PREM 19/2897

Part 18

MT

Confidential filing

743

NHS Expenditure & Efficiency

NATIONAL HEALTH

Part 1: May 1979

Part 18: Jan 89

N.H.S. WHITE PAPERS COUTLINES DATED 13/1/89 AND 20/1/89) IN FOLDER ~~FOLDER - Models for the NHS Review White Paper Cover~~

Referred to	Date	Referred to	Date	Referred to	Date	Referred to	Date
20-1-89 22-1-89							

PART 18 CLOSED

PREM 19/2897

PART 18 ends:-

Dept Health to PS Jan 89

PART 19 begins:-

PS/CST to PS/SS. Health 23.1.89

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

From the Secretary of State for Social Services

Dear Paul, FA - NHS

As promised, I enclose three alternative mock ups for the NHS Review White Paper cover. We do not like I and have not really considered 2 and 3.

As I mentioned, the logo and slogan on the bottom (The Health Service, Caring for the 1990s) is being used on all our material so cannot be altered.

Yours

Andy

cc PU
Mr Prime
Pm 2AKP

10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

22 January 1989

NHS REVIEW: WHITE PAPER SUMMARIES

The Prime Minister was grateful for a sight of the two proposed summaries of the White Paper, enclosed with your letter of 20 January to Carys Evans.

Popular Version

The Prime Minister has the following comments:

- in the first line delete "the best system of its kind" and substitute "unsurpassed";
- add to the end of the last sentence of the first paragraph "bringing the total to X millions a year";
- on the first line of page 3 delete "major";
- the Prime Minister thinks it is essential for the popular version to include a reference to tax relief for the elderly.

Draft Paper for NHS Staff

The Prime Minister has the following comments:

- paragraph 9, second indent, line one, delete "major";
- section on Self-Governing Hospitals, paragraph 4, delete the last sentence (beginning "Initially, major acute hospitals....")
- in the New Funding Arrangements section, delete the last sentence;
- in the GP Practice Budgets section, third paragraph, amend "at least £600,000-£700,000" to "at least £500,000";
- paragraph 15, first sentence should be deleted.

I am copying this letter to Carys Evans (Chief Secretary's Office and Richard Wilson (Cabinet Office).

PAUL GRAY

Andy McKeon, Esq.,
Department of Health.

SECRET

PM2AKR

PA

cc CFFICE

MR. INGHAM

NHS VIDEO RECORDING

You will see that the Prime Minister has marked various changes to the text for the video (attached).

It also now occurs to me that the reference to "Britain" in the first line is not quite right. This is UK business, and the Northern Irish may want - as I gather the Scots will - to make use of the video. So instead of "Britain's" it better say "our" or refer to the UK.

Can we make the necessary amendments to the teleprompter before the recording? (I shall be out of the office tomorrow morning so if you want any Private Office involvement, you will have to call on one of the others).

PAUL GRAY

22 January 1989

PRIME MINISTER

We have had another go at polishing the message for the video recording on Monday and the draft is at Annex I. We are putting it on a teleprompter.

The recording will take place immediately after the diary meeting on Monday morning. I propose you should do it in the White Room against a reasonably plain background.

The video company will be here from 10.30am along with a make-up girl. The whole recording should take no more than 30 minutes. Sarah Charman is in charge of the arrangements and Romola Christopherson is coming over from Department of Health because she is responsible for the whole of the presentation of the NHS Review.

As you know, the video recording will be used at the launch of the White Paper both in London and in the various regional centres and simultaneously in the regional centres to which the Department of Health's roadshow is to go after the launch.

BERNARD INGHAM
January 20, 1989

ANNEX 1

At its best, Britain's National Health Service is without equal. Time and again, the nation has seen just how much we owe to those who work in it.

A skilled and dedicated staff - backed by ~~massively~~ enormously increased resources - have coped superbly with the growing demands of modern medicine. There is a great deal of which they, and we, can rightly feel proud.

The NHS will continue as now to be available to all, regardless of income, and mainly financed out of general taxation.

But a major task now confronts us. It is to bring all parts of the National Health Service up to the very high standard of the best while maintaining the principles on which it was founded.

All the proposals in this White Paper aim further to develop a National Health Service that puts patients first.

We believe that an NHS that is run better will be an NHS that can care better.

Taken together, the proposals represent the most far-reaching reform of the NHS in its forty year history.

They offer new opportunities, and pose new challenges, for everyone concerned with the running of the Service.

I am confident that those who work in it will want to ~~seize~~ these opportunities to provide for the millions of people who rely on the National Health Service even better health care as and when they need it. The patient's needs are paramount.

PRIME MINISTER

NHS REVIEW

I have taken action this evening on the various points you made on the papers you saw over the weekend.

But there are two further points it would be helpful to have your reaction to tomorrow:

(i) do you want Duncan Nichol (the new NHS Chief Executive) to come to Tuesday's meeting on the future organisation? Yes please not

(ii) do you want your name to appear with the four Secretaries of State on the front cover of the White Paper?

I think it would be better for them if my name did not appear.

PRCG.

PAUL GRAY

22 January 1989

PM2AKQ

27a-d B

SECRET

P 03342

PRIME MINISTER

DRAFT WHITE PAPER ON THE REFORM OF THE NATIONAL HEALTH SERVICE
[E(A)(89)2: Memorandum by the Secretary of State for Health]

1. The main purpose of this meeting is to secure collective endorsement of the proposals in the White Paper and formal agreement that, subject to the approval of the Cabinet on 26 January, it should be published on 31 January. The meeting also provides an opportunity to run over any outstanding points about the arrangements for publication.

2. You may wish to begin by summarising briefly the main themes and reforms which have emerged from the Ministerial Group's work (speaking note below) and then inviting the Secretary of State for Health to run through the proposals. In doing this you may wish to make it clear:

i. that the Sub-Committee is being invited to endorse the substance of the proposals. The Secretary of State should retain discretion to polish it, provided that he does not change the sense;

and ii. that discussions are still continuing on the arrangements for central management of the NHS in Chapter 2. Any changes of substance will be reported to Cabinet.

2. If there are any detailed drafting points on the text of the White Paper, you may wish to ask for them to be sent direct to Mr Clarke as a matter of urgency, outside the meeting.

3. You may then wish to check the final arrangements for publication:

SECRET

SECRET

6

i. Cabinet. The draft White Paper has been circulated around Cabinet at the same time as E(A), as agreed, for discussion this coming Thursday, 26 January;

ii. Parliament. You may wish to ask Mr Clarke to circulate for comment the oral statement which he will be making on 31 January. Presumably there will also be a debate.

iii. Cover and illustrations. You may wish to ask what these will be like.

I have given you comments on this to DoH. AJEG 23/1

iv. Popular version. The Department are about to go to print with a 'popular version' of the White Paper. A copy will be in your box this weekend. It appears to contain no reference to tax relief for the elderly.

v. Detailed papers. Soon after the White Paper is issued Mr Clarke proposes to publish eight detailed papers (called working papers in the text, paragraph 1.10) explaining in detail how the Government's proposals are to be implemented. The White Paper also says that the Secretaries of State for Scotland, Wales and Northern Ireland will also publish papers as necessary. You may wish to check that these papers are being cleared with the Treasury, as you asked at the group's meeting on 5 January.

vi. Co-ordination with Wales, Scotland and Northern Ireland. Mr Clarke and his Department have a series of media briefings and meetings with special interest groups (eg the BMA) and NHS management lined up for 31 January. Presumably Mr Walker, Mr Rifkind and Mr King plan briefings too. You may wish to ask what arrangements are being made to co-ordinate what line is taken by these Ministers. It seems essential that they should have common, co-ordinated briefing and an agreed line to take on every aspect.

SECRET

vii. Support for the White Paper. Presumably Mr Clarke is arranging for professional people who support the proposals to speak out when it is published.

POINTS TO MAKE

4. In opening the discussion you may wish to draw on the following:

i. The central theme of the reforms is the need to provide a better Health Service for patients: raising the performance of all hospitals and GP practices to the level of the best. It is particularly important to bring about first, a greater devolution of responsibility throughout the NHS, so that so far as possible those who provide the service can take the decisions; and second, to allow the money to follow the patient, so that the resources go to the hospitals which do the work.

ii. The proposals for self-governing hospitals and for GP practice budgets are major, fundamental reforms. Both are designed to lead to greater choice and value for money for patients who, as taxpayers, are providing huge sums for the NHS and are entitled to expect good value. In presenting the proposals it is essential to avoid the impression that hospitals will 'opt out' of the NHS, which is not what is intended.

iii. Another key theme is to get the public and private sector working together. A healthy and growing private sector adds to the choice for patients. The proposal for tax relief for the elderly is important in this context and will be welcomed.

iv. Finally, there will be an important drive to sharpen up the accountability and efficiency of NHS management. The aim is to take out the political element in District Health Authorities and to streamline the system so that there is a proper chain of command running from the bottom to the top,

SECRET

d

with the Audit Commission providing more effective audit arrangements. On the professional side, there will be much greater use of medical audit and better arrangements for consultants.

v. Taken together these proposals are a radical and far-reaching package which will preserve what is good in the NHS but put right the things which are wrong.

RTJW.

R T J WILSON
Cabinet Office
20 January 1989

SECRET

PRIME MINISTER

20 January 1989

NHS REVIEW: WHITE PAPER SUMMARIES

Comments on the Draft PoP Version of the White Paper as follows:

1. Page 1, first sentence

'All in all, Britain's Health Service is the best system of its kind anywhere in the world' is a rather over-dramatic statement. And comparisons are made difficult by the NHS's uniqueness. I suggest the following introduction to replace the first two sentences:

> "Patients enjoy a very high standard of health care in the United Kingdom. And our Health Service has a skilled and dedicated staff, backed by substantial and growing resources".

2. Page 1, first paragraph, last sentence

As a standalone sentence, the statement 'And to take just one example, the NHS now ~~covers~~ cares for 1½ million more in-patients each year' could give the impression that health standards have fallen. This could be replaced by 'And in view of advances in technology and improved efficiency, the NHS now cares for 1½ million more in-patients each year'.

3. Page 3, first line

Change 'major hospitals' to 'hospitals' as previously agreed.

b

4. We may want to include a reference to tax relief for insurance premiums (people in retirement).

an amazing omission. PRCG.

Comments on the Draft White Paper for NHS Staff as follows:

1. Para 9, second indent, line 1

Change 'major hospitals' to 'hospitals' as previously agreed.

2. Self-Governing Hospitals - fourth indent

Take out the last sentence 'Initially, major acute hospitals will be the most suitable candidates but in due course other hospitals may come within the scope of the proposals'.

Otherwise this statement will send negative signals to non-acute hospitals keen to opt-out.

3. New Funding Arrangements - last sentence

'GPs will still be able to refer a patient to whichever hospital or consultant they think best'.

In the new funding system, GPs will have some discretion. Districts may keep a reserve budget for referrals to hospitals outside their contractual list. But GPs will not have complete freedom of referral. To be on the safe side, we should exclude this sentence.

4. GP Practice Budget - third paragraph

We should be careful with the rather vague reference to 'at least £600,000 - £700,000' for the size of GP budgets. We have yet to decide a full list of treatments and their cost.

To be on the safe side, this may need to be changed to 'at least £500,000'.

5. Paragraph 15, first sentence - in brackets

'There will be no wholesale administrative reorganisation of the NHS'.

This sentence should be removed.

Ian Whitehead

IAN WHITEHEAD

0601A

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

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

25(1)a-d

COVERING SECRET

Ms Carys Evans
Private Secretary to the
Chief Secretary to the Treasury
HM Treasury
LONDON SW1

20 January 1989

Dear Carys

NHS REVIEW: WHITE PAPER SUMMARIES

As promised, I enclose a copy of the two summaries of the White Paper - a popular version for the public which would be in leaflet form and a version for NHS staff. The drafts will need to be updated to ensure consistency with the White Paper as editorial changes are made there (today's summary versions are based on yesterday's White Paper draft!).

We would be grateful if the Chief Secretary could consider the drafts in relation to his wider role concerning Government publicity. We could also be glad to know if you think the drafts include any errors or depart from the substance of the White Paper.

As requested, I am also sending a copy of this letter and enclosures to Paul Gray (No 10) and Richard Wilson (Cabinet Office).

Yours

A J McKEON
Principal Private Secretary

0526A

b

DRAFT - 20/1/89

DRAFT PoP VERSION OF WHITE PAPER

The Health Service today

All in all, Britain's Health Service is ~~the best system of its kind~~ unsurpassed anywhere in the world. It has a highly skilled and dedicated staff, backed by huge and growing resources. There are well over 6,000 more doctors and dentists and 70,000 more nurses and midwives than in 1978. Spending has shot up - from £8 billion in 1978 to £26 billion in 1989 (£154 million each week in 1978 compared with £500 million each week in 1989). And, to take just one example, the NHS now cares for $1\frac{1}{2}$ million more in-patients each year. [illegible] 1½ million a year

There is a lot to be proud of. Today, the Health Service is helping people in Britain to live longer and enjoy a better quality of life. But despite those successes, the performance of the NHS still varies greatly from place to place:

- people have to wait for operations much longer in some places than in others. A patient who has to wait several years in one District could have the same operation within a few weeks in another;

- drug costs in some places are nearly twice as high per head of population as in others.

- some GPs refer twenty times more patients to hospitals than others.

- the average cost of treating someone in hospital varies by as much as 50% between different health authorities.

b

Of course, the NHS is not a business run for profit, but it can certainly become more business-like. What the Government now wants to do is to take all that is best in the NHS, and raise the rest of it to that very high standard. An NHS that is run better will be an NHS that can care better.

The Way Ahead

Over the last year, the Government has been looking at ways of strengthening the Health Service. That review is now over, and its conclusions have just been announced. Some of them will need the approval of Parliament. They all have a simple aim - a service that puts patients first. But while some of them will require major reforms in the way the NHS is run, the basic principles that have guided it over the last 40 years will continue to guide it into the next century. As now, the Health Service will continue to be available to everyone, regardless of income, and paid for mainly out of general taxation.

The proposals are all designed to enable those who work in the NHS to give you even better care. In future:

* as much power and responsibility as possible will be taken from central and regional administration and given to those working to provide care at a local level;

* resources will go more directly to those hospitals which offer the best service - popular hospitals which attract more patients will attract more money. Rewarding the best will increase the quality of patient care, and encourage all hospitals to improve their standards;

* major hospitals will be able to choose to run their own affairs. Known as "NHS Hospital Trusts", those self-governing hospitals will still be part of the NHS, but will have much more freedom to take their own decisions. In order to earn income, they will have to provide the kind of service that patients want. They will of course continue to provide emergency treatment to anyone who needs it;

* large GP practices will be able to buy a range of services direct from hospitals. They will be able to "shop around" to get the best possible care for their patients. This means that they will, for example, be able to send patients to hospitals where waiting times are shortest. All GPs will also be encouraged to offer a better service, because their pay will be increasingly related to the number of patients they attract. It will be easier for patients to choose (and change) their GP;

* there will be 100 new consultants over the next three years. This will help keep up the attack on waiting times and on the long hours worked by some junior doctors.

Putting Patients First

All these reforms will improve the quality of the service that the NHS provides. Some of them will however take time to work through. So there will be other initiatives to tackle the areas of greatest public concern more immediately:

i. the Waiting List Initiative will be continued. Over the last two years, a special £60 million fund has allowed an extra 220,000 people to be treated. Half of all waiting list patients are now admitted from the list within 5 weeks or less. Another £40 million will be spent on this initiative next year.

d

ii. To make sure that patients are treated more sensitively, each hospital will be expected to offer:

- individual and reliable appointment times;
- more attractive waiting areas, with proper facilities for parents with children;
- counselling for family and friends;
- clear and sensitive explanations of what is happening when someone is in hospital;
- rapid notification of the results of diagnostic tests.

iii. In addition, so that patients can feel more at home and exercise more choice, they will in future be able to pay for a number of optional extras such as a choice of meals, a single room, a telephone or a television.

Timetable for Change

Taken together the Government's proposals will bring major change for the NHS. They are too important to rush into, so 1989 will be a year of preparation. By 1990, the new NHS will be taking shape, and the new method of funding hospitals will start. By 1991 the first NHS Hospital Trusts will be up and running, and some GPs will be buying hospital services for their patients. In the nineteen-nineties the new NHS will provide the country with a more modern and effective service, working for patients even better than before.

YA/0613t [3rd DRAFT - 20/1/89]

SUMMARY OF NHS REVIEW WHITE PAPER - FOR NHS STAFF

INTRODUCTION

1. The Government has published a White Paper: ["Working For Patients"] (Cm 555) setting out its plans to reform and strengthen the National Health Service.

2. Underlying every proposal in the White Paper is a simple aim - a service that puts patients first. The achievements of the NHS - in helping increasingly large numbers of people to enjoy a better quality of life and to live longer - will be the foundation from which an even better service can be built. All that is best in the NHS will be retained. The Government supports and will not change the principles on which it was founded - it will continue to be open to all, regardless of income, and financed mainly out of general taxation.

THE ACHIEVEMENTS OF THE NHS

3. The NHS is growing at a truly remarkable pace. There are over 6,000 more hospital doctors and dentists and 70,000 more nurses and midwives than in 1978. Spending has increased massively - up from £8 billion in 1978/79 to £26 billion in 1989/90, an increase of 40 per cent after allowing for general inflation. All this, coupled with improved productivity, means that - to give one example - NHS hospital staff now treat over $1^{1}/2$ million more in-patients a year than in 1978.

THE NEED FOR CHANGE

4. So the NHS has expanded enormously since 1978. The quality of its medical care and its ability to respond to emergencies remain among the best in the world. But increasingly people recognise that rising demand and an ever-greater range of treatments mean that more needs to be done. And that the injection of more and more money is not, of itself, the answer.

5. The organisation of the NHS - the way it delivers care to individuals - needs reform. The Government has already taken a series of measures to improve the way the Service is managed, notably the introduction of general management. Their success points the way ahead.

6. The performance of all hospitals and GP practices needs to be raised to the level of the best. How to do so has been the main question for the Government's review. There is clear evidence of wide variations at present. For instance, in 1986-87, the average cost of treating acute hospital in-patients varied by as much as 50 per cent, even after allowing for the complexity and mix of cases. In the same way, waiting times for operations vary sharply and there are great differences in the referral rates and prescribing habits of GPs.

7. To achieve its aims the Government intends to provide a framework in which the talent and enterprise of all those working in the NHS can flourish. It wants much more delegation of power and responsibility to those who deliver care to patients - mainly the GP and the local hospital. The best run services are those where local staff are given as much responsibility as possible for responding to local needs and are held to account for doing so.

8. The White Paper proposals are a programme of action designed to secure two objectives:

* to give patients, wherever they live, better health care and greater choice of the services available; and

* to produce greater satisfaction and rewards for NHS staff who successfully respond to local needs and preferences.

THE KEY PROPOSALS

9. The White Paper contains seven key measures:

* More delegation of responsibility to local level

To maximise responsiveness to patients' needs, functions will be delegated from Regions to Districts and from Districts to hospitals. All hospitals will be given much more responsibility for running their own affairs, enabling local commitment, energy and initiative to flourish.

* Self-governing hospitals

To stimulate a better service to patients, major hospitals will be able to apply for a new self-governing status within the NHS as NHS Hospital Trusts. These Trusts will be given more freedom to take the decisions which most affect them, such as offering their services to the NHS and private sector, determining the pay of their own staff and (within limits) borrowing capital.

* New funding arrangements

To enable hospitals which best meet patients' needs to get the money to do so, the money required to treat patients will be able to cross administrative boundaries. In future, all NHS hospitals - whether run by health authorities or self-governing - will be free to offer their services to different health authorities or to the private sector. In this way money will go more directly to where the work is done and health authorities will be better able to use their funds to secure a comprehensive range of services.

* Additional consultants

To reduce waiting times and improve the quality of service, 100 new consultant posts will be created over the next three years. These will be over and above the already agreed rate of expansion and will also help reduce the long hours worked by some junior doctors.

* GP practice budgets

To help the family doctor improve his service to patients, large GP practices will be able to apply for their own budgets to buy a defined range of services direct from hospitals. GPs will be encouraged to compete for patients by offering better services and it will be easier for patients to choose (and change) their GP.

* Reformed management bodies

To sharpen the efficiency and accountability of NHS management, regional, district, hospital and family practitioner management bodies will be reduced in size and reformed on business lines. They will have executive and non-executive directors. Community Health Councils will continue to act as a channel for consumer views.

* More rigorous audit arrangements

To ensure that all who deliver patient services make the best use of resources, quality of service and value for money will be more rigorously audited. Arrangements for "medical audit" will be extended throughout the NHS. And the Audit Commission will audit the accounts of health authorities and other NHS bodies and undertake wide-ranging value for money studies. It will report to Ministers and its reports will be published.

10. The Secretary of State for Health will shortly publish a number of working papers explaining in detail how major aspects of these proposals are to be implemented in England.

CONFIDENTIAL

[TO BE IN A SEPARATE BOX]

SELF-GOVERNING HOSPITALS

The Government wants to create a number of "self-governing" hospitals within the NHS in order to:

* make the most of the energy, commitment and ability of hospital staff, by setting them free from many of the current constraints.

* encourage a stronger sense of local pride in hospitals, many of which are substantial organisations spending £10-50 million a year.

* enable them to offer their services throughout the NHS and to the private sector, which should lead to more patient choice, greater efficiency and encourage other hospitals to do even better. As a result patients should receive better services.

The powers and responsibilities of each self-governing hospital will be vested in a new body, known as an NHS Hospital Trust. They will be run by small Boards of Management operating like a commercial Board of Directors, with executive and non-executive members and a General Manager.

Self-governing hospitals will get their money from selling their services, mainly to health authorities. A hospital which is good at its job and attracts increasing numbers of patients will see its income rise.

A simple procedure will apply for establishing an NHS Hospital Trust. A variety of groups will be able to start the ball rolling, such as the hospital management team or the senior medical staff, with the Secretary of State for Health taking the final decision. Initially, major acute hospitals will be the most suitable candidates but in due course other hospitals may come within the scope of the proposals.

Self-governing hospitals will be free to determine the pay and conditions of their own staff. And they will have greater freedom (within limits) to borrow capital.

The first self-governing hospitals should be established from April 1991, subject to the necessary legislation.

CONFIDENTIAL

[TO BE IN A SEPARATE BOX]

NEW FUNDING ARRANGEMENTS

At present, NHS funds are allocated from central Government to individual hospitals (via Regions and Districts) through a complicated and remote process. Regions get their money through the RAWP formula. RAWP has largely achieved its purpose of equalising the resources available to each Region. But it has disadvantages. It's highly complex and slow to compensate those Regions which take many patients from elsewhere. District funding too is slow to reflect these flows of patients across administrative boundaries. This means funding and workload may be out of step. As for hospitals, they are at present subject to the perverse effects of a system which can penalise success.

The Government wants to change all this. So it proposes to:

* change the method of funding Regions and Districts to a simpler one based on population numbers and weighted for the health and age of that population. The cost of treating patients from other Regions and Districts will be reflected in budgets much more quickly than now. The Thames Regions will get slightly higher funding per head - some three per cent - to reflect their populations' higher use of services. The transition to the new system should be complete by April 1992 for Regions and [April 1994] for Districts.

* place the funding of hospitals on a new footing. The objective is a system where the money goes more directly to where the work is done and done best.

At the hospital level there is a clear distinction to be drawn between services where guaranteed immediate access is necessary, such as Accident and Emergency, and those where the patient and his GP have some choice about when and where to be treated. Some immediate access (or "core") services will be funded through a management budget by which the DHA sets clear performance targets for its own hospitals. DHAs will also be able to buy such services from other Districts or from self-governing hospitals.

Where there is some choice over the time and place of treatment, services will be obtained through a contract, specifying the cost and amount of treatment. DHAs will be able to place contracts with their own, directly managed, hospitals, or with self-governing, private or other DHAs' hospitals. [GPs will still be able to refer a patient to whichever hospital or consultant they think best.]

CONFIDENTIAL

[TO BE IN A SEPARATE BOX]

GP PRACTICE BUDGETS

The GP service is one of the great strengths of the NHS. The GP is the patient's key adviser about the best hospitals and specialists. But it can take a long time for good and popular hospitals - which treat more patients - to receive more money. So GPs have little incentive to offer patients a choice of hospitals.

The Government wants GPs in large practices to hold their own budgets with which they can buy hospital services for their patients. These budgets will cover:

* out-patient services;

* a defined group of in-patient and day case treatments, such as hip replacements and cataract removals;

* diagnostic tests, such as X-rays and pathology tests.

And budgets will be bigger and more flexible (at least £600,000-700,000) by also including:

* the 70% of the cost of employing staff which the Government already reimburses;

* money for improving premises; and

* the costs of prescribing drugs.

At first only practices with lists of at least 11,000 patients (twice the national average) will be eligible to join this voluntary scheme. Over 1,000 UK practices could join, covering about 25% of the population. The details of each practice budget will be settled by the RHA with the practice, within national guidelines to ensure consistency and fairness. Savings will be available to finance further improvements in the care delivered. And a fee will be provided to cover the costs of participation. The scheme should start from April 1991.

SCOPE OF THE PROPOSALS

11. Everyone is entitled to better health services with higher quality and more choice, regardless of where they live. So the White Paper proposals apply throughout the UK. The way they are implemented in each country will need to reflect each one's particular organisation of health care, as well as its distinctive needs and circumstances.

PUTTING PATIENTS FIRST

12. People sometimes have to wait too long for treatment and may have little, if any, choice over the time or place of treatment. The Government has already done much to tackle this problem. Over the past two years, £60 million has been spent on a new initiative to reduce waiting lists and times, allowing over 230,000 additional patients to be treated. As a result, half of all waiting list patients are now admitted from the list within five weeks or less. In 1989/90, another £40 million will be spent on this initiative.

13. The changes in the White Paper seek to improve further the quality of services offered by the NHS. At present the service provided on admission to hospital is sometimes too impersonal and inflexible. The Government intends to improve matters by ensuring that, like the best hospitals now, every hospital provides a service which considers patients as people, by offering:

* appointment systems which give people individual and reliable appointment times.

* quiet and pleasant waiting and other public areas.

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

* once someone is in hospital, clear and sensitive explanations of what is happening.

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

* rapid notification of the results of diagnostic tests.

* a wider range of optional extras and amenities, such as single rooms, televisions and choice of meals, for those prepared to pay for them.

THE BEST USE OF RESOURCES

14. A quality Service - which provides not only clinical excellence but also makes patients feel valued - requires a quality management and organisation. To provide the best possible service from its resources, particularly as demands continue to grow, the NHS must always seek to make the best use of the resources available.

15. [There will be no wholesale administrative reorganisation of the NHS.] But local managers must have more freedom to manage. And those whose decisions affect the use of resources must be more accountable for that expenditure. For some time the Government has been concentrating on giving more responsibility for taking decisions to those actually working in hospitals. The White Paper aims to take this process much further by:

* effecting a clearer distinction at national level between Ministers' policy responsibilities and the operational duties of top management.

* continuing the drive towards better information systems for local managers, enabling them to improve their budgeting and monitoring.

* ensuring that hospital consultants - whose decisions about treatment commit substantial sums of money - are more directly involved in hospital management; accept responsibility for their use of resources and are encouraged to use those resources more effectively. Proposals here include agreeing up-to-date job descriptions and modifying the distinction awards scheme.

* ensuring that GPs too take greater responsibility for their use of resources. Additional resources will be made available for developing computer systems for general practice.

* obtaining further improvements in the cost information available to managers, doctors and other professionals by extending the Resource Management Initiative - to up to 50 more acute hospitals in 1989/90, with the aim of covering all 260 major acute units by the end of 1991/92.

* introducing a system of accounting for capital which encourages managers to balance the need for new investment against the maintenance of older stock. Limits on the size of new projects needing central approval will be raised and joint ventures with the private sector encouraged.

* ensuring that drug prescribing costs are kept within reasonable limits.

* ensuring that services are carried out as cost-effectively as possible by contracting out more functions.

* re-examining the work of nurses and other professional staff so as to secure the most cost-effective use of their skills.

* making the reconstituted FPCs accountable to Regional Health Authorities.

PUBLIC AND PRIVATE SECTORS WORKING TOGETHER

16. The NHS and the independent health sector should be able to support each other and provide services for each other, to the benefit of patients. Those who choose to buy health care outside the Health Service take pressure off the NHS and add to the diversity of provision and choice. The Government expects to see further increaes in the number of people wishing to make private provision. But many who do so during their working life find the cost of higher premiums difficult to meet in retirement. The Government therefore proposes to allow tax relief on private medical insurance premuims paid by retired people or, for example, by their families on their behalf.

MANAGING THE FAMILY PRACTITIONER SERVICES

17. Primary care provided by GPs and the work of hospitals are closely intertwined. The Government intends to build on the proposals in its White Paper on primary care services, "Promoting Better Health", by:

* encouraging GPs to take greater responsibility for their use of resources. One objective is to introduce a national framework for medical audit whereby GPs would systematically review their work, supported by a special committee in each FPC.

* pressing ahead with plans to let consumers have more information about GP services and to make it easier to change doctor.

* increasing competition between GPs by raising the proportion of their pay derived from the number of patients on their lists from 46% to at least 60% as soon as possible.

* taking steps to control the total cost of the GP service whilst ensuring that sufficient opportunities remain in general practice. So the Government will seek reserve powers to control, if necessary, the number of GPs in contract with the NHS. It will also seek to reduce the retirement age of GPs from 70 to 65.

* reducing the rate of increase in spending on drugs through a new budgeting scheme whereby RHAs will give FPCs budgets for drug spending and GP practices will receive indicative budgets for their prescribing costs. There will be special arrangements to deal with over- and under-spends at both the practice and FPC level. People will still be able to get the medicines they need.

