iv. Structural change

- smaller HA membership with executive and non-executive membership (ch.x);

- delegation of RHA's executive role to DHAs (ch.x);

- smaller FPC membership and reduced professional membership (ch.x).

v. Patients

All the proposals listed above will in time work towards better delivery of care and thus a better service to patients. But in particular, those who use the NHS will benefit from the greater choice brought by:

- GP budgets with money following the patient (ch.3);

- the publication of information about the clinical records of hospitals and units (ch.x);

- appointments system etc (ch.2);

- ability to pay for "extras" (ch.2);

- more pay beds and private wings (ch.x);

11.7 A Timetable for Change

The programme of reform will have three main phases.

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PHASE 1

1989: planning and preparation

11.8 During 1989, the Government will be consulting those most closely concerned and discussing with them the best way of turning the proposals in this White Paper into action.

The Resource Management Initiative will be extended to more major acute hospitals.

Regional Health Authorities will review their functions, and those of their Districts, and start planning how to devolve operational responsibility down to unit level.

Regions will help identify the first hospitals to become self-governing, and plan for those new status.

PHASE 2

1990: legislation and development

11.9 During the 1989-90 session of Parliament the Government will introduce a Bill to give effect to the major changes proposed in this White Paper; Operational responsibility will be devolved to local level.

The introduction of new management structures and financial and information systems in hospitals will gather momentum.

'Shadow' Boards for the first group of self-governing hospitals or Hospital Trusts will start to develop their plans for the future.

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PHASE 3

1991: the new NHS takes shape

11.10 In April 1991, the first Hospital Trusts will be established.

The new, streamlined Health Authorities will take over from their predecessors, buying services within an internal market in the NHS, and working with the new Hospital Trusts.

The first GP practice budget-holders will exercise their new powers.

11.11 Peroration

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Telephone 01-210 3000

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

File

Approval to plan announced on 22/12.

Dominic Morris Esq
Private Secretary
10 Downing Street
LONDON SW1A

20 December 1988

Dear Dominic

I thought you would like to know that my Secretary of State has now written to the Chief Secretary seeking his agreement to a new hospital on the site of St Stephen's in Riverside Health Authority. A copy of his letter is attached.

Mr Clarke still hopes to make an announcement about the new hospital before Christmas. I shall be in touch again when we hear from the Chief Secretary.

Yours ever

Flora

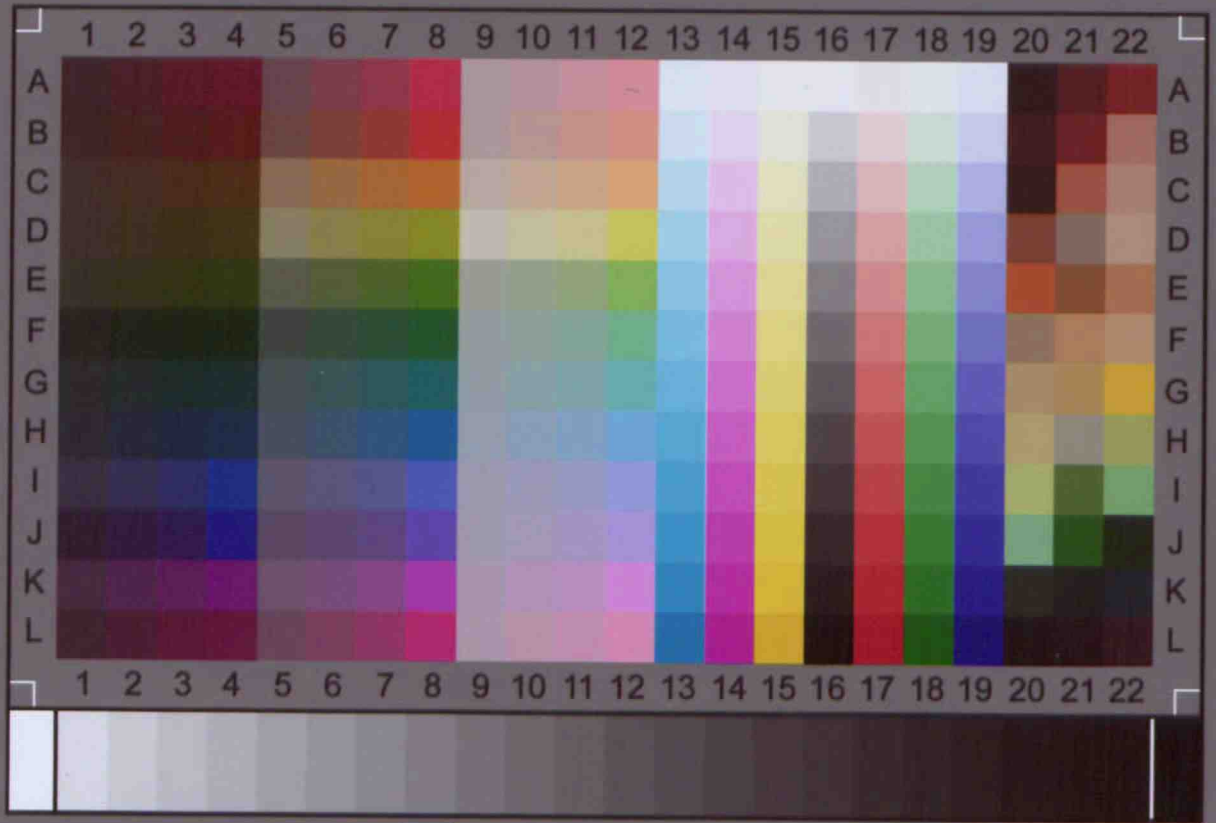
FLORA GOLDHILL
Private Secretary

PART 16 ends:-

PAB to DOH 16.12.88

PART 17 begins:-

DOH to DM 20-12-88



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