PROGRAMME FOR REFORM

18. The White Paper proposals will enable a higher quality of patient care to be obtained from the resources devoted to the NHS. They represent a wide-ranging opportunity to put the interests and wishes of patients at the forefront of decision-making at all levels.

19. They also offer a new and exciting challenge to all those who work in the NHS. The proposals amount to a substantial body of change, which must be implemented with determination and commitment.

20. The provision for health in the coming financial year, 1989/90, includes the likely costs of preparing for the reforms. Over time, any extra costs should be offset by the improved efficiency which will stem from the changes. The total provision for health will take account of progress in implementing the reforms, including the increased efficiency savings. The costs of implementation in future years will be considered in the annual public expenditure surveys.

21. Throughout the programme of reform the Government will hold to its central aims:

to extend patient choice; and

to delegate responsibility to those best placed to respond to patients' needs and wishes.

The result will be a better deal for the public, both as patients and taxpayers. The Government will build further on the strengths of the NHS, but will not flinch from tackling its weaknesses. This is the way to ensure that the NHS continues working for patients.

[TO BE IN A SEPARATE BOX]

A TIMETABLE FOR CHANGE

Legislation will be introduced at the earliest opportunity to give effect to the proposals. The programme of reform will have three main phases:

PHASE 1: 1989

* The Secretary of State for Health will establish a new NHS Policy Board and reconstitute the NHS Management Board.

* The Health Departments, and RHAs in England, will identify the first hospitals to become self-governing as NHS Hospital Trusts, and plan for their new status; will devolve further operational responsibility to Districts and hospitals; and will begin preparing the ground for GP practice budgets.

* The Government will introduce regulations to make it easier for patients to change their GP.

* The first additional consultant posts will be created; Districts will begin agreeing job descriptions with their consultants; and a new framework for medical audit will begin to be implemented.

* The resource management initiative will be extended to more major acute hospitals.

* Preparations for indicative drug budgets for GPs will begin.

* The Audit Commission will begin its work in the NHS.

PHASE 2: 1990

* The changes begun in Phase 1 will gather momentum. Devolving operational responsibility, changing the management of consultants' contracts and extending medical audit throughout the hospital service will near completion.

* "Shadow" Boards of the first group of NHS Hospital Trusts will start to develop their plans for the future.

* RHAs, DHAs and FPCs will be reconstituted, and FPCs will become accountable to RHAs. Regions will begin paying directly for work they do for each other.

PHASE 3: 1991

* The first NHS Hospital Trusts will be established.

* The first GP practice budget-holders will begin buying services for their patients.

* The indicative drug budget scheme will be implemented.

* District Health Authorities will begin paying directly for work they do for each other.

SECRET 25a-b

copy a

PRIME MINISTER

NHS REVIEW

I have taken action to implement the views you expressed on the batch of papers you saw last night. In particular, the Department of Health have been commissioned to produce a full and detailed paper setting down options on exactly how the new central management structure would work.

In terms of meetings, the arrangements are now as follows:

- as previously arranged, E(A) will meet at 1000 next Tuesday, 24 January.

- this will be followed by a newly arranged meeting of the NHS Review Group to consider the DOH paper on organisation (to be circulated on Monday night). I have invited Sir Christopher France to the meeting. You will also want to consider whether to invite the newly appointed NHS Chief Executive, Duncan Nichol - which Ken Clarke would favour.

But meantime, you will want to consider over the weekend the latest papers. These are:

Flag A - revised version of the draft White Paper, for discussion at E(A). (This does not yet reflect all your detailed comments).

Flag B - Richard Wilson's steering brief for that meeting, including some suggested introductory remarks.

Flag C - Note by Bernard with the latest text for your video and the arrangements for Monday's recording session.

Flag D - The DOH drafts of the two summaries of the White Paper - a popular version for the public and a

b

version for NHS staff.

Flag E - Notes by Ian Whitehead on the White Paper summaries.

It would be helpful to have over the weekend your reactions on the following points:

(i) do you want Duncan Nichol to come to Tuesday's meeting on the future organisation?

(ii) do you want your name to appear with the four Secretaries of State on the front cover of the White Paper?

(iii) do you want to feed in Ian's and any other comments on the White Paper summaries?

Regds.

PAUL GRAY

20 January 1989

PM2AKF

CONFIDENTIAL

FILE

SRW

10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

20 January 1989

Dear Stephen.

NHS WHITE PAPER: WELSH CHAPTER

Thank you for your letter of 19 January enclosing a revised draft of the Welsh Chapter.

The Prime Minister is generally content with this. She had two detailed comments:

(i) it might be helpful in the second sentence of paragraph 2 to quote the figures for expenditure per household per week rather than per year;

(ii) the second sentence of paragraph 7 might best be deleted.

The Prime Minister welcomed the emphasis, for example in paragraph 11, on money moving with patients, and hopes this will come out as clearly in the English Chapter.

The Prime Minister has noted that your Secretary of State will be unable to attend the meeting of E(A) next Tuesday.

I am copying this letter to Alex Allan (HM Treasury), Andy McKeon (Department of Health), David Crawley (Scottish Office), Stephen Leach (Northern Ireland Office), Carys Evans (Chief Secretary's Office), Alan Davey (Minister for Health's Office), Sir Roy Griffiths (Department of Health), Richard Wilson (Cabinet Office), and Brian Griffiths and Ian Whitehead (Policy Unit).

Yours,
Paul

(PAUL GRAY)

Stephen Williams, Esq.,
Welsh Office.

CONFIDENTIAL

RJ

week.16.1/m.22

CC I. WHITEHEAD

CONFIDENTIAL

Earlier draft.
Now overtake.
RRCG
20/1

H M Treasury
Parliament Street London SW1P 3AG
Switchboard 01-270 3000
Direct Dialling 01-270 4390

J Anson, CB
Second Permanent Secretary
Public Expenditure

20 January 1989

John Mayne Esq
Departments of Health and Social Security
Richmond House
Whitehall
LONDON SW1

Dear Mr Mayne

PRESENTATION OF THE NHS REVIEW

Thank you for your letter of 19 January.

X The immediate point of this response is to suggest that your Secretary of State should consult his colleagues on the Review Group on the popular version of the White Paper. The Chief Secretary's approval should, in any event, be sought.

I know how the printing timetable can take over at this stage in such a great enterprise, but we must hold it, however briefly, in check, for long enough to consult Ministers.

I am copying this to recipients of my letter of 13 January to Romola Christopherson, and to Richard Wilson.

yours sincerely

M L Reader

pp HAYDEN PHILLIPS

0526A

DRAFT PoP VERSION OF WHITE PAPER

The Health Service today

All in all, Britain's Health Service is the best system of its kind anywhere in the world. It has a highly skilled and dedicated staff, backed by huge and growing resources. There are 6,500 more doctors and dentists and 67,000 more nurses and midwives than in 1978. Spending has shot up over the same period from £8 billion to £24 billion (£XXX each week in 1979 compared with £XXX each week now. And the NHS now cares for 6 million more patients each year.

There is a lot to be proud of. Today, thanks to the Health Service, people in Britain, people are living longer and enjoying a better quality of life. But despite those successes, the performance of the NHS still varies greatly from place to place:

- people have to wait for operations much longer in some places than in others. A patient who has to wait several years in one District could have the same operation within a few weeks in another;

- drug costs in some places are nearly twice as high per head of population as in others.

- some GPs refer twenty times more patients to hospitals than others.

- the average cost of treating someone in hospital varies by as much as 50% between different health authorities.

Of course, the NHS is not a business run for profit, but it can certainly become more business-like. What the Government now wants to do is to take all that is best in the NHS, and raise the rest of it to that very high standard. An NHS that is run better will be an NHS that can care better.

The Way Ahead

Over the last year, the Government has been looking at ways of strengthening the Health Service. That review is now over, and its conclusions have just been announced. They all have a simple aim - a service that puts patients first. But while some of them will require major reforms in the way the NHS is run, the basic principles that have guided it over the last 40 years will continue to guide it into the next century. As now, the Health Service will continue to be available to everyone, free whenever they need it, and paid for mainly out of general taxation.

Some of these changes will need a change in the law, but they are all designed to enable those who work in the NHS to give you even better care. In future:

* as much power and responsibility as possible will be taken from central and regional administration and given to those working to provide care at a local level;

* resources will go more directly to those hospitals which offer the best service - popular hospitals which attract more patients will attract more money. Rewarding the best will increase the quality of patient care, and encourage all hospitals to improve their standards;

* major hospitals will be able to choose to run their own affairs. Known as "NHS Hospital Trusts", those self-governing hospitals will still be part of the NHS, but will have much more freedom to take their own decisions. In order to earn income, they will have to provide the kind of service that patients want. They will of course continue to provide emergency treatment to anyone who needs it;

* large GP practices will be able to buy a range of services direct from hospitals. They will be able to "shop around" to get the best possible care for their patients. This means that they will, for example, be able to send patients to hospitals where waiting times are shortest.

  all GPs will also be encouraged to offer a better service, because their pay will be increasingly affected by the number of patients they attract. Patients will also be totally free to choose their own GP and to change if they want to;

* there will be 100 new consultants over the next three years. This will help keep up the attack on waiting times and on the long hours worked by some junior doctors.

Putting Patients First

All these reforms will improve the quality of the service that the NHS provides. Some of them will however take time to work through. So there will be other initiatives to tackle the areas of greatest public concern more immediately:

i. the Waiting List Initiative will be continued. Over the last two years, a special £60 million fund has allowed an extra 220,000 people to be treated. Half of all waiting list patients are now admitted from the list within 5 weeks or less. Another £40 million will be spent on this initiative next year.

ii. To make sure that patients are treated more sensitively, each hospital will be expected to offer:

- individual and reliable appointment times;
- more attractive waiting areas, with proper facilities for parents with children;
- counselling for family and friends;
- clear and sensitive explanations of what is happening when someone is in hospital;
- rapid notification of the results of diagnostic tests.

In addition, so that patients can feel more at home and exercise more choice, they will in future be able to pay for a number of optional extras such as a choice of meals, a single room, a telephone or a television.

Timetable for Change

Some of these reforms will bring major change for the NHS. They are too important to rush into. 1989 will be a year of preparation. By 1990, the new NHS will be taking shape, and the new method of funding hospitals will start. By 1991 the first NHS Hospital Trusts will be up and running. Some GPs will be buying hospital services for their patients. In the nineteen-nineties the new NHS will provide the country with an even more modern and effective service where patients have a bigger say than ever before.

YA/0613t [2nd DRAFT - 17/1/89]

SUMMARY OF NHS REVIEW WHITE PAPER - FOR NHS STAFF

INTRODUCTION

1. The Government has published a White Paper (Cm 555) setting out its plans to reform and strengthen the National Health Service.

2. Underlying every proposal in the White Paper is a simple aim - a service that puts patients first. The achievements of the NHS - in helping increasingly large numbers of people to enjoy a better quality of life and to live longer - will be the foundation from which an even better service can be built. All that is best in the NHS will be retained. The principles on which it was founded will remain unchanged - it will continue to be available to everyone, free at the point of delivery and financed largely out of general taxation.

A BETTER HEALTH SERVICE FOR PATIENTS

3. The NHS has an enviable record of success. For example, Health Service staff care for over 6 million more patients than in 1978. This increase in workload has called for a massive rise in spending - up from £8 billion in 1978/79 to £24 billion today, an increase of 36 per cent after allowing for general inflation.

4. Such growth in activity has itself placed additional pressures on the Health Service and its staff. At the same time, the demand for health services has risen, and is likely to continue to do so as the proportion of elderly people in the population grows, as new and better ways of treating people are discovered and as the expectations of the public in what can be done continue to increase.

5. So the NHS provides a great deal of excellent medical care. But because it's such a large and complex organisation, it tends to be slow to change so as to keep up with the changing needs of its patients. This can be frustrating and demoralising for its staff. The system needs to be opened up to allow greater patient choice and to give more scope for local responsibility and initiative.

6. The performance of individual hospitals needs to be sharpened-up so that all can reach the level of the best. There is clear evidence of wide variations at present. For instance, in 1986-87, the average cost of treating acute hospital in-patients varied by as much as 50 per cent, even after allowing for the complexity and mix of cases.

7. To achieve its aims the Government intends to provide a framework in which the talent and enterprise of all those working in the NHS can flourish. It wants much more delegation of responsibility to those working in hospitals and the primary care services, increased choice for patients and greater rewards for those who successfully respond to local needs and preferences.

8. The present arrangements do not do nearly enough to encourage this. Hospitals which treat more patients, offer shorter waiting times or give better quality service often receive no additional funding. The White Paper proposals are designed to change this by ensuring that hospitals - and other providers of health care - are funded according to their success in attracting patients.

9. General practitioners have a key role in the Government's proposals because they choose the hospitals to which their patients are referred. The Government wants to help by giving them more information about a hospital's performance. It also proposes to give some of them the opportunity of holding a budget with which to obtain certain hospital services for their patients.

THE KEY PROPOSALS

10. The key changes proposed in the White Paper to secure these objectives are:-

* More delegation of decision-making

  All hospitals will be given much more responsibility for running their own affairs, enabling local commitment, energy and initiative to flourish.

* Self-governing hospitals

  Major acute hospitals will even be able to become independent within the NHS as NHS Hospital Trusts. These "self-governing hospitals" will be given more freedom to take the decisions which most affect them, such as negotiating pay with their own staff and (within limits) borrowing capital.

* New funding arrangements

  Much hospital care, including surgery for which waiting lists tend to build up, will be financed in a new way. At the moment, hospitals receive most funds in a fixed block. If they work harder than planned, they often get no more money [the next year to reflect this]. In future, all NHS hospitals - whether run by health authorities or self-governing - will be free to offer their services to different health authorities or to the private sector. In this way money will in future go more directly to where the work is done and where patients' needs and wishes are best met.

The funding of Regional and District Health Authorities will be simplified - it will not be based on a complex formula but on the size and circumstances of the local population. And instead of providing services directly to their population, DHAs will be expected to obtain the best possible services from whichever source.

* GP practice budgets

General Practitioners in large group practices will be able to join a voluntary scheme whereby they can hold funds to buy a range of operations and treatments for their patients, such as hip replacements, direct from hospitals. Hospitals will have a real incentive to attract those funds and so to improve the quality and quantity of the services they offer patients. And patients will be totally free to choose their GP and to change if they wish.

* Additional medical consultants

[ ] new consultant posts will be created over the next [ ] years, over and above the already agreed rate of expansion. This will help both to reduce waiting times further and to ease the problem of the long hours worked by some junior doctors.

SCOPE OF THE PROPOSALS

11. The White Paper proposals apply throughout the UK. The way they are implemented in each country will need to reflect each country's particular organisation of health care, as well as its distinctive needs and circumstances.

[TO BE IN A SEPARATE BOX]

SELF-GOVERNING HOSPITALS

The Government wants to create a number of "self-governing" hospitals within the NHS in order to:

* make the most of the energy, commitment and ability of hospital staff, by setting them free from many of the current constraints.

* encourage a stronger sense of local pride in major hospitals, many of which are substantial organisations spending £10-50 million a year.

* create an element of competition with other hospitals for NHS services, which should lead to more patient choice, greater efficiency and encourage other hospitals to do even better. As a result patients should receive better services.

Each self-governing hospital will be run by a Board of Management known as an NHS Hospital Trust. Boards will be small and operate like a commercial Board of Directors, with executive and non-executive members and a Chief Executive.

Self-governing hospitals will get their money from selling their services, mainly to health authorities. A hospital which is good at its job and attracts increasing numbers of patients will see its income rise.

A simple procedure will apply for establishing an NHS Hospital Trust. A variety of groups will be able to start the ball rolling, such as the hospital management team or the senior medical staff, with the Secretary of State for Health taking the final decision.

Self-governing hospitals will be free to negotiate pay and conditions with their staff. And they will have greater freedom (within limits) to raise capital for new investment.

The first self-governing hospitals should be established from April 1991, subject to the necessary legislation. A technical paper setting out the details will be published shortly.

[TO BE IN A SEPARATE BOX]

NEW FUNDING ARRANGEMENTS

At present, NHS funds are allocated from central Government to individual hospitals (via Regions and Districts) through a complicated and remote process. Regions get their money through the RAWP formula. RAWP has largely achieved its purpose of equalising the resources available to each Region. But it has disadvantages. It's highly complex and slow to compensate those Regions which take many patients from elsewhere. District funding too is slow to reflect these flows of patients across administrative boundaries. This means funding and workload may be out of step. As for hospitals, they are at present subject to the perverse effects of a system which can penalise success.

The Government wants to change all this. So it proposes to:

* change the method of funding Regions and Districts to a simpler one based on population numbers and weighted for the health and age of that population. The cost of treating patients from other Regions and Districts will be reflected in budgets much more quickly than now. The Thames Regions will get slightly higher funding per head - some three per cent - [to reflect their special problems]. The transition to the new system should be complete by April 1992 for Regions and April 1994 for Districts.

* place the funding of hospitals on a new footing. The objective is a system where the money goes more directly to where the work is done and done best.

At the hospital level there is a clear distinction to be drawn between services where guaranteed immediate access is necessary, such as Accident and Emergency, and those where the patient and his GP have some choice about when and where to be treated. Some immediate access (or "core") services will be funded through a management budget by which the DHA sets clear performance targets for its own hospitals. DHAs will also be able to buy such services from other Districts or from self-governing hospitals.

Where there is some choice over the time and place of treatment, services will be obtained through a contract, specifying the cost and amount of treatment. Hospitals will compete for these contracts, which DHAs can also place with self-governing, private or other DHAs' hospitals. [GPs will remain free to refer a patient to whichever hospital or consultant they think best].

[TO BE IN A SEPARATE BOX]

GP PRACTICE BUDGETS

The GP service is one of the great strengths of the NHS. The GP is the patient's key adviser about the best hospitals and specialists. But it can take a long time for good and popular hospitals - which treat more patients - to receive more money. So GPs have little incentive to offer patients a choice of hospitals.

The Government wants GPs in large practices to hold their own budgets with which they can buy hospital services for their patients. These budgets will cover:

* out-patient services;

* a defined group of in-patient and day case treatments, such as hip replacements and cataract removals;

* diagnostic tests, such as X-rays and pathology tests.

And budgets will be bigger and more flexible (at least £600,000-700,000) by also including:

* the 70% of the cost of employing staff which the Government already reimburses;

* money for improving premises; and

* the costs of prescribing drugs.

At first only practices with lists of at least 11,000 patients (twice the national average) will be eligible to join this voluntary scheme. Over 1,000 UK practices could join, covering about 25% of the population. The details of each practice budget will need negotiation between the parties - it cannot be done through a formula. Half of any savings will be available to finance further improvements in the care delivered. And a fee will be provided to cover the management and other costs of participation. A technical paper will be published setting out the details of this scheme, which should start from April 1991.

PATIENT CARE

12. Whilst the quality of clinical care in the NHS is widely recognised as amongst the best in the world, other improvements could make a real difference to the day-to-day services which patients receive.

13. Many people still have to wait too long for treatment and have little, if any, choice over the time or place of treatment. The Government has already done much to tackle this problem. Over the past two years, £60 million has been spent on a new initiative to reduce waiting lists and times, allowing over 220,000 additional patients to be treated. As a result, half of all waiting list patients are now admitted from the list within five weeks or less.

14. In 1989/90, another £40 million will be spent in this way. On top of that, the Government proposes to create, over the next [ ] years, [ ] new consultant posts in the areas where waiting times are longest. These posts will be in addition to those already agreed through the "Achieving a Balance" programme to improve the medical career structure.

15. People are often at their most vulnerable when they are feeling ill and perhaps need to go into hospital. So it is extremely important to create a more friendly and acceptable hospital environment for those patients. At present the service provided on admission to hospital is too often impersonal, inflexible and unnecessarily stressful. The Government intends to improve matters by ensuring that each hospital offers:

* appointment systems which give people individual and reliable appointment times.

* quiet and pleasant waiting and other public areas.

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

* once someone is in hospital, clear and sensitive explanations of what is happening.

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

* rapid notification of the results of diagnostic tests.

* a wider range of optional extras and amenities, such as single rooms, televisions and choice of meals, for those who want to pay for them.

AN EFFECTIVE HEALTH SERVICE

16. A quality Service - which provides not only clinical excellence but also makes patients feel valued - requires a quality management and organisation. To provide the best possible service from its resources, particularly as demands continue to grow, the NHS must always pursue the search for greater efficiency.

17. There will be no wholesale administrative reorganisation of the NHS. But local managers must have more freedom to manage. And those whose decisions affect the use of resources must be more accountable for that expenditure. For some time the Government has been concentrating on giving more responsibility for taking decisions to those actually working in hospitals. The White Paper aims to take this process much further by:

* ensuring that hospital consultants - whose decisions about treatment commit substantial sums of money - are more directly involved in hospital management; accept responsibility for their 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 compete more effectively with each other.

* building on the arrangements for the effective monitoring of the quality of medical care, which the medical profession have been introducing as "medical audit".

* continuing the drive towards better information systems for hospital managers, enabling them to improve their budgeting and monitoring.

* strengthening the capacity of hospitals to manage their own affairs by ensuring that - wherever possible - they are able to take the decisions that affect them most.

* ensuring that Regional and District Health Authorities focus on their strategic roles (and are staffed accordingly) and are turned into tighter, more effective management bodies. Community Health Councils will continue to act as a channel for consumer views.

* obtaining further improvements in the cost information available to managers, doctors and other professionals by extending the Resource Management Initiative - to up to 50 more acute hospitals in 1989/90, with the aim of covering all 260 major acute units by the end of 1991/92.

* introducing a system of accounting for capital which encourages managers to balance the need for new investment against the maintenance of older stock. Limits on the size of new projects needing central approval will be raised and joint ventures with the private sector encouraged.

* strengthening the audit of the hospital service - and so counterbalancing greater managerial freedom - by using the independent Audit Commission to undertake financial and value for money audits. Their reports will be published.

* ensuring that the rate of growth in drug prescribing costs is kept within reasonable limits.

* ensuring that services are carried out as cost-effectively as possible by contracting out some functions.

* re-examining the work of nurses and other professional staff so as to secure the most cost-effective use of professional skills.

* turning FPCs into smaller, more managerial bodies and making them accountable to Regional Health Authorities.

* strengthening the management of the NHS at the centre and leaving the central corporate team more free to run the Service within Ministers' financial and policy objectives.

18. The Government also wishes to see the development of a genuine mixed economy in health care. Those who choose to buy health care outside the Health Service add to the diversity of provision and choice. The Government does not wish to discourage those already using the private sector from continuing to do so. It therefore proposes to allow tax relief on the much higher insurance fees faced by those leaving employers' schemes and entering retirement.

MANAGING THE FAMILY PRACTITIONER SERVICES

19. Primary care provided by GPs and the work of hospitals are closely intertwined. The Government intends to build on the proposals in its White Paper on primary care services, "Promoting Better Health", by:

* encouraging GPs to take greater responsibility for their use of resources. One objective is to introduce a national framework for medical audit whereby GPs would systematically review their work, supported by a special committee in each FPC.

* pressing ahead with plans to let consumers have more information about GP services and to make it easier to change doctor.

* increasing competition between GPs by raising the proportion of their pay derived from the number of patients on their lists from 46% to at least 60% as soon as possible.

* reducing the rate of increase in spending on drugs through a new budgeting scheme whereby RHAs will give FPCs reasonable budgets for drug spending and GP practices will receive "indicative" budgets for their prescribing costs.

EFFECTS OF THE PROPOSALS

20. The White Paper proposals offer new opportunities - and pose new challenges - for everyone concerned with the running of the Service.

21. They will lead to a more modern, more efficient, even 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 an NHS in which it is more rewarding to work and - most important of all - which becomes even better at delivering the highest possible standards of care.

22. But although the proposals seek to make the NHS fundamentally different, they herald a change of pace and scale rather than of direction. They often build on achievements in some parts of the NHS today; they aim to spread their benefits more widely throughout the Service as a whole.

23. There is nothing new, for example, in delegating management responsibility to local level. What is different is the extent to which that process will in future be taken, and the particular twist it has been given through the concept of the self-governing hospital. Similarly, the drive to extend medical audit will build on well-established principles.

24. A single thread runs through all the proposals - a Service which puts the needs and wishes of patients first. The key to this is the introduction of much greater and more informed choice - particularly choice in the selection of a GP and choice on where to go for treatment. That choice will be made possible by the reforms set out in the White Paper. The outcome will be better care, reflecting much more closely what patients themselves want. In short, a better health service for patients.

[TO BE IN A SEPARATE BOX]

TIMETABLE FOR CHANGE

Legislation will be introduced at the earliest opportunity to give effect to the proposals. The programme of reform will have three main phases:

PHASE 1

1989: planning and preparation

* During 1989, the Government will be consulting those most closely concerned about 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.

* Regional Health Authorities will help identify the first hospitals to become self-governing as NHS Hospital Trusts, and plan for their new status.

* The additional initiative to expand the numbers of consultants will begin.

* Regulations will be amended to make it easier for patients to change their GP.

PHASE 2

1990: development of proposals

* 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 NHS Hospital Trusts will start to develop their plans for the future.

* The new budgeting scheme for drugs prescribed by GPs will be introduced, with full implementation in phase 3.

PHASE 3

1991: the new NHS takes shape

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

* The new Regional Health Authorities will take over responsibility for Family Practitioner Committees and oversee the establishment of NHS Hospital Trusts.

* The new District Health Authorities will take over from their predecessors, buying services for their resident populations.

* The new Family Practitioner Committees, with stronger executive management, will take over from their predecessors.

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

SECRET 24 a FILE a

10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

20 January 1989

Dear Andy,

NHS REVIEW

The Prime Minister was grateful for your Secretary of State's minute of 18 January on the Central Management of the NHS and his minute of 19 January providing revised drafts of Chapters 1 and 13 and part of Chapter 7.

Central Management

The Prime Minister has considered further whether the Body reporting to the Policy Board should be termed the Management Board or Management Committee. She continues to feel that to have two Boards would be highly confusing. But rather than calling it the Management Committee, she suggests the title should be the Management Executive.

The Prime Minister also has some drafting comments on the existing text of paras 2.4 to 2.12. For convenience these are annexed to this letter.

But the Prime Minister continues to be seriously concerned about exactly how the new central management structure will operate. She would be grateful if your Secretary of State would now prepare a detailed paper on this subject, for consideration by the NHS review group following the meeting of E(A) on Tuesday 24 January.

This paper needs to spell out in detail the existing arrangements for the involvement of Department of Health officials in the operation of the NHS (including the numbers involved) and the links between the centre, the regions and districts. It should then go on to specify in detail the proposed new arrangements, spelling out the nature of the support structure for the Policy Board/Management Executive, the way in which policy advice and operational responsibilities at the centre will be separated and the links between the centre, regions and districts. The line of responsibility and chain of command at each point should be specified.

The Prime Minister assumes that alternative options have been developed covering some or all of these points. She thinks it would be helpful for these alternatives to be set out, as well as your Secretary of State's recommended

approach. Her own view is that it is essential for there to be maximum delegation of operational responsibility to the health authorities, with the minimum necessary manpower engaged at the centre on operational matters and a clear distinction at the centre between policy and operational responsibilities. She also thinks it essential that the new arrangements for accountability to Parliament and the way in which they will match the new management structure in the NHS and the Department should be spelled out.

The Prime Minister would be grateful if your Secretary of State would arrange for the Treasury and the Cabinet Office to be associated with the preparation of the paper, which should be circulated on Monday 23 January.

White Paper Title

The Prime Minister has considered your Secretary of State's proposal that the title should be "The NHS - A Healthy Future". She continues to feel however that it is important to include the word "Patient" in the title. She suggested that "Patients First" might be used in the title. But when we spoke about this this morning you explained that this had been used in an earlier publication. You said that the latest proposal from the Department was "Working for the Patient". I will report to the Prime Minister when she returns to the office later today that this is the title you are now planning.

Other Draft Comments

I attach at Annex B the Prime Minister's detailed drafting comments on Chapters 1 and 13.

I am copying this letter to the Private Secretaries to the Chancellor, the Secretaries of State for Wales, Scotland, Northern Ireland, the Chief Secretary, Minister for Health, Sir Robin Butler, and to Richard Wilson (Cabinet Office) and Ian Whitehead (Policy Unit).

Yours,
Paul

(PAUL GRAY)

Andy McKeon, Esq.,
Department of Health.

ANNEX A

Paragraph 2.4: It would be impracticable for the Chief Executive to oversee the day-to-day decisions taken locally by operational units, and any attempt to do so could lead to excessive bureaucracy. Redraft to read:

> "...Such accountability does not mean that Ministers should be involved in operational decisions. On the contrary, these decisions must be taken locally by operational units and oversight of the operational units will be the responsibility of the Chief Executive of the NHS Management Committee. Ministers will be responsible for policy and strategy".

Paragraph 2.6: There needs to be a clearer definition of the role of the Policy Board, as follows:

> "A new Policy Board, chaired and appointed by the Secretary of State, will determine the strategy, objectives and finances of the NHS in the light of Government policy, and will set objectives for the Management Committee and monitor whether they are satisfactorily achieved. It will replace..."

Paragraph 2.8: Delete "and keeping the state of health of the people of the region under review" in the penultimate sentence.

SRWBTV

ANNEX B

Chapter 1

Paragraph 1.3

The reference to "around £35 for an average family of 4" should make clear that this relates to a week.

Paragraph 1.5

Amend the last sentence to read "This is now showing results and has pointed the way ahead".

Paragraph 1.17

It would be better to start each of the indents with the infinitive and in the first indent to start with "To secure" rather than "To effect".

Chapter 13

Paragraph 13.1

This would read better as:

"The proposals in this White Paper put the interests and wishes of the patient first. They offer a new, exciting and potentially rewarding challenge to all the work in the NHS. They add up to the most significant review of the NHS in its 40 year history. And they amount to a formidable programme of reform which will require energy and commitment to carry it through".

Paragraph 13.2

Amend the opening phrase to: "The Government is planning to implement the programme in three main Phases". And add to the first indent under Phase 1 "as a Management Executive".

Paragraph 13.5

Add to the end of the first sentence "and to secure the best value for money".

SECRET

PRIME MINISTER 19 January 1989

CENTRAL MANAGEMENT OF THE NHS

Department of Health officials are keen to maintain the status quo of the current management structure. If Ken Clarke's new draft is included in the White Paper, there is still a high probability they will succeed.

The statement that we are introducing 'for the first time a clear and effective chain of management command running from Districts through Regions to the Chief Executive and from there to the Secretary of State' (Para 2.7) is clearly arguable.

- The proposed organisation is muddled and is bound to be criticised as such. I have attempted to reproduce the structure in chart form. (Appendix 1).

- In particular, the reporting line of the Chief Executive will be very unclear. In paragraph 7 of Ken Clarke's covering note he states 'the Chief Executive will report directly to the Secretary of State on all operational and management matters'. Yet in Para 2.5 of the White Paper, 'the Management Board will be accountable to the Policy Board for the management of the NHS within the strategy and objectives set by the Policy Board'. Who does the Chief Executive report to? Confusion will reign - as before - in this environment.

- It appears that the Chief Executive will hold the purse strings for hospitals and community health services (Para 7 of Ken Clarke's note). Does this mean that the Permanent Secretary will continue to be the accounting officer for the family practitioner service?

b

- In Ken Clarke's note, he states that for 'administrative purposes the Management Board will be located within the Department of Health'. This is bound to be seen as compromising the independence of the Management Board. People will say 'what is different from today'. Surely at the very least, it should be housed separately.

- One of the main objectives of the Review is to devolve responsibility and accountability. Most 'hands-on' management will take place at local level. The role of the centre is to set policy, drive through the changes and monitor the impact. Fine-tuning of policy is also essential to the running of the health service. Artificial distinctions between policy and management will create new layers of bureaucracy at the centre.

ANOTHER OPTION

During the ministerial meeting, you questioned the need for a Policy Board. A streamlined management structure along the lines of Appendix 2 - leaving out the Policy Board - would be far more effective.

The Secretary of State would receive policy advice from his officials as now. But this advice would not form part of the main chain of command. The Management Board would be expanded to include non-executive directors. Perhaps Roy Griffiths could chair the Board. An Executive Committee of the Board would take the day-to-day decisions (similar to companies in the private sector).

C

In summary, this structure would have a number of benefits:

- clear reporting lines;

- clearer separation from department officials giving independent policy advice to Ken Clarke;

- the NHS Management Board would be seen as running the health service with 'real teeth'.

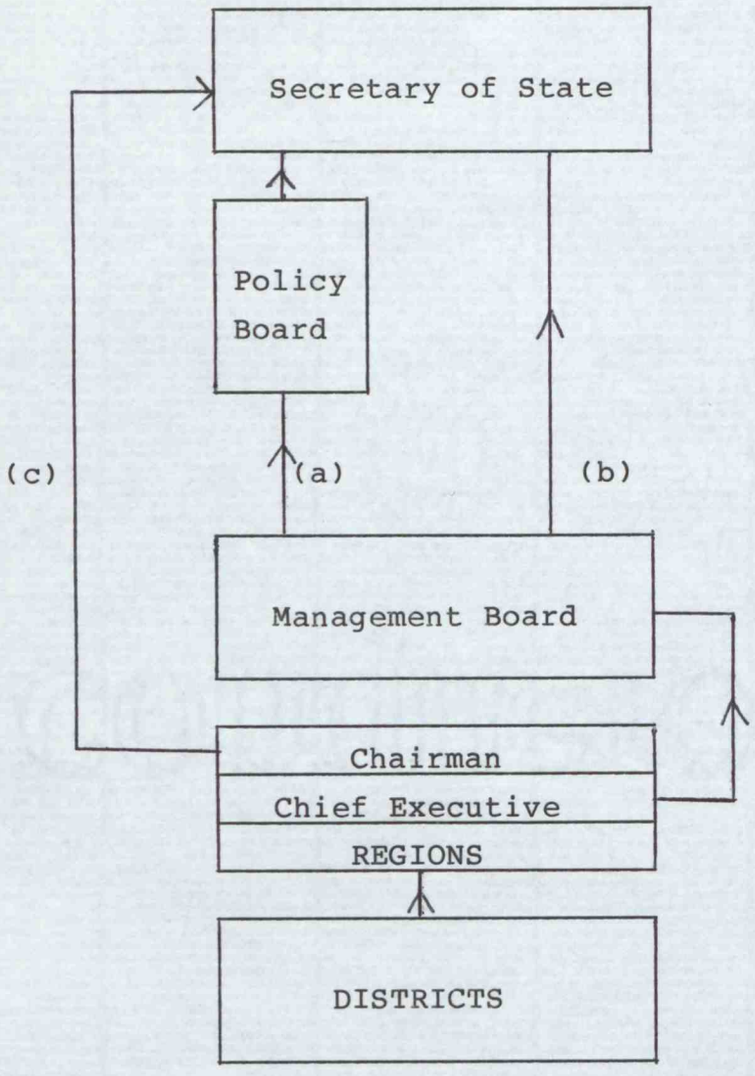
A suggested new draft is enclosed (Appendix 3)

Ian Whitehead

IAN WHITEHEAD

APPENDIX 1

KEN CLARKE'S
PROPOSED CHAIN OF COMMAND



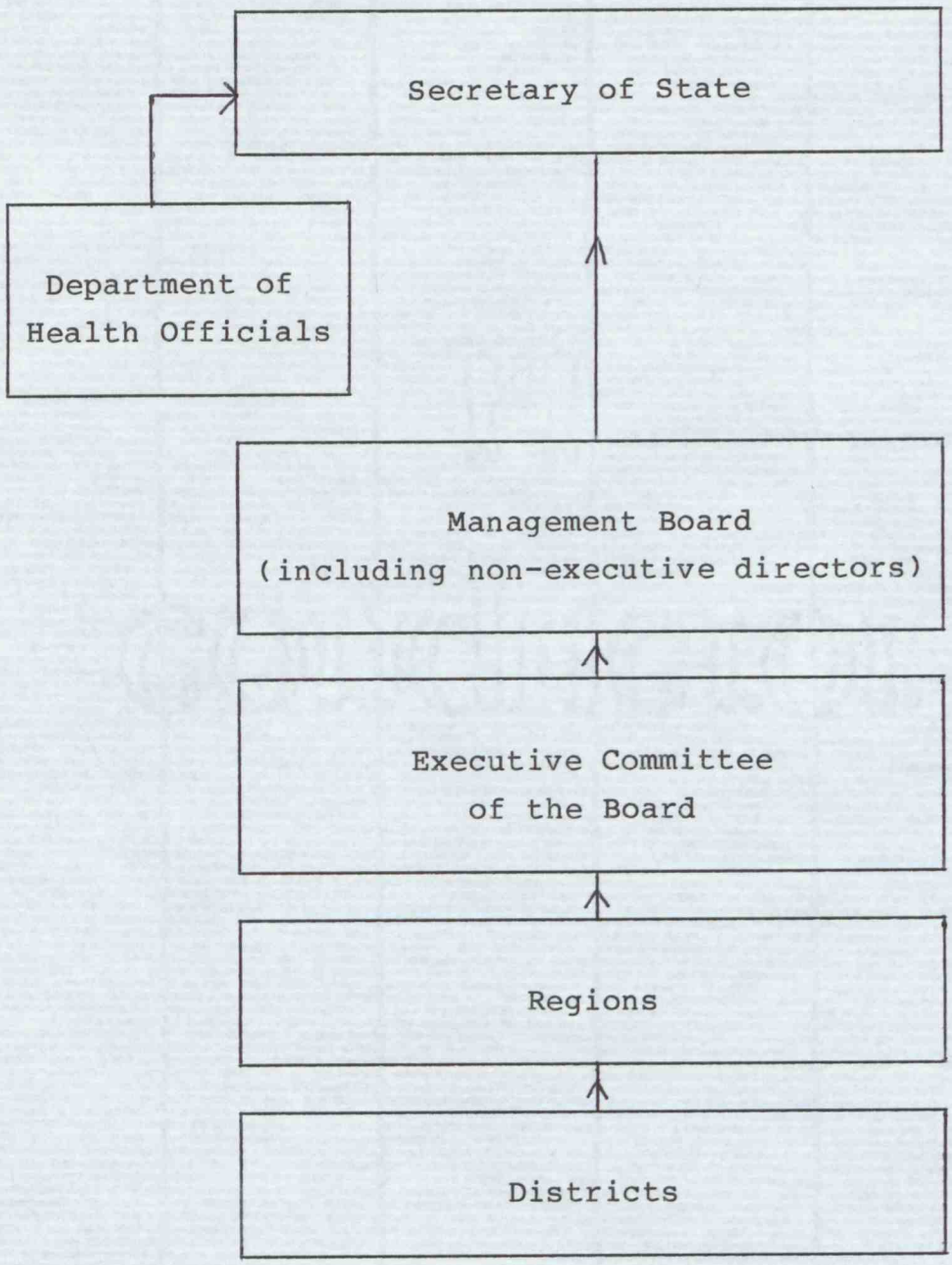
(a) Accountable to the Policy Board for the Management of the NHS within the strategy and objectives set by the Policy Board (Para 2.5)

(b) Chief Executive will report directly to the Secretary of State on all operational and management matters. (Para 7 of Ken Clarke's covering note).

(c) Ken Clarke wants direct consultation because Regional Chairmen 'regard themselves as charged with the delivery of Government Policy in their Regions' (Para 10 of Ken Clarke's note).

APPENDIX 2

ANOTHER OPTION FOR THE CHAIN OF COMMAND



APPENDIX 3

PROPOSED NEW DRAFT
DELEGATING RESPONSIBILITY

Central Management of the NHS

2.4 The NHS will continue to be funded by the Government mainly from tax revenues. Ministers must be accountable to Parliament and to the public for the spending of these huge sums of money. But Ministers cannot, and in future will not, be directly involved in the decisions taken locally by operational units. On the contrary, the oversight of those decisions ought to be the responsibility of the Chief Executive of the NHS Management Board. Ministers must however remain responsible for policy and strategy, with input from the Management Board.

2.5 The specific proposals are:

- A Management Board reporting directly to the Secretary of State will manage the day-to-day operations of the health service. The Secretary of State will appoint the Chairman and Chief Executive. The Management Board, incorporating non-executive directors, will be appointed by the Secretary of State in consultation with the Chairman and Chief Executive. The Board members will be drawn from inside and outside the NHS.

- The Health Service Supervisory Board will be abolished.

- Responsibility for the management of family practitioner services will be brought under the Management Board. The better integration of primary care and hospital services is an important objective.

9

2.7 The overall effect of these changes will be to introduce for the first time a clear and effective chain of management command running from Districts through Regions to the NHS Management Board and from there to the Secretary of State.

(Note: New wording is underlined. Para 2.5 and the first two indents of Para 2.6 have been taken out.)

0569A

22a-k

CCBI

(1)

E9

SECRET

Prime Minister

NHS REVIEW: DRAFT WHITE PAPER

1. At the end of the Ministerial Group meeting on Tuesday, I undertook to circulate revised versions of parts of the draft White Paper in advance of Cabinet circulation tomorrow.

2. I attach for your agreement, and that of other members of the Group, revised drafts of chapters 1 and 13. The former in particular draws heavily on Bernard Ingham's helpful suggestions. I should be grateful for any comments by early tomorrow.

3. I am also attaching a revised draft of the section on GP numbers in Chapter 7. This is based closely on the Chancellor's draft, but I have not included his suggested references to the GP remuneration system. I do not entirely agree with them, they are not relevant to our proposals, and they would provoke a quite needless row.

4. We must settle a title. I have confirmed that "Fit for the Future" has been used before (Report of the Committee on Child Health Services, 1976). The same applies to "Patients First", which is among the suggestions made by Bernard Ingham yesterday. I am not opposed to "Better Health", although it is rather dull and sounds rather like a health promotion or keep fit brochure. I have thought about Bernard's other suggestions, but would myself prefer "The NHS: A Healthy Future". I should be grateful for your and colleagues' agreement. We do not have time to wait any longer for real inspiration. Failure to settle a title by tomorrow morning could jeopardise the printing timetable for a laminated cover.

5. I am copying this minute to the other members of the Ministerial Group, to Professor Griffiths and Mr Whitehead in the No 10 Policy Unit and to Mr Wilson in the Cabinet Office.

19 January 1989

KC

b

Draft (19.1.89)

CHAPTER 1: A BETTER HEALTH SERVICE FOR PATIENTS

Introduction

The achievements of the NHS

1.1 The United Kingdom enjoys high standards of health care. The Health Service has contributed to longer life expectancy, fewer stillbirths and lower rates of perinatal and infant mortality. There have been dramatic increases in the number of people treated in hospital. Transplant surgery is now commonplace. Doctors can carry out successful hip operations on people in their seventies and eighties. People are not only living longer but are enjoying a better quality of life.

1.2 The proposals in this White Paper aim to build on these achievements by providing an even better service for patients. The Government will keep all that is best in the NHS. It supports and will not change the principles of the Service. The service provided by the NHS is, and will continue to be, open to all, regardless of income, and financed mainly out of general taxation.

1.3 The NHS is growing at a truly remarkable pace. The number of hospital doctors and dentists has increased from 42,000 in 1978 to over 48,000 in 1987, and the number of nurses and midwives from 444,000 to 514,000. Total gross expenditure will increase from £8 billion in 1978-79 to £26 billion in 1989-90, an increase of 40 per cent after allowing for general inflation. Expenditure by the NHS will then be equivalent to around £35 for an average family of four, as compared with about £11 in 1978-79. This and improved

productivity mean, for example, that NHS hospital staff now treat over one and a half million more in-patients a year than in 1978.

The need for change

1.4 Throughout the 1980s the Government has thus presided over a massive expansion of the NHS. It has ensured that the quality of care provided and the response to emergencies remain among the best in the world. But increasingly the country as well as the Government has recognised that more needs to be done because of rising demand and an ever-widening range of treatments resulting from advances in medical technology. It has increasingly been recognised that the injection of more and more money is not, of itself, the answer.

1.5 It is clear that the organisation of the NHS - the way it delivers health care to the individual patient - also needs to be reformed. The Government has been tackling these organisational problems. It has taken a series of measures to improve the way the NHS is managed. The main one was the introduction of general management from 1984. ~~This has been particularly successful~~ and has ~~also~~ demonstrated the way ahead.

1.6 The new management information systems have provided clear evidence of a wide variation in performance up and down the country. In 1986/87, the average cost of treating acute hospital in-patients varied by as much as 50 per cent between different health authorities, even after allowing for the complexity and mix of cases treated. Similarly, a patient who waits several years for an operation in one District may get that same operation within a few weeks in another. There are wide variations in the drug prescribing habits of GPs, and in some places drug costs are nearly twice as high per head of

C

population as in others. And at the extremes there is a twenty-fold variation in the rate at which GPs refer patients to hospital.

1.7 The Government wants to raise the performance of all hospitals and GP practices to that of the best. The main question it has addressed in its review of the NHS has been how to achieve that. It is convinced that it can be done only by delegating responsibility as close as possible to where health care is delivered to the patient - predominantly to the GP and the local hospital. Experience in both the public service and the private sector has shown that the best run services are those in which local staff are given responsibility for responding to local needs and are held to account for doing so.

1.8 This White Paper presents a programme of action, summarised in chapter 13, to secure two objectives:

* to give patients, wherever they live in the UK, better health care and greater choice of the services available; and

* greater satisfaction and rewards for those working in the NHS who successfully respond to local needs and preferences.

The Government's proposals

Key changes

1.9 The Government is proposing seven key measures to achieve these objectives:

First: **to maximise the Health Service's ability to respond to the needs of patients, as much power and**

responsibility as possible will be delegated to local level. This includes the delegation of functions from Regions to Districts, and from Districts to hospitals. The detailed proposals are set out in the next chapter. They include greater flexibility in setting the pay and conditions of staff, and financial incentives to make the best use of a hospital's assets.

Second: **to stimulate a better service to the patient, major hospitals will be able to apply for a new self-governing status as NHS Hospital Trusts.** This means that, while remaining within the NHS, they will take fuller responsibility for their own affairs, harnessing the skills and enthusiasm of their staff. NHS Hospital Trusts will be free to offer their services to other parts of the NHS and to the private sector. They will have an incentive to attract patients, so they will make sure that the service they offer is what their patients want. And in turn they will stimulate other NHS hospitals to respond to local requirements. NHS Hospital Trusts will also be able to set the rates of pay of their own staff and, within annual financing limits, to borrow money to help them respond to patient demand.

Third: **to enable hospitals which best meet the needs and wishes of patients to get the money to do so.** The money required to treat patients will be able to cross administrative boundaries. All NHS hospitals, whether run by health authorities or self-governing, will be free to offer their services to different health authorities or to the private sector. Consequently, a health authority will be better able to discharge its duty to use its available funds to secure a comprehensive service, including emergency services, by obtaining the

best service it can whether from its own hospitals, from another authority's hospitals, from self-governing hospitals or from the private sector.

Fourth: **to reduce waiting times and improve the quality of service, to help give individual patients appointment times they can rely on, and to help cut the long hours worked by some junior doctors, 100 new consultant posts will be created over the next 3 years.** These posts will be additional to the two per cent annual expansion of consultant numbers already planned.

Fifth: **to help the family doctor improve his service to patients, large GP practices will be able to apply for their own budgets to buy a defined range of services direct from hospitals.** Again, in the interests of a better service to the patient, GPs will be encouraged to compete for patients by offering better services. And it will be easier for patients to choose (and change) their own GP as they wish.

Sixth: **to sharpen up the efficiency and accountability of NHS management, regional, district, hospital and general practitioner management bodies will be reduced in size and reformed on business lines, with executive and non executive directors.** The Government believes that, in the interests of patients and staff, the era in which the £24 billion NHS has been run by authorities which are neither truly representative nor fully management bodies must be ended. The confusion of roles will be replaced by a clear remit and accountability.

Seventh: **to ensure that all concerned with delivering services to the patient make the best use of the resources available to them, quality of service and value for money will be more rigorously audited.** Arrangements

for what doctors call "medical audit" will be extended throughout the Health Service, helping to ensure that the best quality of clinical care is given to patients. The Audit Commission will assume responsibility for auditing the accounts of health authorities and other NHS bodies, and will undertake wide-ranging value for money studies.

1.10 The Secretary of State for Health will publish shortly eight working papers explaining in detail how major aspects of the Government's proposals are to be implemented in England. [Similar papers will be published as necessary by the Secretaries of State for Scotland, Wales and Northern Ireland.]

Putting patients first

1.11 People sometimes have to wait too long for treatment, and may have little if any choice over the time or place at which treatment is given. The Government has already done much to tackle this problem. Over the past two years, £60 million has been spent on a new initiative to reduce waiting lists and waiting times, allowing over 220,000 additional patients to be treated. As a result, half of all waiting list patients are now admitted from the list within five weeks or less. In 1989/90, another £40 million will be spent on this initiative.

1.12 The changes proposed in this White paper are intended further to improve the quality of the service that the NHS is able to offer to its patients. This applies not only to waiting times for treatment. The service provided on admission to hospital is sometimes too impersonal and inflexible. This is not what either the Government or those working in the Health Service want to see. The best NHS

hospitals provide more than clinical excellence. They provide a service which considers patients as people. The Government is determined that this is what all the NHS should provide.

1.13 The Government believes that each hospital should offer:

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

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

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

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

* once someone is in 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.

* 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 - such as a choice of meals, single rooms, personal telephones and TVs.

1.14 In short, every hospital in the NHS should offer what the best offer now. These improvements will bring greater appreciation and recognition from patients and their families for all the care that the Health Service provides.

The best use of resources

1.15 If the NHS is to provide the best service it can for its patients, it must make the best use of the resources available to it. The quest for value for money must be an essential element in its work. This becomes even more important as the demands on the Health Service continue to grow.

1.16 Those who take decisions which involve spending money must be accountable for that spending. Equally, those who are responsible for managing the service must be able to influence the way its resources are used. The Government believes that most decisions are better taken at local level. Parts Two and Three of this White Paper include a range of important proposals for strengthening local management and improving value for money in addition to those referred to in paragraph [1.9]. They build on the introduction of general management and on the proposals for the better management of the family practitioner service (FPS) set out in "Promoting Better Health" (Cm 249).

1.17 Among the most important aims behind these changes are:

* effecting a clearer distinction at national level between the policy responsibilities of Ministers and the operational responsibilities of top management;

* improving the information available to local managers, enabling them in turn to make their

budgeting and monitoring more accurate, sensitive and timely;

* ensuring that hospital consultants - whose decisions effectively commit substantial sums of money - are involved in the management of hospitals; are given responsibility for the use of resources; and are encouraged to use those resources more effectively;

* 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; and

* ensuring that drug prescribing costs are kept within reasonable limits.

Public and private sectors working together

1.18 The NHS and the independent health sectors should be able to learn from each other, to support each other and to provide services for each other. Anyone needing treatment can only benefit from such a development. People who choose to buy health care outside the Health Service benefit the community by taking pressure off the Service and add to the diversity of provision and choice. The Government expects to see further increases in the number of people wishing to make private provision for health care, but at the moment many people who do so during their working life find the cost of higher premiums difficult to meet in retirement. The Government therefore proposes to make it easier for people in retirement by allowing tax relief on private medical insurance premiums paid by them or, for example, by their families on their behalf.

Scope of proposals

1.19 Everyone is entitled to better health services with higher quality and more choice, regardless of where they live. The White Paper's proposals therefore apply throughout the UK. The way in which they are implemented in England, Scotland, Wales and Northern Ireland will need to reflect the different organisational structures that have grown up in each country, in the light of their own distinctive health care needs and circumstances. Chapters 2-9 are written in terms which apply primarily to England. Those aspects which are particular to the other three countries are dealt with in chapters 10-12.

i

Draft (19.1.89)

Revised Paragraph on GP Numbers

7.21 It is the Government's responsibility to ensure that there is adequate access to primary care services across the country; that opportunities exist for good doctors to enter general practice; and that there is a sensible, overall balance between the numbers of doctors in hospitals on the one hand and in general practice on the other. The Government proposes to take two further steps to enable it better to control the total cost of the service while ensuring that sufficient opportunities remain in general practice. First, it will seek reserve powers to control, if necessary, the number of GPs entering into contract with the NHS. Secondly, 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.

Draft (19.1.89)

CHAPTER 13: PROGRAMME FOR REFORM

13.1 The proposals in this White Paper offer a new and exciting challenge to all those who work in the NHS. They add up to the most significant review of the NHS in its 40-year history. They represent a wide-ranging opportunity to put the interests and wishes of the patient at the forefront of decision-making at all levels. They amount to a substantial body of change, which must be implemented with determination and commitment.

13.2 The Government is planning a programme of reform in three main phases:

* **Phase 1: 1989**

The Secretary of State for Health will establish a new NHS Policy Board and reconstitute the NHS Management Board as a Management Executive.

The Health Departments, and RHAs in England, will identify the first hospitals to become self-governing as NHS Hospital Trusts, and plan for their new status; will devolve further operational responsibility to Districts and hospitals; and will begin preparing the ground for GP practice budgets.

The Government will introduce Regulations to make it easier for patients to change their GPs.

The first additional consultant posts will be created; Districts will begin agreeing job descriptions with

their consultants; and a new framework for medical audit will begin to be implemented.

The resource management initiative will be extended to more major acute hospitals.

Preparations for indicative drug budgets for GPs will begin.

The Audit Commission will begin its work in the NHS.

* **Phase 2: 1990**

The changes begun in phase 1 will gather momentum. Devolving operational responsibility, changing the management of consultants' contracts and extending medical audit throughout the hospital service will near completion.

"Shadow" boards of the first group of NHS Hospital Trusts will start to develop their plans for the future.

RHAs, DHAs and FPCs will be reconstituted, and FPCs will become accountable to RHAs. Regions will begin paying directly for work they do for each other.

* **Phase 3: 1991**

The first NHS Hospital Trusts will be established.

The first GP practice budget-holders will begin buying services for their patients.

k

The indicative drug budget scheme will be implemented.

DHAs will begin paying directly for work they do for each other.

13.3 The reforms in this White Paper will enable a higher quality of patient care to be obtained from the resources which the nation is able to devote to the NHS. The provision for spending on health in the coming financial year, 1989/90, announced in the Autumn Statement, included the likely costs of preparing for the reforms and for the legislation which will give effect to them. Over time, any extra costs should be offset by the improved efficiency which will stem from them. The total provision for spending on health will take account of the progress made in implementing the reforms - including the increased efficiency savings. The costs of implementing the reforms in future years will be considered in the annual public expenditure surveys.

13.4 A number of the changes proposed will require legislation, which will be introduced at the earliest opportunity.

13.5 Throughout this programme, the Government will hold to its central aims: to extend patient choice, and to delegate responsibility to those who are best placed to respond to patients' needs and wishes and to secure the best value for money. The result will be a better deal for the public, both as patients and as taxpayers. The Government will build further on the strengths of the NHS, but will not flinch from tackling its weaknesses. This is the way to give the NHS a healthy future.

cc Mr R J T Wilson
Miss Christopherson

MR GRAY

NHS REVIEW

You asked me to look over the re-drafts, especially of Chapters 1 to 13, and to have another think about the title.

Chapter 1

I think this now reads rather well. White Papers are looking up. I very much like the examples of information which the new management systems have produced in Para 1.6.

I have three points:

i) Should not the last sentence of Para 1.2 read as follows: The service provided by the NHS is, and will continue to be, open to all, regardless of ~~income,~~ as and when required, and financed mainly out of general taxation.

No - this could not be delivered

ii) Under the fourth point of Para 1.9 (key changes) I'm afraid 100 new consultants over 3 years tells me nothing since it is not also expressed as a percentage. If it unfortunately sounds small when presented that way, there may be a reason apart from money; if so should we not very briefly explain why we are expanding at only this pace?

iii) 1.17 in the first indent - I think "securing" is better than "effective".

Chapter 13

I am generally content with this apart from 13.1 which has got the cart before the horse presentationally. By that I mean it places the producer (those who work in the NHS) before the patient. Freudian slip? I think we would also do well to recognise the formidable nature of the reform programme.

Consequently I would like to suggest the following re-draft (new points underlined):

"The proposals in this White Paper put the interests and wishes of the patient first. They offer a new, exciting and potentially rewarding challenge to all who work in the NHS. They add up to the most significant review of the NHS in its 40 year history. And they amount to a formidable programme of reform which will require energy and commitment to carry it through".

I think it would read better if the next para (13.2) started:

"The Government is planning to implement the programme in three main phases".

Board/Committees

Two Boards will make for unutterable confusion. To eliminate confusion, clarify the position and make it sound good why not -

"NHS Policy Board"

and

"NHS Management Executive"?

Title

I am reluctant to be beaten by a title. I concede that "A Healthy Future" ties in beautifully with the last words of the White Paper as now drafted.

But the White Paper is in love with the patient (and so am I). And I believe that the title should be both crisp and consistent with the main thrust of the document itself.

What phrase above all will serve to inculcate a new atmosphere? What do we want to guide managers and staff in their approach? And, not to put too fine a point on it, what will best serve the Government politically?

Against that background -

"Patients Come First
A Programme of Reform for the NHS"

wins hands down.

BERNARD INGHAM
January 19, 1989

SECRET 20

PRIME MINISTER 19 January 1989

NHS WHITE PAPER

Title

Ken Clarke has proposed a new title "The NHS: A Healthy Future". We believe this is a rather weak and awkward title.

The title needs to be more muscular. Tim Bell has suggested two more options.

'A stronger health service: building for the future'

'Building a strong health service'.

The first is a little too long but at least it has real substance and offers a challenge for the future.

Kent Clarke's Redraft of Chapter 1 and 13

These chapters are very much better.

Para 1.3 The statement 'expenditure by the NHS will then be equivalent to around £35 for an average family of four' is too vague. Is this per week?

Para 1.9 First objective line 3

Change 'delegated' to 'devolved' (to avoid repetition on the next line).

No - devolution has other overtones

Ian Whitehead

IAN WHITEHEAD

SECRET

Ref. A089/157

PRIME MINISTER

NHS Review: Central Management of the NHS

--- I attach a note by Mr Wilson about Mr Clarke's minute of
--- 18 January, together with a draft reply for Mr Gray to send.

2. I should like to reinforce what is said in paragraphs 10 and 11 of Mr Wilson's minute about the relationship between the Management Board and the Department. You want the Management Board to have executive responsibility for the operational running of the NHS. Mr Clarke accepts this. So far so good. The issue is the role of the Department.

3. At present, the officials in the Department are the link with the NHS. There are probably about 2000 (out of 9000 total staff of the Department) who are involved in this way. But the officials are civil servants responsible to the Secretary of State. They are not part of the NHS itself. The Management Board is therefore cocooned between the Secretary of State and the mass of officials below them.

4. To make those officials who are the link between the Department and the NHS truly responsible to the Chief Executive and Management Board for the operations of the NHS would be a much more profound change than Mr Clarke is envisaging. A much greater degree of separation is needed between the role of advising the Secretary of State on policy and the role of being the link between the Management Board and the NHS.

FRBARN

5. Officials discussed with Mr Clarke yesterday more radical changes in the relationship between the Management Board and the Department and suggested that the minute to you should say that these would have to be worked out between the White Paper and the legislation. It is certainly true that, if any substantial change is to be made, such further work needs to be undertaken. The fact that Mr Clarke specifically rejected the recommendation of saying in his letter that further work would be needed indicates that he does not have in view any radical change. If, therefore, you want such a change to be made, you will need to insist that more radical work is undertaken.

F.E.R.B.

ROBIN BUTLER

19 January 1989

This won't do. An attempt is being made to base the whole structure on the desire of the department to keep 9000 staff when it needs only about a quarter of that number to serve the Jofs. We shall have to commission more work & delay the White Paper if necessary. The whole thing is a terrible mess.

MT

FRBARN

SECRET

From: R T J Wilson
19 January 1989

P 03337

1. SIR ROBIN BUTLER
2. MR GRAY

NHS REVIEW: CENTRAL MANAGEMENT OF THE NHS

1. You invited comments on Mr Clarke's minute of 18 January.

Revised Paragraphs

2. The revised paragraphs on central management incorporate all the drafting changes which the Ministerial group agreed at the meeting on Tuesday, and are a substantial improvement. The Prime Minister may, however, wish to consider asking for changes on three points.

3. First, paragraph 2(iv) says that the Chief Executive will oversee the day-to-day decisions taken locally by operational units. Interpreted literally this is impracticable, and there may be a risk that it could become an excuse for a growth in bureaucracy and intervention, contrary to the policy of maximum delegation. It might therefore be better to say:

> "...Such accountability does not mean that Ministers should be involved in operational decisions. On the contrary, these decisions must be taken locally by operational units and oversight of the operational units will be the responsibility of the Chief Executive of the NHS Management Committee. Ministers will be responsible for policy and strategy".

4. Second, it might be useful if paragraph 2(vi) were to include an explicit description of the remit of the policy board, along the lines agreed by the Ministerial group, in order to establish firmly the distinction between its role and that of the

Management Committee. This might be done by amending the first indent as follows (the words have been taken from Mr Clarke's covering minute):

> "A new Policy Board, chaired and appointed by the Secretary of State, will determine the strategy, objectives and finances of the NHS in the light of Government policy, and will set objectives for the Management Committee and monitor whether they are satisfactorily achieved. It will replace..."

5. Third, there is the question whether to have a Management Board or Committee. Mr Clarke is still holding out for "Board". The Prime Minister will wish to decide whether to press this point again. It seems to me that one important argument is that a change of name is needed, in order to distinguish the new body from the present management board, which has a different function and has not worked well.

POINTS OF SUBSTANCE

6. More generally, the Prime Minister will want to be satisfied that there are no major points of disagreement or misunderstanding concealed behind this part of the White Paper. She may in particular want to consider the following aspects.

Ministerial accountability to Parliament

7. On Ministerial accountability to Parliament, Mr Clarke proposes to take a robust stance on the basis of paragraph 2.4 of the White Paper. This paragraph does not however say explicitly that Ministers will not be answerable in Parliament for day-to-day operation of the NHS; and Mr Clarke makes it clear that Ministers must realistically expect to come under considerable pressure to continue to answer to Parliament on operational issues in the public eye or of concern in constituencies.

8. This is an important but difficult area where the Prime Minister may want to ask for clear guidelines to be drawn up on how the new arrangements for Parliamentary accountability are going to work. On the face of it, it ought to be possible to have an arrangement as follows.

i. The Secretary of State will continue to be answerable to Parliament, not only for the huge sums of money spent on the NHS as indicated in paragraph 2.4, but also for the matters dealt with by the Policy Board and for the functions dealt with by his Department which lie outside the NHS (eg public health).

ii. If the Secretary of State is asked by a Member of Parliament about an operational matter, his normal course will be to refer it to the Chief Executive or, in appropriate cases, the relevant Regional or District Health Authority for a reply (this is already meant to be the practice). The Chief Executive will be available to appear before Select Committees or to meet MPs on operational issues, where necessary. In the last resort, if the MP is still not satisfied, particularly on a major issue such as a hospital closure, it will still be open to the Secretary of State to reply; but this will not be the normal routine.

iii. In exceptional cases, where for instance an operational issue may be symptomatic of a more general national problem ~~or may become a cause celebre suggesting a serious failing in the NHS~~, the Secretary of State may respond to pressure in Parliament by asking for a report from the Chief Executive, discussing it with him and publishing the report together with an account of the action being taken to deal with the problem. But it will be made clear that the Secretary of State's role is to make sure that the problem is being dealt with, not to deal with it himself.

9. If this general approach - which we have not discussed with the Department of Health - is right, it needs to be worked through in more detail and formally set down and, perhaps, published, as guidance for future practice. The Prime Minister may wish to ask for this work to be set in hand. It is essential to be clear about these groundrules, in broad outline at least, before the White Paper is published, since accountability may be a matter for immediate questioning.

Role of the Department of Health

10. A second point which needs to be clarified is the role of the Department of Health in relation to the Management Committee. Mr Clarke says only that the work of the Committee will be separate from the work of officials whose responsibility is to advise him. What this means in practice and how it is to be achieved, will need to be carefully worked out.

11. At present there are significant parts of the Department of Health which appear to be carrying out operational functions which are part and parcel of the running of the NHS. Our understanding is that they include, for instance, the Department's regional liaison division, its health building directorate, its estate and property management directorate, its procurement directorate and its NHS information technology and planning division as well as those parts dealing with national issues such as pay. The logic of the new arrangements is that parts of the Department which have this sort of operational function should be brought under the Chief Executive and the Management Committee, and be completely separate from the part of the Department which advises the Secretary of State and his Policy Committee. How this is to be done is something which needs to be worked out with some care. The Prime Minister may wish to ask Mr Clarke to carry out an exercise to identify which parts of his Department have operational functions and should therefore come under the Management Committee; and to report to her on how he proposes that the new arrangements should work in practice.

CONCLUSION

12. I attach a possible draft reply for your signature.

R T J WILSON

SECRET

DRAFT LETTER FROM PAUL GRAY TO PRIVATE SECRETARY TO SECRETARY OF STATE FOR HEALTH

NHS REVIEW: CENTRAL MANAGEMENT OF THE NHS

The Prime Minister has seen your Secretary of State's minute of 18 January.

She is generally content with the revised paragraphs for the White Paper which he enclosed, subject to a number of points which she thinks could be further clarified in detail. I enclose some amendments on the attached sheet. You will see that she still considers that Management "Committee" is better than "Board". She believes that having two boards is a recipe for confusion, and that it is also important to mark the change from the present Menanagement Board.

The Prime Minister also has two points of substance.

The first is that she thinks that it is necessary to be clear about the new arrangements for accountability to Parliament and the way in which they will match the new management structure in the NHS and your Department. She thinks this is likely to be raised when the White Paper is published, and that it is essential that all Ministers should say the same thing. She would be grateful if this matter could be discussed between your Department, the Treasury and the Machinery of Government Division of the Cabinet Office, and a suitable note be produced before the White Paper is published.

Second, the Prime Minister is not clear from your Secretary of State's minute that sufficient thought has yet been given to the role of officials in your Department. She takes the view that there needs to be an exercise to identify those parts of the Department which are concerned with operational matters and are therefore responsible to the Chief Executive and the Management

Committee, and those parts which deal with other matters and answer to the Secretary of State and the Policy Board; and that their respective responsibilities need to be defined and the arrangements for keeping them separate clearly set out. Although this does not affect the wording of the White Paper, the Prime Minister thinks that it too needs to be worked up urgently in consultation with the Treasury and the Machinery of Government Division of the Cabinet Office and she would be grateful for a further report as soon as possible.

I am copying this letter to the private secretaries to the Chancellor of the Exchequer, the Secretaries of State for Wales, Scotland and Northern Ireland, the Chief Secretary, the Minister for Health, Sir Robin Butler, Professor Brian Griffiths and Mr Richard Wilson.

AMENDMENTS TO REVISED PARAGRAPHS 2.4 ONWARDS

Paragraph 2.4: It would be impracticable for the Chief Executive to oversee the day-to-day decisions taken locally by operational units, and any attempt to do so could lead to excessive bureaucracy. Redraft to read:

> "...Such accountability does not mean that Ministers should be involved in operational decisions. On the contrary, these decisions must be taken locally by operational units and oversight of the operational units will be the responsibility of the Chief Executive of the NHS Management Committee. Ministers will be responsible for policy and strategy".

Paragraph 2.6. There needs to be a clearer definition of the role of the Policy Board, as follows:

> "A new Policy Board, chaired and appointed by the Secretary of State, will determine the strategy, objectives and finances of the NHS in the light of Government policy, and will set objectives for the Management Committee and monitor whether they are satisfactorily achieved. It will replace..."

Y SWYDDFA GYMREIG
GWYDYR HOUSE
WHITEHALL LONDON SW1A 2ER
Tel. 01-270 3000 (Switsfwrdd)
01-270 0549 (Llinell Union)

ODDI WRTH YSGRIFENNYDD
PREIFAT YSGRIFENNYDD
GWLADOL CYMRU

WELSH OFFICE
GWYDYR HOUSE
WHITEHALL LONDON SW1A 2ER
Tel. 01-270 3000 (Switchboard)
01-270 0549 (Direct Line)

FROM THE PRIVATE SECRETARY
TO THE SECRETARY OF STATE
FOR WALES

COVERING CONFIDENTIAL

19 January 1989

Dear Paul,

NHS WHITE PAPER: WELSH CHAPTER

My Secretary of State has asked me to circulate the attached further draft of the Welsh Chapter which has been revised in the light of discussion at Tuesday's meeting.

As you know, my Secretary of State will unfortunately be unable to attend the E (EA) next Tuesday because of long-standing engagements in Wales. If there are comments on the Welsh Chapter, I would therefore be grateful to receive them by the end of this week, if at all possible, so that they can be considered here before the E(EA) meeting.

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

Yours sincerely,
Stephen

S R WILLIAMS

Paul Grey Esq
Private Secretary
10 Downing Street
LONDON
SW1

CONFIDENTIAL

3RD DRAFT 18.1.89

DRAFT OF WELSH CHAPTER OF NHS REVIEW WHITE PAPER

1. The people of Wales will benefit fully from the improvements which will flow from the Review, and which will make the NHS more responsive to the needs of patients. There are distinctive health care needs and circumstances in Wales. This Chapter describes these and the distinctive programme of action for the Principality.

2. These improvements will build on the remarkable record of achievement of the NHS in Wales over the last decade. NHS expenditure per household in Wales each year has risen from £568 in 1978/79 to the record level of £1,854 planned for 1989/90, a rise of over 44% in real terms. This has made possible the highest ever number of front line staff. By 1987 there were 327 more hospital, medical and dental staff than in 1979 - an increase of nearly 18% - and 4,733 more nursing and midwifery staff - a real increase of 13% (ie after allowing for the reduction in the standard working hours for nurses). Over £600million (at 1988/89 prices) has been spent since 1978/79 on new and improved hospitals and other health service facilities. Most important of all, record numbers of patients are receiving the treatment they need: comparing 1987 with 1979, over 99,000 more in-patients were treated (up over 28%); over 88,000 more new out-patients (up over 20%); and over 45,000 more day cases (up nearly 150%). Additional and recurrent Welsh Office investment (£13.75million in 1988/89) has made possible an unprecedented expansion of community services for those with mental handicaps, at the same time as improvements in the hospitals. Mental illness services are receiving similar recurrent additional investment (over £10million in 1988/89).

Per week?

3. 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 prevent ill health and promote better health.

4. 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 in the Welsh Office. 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 focused to ensure the delivery of the programme of action described in this chapter.

PUTTING THE PATIENT FIRST: THE PROGRAMME FOR ACTION

Increased autonomy for hospitals

5. 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 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 individual medical treatments cost.

6. The managerial autonomy of hospitals will be further enhanced and hospital management and clinical staff will be given direct responsibility for the services they provide. They will move as quickly as possible to a position where they are, in effect, contracted to provide a given level, range and quality of service.

7. It will be possible by the early 1990s for a major acute hospital that so desires to become self-governing, provided that it shows clearly that it will have the capacity to provide efficiently and effectively an adequate range and depth of services to the population it serves. The Secretary of State will determine that range and depth of services. During the 1990s a wider range of Welsh hospitals might be regarded as potential candidates for self-government providing the Secretary of State is satisfied that they can carry out the functions required of them.

Widening the choice of health care

8. These changes in the management of hospitals will take place against a general background of widening choice of health care.

9. Private sector hospital care is relatively poorly developed in Wales, with just 215 in-patient beds. And there are just 54 pay beds in NHS hospitals. These facilities will need to expand to increase patient choice.

10. 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 treatment 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.

11. The drive to widen choice in health care for the benefit of patients will be supported and encouraged by changes in the way in which resources are allocated. Money must move with the patient so that hospitals which are efficient and effective, and attract more work, get the resources they need. Detailed proposals will be the subject of consultation.

Assuring quality of care

12. 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. The NHS in Wales will embark upon a programme to improve the quality of acute care and other services, commencing with proposals in 1989 for better ways to inform patients about services and to take account of patients' views in the development of services.

Additional Consultants

13. Between 1982 and 1987 there was an increase of 121, or 18.5%, in the whole-time equivalent number of medical consultants in Wales. Proposals for additional permanent posts will be announced shortly.

Closer involvement of doctors in management

14. 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 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 the role of the GP

15. The NHS in Wales has taken the lead in encouraging 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 experience gained will be used to develop the role of GPs in service planning across Wales.

16. 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 will have up-to-date information on which to base their decisions.

17. 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. At first, practices with lists of at least 11,000 will be eligible to apply to hold budgets; this represents about 30 practices in Wales. Details of the scheme will be set out in the detailed document which the Secretary of State will publish following the Review. Subject to suitable arrangements being worked out with the appropriate health authorities, the Government would like to see a number of GP budgets in operation by the early 1990s.

Promoting better health

18. 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.

The health authorities

19. 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 to appoint at least one member to each authority in Wales from 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.

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

The Family Practitioner Committees

21. The Family Practitioner Committees have major leadership and management tasks, which are taken further by the proposals in this Review. They too will therefore have newly structured memberships, along the lines set out in Chapter 7. Each FPC in Wales will have a Chief Executive, selected by the Committee following open competition, who will be a member of the Committee.

The consumer voice

22. 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 focused way. The Secretary of State will publish proposals along these lines for consultation.

Value for money

23. 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 in the NHS Directorate. There will be increased emphasis on independent value for money studies. To help secure this the external audit of the NHS in Wales will become the responsibility of the Audit Commission.

A

PRIME MINISTER

You have agreed to record a video message for the NHS Review presentation up and down the country.

You generally approved the text when you saw it on Monday ~~(see your response to my minute opposite)~~

I have polished it and now need your final approval overnight for the attached text so that we can put it on a teleprompter.

Agree attached text?

BERNARD INGHAM
January 19, 1989

(N.B. - I haven't been treated in it myself)

the nation has

At its best, Britain's National Health Service is without equal. Time and again, we have all seen just how much we owe to those who work in it.

A skilled and dedicated staff - backed by massively increased resources - have coped superbly with the growing demands of modern medicine. There is a great deal of which they, and we, can rightly feel proud.

The NHS will continue as now to be available to all, regardless of income, and mainly financed out of general taxation.

But a major task now confronts us. It is to bring all parts of the National Health Service up to the very high standard of the best while maintaining the principles on which it was founded.

All the proposals in this White Paper aim to further develop a National Health Service that puts patients first.

We believe that an NHS that is run better will be an NHS that can care better.

Taken together, the proposals represent the most far-reaching reform of the NHS in its forty year history.

They offer new opportunities, and pose new challenges, for everyone concerned with the running of the Service.

We need a better final para

I am confident that those who work for it will want to seize the opportunities to provide even better health care for the millions of people who rely on the National Health Service.

and the millions whom they spoke - will know that consideration of their needs ~~comes first~~ is paramount

SECRET

PRIME MINISTER

NHS REVIEW

If we are to keep to the timetable, it would be very helpful if you could deal with the attached clutch of NHS Review papers this evening, so that we can put the necessary action in hand tomorrow.

Video Message

At Flag A is a note from Bernard with a polished version of the video message that you will be recording on Monday. You will want to consider whether you are content with it, so that we can put it on a teleprompter.

Central Management of the NHS

You had a first look last night at Ken Clarke's minute at Flag B which he submitted following the discussion at the last Review Group meeting. You had a word about this with Robin Butler this morning; and we have been discussing the issue further with Robin and Richard Wilson during the afternoon.

At Flag C are minutes from Robin Butler and Richard Wilson addressing this problem, to which they attach a draft letter for me to send to the Department of Health recording your comments, both on the detailed drafting of the White Paper and the underlying issues of substance. The proposed revisions to the text are relatively modest but, on the substance, Robin recommends you to raise some fundamental points and commission further work.

The Policy Unit have also been looking at these papers, and Ian Whitehead's minute at Flag D gives his reactions. Ian is much more radical, and recommends you now to put forward a substantially different central management structure, going beyond the possibilities discussed in the Review Group, which would I imagine lead to a clash with Ken Clarke.

SECRET

You need to consider whether to accept the approach recommended by Robin Butler or that favoured by Ian Whitehead.

Revisions to Chapters 1, 7 and 13

Ken Clarke's further minute at Flag E provides revised drafts of these chapters. The Cabinet Office have not provided a note on these, but think the drafts are now generally on the right lines. Bernard Ingham (Flag F) and Ian Whitehead (Flag G) suggest some minor amendments you will want to consider.

White Paper Title

The papers at Flag E to G also cover the question of the title. Ken Clarke (Flag E) now suggests "The NHS: A Healthy Future". Bernard (Flag F) sees something in this, but prefers "Patients Come First: A Programme Of Reform For the NHS". Ian Whitehead (Flag G) puts forward two further suggestions from Tim Bell, but I gather Ian feels that Bernard's suggestion is probably a better one.

You will want to consider whether to accept Ken Clark's proposal or urge him to accept Bernard's alternative.

I think the word Patients should be in the title. I like Patients First - A Healthy Future.

Welsh Chapter

Finally, Peter Walker has circulated a revised draft of the "Welsh Chapter" (Flag H). This looks much better, but you will want to see whether you have any further comments.

Patients first - A programme of reform for the NHS.

ACTION

(i) Content with the text for the video message (Flag A)?

Ken amendments.

(ii) Content with the response recommended by the Cabinet Office on the central management of the NHS (Flag C), or do you prefer the more radical approach of the Policy Unit (Flag D)? More radical approach. Parent proposals leave many questions unanswered. - as indicated on minute

(iii) Content to endorse the detailed comments by Bernard (Flag F) and Ian Whitehead (Flag G) on chapters 1-13? Some - see comments

(iv) For the title, do you prefer "The NHS: A Healthy Future" or "Patients Come First: A Programme Of Reform For The NHS"? I think the word Patients needs to be in the title.

(v) Any comments on the Welsh Chapter (Flag H)? - it reminds us very effectively that the money must move with the patient. Have we made that point in the English version?

PP PAUL GRAY
19 January 1989

DS3AFK

CONFIDENTIAL

file UK

bc :- BG

10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

19 January 1989

Dear Andy,

NHS REVIEW: DATE OF PUBLICATION OF WHITE PAPER

Thank you for your letter of 18 November which the Prime Minister has seen. She is content for the arrangments you describe to be put in hand for the publication of the White Paper on 31 January.

I am sending a copy of this paper to Alison Smith (Lord President's Office), to the Private Secretaries of members of the Ministerial Group and to Richard Wilson (Cabinet Office).

Yours,

Paul

(PAUL GRAY)

Andy McKeon, Esq.,
Department of Health.

CONFIDENTIAL

010 cst.ps/3jm18.1/drfts

CONFIDENTIAL

cc P.U.

NBPM
PLC6
19/1

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
SW1A 2NS

19 January 1989

Dear Secretary of State,

NHS REVIEW: DRAFT WHITE PAPER

At Tuesday's meeting I said that I would write to you about some further points which the Chancellor and I have on the draft.

The present draft of paragraph 2.23 gives the misleading impression that health authorities will become major property developers in their own right. This is not the case: property development is an activity which is properly for the private sector, and health authorities do not in any case have the expertise to control the considerable risks that would be involved. In the first sentence, therefore, delete "imaginative use of property assets" and substitute "property which is surplus to requirements". In the fourth sentence, delete "encourage more imaginative property development", substitute "assist them in this", and insert "central" before "group of professionals". The present text invites a replay of the Crown Agents' scandal.

The third sentence of paragraph 2.28 mistakenly implies that the Audit Commission will be responsible for auditing the consolidated accounts of the NHS, which is and will continue to be the responsibility of the NAO. This sentence should instead read "... the external audit of health authorities and other NHS bodies at present audited by the department. In this capacity, it would report to the Secretary of State."

In the fourth indent of paragraph 3.14, the requirement on hospital trusts will be rather more than simply to break even taking one year with another. Like other public sector bodies, hospital trusts will need to earn a rate of return on their capital, which will be reflected in their annual financing limits. The sentence should read "... temporary deficits, but will be set overall financial targets designed to yield an appropriate rate of return on the capital employed."

18.1.89.3

CONFIDENTIAL

The first sentence of paragraph 3.15 has got a little garbled. I suggest it should read:

> "Hospital trusts will be subject to annual financing limits, within which they will be free to borrow, either from the Government or from the private sector."

The third indent of paragraph 6.9 suggests that the drugs element of practice budgets should be higher than if the GP was not in the scheme and hence had only an indicative drugs budget. This is not a proposal we have previously discussed, and it seems to me to have no merit at all. There is no reason why holders of real budgets should be more likely to overspend than those with indicative budgets: if anything the reverse will be the case. Moreover, the agreed 5% flexibility will give GPs adequate scope to manage fluctuations in their drugs expenditure. This extra margin seems unnecessary and wasteful. The words "but with a small premium because it will be a component of a real budget" should therefore be deleted.

As the Chancellor said at the meeting, the present paragraph 7.21 does not include the point agreed at our 5 January meeting about the failing in the present system that the remuneration of GPs in aggregate does not take account of falling list sizes. We suggest replacing it with the following two paragraphs:

> "7.21. It is the Government's responsibility to ensure that there is adequate access to primary care services across the country, and that opportunities exist for good doctors to enter general practice. But the Government also has a responsibility to the taxpayer to ensure that the total cost of the service does not rise beyond acceptable bounds. The present system by which fees and allowances are set so as to deliver a target average net income for GPs, irrespective of changes in the average numbers of patients on their lists, is a matter for concern. It means that the costs of the system increase in direct proportion to the numbers of practitioners.
>
> 7.22. The Government proposes therefore to take two further steps to enable it better to control the total cost of the service while ensuring that sufficient opportunities remain in general practice for the best young doctors. First, it will seek reserve powers ... Health and Medicines Act 1988. [as in present draft]"

I am copying this letter to the Prime Minister, the Chancellor, Secretaries of State for Scotland, Wales and Northern Ireland, the Minister for Health, Sir Roy Griffiths, Sir Robin Butler, Mr Wilson (Cabinet Office), and Mr Whitehead (Policy Unit).

Yours sincerely,

P. Walker

pp **JOHN MAJOR**

[Approved by the Chief Secretary and signed in his absence.]

19

SCOTTISH OFFICE
WHITEHALL, LONDON SW1A 2AU

NBPM

BMG
19/1

SECRET

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

19 January 1989

Dear John,

NHS REVIEW

As I mentioned at our discussion on 17 January I have decided that I want to make a firm announcement of my intention to appoint a Chief Executive of the NHS for Scotland. For that purpose I want to amend paragraph 17 in Chapter 10 to read:

> "The responsibility for health service policy will continue to rest with the Scottish Home and Health Department, reporting to the Minister for Education and Health and the Secretary of State. However, it is desirable that the management of the Health Service should be strengthened and the Government has decided to appoint a Chief Executive for the NHS in Scotland. The Chief Executive will be responsible for the efficiency and performance of the Health Service and for the overall supervision of the execution of policy. He will have responsibility for the establishment of appropriate and adequate information and data systems required to ensure the effective delivery of patient services."

This would be a new post for which the appropriate nominal level would appear to be Grade 3 and I would propose to retain the existing two Health Grade 3 posts, at least for the period of active implementation of our proposals, and to review the situation in 1990.

I hope you are content with this wording and the proposal. My people will write to yours about the details.

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

Yours ever,

MALCOLM RIFKIND

HMP018M5.016

0559A

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

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

cc PS

CONFIDENTIAL

Paul Gray Esq
No 10 Downing Street
LONDON SW1

Prime Minister
Content now 18 January 1989
to announce publication
will be on 31st January?
RRCB 18/1

18 January 1989

Dear Paul

NHS REVIEW: DATE OF PUBLICATION OF WHITE PAPER

The Ministerial Group have been aiming towards publishing the White paper on 31 January and the Department has been making preparations to launch the White Paper on that day. These include a very substantial exercise to communicate the content of the White Paper as soon as possible to about 2,000 NHS chairmen, managers and clinicians who will be important opinion formers within the service. The plans include a teleconference on the day and roadshows led by Ministers over the following three days. We have now reached the stage where if the White Paper is to be published on 31 January we need to send invitations this week to those attending the teleconference and roadshows. My Secretary of State would also like to tell Parliament, via letters to the Chairman of the Social Services Committee and Robin Cook, of the expected date in advance of it becoming widely known throughout the service.

Once the letters and invitations have been sent it will be extremely difficult to alter the date but we must advise people sufficiently in advance if the launch is to be a success.

I would be grateful for clearance to issue the letters and invitations for publication on 31 January. The Lord President is content with the Parliamentary arrangements.

I am sending a copy of this letter to Alison Smith (Lord President's Office) to the Private Secretaries of members of the Ministerial Group and to Richard Wilson.

Yours

Andy

A J McKEON
Principal Private Secretary

KH/0694t

18a-c

B a

SECRET

PRIME MINISTER

NHS REVIEW: CENTRAL MANAGEMENT OF THE NHS

We have now revised the paragraphs of the draft White Paper that deal with the central management of the NHS in the light of yesterday's discussion. I attach the new version.

2. You said yesterday, and I entirely agree, that while the text of the White Paper does not need to go into detail, we ourselves must be clear about the details before the White Paper is published and the issues are debated publicly. This is the object of my minute.

3. We did not resolve yesterday whether we should have a Management Board or Committee. For convenience, I use the term "Board" in this minute. I still prefer it because to my mind "Board" underlines the importance we attach to its role. A change to "Committee" would mistakenly be taken to signal a reduction in its functions and status.

4. There are four main points to settle:

first, the relationship of the Secretary of State and the Policy Board to the Chief Executive and the Management Board.

second, the constitutional position of the Management Board and its relationship to the Department.

third, the relationship between the Management Board and Regional Health Authorities.

fourth, accountability to Parliament.

5. On the first point, we are agreed that the Secretary of State is responsible for strategy and policy on the NHS and, as part of the exercise of this responsibility, will chair the Policy Board. The Policy Board's remit will be to determine the strategy, objectives and finances of the NHS and to set objectives for the Management Board and monitor whether they are satisfactorily achieved.

6. All operational and managerial issues will be the responsibility of the Chief Executive and the Management Board which he will chair. The Management Board will be accountable to the Policy Board for the delivery of the objectives set by the Policy Board. This is an important and new separation of their respective responsibilities.

~~[illegible]~~ ? role of Cabinet in policy [illegible].

D

7. On the second point, the Management Board will have a separate line of accountability from that of the Department, clearly marked by the fact that the Chief Executive will report directly to the Secretary of State on all operational and management matters. The Chief Executive will also be accounting officer for all expenditure on the hospital and community health services.

8. For administrative purposes the Management Board will be located within the Department of Health. I fully accept that the work of the Management Board will be separate from the work of officials whose responsibility is to advise me.

9. It will take time and require careful political handling to establish the Management Board with the separate and accepted identity of its own that I certainly intend it to have. To take a particularly difficult but very important example, it is a long standing practice for the British Medical Association to have direct access to the Secretary of State. I have long felt that it is a nonsense that the employment and management of doctors has become part of the political process, and not simply part of the management of the Service. The BMA feel equally strongly that this is a part of the understanding on which the NHS rests. We need to move to a position where they accept it is normal practice to meet and deal with the Chief Executive on operational matters such as the management of consultants' contracts. I intend to move towards that as quickly as possible.

10. On the third point, I will continue to maintain contact with and to consult Regional Chairmen, who are appointed by the Secretary of State and regard themselves as charged with the delivery of Government policy in their Regions. In future, however, the General Managers of the Regional Health Authorities will be accountable to the Chief Executive who will set objectives for them. Is he not also accountable to his own chairman.

11. The overall effect of these changes will be to introduce for the first time a clear and effective chain of command running from Districts through Regions to the Chief Executive and from there to the Secretary of State.

12. On the fourth point, the normal Accounting Officer rules will apply to the Chief Executive. I shall expect him to take a prominent role in dealing with Select Committees and the like.

13. So far as Ministerial responsibility to Parliament is concerned, we shall follow the line set out in para 2.4 of the draft White Paper. This will require us all to take a robust stance. Realistically we must expect considerable pressure from backbenchers on both sides for Health Ministers to continue to answer on any operational issues which are in the public eye or which are seen as major constituency concerns. This will be so whether or not such issues have been delegated to the Management Board. It is very important that we maintain a common line on this in Scotland, Wales and Northern Ireland.

14. I intend to operate the Department on the basis that I have set out in this minute. It is an important part of the way in which I expect to see our reforms implemented. I trust that the form of words attached for the White Paper backed up by this minute clearly express our new approach.

15. I am copying this to the Chancellor of the Exchequer, the Secretaries of State for Wales, Scotland and Northern Ireland, the Chief Secretary, the Minister for Health, Sir Robin Butler, Mr Brian Griffiths and Mr Richard Wilson.

AJM

18/1 K C

(Approved by the Secretary of State and signed in his absence)

DELEGATING RESPONSIBILITY

Central Management of the NHS

2.4 The NHS will continue to be funded by the Government mainly from tax revenues. Ministers must be accountable to Parliament and to the public for the spending of these huge sums of money. But Ministers cannot, and in future will not, be directly involved in the decisions taken locally by operational units. On the contrary, the oversight of those decisions ought to be the responsibility of the Chief Executive of the NHS Management Board. Ministers must however remain responsible for policy and strategy.

2.5 The central management of the NHS must reflect this division of responsibilities. The Government proposes that responsibility for strategy will be for a Policy Board chaired by the Secretary of State for Health. Responsibility for all operational matters will be for a Management Board chaired by a Chief Executive. The Management Board will be accountable to the Policy Board for the management of the NHS within the strategy and objectives set by the Policy Board.

2.6 The specific proposals are:

* a new Policy Board, chaired and appointed by the Secreatary of State, will consider all strategic issues for the NHS in the light of Government policy. It will replace the former Health Service Supervisory Board and will include non-executive members drawn from inside and outside the NHS;

* the Management Board will be chaired by the Chief Executive and appointed by the Secretary of State in consultation with the Chief Executive. It will deal with all operational matters within the strategy and objectives set by the Policy Board;

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

2.7 The overall effect of these changes will be to introduce for the first time a clear and effective chain of management command running from Districts through Regions to the Chief Executive and from there to the Secretary of State.

The role of regions

2.8 The Management Board could not directly exercise effective authority over the current 190 District Health Authorities (DHAs) which have a total expenditure of nearly £14 billion (nearly £19 billion with family practitioner services). Regional Health Authorities (RHAs) will therefore continue to ensure that Government policies are properly carried out within their regions. To be effective they will need to concentrate their efforts on their essential tasks. These include monitoring the performance of the health service, evaluating its effectiveness and keeping the state of health of the people of the region under review. They will have a key role to play in managing the wider programme of changes that are set out in the White Paper.

2.9 In addition, RHAs have traditionally provided a range of operational and management services. These include distribution centres, ambulance and blood transfusion services which could not be provided economically in every District. They also include legal, information and management services to Districts themselves. 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 already been

streamlined, delegated to Districts or contracted out to the private sector.

2.10 There remains, however, a wide variation in the size of each Region's operations. The Government believes that there is still considerable scope for reductions in the number of staff directly employed by RHAs on these operations. The Management Board will therefore review the provision of all regionally managed services. It will only approve the retention of services at the regional level if it is cost-effective to do so. As part of this exercise, Districts will be asked whether they can provide more of these services themselves or purchase them from the private sector.

The role of districts and hospitals

2.11 The Government also believes that there is further scope for delegating decision-making from DHAs to hospitals and their associated management units. Many large hospitals already have a significant degree of self-determination. RHAs should now satisfy themselves that, whenever possible, all DHAs delegate operational functions to their hospitals, taking account of the availability of staff in key disciplines and the need to ensure that, overall, the management of services remains cost-effective.

2.12 The Government's objective is to create an organisation in which those who are actually providing the services are also responsible for day-to-day decisions about operational matters. Like RHAs, DHAs can then concentrate on ensuring that the health needs of the population for which they are responsible are met; that there are effective services for the prevention and control of diseases and the promotion of health; that their population has access to a comprehensive range of high quality, value for money services; and on setting targets for and monitoring the performance of those

management units for which they continue to have responsibility.

17a-b

CCBI a

PRIME MINISTER

PA

NHS REVIEW

Kenneth Clarke has sent over late this evening a further minute on the central management of the NHS and a revised draft of the key section of Chapter 2 of the draft White Paper.

Others will no doubt be considering this tomorrow and registering their reaction. But you may want to have a first look at it tonight to consider whether things are now getting on to the right lines. My immediate reactions on the covering minute are:

- We are now getting closer to what you want.

- He now seems to be envisaging two separate but parallel chains of command running up from the regions to the centre. At the Executive level, the Regional General Managers will be accountable to the NHS Chief Executive, and at the non-Executive level, the Regional Chairmen will report to the Secretary of State. There are some problems with this, eg if the Regional General Managers are accountable to the Chief Executive, what is their relationship with the Regional Chairmen? But, overall, this looks a promising approach.

- A particularly welcome proposal is for the NHS Chief Executive to be the Accounting Officer.

- The relationship of the Management Board to the Department of Health is still unclear - see paragraph 8 of the minute. What we need to know is exactly who Mr Clarke envisages as members of the Management Board - your wish, as I understand it, is that it should include no DoH civil servants. SMS may wish to have someone from the dept on the Management Committee on a personal basis

6

- I still think it would be much better to talk about a Management Committee rather than Board. Having two Boards is a recipé for confusion. Having the Management tier as a Committee of the Policy Board emphasises the necessary links between them.

On the revised draft Chapter, my immediate thoughts are:

- The worst problems with the earlier draft have now gone.

- It is worth making clear, particularly if we are to have two Boards rather than a Board and a Committee, that the Chief Executive will be a member of the Policy Board.

- If early agreement can be reached on this, it would be worth including in the draft that the Chief Executive will be the Accounting Officer. It would also help to spell out the proposed relationship between Regional General Managers and the Chief Executive.

- Paragraph 2.11 needs to make clear that it relates only to hospitals still run by DHAs and not to self-governing hospitals.

RRCG.

PAUL GRAY
18 January 1989

EAMALO

SECRET

PA CCBI

Prime Minister
I'm sure Bernard is right about the patient.
Do you like "Power to the Patient"?
If not, how about a variant of
his second idea - "Putting Patients First"?

cc Mr R T J Wilson
Miss Christopherson

MR GRAY

PRC 6 18/1. It has been used before

NHS REVIEW

I drove home very dangerously last night racking my brains over a title.

I was very much influenced in my thinking by my redrafting of Para 1.7. This passage on the key proposals leaves no-one in any doubt that the White Paper is intended to serve the patient.

Moreover, the surest way to put the Opposition in baulk, or to make life difficult for them, is to focus attention on the Government's determination to take on all-comers to ensure a better service for the patient.

Consequently I suggest:

- Caring for the Patient
  a programme of reform for the NHS

  Serving the Patient?

- ✓ Patients First
  a programme of reform for the NHS

  Patients come first-

- A Plan for Patients
  a programme of reform for the NHS

- More Power to the Patient
  a programme of reform for the NHS

  Don't like this very much

I prefer the last. It is by far the most powerful and in my view suffers not at all from its revolutionary connotations. It's about time somebody thought of the poor bloody infantry/patient.

B. Ingham

BERNARD INGHAM
January 18, 1989

SECRET

SECRET - CMO

10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

18 January 1989

NATIONAL HEALTH SERVICE REVIEW

The Prime Minister chaired on 17 January the nineteenth and twentieth meetings of the group reviewing the National Health Service. The group had before them a draft of the White Paper on the review circulated by the Secretary of State for Health.

I should be grateful if you and copy recipients would ensure that this record of the discussion is handled strictly in accordance with CMO arrangements.

Those present at the first meeting on the morning of 17 January were the Chancellor of the Exchequer, the Secretary of State for Wales, the Secretary of State for Northern Ireland, the Secretary of State for Scotland, the Secretary of State for Health, the Chief Secretary to the Treasury, the Minister for Health, Sir Roy Griffiths, Sir Robin Butler, Mr Wilson and Mr Monger (Cabinet Office), Mr Whitehead (No 10 Policy Unit) and Mr Ingham.

Those present at the second meeting in the afternoon of 17 January were the Chancellor of the Exchequer, the Secretary of State for Northern Ireland, the Secretary of State for Scotland (for discussion of Chapter 10), the Secretary of State for Health, the Chief Secretary to the Treasury, the Minister for Health, Sir Roy Griffiths, Mr Wilson and Mr Monger, Mr Whitehead and Mr Ingham.

Chapter 1

The group discussed first the statement in paragraph 1.2 that the NHS was 'free at the point of delivery'. It was argued that this statement was not strictly true, because of the existence of charges; that it was important not to close options for the future unnecessarily; and that the drafting did not recognise that the Service was financed by taxpayers who were entitled to the best possible service and value for money. It was also argued however that outside opinion would attach great importance to a clear statement of the Government's intention on the point, and that it was not

realistic to expect any change on it during this Parliament. The group agreed that the words 'free at the point of delivery' should be replaced by a statement that the service provided by the NHS was, and would continue to be, open to all regardless of income. They agreed that the words 'financed mainly out of general taxation' were right, and that 'mainly' would be better than 'largely' in 2.4.

In paragraph 1.3, the group agreed that the words 'out of all recognition' in the first sentence should be replaced by such words as 'at a remarkable pace'.

The group noted that the figures in paragraph 1.3 for the number of staff employed were 1986 figures. They agreed that it was essential to use up-to-date figures. They also agreed that the figures for total expenditure should be for 1989-90, and that the paragraph should also say what the cost of the NHS would be in that year for an average family, and how it had changed since 1978-79. The group regarded it as important to bring home the increase in NHS spending. There was still considerable misunderstanding about this among the public and even the profession.

The group broadly agreed the redraft of paragraphs 1.4 to 1.6 which had been put forward by Mr Ingham.

In discussion of the structure of paragraphs 1.7 and 1.8, it was argued that the drafting lost sight of the paramount importance of practical improvements in services to patients. This theme was not introduced until paragraph 1.8 after the 'key changes' had been described in paragraph 1.7. One possibility was to use the opening of paragraph 1.8 as a preface to the list of key changes, although this had not worked well in earlier drafting. The group agreed that Mr Ingham should be asked to consider how the presentation of paragraphs 1.7 and 1.8 could best bring out the importance of improving services to patients. At the meeting on the afternoon of 17 January, the group agreed the structure of the revision of paragraphs 1.7 and 1.8 circulated subsequently by Mr Ingham, subject to further consideration of the detailed drafting by the Secretary of State for Health.

In discussion of paragraph 1.7, on 'key changes', the group agreed that:

i. The second inset, on self-governing hospitals, appeared to emphasise their ability to decide the pay of their staff. This was wrong. It would be better to replace the second sentence of the inset by:

> 'This will enable them, while remaining in the NHS, to take fuller responsibility for their own affairs, harnessing the skills and enthusiasm of their staff';

and ending with:

'Within annual financing limits, they will be free to borrow money. And they will be able to set the rates of pay of their own staff'.

ii. The last sentence in the third inset contained the word 'best' twice. One of these references should be deleted.

iii. The word 'defined' should be inserted before 'range' in the first sentence of the fourth inset.

Finally, on paragraph 1.7, the group agreed that two other key changes should be included:

i. The new audit arrangements. The Chancellor had suggested an addition as follows:

'Fifth, steps will be taken to improve value for money. The Audit Commission will assume responsibility for auditing the accounts of health authorities and other NHS bodies, and will undertake wide-ranging value for money studies. Complementary to this, arrangements for medical audit will be extended throughout the health service, thus helping to ensure that the best quality of clinical care is given to patients'.

The group agreed this addition, subject to moving to the front of the sub-paragraph the reference to improving the quality of care for patients. They noted that the last sentence of the first key point, which also reflected the new audit arrangements, would have to be reconsidered. It was anyway separate in substance from the rest of the point.

ii. The organisational changes affecting health authorities and FPCs should be covered. The wording suggested was:

'Seventh, health authorities will be streamlined, with functions delegated from regions to districts and from districts to hospitals where appropriate. Their membership will be reduced to make them more management-oriented bodies. Local authorities will no longer have the right to appoint members. Family practitioner committees will in future report through regional health authorities to the NHS Management Board'.

The group agreed that the penultimate sentence of paragraph 1.9 should end with words such as 'treats patients as people'.

The group noted that the opening words of paragraph 1.10 might be misleading since the Government could not require the hospitals to make the improvements listed. It was agreed that they should be replaced by: 'The Government believes that each hospital should offer:'.

The group agreed that in paragraph 1.11, the word 'only' in the first sentence should be deleted, the second sentence should be omitted, and the third sentence should start with the words, 'These improvements will bring greater appreciation ... '.

The group agreed that the heading before paragraph 1.12 should be, 'The best use of resources'.

In paragraph 1.14 it was agreed that the third inset should refer explicitly to the Audit Commission.

The group agreed that the heading before paragraph 1.15 should be, 'Public and private sectors working together'.

In paragraph 1.16, the group agreed that the word 'prohibitive' in the second sentence was exaggerated and that the second and third sentences should be recast to read:

> '... many people who do so during their working life find the cost of the higher premiums difficult to meet in retirement. The Government therefore propose to make it easier for people in retirement by allowing income tax relief on ...'.

It should be made clear that the relief would apply to premiums paid on behalf of, as well as by, the elderly. At the meeting on the afternoon of 17 January, the group also agreed that the drafting in this paragraph must be brought into line with the drafting agreed for paragraph 9.4.

The group decided that paragraph 1.17 should be deleted.

As to paragraph 1.18, the group agreed that the thought in the last two sentences should be moved to the front of the paragraph; and that 'some aspects' should be replaced by 'those aspects'.

Chapter 2

The group agreed that there should be a preamble along the lines of the draft which had been circulated, but the final words of the third inset should be: '... which treat most patients'. On the opening paragraphs, the group agreed as follows:

> i. The figure of 'well in excess of £20 billion' in 2.1 needed to be precise. References elsewhere were to one of £24 billion.
>
> ii. In paragraph 2.3 the word 'dictated' should be replaced by 'administered'.

The group then discussed the section on the central management of the NHS in paragraphs 2.4 and 2.8. Summing up this part of the discussion, the Prime Minister said that this section was of considerable importance and had to be got right. The group were agreed as follows:

a. It was essential to make it clear that there would be an effective chain of command running through the NHS to the Management Committee and, through that Committee, to the Secretary of State. The section as drafted did not do this.

b. It was also essential to make it clear in the White Paper that Ministers would not be answerable in Parliament for day-to-day operation. A clear distinction must be drawn throughout between the responsibilities for policy of the Policy Board, chaired by the Secretary of State, and those for operation of the Management Committee (which was a better name than Management Board) chaired by the Chief Executive (who would be a member of the Policy Board). The respective responsibilities of the Policy Board and the Management Committee had been agreed at the last meeting of the group.

c. Defining the distinction between strategy and operation would however require more work. Hospital closures would, for example, have to be regarded as a matter of policy. It was also important to define more clearly the responsibilities at different levels within the chain of command of the NHS.

d. The present draft involved the Department of Health too much in management. The Management Committee would not be part of the Department, although it would be located there. There should be no misunderstanding of the role of departmental officials, which was to advise the Secretary of State but not to be involved in the management of the NHS. The Management Committee was not to consist of departmental officials, although there might be one or two on it in a personal capacity. The Policy Board should be kept small and include outsiders.

e. The Management Committee would not itself run the detailed operation in the NHS. That would continue to be the responsibility of the Health Authorities. The relationship between the Committee and the Authorities must be determined according to the principle of maximum devolution of functions which underlay the White Paper. The role of the Committee would be to exercise a general oversight over the operation of the NHS.

f. There was some danger that establishment of the Management Committee would increase bureaucracy. This was because the Committee would be another layer in the management structure and because the Committee and the Regions might in practice take on more staff for managing the relationship between them.

g. The danger of excessive bureaucracy also arose in relation to the Regions. Many of their functions would be increased by the proposals in the White Paper. While it might be true that the Regions were needed to implement the programme of reforms, that would not by its

nature be a permanent task. In the longer term their functions would diminish. They might become little more than the regional arms of the Management Committee, although it would be better not to say that in the White Paper.

h. It was clear that the central structure had not yet been fully worked out. In these circumstances, it would be prudent for the White Paper to be as general as possible in its description. Detailed work on the structure should be set in hand.

The Prime Minister said that the Secretary of State for Health should now redraft this section in the light of the discussion. It clearly needed a good deal more work. The drafting would have to be reconsidered as a whole, but some particular changes in the text which the group had identified were:

- Deletion of 'for the services which they finance' in 2.4.

- Replacement of 'in practice' in the fourth sentence of 2.4 by 'on the contrary'.

- Deletion of the last sentence of 2.4.

- Deletion of 'within the Department of Health' in the first sentence of 2.5.

- Amalgamation of the first two insets in 2.5.

- Deletion of 'management' from the second inset in 2.5.

- Appointments to the Management Board should not be made by the Chief Executive, as the third inset in 2.5 said, but by the Secretary of State in consultation with him.

- In the last inset of 2.5, insert at the end of the first sentence words such as 'except for policy'.

- Remove the implication in 2.7 that it is for the Regional Health Authorities to review themselves and decide what action to take on the reviews. They should be given clear instructions on the points at issue.

The group also noted that there were points on paragraphs 2.23 and 2.28 which could be dealt with in correspondence.

Chapter 3

The group agreed that the drafting of the White Paper should not preclude the possibility that some smaller hospitals, with less than 250 beds, might be suitable for self-government. This point was covered more fully in discussion on Chapter 11 below.

It was also agreed that the requirement as to members in the first inset of 3.4 applied only to the larger hospitals

and that the White Paper should say so.

Chapter 4

The word 'crises' at the end of 4.7 struck the wrong note. It might be better to refer to 'problems'.

Chapter 5

The group agreed the following points in discussion of Chapter 5:

i. It was essential to give up-to-date figures for the number of consultants.

ii. The language of 5.2 was over-simplified, and should be reconsidered.

iii. Paragraph 5.10 proposed a double check that self-governing hospitals had an effective audit system. This seemed excessive.

iv. The White Paper should state clearly that joint enquiries covering both medical and management audit would sometimes be necessary. The reference in the last inset of 5.9 was not explicit enough.

v. The words 'and the time they devote to the NHS' should be added to the second sentence of 5.14.

vi. It should be made clear in this Chapter that in the case of self-governing hospitals the hospitals themselves would hold the consultants' contracts.

vii. At the end of 5.18 it should be made clear that the timetable for concluding an appeal should be not more than nine months, and the word 'normally' should be deleted.

Chapter 6

The group agreed that in paragraph 6.8 the accuracy of the first sentence would need to be checked; that the word 'direct' should be inserted after 'budgets' in the second sentence; and that the reference to consultation with the FPC should be omitted, in the interest of reducing the apparent complexity of the arrangement.

The group discussed paragraph 6.13. They agreed that GPs should have the maximum possible incentive to make savings, and that they should accordingly be able to plough back 100 per cent of the savings into their practices. The group decided therefore that the paragraph should say that GPs would be able, as they judged best, to spend all such savings on improving their practices and offering better services to their patients.

Chapter 7

In paragraph 7.14, the words 'the rate of increase in' contained in the second sentence should be deleted.

In paragraph 7.21 the group agreed that there must be an opening passage to explain why the problem arose and to pave the way for the policy proposal. It was quite wrong that people could set up as doctors whether or not there was sufficient work for them to do, and the paragraph should reflect this. The group asked the Secretary of State for Health to agree a redraft of the paragraph with the Chancellor of the Exchequer, in the light of the discussion.

The group agreed that the second indent of paragraph 7.23 should be amended by the addition at the end of: 'serving in a personal rather than a representative capacity'.

The group also agreed that paragraph 7.24 needed revision. It was not clear that the two sentences of the paragraph were consistent with each other. The paragraph should begin with a clear statement that the present committee structure must be slimmed down and that only a reasonable number of members could be co-opted to committees. The Secretary of State was asked to revise the paragraph in the light of these comments.

Chapter 8

It was agreed that the fifth sentence in paragraph 8.4 exaggerated the point it was trying to make, and should be replaced by a statement that managers were not members of the decision-making body.

It was also agreed that the word 'automatic' should be deleted from the sixth inset in 8.6.

The group thought that paragraph 8.7 exaggerated the value of the Community Health Councils and asked the Secretary of State for Health to reconsider the drafting. A possibility would be to delete both the second and third sentences.

Chapter 9

The paragraph on tax relief suggested by the Chancellor of the Exchequer was agreed, subject to further consideration of detailed drafting. The paragraph made it clear that relief would be given on premiums paid on behalf of the elderly only in certain circumstances, for example when they were paid by other members of their family. The reference in 1.16 to tax relief had to be amended to reflect the final wording adopted in this Chapter.

The group agreed that the drafting of this Chapter should be revised to give it a more positive tone about the actual and potential contribution of the private sector to health care. There were lessons to be learnt from the treatment of this topic in the Chapter on Scotland. For example, it should

I

be possible to say of England, as that Chapter did of Scotland, that more people were looking to the private sector for the diagnosis and treatment of their health problems. A more positive flavour would also be given if the beginning of 9.2 made it clear that, at least in recent years, the private sector had been growing; and perhaps if 9.2 and 9.3 were made the opening paragraphs of the Chapter. The words 'the mixed economy' in 9.1 were not right. The reference should convey a sense of the growth of the private sector, and also of co-operation between it and the public sector.

In paragraph 9.8, it was agreed that the Secretary of State for Health should check the consistency of the figures of 17 per cent and £1 billion a year. If they were consistent, the paragraph should explain why.

In paragraph 9.11, it was agreed that the words 'without capital funding from the health authority' at the end of the second sentence were not right. It should be made clear that such schemes could go ahead either jointly or without capital funding from the Health Authority.

Chapter 10

In discussion of this Chapter, the group agreed that the different treatment proposed in Scotland for central organisation, size of boards, and audit resulted from the different circumstances in Scotland. They also decided on the following amendments:

a. The list of practical improvements in paragraph 10.4 would be reconsidered to see if it could contain all the items in the corresponding list for England. There was one item in the Scottish list that did not appear in the English list: that authorities would work towards ensuring that all out-patients were seen by a consultant on their first visit. The Secretary of State for Health was asked to consider whether this item could be added to the English list.

b. In paragraph 10.5, the words 'not later than' should be inserted before '1992' in the third sentence.

c. The wording in paragraph 10.17 had been temporary. The Secretary of State for Scotland had now reached the view that it would be right to appoint a Chief Executive in Scotland, and the paragraph would be revised to say this.

Chapter 11

The group agreed on the following changes in this Chapter:

a. There would be a preface on the record of the NHS in Wales.

b. The reference to a corporate strategy at the end of 11.3 should be deleted.

c. In the passage on the timetable for self-governing hospitals at the end of paragraph 4(i), the suggestion that eligible hospitals would necessarily have to have 250 or more beds should be removed. Some smaller hospitals might also be suitable for self-government, and the drafting should reflect this. It should also be made clear however that there must be safeguards against smaller hospitals which became self-governing changing their functions to the detriment of services to patients. Finally, the word 'a' in the fourth line of the last sub-paragraph of 4(i) should be replaced by the word 'any'.

d. The reference at the end of paragraph 4(vii) to examining the arguments for bringing hospital and community services and family practitioner services under one management should be deleted.

Chapter 12

In discussing this Chapter, the group agreed that:

i. The Secretary of State for Northern Ireland would reconsider the reference at the end of paragraph 12.3 to 'streamlining' the acute hospital service, since its meaning was not clear.

ii. He would also remove the reference in 12.3 to 'care in the community', since the White Paper did not deal with this topic in England.

iii. An indented list of practical benefits to patients, similar to the list for England, should be given in 12.4.

iv. There should be a reference to the timing of the development of self-governing hospitals, probably 'not later than 1992', as for Scotland.

Chapter 13

The group agreed on the following amendments to this Chapter:

i. The title of the Chapter should be 'The Programme for Reform'.

ii. The timetable should reflect the fact that many of the reforms did not require leigslation, and could be implemented quickly. This was true for example of the practical benefits for patients. Even in the case of those which did require legislation, preparatory work would be possible before the legislation was passed.

iii. The Chapter should not be confined to those changes likely to be popular with those concerned. The list of changes should be reconsidered with a view to making it

more comprehensive. The reference to the changes affecting consultants, for instance, should not be confined to the increase in their numbers. There should also be a reference to the new audit arrangements.

iv. The reference to consultation should be reconsidered. It should be tied to the issue of the detailed documents which were due to be published after the White Paper. The reference to these documents should be along the lines: 'Detailed documents on how to implement the proposals will be published in the next few days'.

v. The reference to a review by the RHAs of their own functions should be removed, in accordance with the earlier decision by the group. It should be made clear that they would be told to plan for delegation of management to operational units, and the development of self-governing hospitals.

Finally, the group agreed that the Chapter should begin with 'wrap up' paragraphs which re-stated the main themes of the Government's policy and proposals. It would not matter that this would repeat or overlap with earlier Chapters.

Public Expenditure

The group accepted the draft paragraph on public expenditure put forward by the Secretary of State for Health and the Chief Secretary. No figure would be given for the public expenditure cost.

Consultants

The group also accepted the draft paragraph on the increase in consultants numbers put forward by the Secretary of State for Health and the Chief Secretary. The paragraph should not give a figure for the cost of or source of funding for extra consultants, but it should make it clear, by an amendment to the penultimate sentence, that this would be above the cost of the two per cent annual expansion already planned.

Title and Presentation

The group agreed that the title of the White Paper required further thought, but they saw attraction in 'Better Health'. They also agreed on the importance of an attractive presentation and good illustrations. The Department of Health had in hand arrangements to inform NHS staff of the proposals in the White Paper. Copies should be available in hospitals.

Next Steps

The Prime Minister said that the Secretary of State for Health should urgently circulate to the group new versions, revised in the light of its discussion, of those parts of the

White Paper of particular importance and difficulty in Chapters 1, 2 and 13. The aim should be to clear these in time for circulation of the entire draft to Cabinet and E(A) on Friday, 20 January, with a view to a discussion in E(A) on 24 January and in Cabinet on 26 January, before publication on 31 January.

I am sending copies of this letter to the Private Secretaries of the Ministers at the meetings, and to the others present.

Yours,
Paul

PAUL GRAY

A. J. McKeon, Esq.,
Department of Health

SECRET

PRIME MINISTER

NHS REVIEW

Kenneth Clarke has sent over late this evening a further minute on the central management of the NHS and a revised draft of the key section of Chapter 2 of the draft White Paper.

Others will no doubt be considering this tomorrow and registering their reaction. But you may want to have a first look at it tonight to consider whether things are now getting on to the right lines. My immediate reactions on the covering minute are:

- We are now getting closer to what you want.

- He now seems to be envisaging two separate but parallel chains of command running up from the regions to the centre. At the Executive level, the Regional General Managers will be accountable to the NHS Chief Executive, and at the non-Executive level, the Regional Chairmen will report to the Secretary of State. There are some problems with this, eg if the Regional General Managers are accountable to the Chief Executive, what is their relationship with the Regional Chairmen? But, overall, this looks a promising approach.

- A particularly welcome proposal is for the NHS Chief Executive to be the Accounting Officer.

- The relationship of the Management Board to the Department of Health is still unclear - see paragraph 8 of the minute. What we need to know is exactly who Mr Clarke envisages as members of the Management Board - your wish, as I understand it, is that it should include no DoH civil servants.

- I still think it would be much better to talk about a Management Committee rather than Board. Having two Boards is a recipé for confusion. Having the Management tier as a Committee of the Policy Board emphasises the necessary links between them.

On the revised draft Chapter, my immediate thoughts are:

- The worst problems with the earlier draft have now gone.

- It is worth making clear, particularly if we are to have two Boards rather than a Board and a Committee, that the Chief Executive will be a member of the Policy Board.

- If early agreement can be reached on this, it would be worth including in the draft that the Chief Executive will be the Accounting Officer. It would also help to spell out the proposed relationship between Regional General Managers and the Chief Executive.

- Paragraph 2.11 needs to make clear that it relates only to hospitals still run by DHAs and not to self-governing hospitals.

RLCG.

PAUL GRAY
18 January 1989

EAMALO

14 9
RR8 (a-b)

PRIME MINISTER

RECONVENED NHS REVIEW MEETING

You may like to have a check-list of points we still need to go through. I suggest you take them in the following order:

1. Bernard has had a go at re-drafting the 'Seven Wonders of the World' for paragraph 1.7.

2. Chapter 8 of the draft. Richard Wilson's brief has points on paragraphs 8.4 and 8.6.

3. Chapter 9. Richard Wilson's brief has points on tax relief, and paragraphs 9.7 and 9.10 - 9.13.

4. Territorial Chapters. It seems unlikely Peter Walker will be at the reconvened meeting, but I think we have already covered Wales. So that leaves Scotland and Northern Ireland. Richard Wilson's and the Policy Unit's briefs raise a number of points.

5. Chapter 13. Richard Wilson has points on this, and you will want to mention Bernard's suggestion of re-titling it 'The Action Programme'.

6. Bernard also suggests a glossary of abbreviations at the front of the White Paper would be helpful.

7. You may like to have a word about the DoH paper on additional consultants' posts, unless you feel this was adequately dealt with this morning.

8. It might be helpful to have a brief word about the Chief Secretary's note on expenditure implications of the Review which came in late last night.

b

9. There are a number of issues about presentation, covered in paragraph 5 of Richard Wilson's steering brief:

- the title of the White Paper. Ian Whitehead's brief mentions the Tim Bell suggestion, 'Fit for the Future';

- cover and illustrations;

- consultation document;

- general presentation. You might mention here your willingness to sign the foreword and to put this on video;

- Parliament.

10. Finally, the next steps:

- invite Mr Clarke to circulate the revised White Paper to E(A) and all members of the Cabinet by next Friday, 20 January;

- discuss at E(A) on 24 January and Cabinet on 26 January;

- publish on 31 January.

RCC.

PAUL GRAY
17 January 1989

EAMALI

SECRET

9

13
ATTM(a-c)

MR GRAY

cc Mr R T J Wilson
R Christopherson

NHS REVIEW - PARA 1.7

I have had a ~~start~~ shot at redrafting Para 1.7 as suggested at this morning's meeting and the result is attached. I do not claim it is authoritative or polished, but I confess to being rather pleased at the way it has come out presentationally.

Could I draw attention to three things:

- I have moved up the consultants point because it follows more logically on the hospital stuff

- I believe it is quite possible to deal with the depoliticisation and audit points quite acceptably, and without any offence to the ordinary reader, if we present them in what I believe the group calls patient-friendly terms.

- I think it would be useful to print in bold the summaries of key proposals as underlined.

BERNARD INGHAM
January 17, 1989

SECRET

6

DRAFT 17 JANUARY 1989

The Government is proposing 7 key measures to achieve these objectives. They are:

First: to maximise the NHS's ability to respond to the needs of patients as much power and responsibility will be delegated to local level. These include the delegation of functions from regions to districts and from districts to hospitals. The detailed proposals are set out in the next chapter. They include power to settle the details of pay and conditions of staff and financial incentives to make the best use of their assets.

Second: to stimulate a better service to the patient, major hospitals will be able to apply for a new self-governing status as NHS Hospital Trusts. This means that, while remaining within the NHS, they will be free to offer their services to other parts of the NHS and to the private sector. They will have an incentive to attract patients so they will make sure that the service they offer is what their patients want. And in turn they will stimulate other NHS hospitals to respond to local requirements. NHS Hospital Trusts will also be able to set the rates of pay for their own staff and, within annual financing limits, to borrow money to help them respond to patient demand.

Third: to enable hospitals which best meet the needs and wishes of patients to benefit financially from doing so. The old barriers to money required to treat a patient crossing administrative area boundaries will be scrapped. All NHS hospitals, whether run by health authorities or self-governing, will be free to offer their services to different health authorities or to the private sector. Consequently, a health authority will be able to discharge its duty to use its available funds to secure a comprehensive service, including emergency services, by obtaining the best service it can whether from its own hospitals, another authority's hospitals, from self-governing hospitals or from the private sector.

Fourth: to reduce waiting times, help give individual patients appointment times they can rely on and cut the long hours worked by some junior doctors, X new consultant posts will be created over the next Y years. These new posts will be over and above the Z already being created under the Government's "Achieving a Balance" initiative in July 1986.

Fifth: to help the family doctor (or general practitioner, (GP)) improve his service to patients initially large GP practices will be able to secure their own budgets to buy a defined range of services direct from hospitals. Again, in the interests of a better service to the patient, GPs will be encouraged to compete for patients by offering better services. And patients will be totally free to choose (and change) their own GP as they wish.

Sixth: to streamline and sharpen up the efficiency and accountability of NHS management regional, district, hospital and general practitioner management bodies will be sharply reduced in size and reformed on business lines, with executive and non executive directors. The Government believes that in the interests of patients and staff the era in which the £24billion NHS has been run by neither truly representative nor proper management bodies must be ended. The confusion of roles will be replaced by a clear remit and accountability.

Seventh: to ensure that all concerned with delivering services to the patient have the basic information to assess and improve their performance a system of auditing and monitoring the use of resources is to be steadily applied throughout the NHS. To secure self-governing status a hospital will for example have to have a medical audit in place. Similarly, as with the hospital service, the Government intends to work with the medical profession to establish a system of medical audit in general practice.

The Government will publish in the near future X technical papers elaborating in detail on how these key proposals are to be implemented.

cc Mr R T J Wilson
Miss Christopherson
D/Health

MR GRAY

NHS REVIEW

I have read the Review White Paper this weekend and find it a curious example of its kind - not so much a White Paper; more an action document.

It has one major defect among many merits. This is that, on the basis of the present draft, it more or less concedes game, set and match the argument of those who claim that the Government decided what it was going to do, never consulted anyone who was likely to disagree with it and is now simply giving the country due notice of its intentions. It may well be no worse for this. But the singular lack of detailed argument in support of its proposals will reinforce the criticism that this is an arrogant Government which is simply going to brook no argument in pursuit of its aims.

We need to deal with this important presentational point if we are to give the document the fairest wind. I believe we can do so fairly readily if we:

i) recognise this is an action document, take credit for it and reflect this in the presentational approach;

ii) pay particular attention to Chapters 1 and 13;

iii) and pay especially close attention to Paras 1.4-1.6 in Chapter 1 and the title and introduction to Chapter 13.

The key passage which will set the tone is Paras 1.4-1.6 under the heading "The Need for Change". I suggest this passage should be re-written to present the outcome of the review - an action programme - as a logical consequence of the Government's experience over the last 10 years. The Government needs to demonstrate that it has not conjured this White Paper out of thin air but that its programme is deeply rooted in its long experience of trying to improve health care for the British people over a decade. As we discussed, it can also legitimately call in aid the views and opinions of a wide variety of organisations and people who have written to Departments.

SECRET

Consequently I suggest Paras 1.4-1.6 should follow this construction:

"Throughout the 1980s the Government has thus presided over a massive expansion of the NHS. It has ensured that the quality of care provided and the response to emergencies remain among the best in the world.

"But increasingly the country as well as the Government have recognised that more needs to be done because of rising demand and an ever-widening range of treatments resulting from advances in medical technology. It has increasingly been recognised that the injection of more and more money per se is not the answer.

"It is clear that the organisation of the NHS - the way it delivers health care to the individual patient - also needs to be reformed.

"The Government has been tackling these organisational problems. It has taken a series of measures to improve the way the NHS is managed. The main one was the introduction of general management in 198-. This has been particularly successful and has also demonstrated the way ahead.

"The new management information systems have provided clear evidence of a wide variation in performance up and down the country. [Take in rest of Para 1.5]

"The Government wants to raise the performance of all hospitals and GP practices to that of the best and the main question which this review has addressed is how to achieve that.

"It is convinced that this can be done only by two related measures:

i) devolving responsibility down the Service as close as possible to the delivery of health care to the patient - predominantly to the GP and the local hospital; and

ii) developing clear accountability for the use of the resources involved in dealing with patients.

[Take in rest of Para 1.6, omitting last sentence]

"This White Paper presents a programme of action, summarised in Para 13, to secure two objectives:-

i) to give patients wherever they live in the UK, better health care and greater choice of the services available; and

ii) greater satisfaction and rewards of those working in the NHS who successfully respond to the opportunity to meet local needs and performances."

So far as Chapter 13 is concerned I do not like the heading "The new NHS takes shape". Surely we should describe this Chapter as "The action programme". We also need to introduce it properly rather than go bald into the commitment to early legislation.

The other main point I have is the confusion I find when I come to Part 3 on general practice. It stems from the use of "buying a defined range of services" and an annual budget of only £600-700,000 for 11,000 patients. This raised in my mind just how substantial a scheme we are talking about or whether we are just tinkering. It would help if the word "defined"" were inserted into the fourth action point in Para 1.7 and similarly in the third para of the introduction to Part 3.

I think another point of political controversy - the ending effectively of representational authorities etc - is adequately explained in Para 8.4. But this raises a general point: any publicity or explanatory material needs to make clear the reasons for the actual points as well as the proposals themselves.

In the media's eyes money will talk and I have yet to see the Treasury's paras, so judgment must be reserved. But another aspect of this is equipment. The Scottish section (Para 14) helpfully says that in time a GP should be able to call up a range of information on best buys and hospital waiting lists/vacancies. This is not mentioned as a goal in England or elsewhere. Surely it should be. It is quite clear that the media are expecting something like this. Shouldn't we avoid disappointment?

Finally, I found the Scottish, Welsh and Northern Irish stuff a bit repetitive, though they are clearly necessary because of the differences. We need to be absolutely certain, however, that in polishing the drafting they are consistent in spirit as well as form. I am not sure some of them are living in the same islands as us.

d

Other points

1. We need to import into Para 1.2 the important political point (defensively over-emphasised in Para 3.7) that there will be no question whatsoever of patients who need urgent treatment being denied it.

2. I am uneasy about the words in the first sentence of Para 1.3 "out of all recognition". It is a bit colloquial and not really accurate. The public still recognise it only too well. But rapidly, massively, hugely or formidably hardly do the job either. I wonder whether "is growing at a truly remarkable pace" is better.

3. We need to get greater consistency in our figures. In Para 1.3 we put the budget at "£24billion" and in 2.1 at "in excess of £20billion".

4. A glossary of abbreviations at the front would help. I was somewhat stunned by FPCs appearing (I think) unadorned for the first time in 3.21.

I hope this is helpful.

BERNARD INGHAM
January 16, 1989

SW2AQT

SECRET

PRIME MINISTER

NHS REVIEW MEETING: 17 FEBRUARY

You had a chance to look through some of the papers over the weekend.

These are now enclosed again below.

The additional papers, not in the weekend box, are:

Flags E and F - notes by Bernard Ingham on his reactions to the draft white paper and your role in presenting it. You will want to look at these and, if you agree with them, draw on these notes during the meeting.

Flag G - a further note by Ian Whitehead on possible titles for the white paper.

The main handling paper for the meeting is Richard Wilson's brief at Flag B.

We have allowed three hours for the meeting, from 1000-1300. If the main business is completed before 1300, you will want to consider whether to have a private word with the Chancellor, Chief Secretary and Mr. Clarke about the link with the handling of the Pay Review Body Reports.

PLCG.

(PAUL GRAY)
16 January 1989

SECRET

cst.ps/17ce16.1/lets

COVERING SECRET

cc PL
a

000038

10
~~PM~~ (a-e)

CHIEF SECRETARY TO THE TREASURY

Treasury Chambers, Parliament Street, SW1P 3AG

Paul Gray Esq
Private Secretary
10 Downing Street
London
SW1

16 January 1989

Dear Paul

NHS REVIEW: EXPENDITURE IMPLICATIONS

... I attach a joint note by the Chief Secretary and the Secretary of State recording the outcome of their discussions on the expenditure implications of the Review.

One point which remains to be resolved is whether the amount, £43 million, provided in the Survey for expected Review costs in 1989-90 should be spelt out in the paragraph on public expenditure implications in the White Paper. The Secretary of State for Health feels that it should, on the grounds that it is a substanial sum indicating that the Government means business, and it is in any event certain that people will ask how much money has been provided. The Chief Secretary feels that the sum should not be mentioned in the White Paper. He feels that it may be seen as inadequate in relation to expectations raised by the reforms, and that to include the sum in the public expenditure paragraph will sit oddly with the rest of the White Paper which does not include any costings in relation to individual measures. He is content for the £43 million figure to be used in response to questions.

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, and Sir Robin Butler and Ian Whitehead (Policy Unit).

Yours
Carys

MISS C EVANS
Private Secretary

SECRET

b

PUBLIC EXPENDITURE IMPLICATIONS OF THE NHS REVIEW

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

At the last meeting of the Ministerial Group we were asked to discuss bilaterally the line to be taken in the White Paper on the public expenditure implications of the NHS Review measures.

2 We have reached agreement on a suitable paragraph on public expenditure for the White Paper. The text we propose is shown in Annex A. We have also agreed the line to take in response to specific questions about the adequacy of provision for the costs of the Review reforms in 1989-90. This is outlined in Annex B.

3 We have agreed that we should handle the position in 1989-90 as follows. The progress in implementing the reforms will determine whether or not any extra costs in that year will exceed the provision made in the Survey for Review measures or associated expenditure. Offsetting factors to be taken into account include the scope for increased efficiency and other savings within the health budget - reflecting, for example, revised priorities; any replacement by Review-related work of other items already provided for; together with any underspending on services which may emerge during the course of the year. If in the light of these factors, a bid on the Reserve is sustained, the Chief Secretary will be prepared to consider it, but on the basis that any essential additional net provision will not be financed at the expense of patient services.

4 The Department of Health's preliminary assessment of the costs of implementing the Review measures is that there will be a rising scale of expenditure up to some £½ billion in gross terms by 1992-93. Some further items of expenditure may be identified and, as yet, there are no estimates of the offsetting savings from the improved efficiency which will result from the reforms. We have agreed that the question of the provision of any additional

resources cannot be addressed until more detailed proposals have been put forward and scrutinised, with a full cost benefit analysis, and the extent of the resulting efficiency savings and the scope for offsetting savings from elsewhere within the health programme have been examined. This will be essential information for the 1989 Survey in the context of which decisions will be reached.

16 January 1989

d

ANNEX A

DRAFT PARAGRAPH FOR NHS REVIEW WHITE PAPER

Public expenditure

The reforms in this White Paper will enable a higher quality of patient care to be obtained from the resources which the nation is able to devote to the NHS. The provision for spending on health in the coming financial year, 1989-90, announced in the Autumn Statement, included the likely costs of preparing for the reforms and for the legislation which will give effect to them. Any extra costs should over time be offset by the improved efficiency which will stem from them. The total provision for spending on health will take account of the progress made in implementing the reforms - including the increased efficiency savings. Costs in future years will be considered in the annual public expenditure surveys.

SECRET

e

ANNEX B

LINE TO TAKE ON PROVISION FOR COSTS OF REVIEW MEASURES IN 1989-90

1. NHS expenditure plans for 1989-90 announced in Autumn Statement anticipated the likely costs of the NHS Review reforms. [Figure of £43 million can be used if pressed.]

2. Impossible to foresee precise costs, which will depend on speed of implementation. Total level of spending will take account of progress made in implementing the reforms, including resulting savings from improved efficiency.

[If pressed]

3. If - which we do not expect at this stage - actual costs in 1989-90 turn out to be greater than anticipated, the necessary funding will be made available without detriment to patient services.

SECRET

PRIME MINISTER

16 January 1989

TITLE FOR THE NHS WHITE PAPER

Many titles have been proposed for the NHS White Paper. I have attached a selection. One of the options - proposed by Tim Bell - stands head and shoulders above the others:

'FIT FOR THE FUTURE'

The Government's plans for reforming the NHS.

It is snappy and simple - encapsulating the underlying theme of the Review. And it applies equally to patients and the NHS without being patronising to either.

Ken Clarke appears to favour 'Caring for the 1990s'. I believe this phrase is rather too hackneyed and short-term in vision. It would be more appropriate for a review of social services.

Ian Whitehead

IAN WHITEHEAD

SECRET

SECRET

b

APPENDIX

SELECTION OF PROPOSED TITLES FOR THE NHS WHITE PAPER

1976

Fit for the future

A better deal (or service) for patients

Putting patients first

40 years on

Patient choice, patient care

Caring for the 1990s

Health 2000

Better health, better care

Managing health

SECRET

[redacted]

PRIME MINISTER

FOREWORD TO NHS WHITE PAPER

The D/Health would like you to contribute a short foreword to the NHS Review White Paper.

They have sent out the attached draft which seems to Paul Gray and me to be something to which you could put your name. It strikes the right notes on:

1) the NHS's performance

2) the increased resources devoted to it

3) the task ahead based on the founding principles

4) the primacy of the patient

5) the responsibility of the staff of the NHS for implementing the biggest reforms in the NHS's 40-year history.

The "largely" in brackets in the last line of Para 2 is necessary. I think the last sentence could be improved by using, as indicated in manuscript, the words "the millions who rely on it".

If you feel able to sign the attached, would you also agree to set aside a few minutes at any time before January 23 to repeat these words for a video recording which would be used at each of the presentations after publication?

We need to make a success of these presentations and a message from you on video would greatly help.

Agree:

1) attached foreword? Yes

2) to record video? Yes

1100 - 1215
Monday 23 January
(wic. make up)

BERNARD INGHAM
16 January 1989

NHS WHITE PAPER DRAFT FOREWORD

At its best, Britain`s Health Service is without equal. Time and again, we have all seen just how much we owe to those who work in it. A skilled and dedicated staff - backed by massively increased resources - have coped superbly with the growing demands of modern medicine. There is a great deal of which they, and we, can rightly feel proud.

Our task now is to bring all parts of the Health Service up to the very high standard of the best while standing by the principles on which it was founded. The NHS will continue as now to be available to all, regardless of income, free at the point of delivery and {LARGELY} funded out of general taxation.

All the proposals in this White Paper have as their aim a Health Service that puts patients first. We believe that an NHS that is run better will be an NHS that can care better. Taken together, they represent the most far-reaching reform of the NHS in its forty year history. They offer new opportunities, and pose new challenges, for everyone concerned with the running of the service. I am confident that those who serve the NHS will want to seize those opportunities and meet those challenges on behalf of ~~those who use it~~. the millions who rely on it.

8 cc BY/up 9
AM(a-b)

PRIME MINISTER

NHS REVIEW MEETING: TUESDAY 17 JANUARY

I enclose the papers for next Tuesday's final (hopefully) meeting of the NHS Review Group.

These are:

Flag A - the revised White Paper text;

Flag B - the Cabinet Office brief;

Flag C - the Policy Unit brief;

Flag D - the paper by Kenneth Clarke on additional consultants.

Richard Wilson's brief (Flag B) provides material both on handling the meeting and detailed points on the draft White Paper. I suggest you read that first. Then, if you want to go through the revised draft in detail, I suggest you work through it chapter by chapter, with the Cabinet Office and Policy Unit detailed comments to hand. I have added a few extra thoughts in the margin of Richard Wilson's note.

The note on consultants at Flag D has only just come in and is not covered in the briefs. You will want to consider whether to discuss this paper separately at the end of Tuesday's meeting, just with the Chancellor, Chief Secretary and Mr Clarke, and to take that opportunity for a first exchange of views on the potential trade-off with the Doctors' and Dentists' Review Body Report (by the time of Tuesday's meeting, Kenneth Clarke will have been briefed by his Permanent Secretary on the DDRB Report).

I have let Bernard Ingham have a copy of the latest draft of the White Paper so that he can brief himself on the content and advise on the presentational aspects. One point I have

b.

marked on Richard's brief is that you will want to reflect on what, if any, role you wish to play in the presentation of the White Paper.

PP PAUL GRAY
13 January 1989

DASATJ

PRIME MINISTER

13 January 1989

NHS WHITE PAPER: SECOND DRAFT

The draft White Paper is much improved. But it is crucial that a number of points - mainly presentational - are addressed in the meeting:

- A single clear chain of command between the Regions, NHS Management Board and Secretary of State should be stated explicitly (Chapter 2).

- Self-Governing Hospitals should not be limited to the major acute hospitals (Chapter 3).

- Chapter 5 is stilted and clumsily written.

- The chapter on GP budgets needs more discussion (Chapter 6).

- The Welsh contribution is still extremely disappointing.

CHAPTER 1 - A Better Health Service for Patients

This introductory chapter is much better. But the section 'the need for change' should bring out far more clearly one of the main reasons for the Review: long waiting times for out-patients and in-patients.

b

CHAPTER 2 - Managing the Hospital Service

Para 2.4 Central Management of the NHS

The paper now distinguishes more clearly between policy formulation and operational management. But there is one glaring omission in this section. What is the precise reporting line?

A few days ago, I was not surprised to hear that top DH officials are more concerned over the drafting of this section than any other in the White Paper. In the past, department officials have filled the gaping holes created by unclear lines of accountability. One such hole appears in the last sentence in the paragraph 'For that reason, the Board has to be part of the Department of Health.' In practice, the Board will be located in the same building as officials. But there is no need to state this in the White Paper. This sentence should be taken out.

Strong leadership of the NHS is fundamental to the success of the reforms. It is essential that the NHS Management Board is given clear responsibility.

This section of the paper should incorporate a statement that Regions will be accountable directly to the NHS Management Board and the Management Board will be accountable directly to the Secretary of State.

CHAPTER 3 - Self-Governing Hospitals

Para 3.1 Self-Governing Hospitals.

The paper proposes that self-governing hospitals will be limited to the major acute hospitals - "major" defined as having more than 250 beds. This is far too restrictive. Should we discriminate against a well-run 100 bed hospital?

In the recent Gallup Poll for Central Office, more than two out of three of all those surveyed supported the notion of greater self-government for individual hospitals. This positive response was not just limited to areas where a substantial cross-boundary flow of patients can be expected. In Wales and Scotland, over three-quarters of the consultants sampled supported self-governance.

A number of key figures have expressed to me their concern about this issue:

Sir Roy Griffiths has noted that there is no reason why smaller hospitals should be excluded. He is particularly concerned that this restriction will substantially reduce the potential impact of this reform.

Duncan Nichol, the new Chief Executive of the NHS Management Board has spent many years working in the health service. He has also expressed strong reservations about this restriction.

John Redwood does not have a major acute hospital in his constituency. But he has expressed his hope that a local cottage hospital will be given the opportunity to apply for self-governing status.

Many small independently-run private hospitals manage their services very efficiently with far fewer beds than the 250 bed minimum proposed by Ken Clarke.

Examples in London include:

	Number of Beds
The Lister	106
Clementine Churchill	114
Harley Street Clinic	115
Princess Grace	119

In conclusion, there is no valid reason why this central reform should be restricted to large hospitals only. Kenneth Clarke should be asked to place no restriction on the minimum size of a self-governing hospital.

CHAPTER 4 - Funding Hospital Services

Para 4.22 Other services.

This paragraph states:

> 'DHAs will want to keep a relatively small sum for buying services case by case, at a price quoted by a hospital. This opens up the scope for buying services at marginal costs as hospitals try to use spare capacity'

The words 'relatively small' should be excluded. In practice, such a statement may apply in many cases but we should avoid being either too restrictive or too prescriptive.

CHAPTER 5 - The Work of Hospital Consultants

In general, chapter 5 is stilted and clumsily written. The change in style is immediately apparent.

Para 5.1 The Work of Hospital Consultants.

The sentence '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' is far too vague as an introduction.

We will need to make a clear statement that whereas many consultants provide a high quality service for their patients, there is a wide variation in performance.

Para 5.18 Disciplinary procedure.

There is a danger that consultant dismissals will continue to drag on for years, using up valuable management time and substantial amounts of money. The final sentence in the paragraph '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' is meaningless. This could be a recipe for the status quo.

Ken Clarke should be asked to redraft this paragraph and give a more positive statement of Government policy.

CHAPTER 6 - GP Practice Budgets

Para 6.7 In view of the limited impact of this reform, it would be helpful to incorporate a line from the Scottish Chapter (Chapter 10, Para 10):

f

'Smaller practices (in Scotland) will however be able to group together if they wish to do so in order to opt for GP practice budgets.'

Para 6.8 Determination of budgets

The sentence 'GP practices within the scheme will receive their budgets from the relevant DHA, which will in turn need to consult the practices FPC' is imprecise. The tripartite discussions between the GP, DHA and FPC will be never ending. In practice, many large GP practices may decide not to bother applying. Furthermore, the statement in Para 6.9 'There are social and other local features which affect usage of hospital services, and these will be reflected in the budget' is bound to lead to endless discussion and more bureaucracy. Inevitably, the further we move away from a simple formula, the more discretion will be available. There is a significant danger that any budget which is not based on a simple 'per capita funding' will benefit the inefficient GPs.

Ken Clarke should be asked to simplify the budget determination.

Para 6.13 Scope for flexibility

The second sentence states:

'The Government intends that they (the practices) should be free to spend up to 50% of any savings as they wish, with the balance reverting to the DHA'.

How is this 'freedom' reconciled to the rather vague statement in the next sentence 'This flexibility will allow them to plough money back into improving their practices and offering more and better services to their patients'. How will this proposal work in practice?

I am certain that this airey fairy proposal will be impractical to operate.

CHAPTER 7 - Managing the Family Practitioner Services

Para 7.3 The proposed procedure for medical audit of GP practices is likely to be ineffective. Peer review and self-audit sound too cosey. It is essential that an external peer review is carried out every 2 to 3 years. The phrase "where necessary' in the fourth indent is meaningless.

Para 7.8 Choosing a doctor

The sentence 'GP practices will be encouraged to produce and distribute information about the services they offer' lacks any teeth. If we hope to give patients better choice, good information will be crucial. Ken Clarke should be more positive.

Para 7.15 Indicative drug budgets

Again, the phrase 'DHAs will set drug budgets for each FPC on the basis of reasonable assumptions about prescribing costs in the FPC area' is too open. And the next statement 'FPCs will then set indicative budgets for each practice in discussion with the GPs themselves' is again too discretionary. In practice, it is probable that inefficient GPs will not be penalised for poor performance.

Ken Clarke will need to simplify the process and eliminate any room for endless discussions.

CHAPTER 10 - SCOTLAND

Para 5. This paragraph suggests that 'at least 2 major acute hospitals might attain self-governing status by 1992'.

h

This time horizon should be brought forward to 1991 in line with the overall target in Chapter 3 Para 22.

CHAPTER 11- WALES

This draft is still very poor. It is badly written and lacks any conviction.

Para 3. This paragraph is too bureaucratic and uninteresting. As in the previous draft, Peter Walker is clearly setting his own agenda. The last sentence 'a full corporate strategy for the NHS in Wales will be published in 1992' should be taken out.

Section 4(i) Final Paragraph. He needs to be far more upbeat about self-governing hospitals.

Section 4(ii) Final Paragraph. He plans to merge DHAs and FPCs unilaterally. This sentence should be excluded.

CHAPTER 12 - Northern Ireland

Para 12.10 Tom King is also too tentative. The statement 'will facilitate progress towards self-governing status for a small number of hospitals' is weak.

Para 12.17. To be consistent with the rest of the country we should not say that District Councils will no longer be represented on the Boards. We should say that there is no longer any automatic right to appointment of local councillors.

Ian Whitehead

IAN WHITEHEAD

0506A

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

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

CONFIDENTIAL

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

13 January 1989

Dear Chief Secretary

NHS REVIEW: ADDITIONAL CONSULTANTS POSTS

At our meeting Wednesday we discussed the suggestion outstanding from the Prime Minister's Group to fund additional consultants posts in the NHS. I undertook to let you have a firm proposal, with costs.

I have worked up the enclosed paper to give a brief, but I hope sufficiently clear, picture of what I think we need to set in hand, and of the presentation I think we should give it in the White Paper. As we agreed on Wednesday, the fine details do not need to be in place before publication, but the basic principles and commitment do. I hope we can agree on these at least.

Because we are so much up against time with our meeting on 17 January, I am copying this letter to other members of the Ministerial team.

Yours sincerely

Elaine Goldhill

for KENNETH CLARKE

(approved by the Secretary of State and signed in his absence).

CONFIDENTIAL

NHS REVIEW: ADDITIONAL CONSULTANTS POSTS

120

Introduction

1. Papers HC36 and HC49 set out some preliminary proposals for additional consultant posts. Paper HC49 proposed the creation of 120 additional posts over two years, at a cost of £250,000 a post. However the Group did not reach a final decision on this proposal. This note now sets out a firm proposal for a significant expansion in consultant numbers, and suggests how this should be handled in the context of the White Paper.

2. The Review confronts a number of problems:

- waiting times in elective surgery.
- most topically, junior doctors' hours
- a number of time-expired senior registrars (ie qualified, but waiting, for consultant post)

3. The White Paper needs to unveil a package of funding for additional consultant posts over the next couple of years, to make further inroads into these problems. This should result in at least 100 new posts by the end of the period.

Numbers, specialties and costs

4. The new scheme will be designed to ensure that these posts would fall in waiting list specialties. Paper HC36 set out the availability of senior registrars in these specialties over and above the numbers needed to fill current consultant posts (and allow for planned expansion). This is reproduced in Annex A. The average cost of a consultant (including the cost of various support services such as nursing and facilities), by specialty, is shown in Annex B.

5. Where a new consultant post is created to deal with wholly new work, as would be the case with an effective attack on waiting lists, virtually full on-costs are likely to be incurred. At the other extreme where a post replaces, say, an existing senior registrar post and takes over mostly existing work, the on-costs may already be accounted for.

6. Since one of the objectives of this initiative is additionality, in terms of tackling waiting times, the proposed posts should be costed to include full on-costs. The Annexes show that most posts will fall in the most expensive specialties. It would therefore be prudent to cost the exercise on the basis of £500,000 per post.

7. Mopping up the entire stock of theoretically available candidates (Annex A) over the next year would mean creating 130 posts. This would imply a continuing full-year cost of £65 million at current prices. However it would not be realistic to

create this many posts in 1989/90, and in any case the bidding procedure proposed below may result in different unit costs in practice. Taken together, these factors suggest that an initial "fund" of £50 million in a full year would be an appropriate provision.

A bidding scheme

8. Districts would be invited to "bid", through Regions, for funds to support new consultant posts in specified specialties, advancing evidence on the following points:

- how the proposal tackled waiting lists, where consultant posts were the bottleneck

- alternatively, how the proposal tackled excessive junior doctors' hours or helped towards structural change as in "Achieving a balance"

- what on-costs were bid for, and consequently how existing resources would be most effectively brought into use.

9. One of the criteria against which bids would be evaluated would be the ability of Regions to marshall the necessary supporting services, in particular nursing staff. Support costs are, however, included in the total cost per post.

10. In addition to receiving bids on the initiative of Districts, DH would require bids from those with excessive waiting times, or a serious junior doctors' hours problem. It is possible that the mere threat of an additional consultant may cause some existing consultants to cut their waiting lists.

Funding

11. The exact phasing of expenditure would be for consideration with the Treasury. Given a start so close to the start of the year, the first year cost (in 1989/90) would be likely to be some £10 million - say up to 40 posts created. The programme could be completed during the next year, giving expenditure of £35 million in 1990/91. The full cost of £50 million would then arise in 1991/92 and thereafter.

12. This should be in addition to the existing planned spend of £30 million on the waiting list initiative. All of this fund has been committed and cannot now be clawed back for another (even if related) purpose without accusations of bad faith. In any case, there are good uses for "waiting list" money not linked to consultants posts: not all waiting list problems are caused by lack of consultants. In fact, in the current waiting list initiative, the predominant action which authorities have taken is to enable fuller use to be made of operating theatres. Moreover, the present problem of junior doctors' hours is not a "waiting list" problem at all. In this case, the work is being done, but in an unsatisfactory way, leading arguably to unsafe and low quality care.

13. It is therefore proposed that the 1989/90 cost should be met from the Reserve. This is justified as a new development in the Review context, providing some "good news" on waiting times and in the face of the junior doctors issue. The continuation - or expansion - of the scheme would of course be for consideration in subsequent PES.

Presentation

14. It would be more relevant to present this proposal in terms of the number of posts created, than the amount of money to be spent. This will, in particular, commend the proposal to the medical profession - which will otherwise be suspicious of many of the Review proposals. It would be neither practicable, nor appropriate, to set out the scheme in detail in the White Paper. However a sufficiently firm reference needs to be made in the text, to prepare the way for detailed discussions, both within Government, and with the NHS. Annex C provides a possible passage for inclusion in the White Paper chapter on consultants.

Annex A

Availability of qualified senior registrars for consultant posts by specialty:

Specialty	number available after 1 year	number available after 4 years
General surgery	75	125
Trauma and orthopaedic surgery	30	65
Obstetrics and gynaecology	10	50
Ophthalmology	10	30
Ear nose and throat surgery	5	20
Total	130	290

Annex B

Average annual cost per consultant of in-patient work:

	£,000, 1989/90 prices
All surgical specialties	720
of which:	
General surgery	980
Trauma and orthopaedic	960
Ear nose and throat	500
Gynaecology	830
All internal medicine	440
of which:	
General medicine	750
Neurology	660
Paediatrics	350

Annex C

Additional consultants

The Government believes that faster progress in reducing waiting times for treatment and in improving the quality of services for NHS patients can be made by the creation of more consultant posts. This would also help to improve the career prospects, and to reduce the working hours, of junior doctors. The Government therefore proposes to introduce a scheme under which [100] additional, permanent consultant posts can be created over the next [three] years at a cost of [£50 million] including all support costs. These posts will be over and above the 2 per cent annual expansion in consultant numbers already planned. The scheme will concentrate on increasing the number of consultants in those acute specialties which currently have the longest waiting times for treatment.

SECRET

P 03334

PRIME MINISTER

NHS REVIEW
[Draft White Paper
Chapters circulated by the Secretary of State for Health on 12 and 13 January and by Secretary of State for Wales on 11 January]

1. This is the last meeting arranged for the group. It provides a final opportunity to discuss the style of the White Paper and to make sure that the policy is correctly set out, before the proposals go to E(A) on 24 January and to Cabinet on 26 January. All arrangements are being made on the basis of publication on 31 January.

2. This draft is an improvement on its predecessor. It has been restructured as you asked, and most of the points made by the group appear to have been taken into the text. Some exceptions are set out below.

3. First, you may wish to pick out any major points which still concern you. Possibilities include:

i. Chapter 1. This is the key part which you asked should set out the rationale of the Government's reforms and of the key proposals, so that readers would know what the Government had in mind even if they read no further. It is now much better. But you will wish to consider whether there are still some improvements which could be made.

ii. Central Management of the NHS. The description in paragraphs 2.4 and 2.5 of the relative roles of Ministers, the policy board and the NHS management board is important.

iii. Funding of Core Services. You were concerned at the last meeting that the White Paper should include criteria by which the funding of core services should be determined.

SECRET

b

Paragraphs 4.17 and 4.18 are similar to what was said before but shorter. You will wish to consider whether you are content.

iv. Scotland, Wales and Northern Ireland. The territorial chapters need discussion, first so as to make sure that they are working to the same timetable as England for self-governing hospitals and GP practice budgets, and second to make sure that they carry conviction (particularly relevant to Wales).

4. Second, you may wish to work through the text chapter by chapter to pick up any drafting or other points which the group may have. Some comments are set out below.

5. Third, you may wish to ask Mr Clarke about his plans for presentation. Particularly important are:

i. Title. I understand that Mr Clarke has not yet decided on the title. A decision is now needed. One possibility might be: "The National Health Service: The Way Ahead".

ii. Cover and Illustrations. You may wish to ask Mr Clarke what these will be like.

iii. Consultation Documents. Mr Clarke is planning a popular version of the White Paper. He is also preparing a number of consultation documents, which will be ready by the day of publication but not issued until a day or two afterwards. It is important that these should all be cleared with Treasury and represent agreed policy.

also very important for the popular version to be cleared with you. RCC

iv. General Presentation. We understand that Mr Clarke is planning a series of media briefings together with meetings with special interest groups and the NHS management on 31 January.

You also need to consider whether you wish to play a part in the 31 January media presentation; DoH seem to be assuming that you will not.

v. Parliament. Mr Clarke will be making a statement in the House. We understand that he may want to tell Parliament soon that the White Paper will be issued on 31 January, since it will not be possible to keep it secret. If he raises this you may wish to make sure that he clears his lines with the Lord President.

6. Finally, the next step will be for Mr Clarke to revise the text in the light of discussion and to circulate the White Paper to E(A) by next Friday, 20 January, at the latest, in preparation for the discussion on 24 January. You may wish to invite him to circulate it to all members of Cabinet at that time, so that they can have the weekend in which to read it. There will be very little time between E(A) on 24 January and Cabinet on 26 January.

MAJOR POINTS

7. You may wish to begin by concentrating on any major points which still concern you. Possibilities are as follows.

CHAPTER 1

8. It is very important that this chapter should be as good as they can get it. The present text is a substantial improvement, particularly in its opening. It has taken on board a number of the themes which you stressed. But you may think that it could still be improved:

i. patients as taxpayers. It does not appear to make the point explicitly that patients as taxpayers are paying for the NHS and are therefore entitled to expect an efficient, considerate service and better choice.

ii. value for money. The need to emphasise the benefit to patients applies particularly to paragraphs 1.12 to 1.14 on an effective health service. This section might make the point that getting better value for the taxpayers' money is of direct benefit to patients because it means that more people can be treated and waiting times can be reduced.

iii. structure. It might be better if the passage about 'putting patients first' (paragraphs 1.8 to 1.11) came before the summary of key proposals (paragraph 1.7). This would establish early on the thinking behind the proposals, before spelling out what they are.

iv. numbers. The numbers ought to be as up to date as possible. It looks odd only to be able to quote the 1986 figure for doctors, dentists, nurses and midwives in paragraph 1.3, and the 1986/87 figure for the average cost of treating patients in paragraph 1.5.

v. The new role for the Audit Commission is an important reform and ought to be mentioned in paragraph 1.14.

vi. Paragraph 1.17 does not seem to fit in. You might ask whether it could be dropped.

CENTRAL MANAGEMENT OF THE NHS

9. You emphasised at the last meeting that Ministers could not be expected to manage the NHS or to answer for every detail of the running of the NHS on the floor of the House. The Policy Board, chaired by the Secretary of State, would be responsible for strategy on the NHS, its objectives, its finance and the monitoring of the Management Board. The Management Board, chaired by the Chief Executive, would be responsible for all operational matters, within the policy framework laid down by the Secretary of State.

10. Paragraphs 2.3, 2.4 and 2.5 appear to differ from this approach in a number of respects:

i. accountability to Parliament. The text still says that Ministers must be accountable to Parliament and the public not only for the spending of huge sums of money but also "for the services which they finance" (paragraph 2.4, second sentence). This seems to lay Ministers open to questions of detail about those services in Parliament.

e

and there is still confusion from failing to call it the Management Committee, as agreed at the last meeting. PRCG.

ii. Management Board part of the Department of Health. The last sentence of paragraph 2.4 says that the NHS Management Board, chaired by the chief executive, has to be part of the Department of Health. This contrasts with the logic of what was said at the last meeting, which was the Management Board should be part of the NHS.

iii. responsibility for management. Paragraph 2.5 (second indent) says that the Policy Board, chaired by the Secretary of State, will consider all strategic management issues for the NHS. This seems to carry some risk of confusion, as to who is responsible for management.

iv. appointments to the Management Board. Paragraph 2.5 (third indent) seems to indicate that the Chief Executive will himself select and appoint members of the Management Board. This seems odd. One legitimate function for the Secretary of State might be to approve and appoint the people who are to be responsible for operational management of the NHS.

11. This is a confused area which it is important to get right. One underlying problem is that in legal terms the NHS comprises a number of distinct entities - the Department, the Regional Health Authorities, the District Health Authorities, each of which is a separate statutory body - which do not easily form a management entity. As Mr Clarke indicated at an earlier meeting, however, it would require legislation to alter this; and the group has not considered any proposals on what might take the place of the present structure. You may at least want the White Paper to set out a clear account of the relative responsibilities of the Policy Board and the Management Board, on the lines perhaps of paragraph 9 above. If you wished there could then be further work on the issue, before the legislation next session was introduced.

SECRET

6

CORE FUNDING

12. At the last meeting you questioned the proposed arrangements for funding core services through an annually negotiated contract. You asked Mr Clarke to consider whether the White Paper could include some indication of the criteria by which funding would be determined, so as to avoid perpetuating existing inefficient patterns. You may wish to ask Mr Clarke what his thinking on this now is.

SCOTLAND, WALES AND NORTHERN IRELAND

13. In considering these chapters, you will want to ensure that differences between the proposals for the regions and those in the rest of the White Paper are readily explicable and do not cast doubt on the commitment to the fundamental reforms throughout the UK.

Scotland

14. You may want to ask about the following apparent differences between the proposals for Scotland and those for England.

a. The list of practical improvements for patients in paragraph 10.4 does not include a better complaints procedure or optional extras, as the English list (Chapter 1.10) does. Conversely the Scottish list contains one improvement - ensuring that all outpatients are seen by a consultant - which the English list does not.

b. For England, the objective is to establish a substantial number of self-governing hospitals by 1991 (paragraph 3.22); for Scotland, it is for "at least two" to attain self-governing status by 1992 (paragraph 10.5).

c. The Scottish Health Policy Board in Scotland is to be abolished (paragraph 10.18) mainly because 'broad issues of policy can be dealt with more effectively by Ministers directly'. This does not seem to fit well with the Policy Board in England. Paragraph 10.17 also says that the

SECRET

Government are 'considering ways of discharging the central strategic management role more effectively', whereas for England of course the White Paper makes definite proposals.

d. Similarly, the Scottish Chapter says only that the size of the Health Boards will be reduced (paragraph 10.20) whereas definite proposals are made for the Health Authorities in England.

e. Scotland has the SHARE system of allocation to Health Boards which is apparently similar to the RAWP system in England. Paragraph 10.24 says only that it 'may' be possible to abolish SHARE, and implies that any such move could be some way off.

f. Paragraph 10.15 says that the Secretary of State will 'keep under review' the current arrangements for audit of the health authorities, which are now undertaken within the Scottish Office. This seems a clear difference from England, where the audit function will move from DOH to the Audit Commission.

Wales

15. You will want to probe the following apparent differences between the proposals for Wales and those for England:

i. On the development of self-governing hospitals paragraph 4.i of the Welsh Chapter says that "it will be possible by the early 1990s for a major acute hospital" to become self-governing provided that it satisfies certain tests. There seems a distinct difference of flavour from Chapter 3.22 which says that in England the Government's aim is to establish a substantial number by 1991.

ii. The timetable for GP practice budgets in paragraph 4.iii is that a 'number' will be in operation by 1992 'subject to suitable arrangements being worked out with the

h

appropriate health authorities'. Chapter 6.16 says that for England the Government's aim is encourage a 'substantial number' by 1991.

iii. Paragraph 4.vii says that the Secretary of State will examine the case for bringing hospitals and the FPS in Wales under common management.

16. There are also three proposals for Wales which have no counterpart in England:

i. a 'full corporate strategy' to be published in 1992 (paragraph 3);

ii. a 'programme to improve the quality of acute care and other services' (paragraph 4.iii);

iii. the establishment of a value for money unit under the NHS Directorate (paragraph 4.ix).

Northern Ireland

17. The Northern Ireland chapter is less specific than those for Scotland and Wales and there are fewer apparent discrepancies with what is proposed in England. But you may want to probe the following:

i. What underlies the reference in paragraph 12.2 to the Government's 'health strategy' for the Province, especially the reference to the need to 'streamline' acute hospital services?

ii. Paragraph 12.4 is much less specific than the sections on England and Scotland about practical improvements for patients, referring only to a guide on the subject not yet issued.

iii. There is no timetable given for the development of self- governing hospitals (for which only a 'small number' of hospitals would qualify - paragraph 12.10) of GP practice budgets (paragraph 12.13), or for the replacement of the PARR system, apparently the equivalent in Northern Ireland of RAWP (paragraph 12.18).

iv. Although local authorities would no longer be represented on Health Boards they would have a 'stronger' advisory and consultative role (paragraph 12.17).

CHAPTER-BY-CHAPTER DRAFTING COMMENTS

Chapter 1

18. Main points on this chapter are above. On points of detail:

i. para. 1.6. The second sentence has been taken from the Scottish text considered at the last meeting, except that it now refers to giving staff a more stimulating measure of responsibility, rather than a more satisfying one. Given the need to bring out the benefit to staff and win them over, you may think that 'satisfying' was better.

ii. para. 1.7. The fourth indent refers to encouraging GPs to compete for patients. Would it be better to refer to increasing patient choice?

Chapter 2

19. In paragraph 2.1,, rather than refer to an annual budget "well in excess of £20 billion", it might be better to give the actual figure.

20. In paragraph 2.3, rather than refer to local management being accountable "for its delivery of the Government's objectives", it might be better to say "for its service to patients".

j

21. Paragraph 2.16 refers to the fact that nurses benefit both from London supplements and London weighting, without indicating that this is in any way unsatisfactory. Might it be interpreted as endorsing this state of affairs?

22. Paragraph 2.22 deals with funds for capital investment as though they come exclusively from the Exchequer. Might there be a reference to the private sector (eg Bromley?)

Chapter 3

23. It is important that there should be no misconception that self-governing hospitals will 'opt out' of the NHS. This point is implicit in paragraph 3.1 but you may want it to be made more strongly.

24. The last sentence of paragraph 3.7 is making the right point - that no one will be denied urgent treatment - but seems badly put. It is important that there should be no impression that the Government has contemplated arrangements which would allow people to be turned away.

25. The last sentence of paragraph 3.18 is similarly making the right point, that self-governing status must not be misused to prevent necessary closures, but in a rather negative way. It might better read: "The NHS must not be obliged to retain hospitals at the expense of introducing new and better facilities elsewhere for its patients".

26. You will wish to note the last sentence of paragraph 3.21 which, as you asked, explicitly refers to the possibility eventually of merging FPCs and DHAs.

Chapter 4

27. There are a couple of small points which you might raise:

i. Para. 4.7 in its last sentence refers to 'local financial "crises"'. Could this be misinterpreted?

ii. Para. 4.27 might be strengthened by making the point explicitly that hospitals will also be given an incentive to take on more work.

Chapter 5

28. The main point on this chapter is that it does not include any reference to the possibility of joint inquiries, involving both management audit and medical audit. This point was made at the last meeting. You will wish to ask why it has not been taken into account.

Chapter 6

29. You will want to consider especially paragraphs 6.8 - 6.10 on the determination of budgets for GP practices. These proposals are new. They follow the discussion at the previous meeting and move, as was agreed, towards a formula approach, though retaining some flexibility. They do however make the system look complicated, and an alternative would be to have a briefer discussion in the White Paper, with more detail left for the technical paper promised in paragraph 6.10.

30. Paragraph 6.13 says that practices within the scheme will be 'free' to spend half of any savings. The group has agreed that it is important to give GPs incentives to save costs, but you might ask whether the word 'free' is quite right. As an obvious point, any such spending must improve services to patients.

Chapter 7

31. The statement in 7.8 that the Government believes that advertising by GPs should become the norm is new, but you may be content to agree it.

32. Paragraph 7.14 still contains, in a watered-down form, the statement that expenditure on drugs will increase. At its last meeting the group wanted to delete a more explicit statement to this effect. You may wish to ask why anything at all need to be said on this point.

33. Paragraph 7.16 says that a practice may exceed its indicative drug budget for reasons which are 'entirely acceptable'. It is of course important to reassure public opinion that the new arrangements will not deprive patients of drugs they need, but you may wish to consider whether the right tone has been adopted on this point.

34. Paragraph 7.19 says that the FPC can keep half the underspend on indicative drug budgets. You may wish to consider whether the text should say what happens to the other half, to avoid misunderstanding.

35. Paragraph 7.24 says both that FPCs will be freer to determine their Sub-Committees and that the number of Sub-Committees will be reduced. You could ask Mr Clark if he is confident that these two statements are consistent.

Chapter 8

36. In paragraph 8.4, lines 9-10 say that the 'actual managers themselves have no direct say in this decision-making process'. Even with DHAs operating as at present, this seems likely to be an exaggeration. It might be more accurate to say that final decisions are taken not by managers but by members of the authorities.

37. The last inset but two in paragraph 8.6 says that local authorities should no longer have an 'automatic' right to appoint members of DHAs. The group have considered it important to take away the local authority power of appointment, and you might ask Mr Clarke to explain the meaning of the word 'automatic'.

SECRET

M

Chapter 9

38. This chapter still lacks the key Treasury passage on tax relief. You may wish to ask where this stands.

39. The group earlier considered the possibility of Government regulation of the private sector, although no decision was reached on it. The nearest reference to the point in this Chapter is in paragraph 9.7 which says that health authorities will need to be satisfied before they use private sector facilities that they offer adequate standards of medical care. You will want to consider whether more needs to be said on this point.

40. The paragraphs on joint ventures in 9.10-9.13 are important and seem positive in flavour. Paragraph 9.11 would seem for example to open the way to a scheme of the type the Treasury were earlier resisting for Bromley. You will want to check whether a Bromley-type scheme would be permissible under these paragraphs. You may also want to ask where matters stand on the Bromley scheme itself.

Chapter 13

41. This chapter seems more like a briefing note than a conclusion to the White Paper. It is all the odder to add to it a final paragraph on public expenditure which has relatively little to do with the earlier paragraphs which are about the timetable for implementation. You may wish to ask whether the chapter is needed. Public expenditure could be dealt with elsewhere, for instance in Chapter 1. You may wish to ask how the discussions between the Chief Secretary and the Secretary of State are getting on. It is getting late in the day to have public expenditure aspects unresolved.

R T J WILSON RJW.
Cabinet Office
13 January 1989

SECRET

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

From the Secretary of State for Social Services

(1)

cc BI
cc R. Wilson

COVERING SECRET

PA

Paul Gray Esq
10 Downing Street
LONDON SW1

13 January 1988

Dear Paul

NHS REFORM WHITE PAPER

As promised, I enclose the remaining three chapters of the draft NHS reform White Paper and of the draft ouline.

I am copying this letter and enclosures to the Private Secretaries to the Chancellor of the Exchequer, to the Secretaries of State for Scotland, Wales and Northern Ireland, to the Chief Secretary, to the Minister of State and Sir Roy Griffiths in this Department, to Professor Griffiths and Mr Whitehead in the No. 10 Policy Unit, and to Mr Wilson (CO), Mr Saunders (HMT), Mr Hamill (SHHD), Mr Jarman (WO) and Mr Hunter (DHSS NI).

yours ever
Flora

for A J MCKEON

B:D8.48/1

010

DEPARTMENT OF HEALTH ~~AND SOCIAL SECURITY~~
Richmond House, 79 Whitehall, London SW1A 2NS
Telephone 01-210 3000
From the Secretary of State for Social Services

cc R Wilson
cc B1

COVERING SECRET

Paul Gray Esq (1)
10 Downing Street
London SW1

12 January 1989

Dear Paul

NHS REFORM WHITE PAPER

As promised in my earlier letter, I enclose four further draft chapters of the White Paper on the reform of the NHS. The remaining three chapters will be circulated tomorrow morning.

I am copying this letter and enclosures to the Private Secretaries to the Chancellor of the Exchequer, to the Secretaries of State for Scotland, Wales and Northern Ireland, to the Chief Secretary, to the Minister of State and Sir Roy Griffiths in this Department, 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

B:D8.47/8

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

From the Secretary of State for Social Services

cc Richard Wilson

COVERING SECRET

Paul Gray Esq (1)
10 Downing Street
London SW1

12 January 1989

Dear Paul

NHS REFORM WHITE PAPER

I enclose the first ~~two~~ three Chapters of the second draft of the White Paper on the reform of the NHS and draft Chapters on Scotland and Northern Ireland prepared by the relevant health departments. These are for discussion at the meeting of the Ministerial Group to be held on 17 January. A draft Chapter on Wales has been circulated by the Welsh Office. Further draft Chapters will be circulated later today.

I am copying this letter and enclosures to the Private Seretaries to the Chancellor of the Exchequer, to the Secretaries of State for Scotland. Wales and Northern Ireland, to the Chief Secretary, to the Minister of State and Sir Roy Griffiths in this Department, 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

B:D8.47/5

FILE MJ

10 DOWNING STREET
LONDON SW1A 2AA

From the Private Secretary

11 January 1989

Dear Julie,

This is confirm my telephone call today to change the starting time of the NHS meeting on Tuesday 17 January from 1100 to 1000. The Prime Minister looks forward to seeing your Secretary of States then and the meeting will run until 1300.

I am copying this letter to the Diary Secretaries at the Department of Health, Department of Social Security, Chief Secretary's Office, Northern Ireland Office, Scottish Office and Welsh Office.

Yours sincerely,

Tessa

Tessa Gaisman

Mrs. Julie Thorpe
HM Treasury.

MEM

SECRET

PRIME MINISTER

NHS REVIEW

I was, of course, unable to attend the meeting of the Ministerial Group of the review on 5 January but I have now seen the minutes and a copy of your Private Secretary's letter of 3 January 1989 which conveyed your views about the first drafts of White Paper material. In view of the tight timetable for completing our work, I am writing to record the points of major concern to me.

2. I am enclosing with this note a revised text of the Welsh Chapter which I believe reflects the distinctive needs and circumstances of Wales, as well as dealing with the points in the earlier text on which you commented. I note that at the meeting on 5 January it was agreed that there should be separate chapters covering Northern Ireland, Scotland and Wales. These need to follow a broadly common format, although they need not, of course, have the same detailed content. I have not produced an introductory section on distinctive achievements of the NHS in Wales in the belief that early in the main body of the White Paper we would put across stongly our record of achievement for the UK as a whole since 1979. But if a nation by nation approach were preferred, I could provide additional text quickly.

3. Turning to the White Paper material produced by the Department of Health and discussed on 5 January, I am pleased to note that it is to be made clear what passages apply to England and what to other parts of the the UK. This could be achieved by expanding the paragraph 2.16 which ends Chapter 2 as follows:-

"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 quality care. Chapters 3 to 10 set out these proposals in full for England. Chapter 11 summarises these and gives an action timetable and Chapters 12 to 14 set out how the general proposals are to be translated into detailed programmes of action pertaining to the particular needs and circumstances of Scotland, Wales and Northern Ireland."

4. Also in Chapter 2, the last inset paragraph in 2.12 it should make it clear that it refers to the national management of the service in England.

5. Turning to Chapter 4, I believe it is important to make it clear that there will be a guarantee of adequate service coverage. Already our opponents are saying that self-governing hospitals will concentrate on the most profitable lines and neglect other services. We must find an emphatic statement, such as that I have proposed in the Welsh Chapter, which sets out clearly our reply to this accusation.

..../6.

b

6. On Chapter 5, throughout our discussion I have expressed my very real concern that we have not given the priority we should to obtaining a much higher quality of general and financial managers. In other parts of the White Paper we do acknowledge that these skills will be crucial to the success of the reforms we propose. I do consider it essential to express stongly our intention of having top standards of financial and general management and that means seeing that people of the quality desired get their appropriate reward.

7. Last, I return to Chapter 1 - the foreword. I believe that we would set the right climate by restating unequivocally our sole objective that everybody, no matter what their means, should be entitled to a higher standard of health care, and that the treatment of major disease and illness will and must remain available to everybody. This would, of course, be linked with our having made available vastly increased expenditure for the NHS.

8. I am sending copies of this minute to Nigel Lawson, Kenneth Clarke, Malcolm Rifkind, Tom King, John Major and David Mellor; to Sir Roy Griffiths, Professor Griffiths and Mr Whitehead in the No 10 Policy Unit; and to Mr Wilson in the Cabinet Office.

11 January 1989

PW

CONFIDENTIAL 2ND DRAFT 10.1.89

DRAFT OF WELSH CHAPTER FOR NHS REVIEW WHITE PAPER

Introduction described in previous chapter

1. The people of Wales will benefit fully from the improvements which will flow from the Review, and which will make the NHS more responsive to the needs of patients. There are distinctive health care needs and circumstances in Wales. This Chapter describes these and the distinctive 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 focused to ensure the delivery of the programme of action described in this ~~Chapter~~ Review. 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 effectiveness. Unit general managers have been appointed to run hospital and

allocated. Money must move with the patient so that hospitals which are efficient and effective, and attract more work, get the resources they need. Detailed proposals will be the subject of consultation.

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. The NHS in Wales will embark upon a programme to improve the quality of acute care and other services, commencing with proposals in 1989 for better ways to inform patients about services and 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 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.

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 will 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

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.

The managerial autonomy of hospitals will be further enhanced and hospital management and clinical staff will be given direct responsibility for the services they provide. They will move as quickly as possible to a position where they are, in effect, contracted to provide a given level, range and quality of service.

There are 17 major acute hospitals in Wales, ie with 250 or more beds, many of which serve widely dispersed populations. It will be possible by the early 1990s for a major acute hospital that so desires to become self-governing provided that it shows clearly that it will have the capacity to provide efficiently and effectively an adequate range and depth of services to the population it serves.

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 54 pay beds in NHS hospitals. These facilities will need to expand to increase patient choice.

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 treatment 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 changes in the way in which resources are

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. At first, practices with lists of at least 11,000 will be eligible to apply to hold budgets; this represents about 30 practices in Wales. Details of the scheme will be set out in the discussion document which the Secretary of State will publish following the Review. Subject to suitable arrangements being worked out with the appropriate health authorities, the Government would like to see a number of GP budgets in operation by 1992.

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.

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 to appoint at least 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 DHAs' role as enablers and purchasers of services, rather than simply as direct providers.

The Secretary of State will be examining the arguments, in the circumstances of Wales, for bringing 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.

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 focused 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.

NAT HEALTH: Exp + Efficiency Pt 7

SECRET CMO 4 18 a-k. a

Mtg record
Subject cc Master

UNTIL 31/12/89

file MRMADQ

cc W.O.
N.I.O
+ those present

10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

6 January 1989

NATIONAL HEALTH SERVICE REVIEW

The Prime Minister yesterday chaired the eighteenth meeting of the group reviewing the National Health Service. The group had before them papers HC67, 68, 69, and draft chapters of the White Paper contributed by the Secretaries of State for Wales, Northern Ireland and Scotland (letters of 20 December, 20 December and 21 December respectively).

I should be grateful if you and copy recipients would ensure that this record of the discussion is handled strictly in accordance with CMO arrangements.

Those present at the meeting were the Chancellor of the Exchequer, the Secretary of State for Health, the Secretary of State for Scotland, the Chief Secretary to the Treasury, the Minister for Health, Sir Roy Griffiths, Mr. Wilson (Cabinet Office) and Professor Griffiths (No.10 Policy Unit).

NHS REVIEW: FPS - HEADS OF AGREEMENT (HC68)

The group first considered a joint paper by the Secretary of State for Health and the Chief Secretary about the Family Practitioner Service (FPS). In discussion, the following were the main points made:

a. The aim was to issue a consultation document at the same time as the White Paper, explaining how the Government expected indicative drug budgets to work in practice and inviting views. But considerable work was required and this timing might not be possible.

b. It was desirable that Family Practitioner Committees should determine the size of drug budgets in accordance with a formula as far as possible, but in practice there would need to be considerable flexibility to accommodate regional differences, including the problems of rural areas, and wide variations in prescribing patterns.

SECRET CMO

UNTIL 31/12/89

b

c. The most satisfactory way of controlling GP numbers would be through action on remuneration. It could be argued that the proportion of average remuneration accounted for by capitation fees should be raised from 46% to 75% rather than the 60% proposed in paragraph 8.7 of HC67. On the other hand, even the figure of 60% would be controversial, and a substantial increase on what had been proposed in the White Paper on Primary Care. It was not realistic to go higher.

d. The way in which the Doctors' and Dentists' Review Bodies (DDRB) determined the pay of GPs was insensitive to the number of patients whom they treated. This needed to be put right. One approach would be to include the point in the White Paper, so that it could be referred to in future evidence to the DDRB and form a basis for possible later action. On the other hand, eventual abolition of the Basic Practice Allowance in some parts of the country would have a significant effect; and it was important not to make the White Paper too negative towards GPs.

The Prime Minister, summing up this part of the discussion, said that the group endorsed the proposals outlined in paper HC68. The Secretary of State for Health would consider further whether the White Paper should include a passage which could be referred to in future evidence to the DDRB. Any such passage would need to be drafted very carefully and given a positive flavour.

GP PRACTICE BUDGETS (HC69)

The group then considered a joint note by the Secrtary of State for Health and the Chief Secretary to the Treasury on GP Practice Budgets (HC69). In discussion, the following were the main points made:

a. There was a risk that GPs would not be able to exercise sufficient control over their budgets because decisions determining expenditure would be taken by hospital doctors. For instance, the costs of treatment could be significantly different from what the GP had expected if a consultant made an unexpected diagnosis. On the other hand, GPs would be able to protect themselves by placing fixed-price contracts with hospitals. There would also be some averaging of risks across all the patients belonging to the practice. More generally, the problem of controlling expenditure was not confined to GP budgets and could not be decisive.

b. There was general agreement on the need to provide incentives for GPs. It could however be argued that the particular proposals in HC67 might lead to impropriety if GPs were induced to divert patients' money to their own income. On the other hand, the arrangements for medical audit and for monitoring by FPCs would provide protection against impropriety The

risk of impropriety was not new: it applied in relation to capitation fees. The proposals in the White Paper were designed to allow GPs to plough money back into improving their practices (paragraph 3.18 of HC67). This was a desirable objective and it was important not to have controls which were too bureaucratic.

c. It was important that the scheme should deal with the problem of excessive referrals by GPs, as well as with prescribing costs. The combination of medical audit and tougher monitoring by FPCs was however designed to achieve this.

d. The system for negotiating practice budgets in paragraph 3.12 of HC67 was unacceptable. GP practices would never know what to expect from one year to the next. Moreover, there was a real risk that Regions would adopt different approaches to different GP practices and also that different Regions would follow different approaches (as had happened with nurses' pay); so that there would be no consistency. It was essential that a satisfactory, workable approach should be devised before the White Paper was published, which ensured consistency. A straightforward formula, based on the formula for allocations to District Health Authorities, might be appropriate. If need be, there might have to be a transitional period, starting with existing patterns but moving gradually to the new system.

e. The aim was to achieve maximum devolution of responsibility, subject only to administrative practicability. In England and Wales this pointed to budgets only for practices with at least 11,000 patients. But a smaller number might be possible for Scotland, at least in the light of experience.

The Prime Minister, summing up this part of the discussion, said that the proposals on GP practice budgets were as fundamental to the Reviews' conclusions as the proposals on self-governing hospitals and would be set out accordingly in the White Paper. It was however essential that the arrangements for determining the size of budgets should be revised, as indicated in discussion. The Secretary of State for Health would review this aspect of his proposals. The Secretary of State for Scotland would consider whether anything could be said in the White Paper about extending budgets to smaller practices in Scotland.

WHITE PAPER: FIRST DRAFT (HC67)

The group then turned to the first draft of the White Paper (HC67), circulated by the Secretary of State for Health.

Summing up preliminary discussion about the broad structure of the White Paper, the Prime Minister invited the Secretary of State for Health to arrange for the material to be reorganised so that it fell into four main parts.

d

The first part would be to set out the Government's strategy for the NHS. This would be the key section which would cover all the important points, so that readers would know in essence what the Government was proposing and why, even if they read no further. It would include the topics in chapters 1 and 2 of the draft, but would go further as indicated in discussion below. The draft provided by the Secretary of State for Scotland struck the right sort of note, particularly in its first seven paragraphs. There would be no need for a separate foreword of the kind proposed in chapter 1. There could however be a short paragraph at the beginning signed either by the Secretary of State for Health or herself.

The remaining three parts would spell out the Government's proposals in more detail. Part two would deal with the proposals concerning hospitals. It would need to have an introductory section which explained the Government's overall approach and provided a framework for understanding the detailed material on hospitals, including managing the hospital service and self-governing hospitals. Part three would deal with the Family Practitioner Service and GPs, including practice budgets. Part four would bring together the remaining proposals.

Chapters 1 and 2

In discussion of chapters 1 and 2, the following were the main points made:

a. It was essential to use the right language in these and subsequent chapters. The drafting needed to show constant awareness that the NHS provided health care for individuals who contributed to the cost through their taxes and were entitled to expect considerate treatment and good value for money. It should avoid giving the impression of an impersonal approach: it was for instance more appropriate to talk about patients rather than customers, and about choice and value for money rather than competition and the market.

b. Similarly it was important not to use language which could be interpreted as running down the NHS. It would for instance be preferable to refer to improving the NHS or making it better rather than bringing it up to date. It was also important to draw attention in this first part of the White Paper to the benefits which the Government's proposals would bring to people who worked in the NHS.

c. In paragraph 1.2 it would be more accurate to refer to the NHS as being financed largely out of general taxation.

d. In paragraph 2.4 the last sentence about bringing the NHS up to date should be deleted.

e

e. Another major theme of the White Paper which needed to be reflected in this opening section was the Government's wish to devolve responsibility. It had to be made clear that Ministers could not be expected to answer for every detail of the running of the NHS on the floor of the House. One central principle behind the Government's proposals was that the more responsibility and accountability could be delegated to people at the point where decisions were taken, the better would be the service which they provided and the more satisfying would be their jobs. Hitherto they had been too much constrained, and there were big differences in their performances. The Government wanted to put this right.

f. The language in paragraph 2.6 about talented people being 'given their head' and everyone being encouraged to 'give of their best' was not right. The Scottish Office draft provided a better model.

g. In paragraph 2.12 it would be better not to refer to "constraining" the rate of growth in drug costs. The point was that these costs had to be kept to reasonable proportions.

h. Paragraph 2.14 on waiting times ended lamely and needed to be more positive. In particular, the proposal for appointing more consultants ought to be mentioned. It was also an area which illustrated the patient's interest in good value for money.

i. In paragraph 2.15, the second sentence should be deleted. The paragraph needed to include a reference to making it easier for patients to change their GPs.

j. Whenever figures were quoted in these and subsequent paragraphs they should where possible be for the UK as a whole, and not just for England and Wales. The basis of the figures should always be made clear.

The Prime Minister, summing up this part of the discussion, said the group were agreed that chapters 1 and 2 of the present draft needed to be merged and substantially rewritten to reflect the points made in discussion, taking account of the first seven paragraphs of the Scottish draft and the material circulated by the Chancellor's private office on 4 January. It was essential to bring out the twin themes of, first, devolving responsibility and, second, the money following the patient, which lay behind the proposals for self-governing hospitals and GP practice budgets. Both were designed to lead to greater choice and value for money for patients who, as taxpayers, were providing huge sums for the NHS. These themes had to be developed clearly in language which was not impersonal. The Secretary of State for Health would arrange for this redrafting to be done.

On the public expenditure implications of the Government's proposals, the Prime Minister asked the Secretary of State for Health to consult bilaterally with

the Chief Secretary on the line to be taken, and to arrange for his officials to clear the relevant passages of the White Paper and all consultation documents with the Treasury.

Chapter 3

Summing up discussion of chapter 3, the Prime Minister said that the group had agreed the policy in this chapter subject to revision of the approach on funding in paragraph 3.12. They were content that expenditure on accidents and emergencies should not be included within practice budgets. The proposal in paragraph 3.10 for practices to be able to choose whether or not to include prescribing costs within their budgets had been overtaken by the new proposals for indicative drug budgets and would be amended. On paragraph 3.21 it was important to ensure that the timetable for introducing a substantial number of subjects by April 1991 was consistent with the proposals for Scotland: at present the Scottish text referred to 1991. More generally, the language of the drafting in this chapter could be improved: for instance, paragraph 3.4 was clumsy, and the reference to extending competition in paragraph 3.6 was inappropriate.

Chapter 4

In discussion of chapter 4, the following were the main points made:

a. It was very important to spell out clearly, right at the beginning of the section on the hospital service, that self-governing hospitals would remain within the NHS.

b. On paragraph 4.3 it was wrong to refer to 'pushing down' decision-taking since this implied resistance and an inferior position. The Government would 'delegate' and 'devolve' responsibility.

c. On paragraph 4.5 it should be made clear that people who were non-executive members would all be appointed in their own right and for the contribution which they would make in a personal capacity; and that there would be no representatives from any organisation or special interest group, whether from those listed in the text, from local authorities or from any other body.

d. On paragraph 4.7, the reference to a hospital 'generating income by selling its services' was inappropriate: 'earning its income from the services it performs' was better. The use of 'buyers' in the second sentence should be changed.

e. Paragraph 4.7 was incomplete without some reference to, and explanation of, core funding.

9

f. The last sentence of paragraph 4.10 conveyed too negative an impression. There should be no possible implication that the Government had ever contemplated an arrangement in which people requiring urgent treatment might be turned away from a hospital.

g. The last sentence of paragraph 4.14, as drafted, might help perpetuate restrictive practices. It would be better if it read: "But subject to their contractual obligations Hospital Trusts will be free either to...."

h. Paragraph 4.17 should refer to the group's decision that self-governing hospitals would bid for an allocation of capital from within the annual financing limit.

i. The point in the last sentence of paragraph 4.20 was important and had to be made. But the drafting could be given a more positive flavour, for instance by explaining that the closure of old hospitals was often an unavoidable part of proposals designed to provide new hospitals and a better service for patients.

j. The first sentence of paragraph 4.22 gave the impression that Regional Health Authorities would have a directive role in relation to self-governing hospitals. It should be made clear that what was being described was an aspect of core-funding.

k. Paragraph 4.24 should convey the flavour that the Government expected many hospitals to be keen to win self-governing status. The initiative in identifying candidates would rest jointly with the Government and Regional Health Authorities. This should be made clear.

l. The logic of paragraph 4.25 was that where the roles of DHAs declined they might eventually be merged with FPCs. The paragraph should be drafted so as not to exclude this possibility. Keeping open the option of merger through natural evolution would give DHAs some hope of a continuing role and would reflect the views which had been expressed in earlier meetings of the group.

The Prime Minister, summing up this part of the discussion, said that the group had agreed the points made in discussion and invited the Secretary of State to arrange for them to be incorporated in revision of this part of the White Paper.

Chapter 5

In discussion of chapter 5, the group first considered the respective roles and responsibilities of the Secretary of State, the Department of Health, and managers within the NHS, as reflected in paragraph 5.2. Their discussion also covered paragraphs 9.8 and 9.9, about the central management

of the NHS. The Prime Minister, summing up this discussion, said that Ministers could not be expected to manage the NHS. The whole thrust of the Government's proposals was greater devolution of responsibility, and the implications had to be spelled out in the White Paper. The second sentence of paragraph 9.2 should be amended by deletion of 'fully' and 'and for the services which they finance'. The third sentence appeared to run contrary to the conclusions of the review. Ministers would have benchmarks for judging performance and would be able to ask the National Audit Commission to investigate particular matters; but neither they nor the Department should be involved in operational management, nor would they direct it. Subject to the normal arrangements for collective responsibility, the Policy Board, chaired by the Secretary of State, would be responsible for strategy on the NHS, its objectives, its finance and the monitoring of the Management Committee. The Management Committee, chaired by the chief executive, would be responsible for all operational matters, within the policy framework laid down by the Secretary of State. The Secretary of State should arrange for this approach to be brought out clearly in the White Paper.

In discussion of the rest of chapter 5, the following were the main points made:

a. The heading to paragraph 5.7 - leaner and fitter regions - should only be used if it were true that there would be a net reduction in the size of RHAs. The group had earlier agreed that there should be.

b. The opening of paragraph 5.19 with its reference to regional information strategies was obscure. It should be shortened to read: "The Government remains committed to introducing modern information systems to support.."

c. Paragraph 5.24 should be included. But 'market' should be deleted from the first sentence. The second sentence should be amended to read: "...national pay spine, to reward individual performance and to take account of market conditions".

The Prime Minister, summing up this part of the discussion, said that the group invited the Secretary of State to revise the chapter in the light of these points.

Chapter 6

In discussion of chapter 6, the following were the main points made:

a. Paragraph 6.7 should make it clear that the results of audits should be available to management, and that there could be joint inquiries, as agreed earlier.

b. It should be possible for consultants to contract to provide the NHS with a smaller proportion of their time than nine-elevenths, say five-elevenths. The

point could be met by amending the first sentence of paragraph 6.13 to read "...their use of resources and the extent of their services".

The Prime Minister, summing up this part of the discussion, said that the group accepted the minor modification of its earlier proposals indicated in the last indent of paragraph 6.20, namely that distinction awards should still be payable, but not pensionable, within three years of a consultants' retirement. The Secretary of State was invited to revise the text to reflect the points made in discussion.

Chapter 7

In discussion on chapter 7, the following were the main points made:

a. The graph should be dropped.

b. The reference to "some two per cent" in paragraph 7.8 should be "three per cent" as agreed earlier.

c. In the penultimate sentence of paragraph 7.13 the reference should be to changes managed "over a transitional period".

d. The first sentence of paragraph 7.16 should be deleted, as should 'where necessary' in the second sentence. Both could be taken to suggest that there had been some doubt about immediate access for those needing urgent treatment.

e. The proposals in paragraph 7.18 for core services to be funded on an annually negotiated contract could lead to the perpetuation of existing inefficiencies. There had to be some basis or formula for determining core funding, other than by reference to existing expenditure: the proposals would otherwise work to the disadvantage of good, efficient hospitals. On the other hand, the whole concept of DHAs buying health care involved the concept of shopping around and of negotiating the price at which core services were provided.

f. Paragraph 7.31 on waiting-times should be expanded and strengthened, if possible. Paragraph 7.32 on the appointment of more consultants should include a reference to the position of junior hospital doctors.

The Prime Minister, summing up this part of the discussion, invited the Secretary of State to consider further the passage in paragraph 7.18 on the funding of core services, with a view to including some indication of the criteria by which funding would be determined. More generally, the Secretary of State was invited to revise the chapter in the light of discussion.

Chapter 8

In discussion on chapter 8, the following were the main points made:

a. Paragraph 8.4 should make it clear that Family Practitioner Committees will have access to the results of medical audits of GPs. This would have to be built into their contracts.

b. Paragraph 8.5 should if possible give credit to GPs as a profession for the contribution they had made to the introduction of medical audit.

c. The heading 'Competition' before paragraph 8.6 should read 'Patient Choice'. The reference to competition in paragraph 8.6 should be rephrased in terms of better value for money.

d. Paragraph 8.8 was needlessly dismissive of the contribution which some older doctors made to the NHS, and needed substantial modification and revision. The first and second sentences could be omitted, as could the second of the two steps which it was proposed the Government should take.

e. The heading 'Patients as consumers' before paragraph 8.9 should be deleted.

f. The last four lines of paragraph 8.11 should be deleted.

g. On paragraph 8.18 it would be better not to change the name of FPCs to Family Practitioner Authorities.

The Prime Minister, summing up this part of the discussion, invited the Secretary of State to revise the text in the light of the points made. The group also agreed that the White Paper should include an incentive for FPCs to reduce drug bills, by allowing them to plough back 50 per cent of savings into local services.

Chapter 9

The group had already discussed paragraphs 9.8 and 9.9. Summing up discussion of the rest of the chapter, the Prime Minister said that the proposal in paragraph 9.6 to allow local authorities to be consulted by RHAs as part of the normal appointments procedure for DHAs should not be made in the White Paper. The group considered that it should be kept in reserve as a concession to be offered during the passage of legislation.

Chapter 10

Summing up discussion of this chapter, the Prime Minister said that the group were agreed that the White

K

Paper should include the proposals agreed earlier for giving tax relief in respect of private health insurance taken out by, or on behalf of, people over the age of 60. The earlier proposals in relation to company health insurance schemes would not however be pursued. The Treasury would monitor the growth of company schemes, in case action was needed at a later date.

SCOTLAND, WALES AND NORTHERN IRELAND

Summing up discussion, the Prime Minister said that there should be separate chapters on each of the territories. The first seven paragraphs of the Scottish chapter were excellent but the Secretary of State would wish to reconsider later passages, in particular in paragraphs 8 to 10 and paragraph 15, in the light of the discussion at the meeting. She was very concerned that the chapter on Wales should give a more positive slant to the introduction of self-governing hospitals and GP practice budgets, for example by introducing a planned timetable; and the rationale for these important developments should be brought in line with the rest of the White Paper. (I have elaborated her concerns more fully in my letter of 3 January). The Prime Minister invited the three Secretaries of State to send revised texts of their chapters to the Secretary of State for Health who would have overall responsibility for preparing a complete new text of the White Paper, reflecting the discussion.

NEXT STEPS

Concluding the meeting, the Prime Minister invited the Secretary of State for Health to circulate the revised text of the White Paper to the group on Thursday, 12 January, for discussion at its meeting on Tuesday, 17 January. Thereafter, the proposals would be considered by E(A) at the meeting arranged for Tuesday, 24 January, and by Cabinet on Thursday, 26 January. The aim would be publication on Tuesday, 31 January.

I am copying this letter to the private secretaries to Ministers on the group, to Sir Robin Butler and to the others present.

PAUL GRAY

Andrew J. McKeon, Esq.,
Department of Health

d. The system for negotiating practice budgets in paragraph 3.12 of HC67 was unacceptable. GP practices would never know what to expect from one year to the next. Moreover, there was a real risk that Regions would adopt different approaches to different GP practices and also that different Regions would follow different approaches (as had happened with nurses' pay); so that there would be no consistency. It was essential that a satisfactory, workable approach should be devised before the White Paper was published, which ensured consistency. A straightforward formula, based on ~~that~~ the formula for allocations to District Health Authorities, might be appropriate. If need be, there might have to be a transitional period, starting with existing patterns but moving gradually to the ~~desired~~ new ~~allocations~~ system.

e. The aim was to achieve maximum devolution of responsibility, subject only to administrative practicability. In England and Wales this pointed to budgets only for practices with at least 11,000 patients. But a smaller number might be possible for Scotland, at least in the light of experience.

The Prime Minister, summing up this part of the discussion, said that the proposals on GP practice budgets were as fundamental to the Review's conclusions as the proposals on self-governing hospitals and would be set out accordingly in the White Paper. It was however essential that the arrangements for determining the size of budgets should be revised, as indicated in discussion. The Secretary of State for Health would review this aspect of his proposals. The Secretary of State for Scotland would consider whether anything could be said in the White Paper about extending budgets to smaller practices in Scotland.

WHITE PAPER: FIRST DRAFT (HC67)

The group then turned to the first draft of the White Paper (HC67), circulated by the Secretary of State for Health.

Summing up preliminary discussion about the broad structure of the White Paper, the Prime Minister invited the Secretary of State for Health to arrange for the material to be reorganised so that it fell into four main parts.

The first part would set out the Government's strategy for the NHS. This would be the key section which would cover all the important points, so that readers would know in essence what the Government was proposing and why, even if they read no further. It would include the topics in chapters 1 and 2 of the draft, but would go further as indicated in discussion below. The draft provided by the Secretary of State for Scotland struck the right sort of note, particularly in its first seven paragraphs. There would be no need for a separate foreword of the kind proposed in chapter 1. There could however be a short paragraph at the beginning signed either by the Secretary of State for Health or herself.

The remaining three parts would spell out the Government's proposals in more detail. Part two would deal with the proposals concerning hospitals. It would need to have an introductory section which explained the Government's overall approach and provided a framework for understanding the detailed material on hospitals, including managing the hospital service and self-governing hospitals. Part three would deal with the Family Practitioner Service and GPs, including practice budgets. Part four would bring together the remaining proposals.

Chapters 1 and 2

In discussion of chapters 1 and 2, the following were the main points made:

a. It was essential to use the right language in these and subsequent chapters. The drafting needed to show constant awareness that the NHS provided health care for individuals who contributed to the cost through their taxes and were entitled to expect considerate treatment and good value for money. It should avoid giving the impression of an

impersonal approach: it was for instance more appropriate to talk about patients rather than customers, and about choice and value for money rather than competition and the market.

b. Similarly it was important not to use language which could be interpreted as running down the NHS. It would for instance be preferable to refer to improving the NHS or making it better rather than bringing it up to date. It was also important to draw attention in this first part of the White Paper to the benefits which the Government's proposals would bring to people who worked in the NHS.

c. In paragraph 1.2 it would be more accurate to refer to the NHS as being financed largely out of general taxation.

d. In paragraph 2.4 the last sentence about bringing the NHS up to date should be deleted.

e. Another major theme of the White Paper which needed to be reflected in this opening section was the Government's wish to devolve responsibility. It had to be made clear that Ministers could not be expected to answer for every detail of the running of the NHS on the floor of the House. One central principle behind the Government's proposals was that the more responsibility and accountability could be delegated to people at the point where decisions were taken, the better would be the service which they provided and the more satisfying would be their jobs. Hitherto they had been too much constrained, and there were big differences in their performances. The Government wanted to put this right.

f. The language in paragraph 2.6 about talented people being 'given their head' and everyone being encouraged to 'give of their best' was not right. The Scottish Office draft provided a better model.

g. In paragraph 2.12 it would be better not to refer to "constraining" the rate of growth in drug costs. The point was that these costs had to be kept to reasonable proportions.

h. Paragraph 2.14 on waiting times ended lamely and needed to be more positive. In particular, the proposal for appointing more consultants ought to be mentioned. It was also an area which illustrated the patient's interest in good value for money.

i. In paragraph 2.15, the second sentence should be deleted. The paragraph needed to include a reference to making it easier for patients to change their GPs.

j. Whenever figures were quoted in these and subsequent paragraphs they should where possible be for the UK as a whole, and not just for England and Wales. The basis of the figures should always be made clear.

The Prime Minister, summing up this part of the discussion, said the group were agreed that chapters 1 and 2 of the present draft needed to be merged and substantially rewritten to reflect the points made in discussion, taking account of the first seven paragraphs of the Scottish draft and the material circulated by the Chancellor's private office on 4 January. It was essential to bring out the twin themes of, first, devolving responsibility and, second, the money following the patient, which lay behind the proposals for self-governing hospitals and GP practice budgets. Both were designed to lead to greater choice and value for money for patients who, as taxpayers, were providing huge sums for the NHS. These themes had to be developed clearly in language which was not impersonal. The Secretary of State for Health would arrange for this redrafting to be done.

On the public expenditure implications of the Government's proposals, the Prime Minister asked the Secretary of State for Health to consult bilaterally with the Chief Secretary on the line

to be taken, and to arrange for his officials to clear the relevant passages of the White Paper and all consultation documents with the Treasury.

Chapter 3

Summing up discussion of chapter 3, the Prime Minister said that the group had agreed the policy in this chapter subject to revision of the approach on funding in paragraph 3.12. They were content that expenditure on accidents and emergencies should not be included within practice budgets. The proposal in paragraph 3.10 for practices to be able to choose whether or not to include prescribing costs within their budgets had been overtaken by the new proposals for indicative drug budgets and would be amended. On paragraph 3.21 it was important to ensure that the timetable for introducing a substantial number of budgets by April 1991 was consistent with the proposals for Scotland: at present the Scottish text referred to 1992 ~~but should be consistent~~. More generally, the language of the drafting in this chapter could be improved: for instance, paragraph 3.4 was clumsy, and the reference to extending competition in paragraph 3.6 was inappropriate.

Chapter 4

In discussion of chapter 4, the following were the main points made:

a. It was very important to spell out clearly, right at the beginning of the section on the hospital service, that self-governing hospitals would remain within the NHS.

b. On paragraph 4.3 it was wrong to refer to 'pushing down' decision-taking since this implied resistance and an inferior position. The Government ~~intended to~~ would 'delegate' and 'devolve' responsibility.

c. On paragraph 4.5 it should be made clear that people who were non-executive members would all be appointed in their own right and for the contribution which they could make in a personal capacity; and that there would be no representatives from any organisation or special interest group, whether from those listed in the text, ~~or~~ from local authorities or from any other body.

d. On paragraph 4.7, the reference to a hospital 'generating income by selling its services' was inappropriate: 'earning its income from the services it performs' was better. The use of 'buyers' in the second sentence should ~~also~~ be changed.

e. Paragraph 4.7 was ~~also~~ incomplete without some reference to, and explanation of, core funding.

f. The last sentence of paragraph 4.10 conveyed too negative an impression. There should be no possible implication that the Government had ever contemplated an arrangement in which people requiring urgent treatment might be turned away from a hospital.

g. The last sentence of paragraph 4.14, as drafted, might help perpetuate restrictive practices. It would be better if it read: "But subject to their contractual obligations Hospital Trusts will be free either to...."

h. Paragraph 4.17 should refer to the group's decision that self-governing hospitals would bid for an allocation of capital from within the annual financing limit.

i. The point in the last sentence of paragraph 4.20 was important and had to be made. But the drafting could be given a more positive flavour, for instance by explaining that the closure of old hospitals was often an unavoidable part of proposals designed to provide new hospitals and a better service for patients.

j. The first sentence of paragraph 4.22 ~~wrongly~~ gave the impression that Regional Health Authorities would have a directive role in relation to self-governing hospitals. It should be made clear that what was being described was an aspect of core-funding.

k. Paragraph 4.24 should convey the flavour that the Government expected many hospitals to be keen to win self-governing status. The initiative in identifying candidates would rest jointly with the Government and Regional Health Authorities. This should be made clear.

l. The logic of paragraph 4.25 was that where the roles of DHAs declined they might eventually be merged with FPCs. The paragraph should be drafted so as not to exclude this possibility. Keeping open the option of merger through natural evolution would give DHAs some hope of a continuing role and would reflect the views which had been expressed in earlier meetings of the group.

The Prime Minister, summing up this part of the discussion, said that the group had agreed the points made in discussion and invited the Secretary of State to arrange for them to be incorporated in revision of this part of the White Paper.

Chapter 5

In discussion of chapter 5, the group first considered the respective roles and responsibilities of the Secretary of State, the Department of Health, and managers within the NHS, as reflected in paragraph 5.2. Their discussion also covered paragraphs 9.8 and 9.9, about the central management of the NHS. The Prime Minister, summing up this discussion, said that Ministers could not be expected to answer to Parliament for every detail of the running of the NHS. Nor could, or should, the Department of Health be expected to manage the NHS. The whole thrust of the Government's proposals was greater devolution of responsibility, and the implications had to be spelled out in the White Paper. The second sentence of paragraph 9.2 should be

amended by deletion of 'fully' and 'and for the services which they finance'. The third sentence appeared to run contrary to the conclusions of the review. Ministers would have benchmarks for judging performance and would be able to ask the National Audit Commission to investigate particular matters; but neither they nor the Department should be involved in operational management, nor would they direct it. Subject to the normal arrangements for collective responsibility, the Policy Board, chaired by the Secretary of State, would be responsible for strategy on the NHS, its objectives, its finance and the monitoring of the Management Committee. The Management Committee, chaired by the chief executive, would be responsible for all operational matters, within the policy framework laid down by the Secretary of State. The Secretary of State should arrange for this approach to be brought out clearly in the White Paper.

In discussion of the rest of chapter 5, the following were the main points made:

a. The heading to paragraph 5.7 - leaner and fitter regions - should only be used if it were true that there would be a net reduction in the size of RHAs. The group had earlier agreed that there should be.

b. The opening of paragraph 5.19 with its reference to regional information strategies was obscure. It should be shortened to read: "The Government remains committed to introducing modern information systems to support..."

c. Paragraph 5.24 should be included. But 'market' should be deleted from the first sentence. The second sentence should be amended to read: "...national pay spine, to reward individual perforamnce and to take account of market conditions".

The Prime Minister, summing up this part of the discussion, said that the group invited the Secretary of State to revise the chapter in the light of these points.

Chapter 6

In discussion of chapter 6, the following were the main points made:

a. Paragraph 6.7 should make it clear that the results of audits should be available to management, and that there could be joint inquiries, as agreed earlier.

b. It should be possible for consultants to contract to provide the NHS with a smaller proportion of their time than nine-elevenths, say five-elevenths. The point could be met by amending the first sentence of paragraph 6.13 to read "...their use of resources and the extent of their services".

The Prime Minister, summing up this part of the discussion, said that the group accepted the minor modifications of its earlier proposals indicated in the last indent of paragraph 6.20, namely that distinction awards should still be payable, but not pensionable, within three years of a consultant's retirement. The Secretary of State was invited to revise the text to reflect the points made in discussion.

Chapter 7

In discussion on chapter 7, the following were the main points made:

a. The graph should be dropped.

b. The reference to "some two per cent" in paragraph 7.8 should be "three per cent" as agreed earlier.

c. In the penultimate sentence of paragraph 7.13 the reference should be to changes managed "over a transitional period".

d. The first sentence of paragraph 7.16 should be deleted, as should 'where necessary' in the second sentence. Both could be taken to suggest that there had been some doubt about immediate access for those needing urgent treatment.

e. ~~It was argued that~~ The proposals in paragraph 7.18 for core services to be funded on an annually negotiated contract could lead to the perpetuation of existing inefficiencies. There had to be some basis or formula for determining core funding, other than by reference to existing expenditure: the proposals would otherwise work to the disadvantage of good, efficient hospitals. On the other hand, the whole concept of DHAs buying health care involved the concept of shopping around and of negotiating the price at which core services were provided.

d. Paragraph 7.31 on waiting-times should be expanded and strengthened, if possible. Paragraph 7.32 on the appointment of more consultants should include a reference to the position of junior hospital doctors.

The Prime Minister, summing up this part of the discussion, invited the Secretary of State to consider further the passage in paragraph 7.18 on the funding of core services, with a view to including some indication of the criteria by which funding would be determined. More generally, the Secretary of State was invited to revise the chapter in the light of discussion.

Chapter 8

In discussion on chpater 8, the following were the main points made:

a. Paragraph 8.4 should make it clear that Family Practitioner Committees will have access to the results of medical audits of GPs. This would have to be built into their contracts.

b. Paragraph 8.5 should if possible give credit to GPs as a profession for the contribution they had made to the ~~development~~ introduction of medical audit.

c. The heading 'Competition' before paragraph 8.6 should read 'Patient Choice'. The reference to competition in paragraph 8.6 should be rephrased in terms of better value for money.

d. Paragraph 8.8 was needlessly dismissive of the contribution which some older doctors made to the NHS, and needed substantial modification and revision. The first and second sentences could be omitted, as could the second of the two steps which it was proposed the Government should take.

e. The heading 'Patients as consumers' before paragraph 8.9 should be deleted.

f. The last four lines of paragraph 8.11 should be deleted.

g. On paragraph 8.18 it would be better not to change the name of FPCs to Family Practitioner Authorities.

The Prime Minister, summing up this part of the discussion, invited the Secretary of State to revise the text in the light of the points made. The group also agreed that the White Paper should include an incentive for FPCs to reduce drug bills, by allowing them to plough back 50 per cent of savings into local services.

Chapter 9

The group had already discussed paragraphs 9.8 and 9.9. Summing up discussion of the rest of the chapter, the Prime Minister said that the proposal in paragraph 9.6 to allow local authorities to be consulted by RHAs as part of the normal appointments procedure

for DHAs should not be made in the White Paper. The group considered that it should be kept in reserve as a concession to be offered during the passage of legislation.

Chapter 10

Summing up the discussion of this chapter, the Prime Minister said that the group were agreed that the White Paper should include the proposals agreed earlier for giving tax relief in respect of private health insurance taken out by, or on behalf of, people over the age of 60. The earlier proposals in relation to company health insurance schemes would not however be pursued. The Treasury would monitor the growth of company schemes, in case action was needed at a later date.

SCOTLAND, WALES AND NORTHERN IRELAND

Summing up discussion, the Prime Minister said that there should be separate chapters on each of the territories. The first seven paragraphs of the Scottish chapter were excellent but the Secretary of State would wish to reconsider later passages, in particular in paragraphs 8 to 10 and paragraph 15, in the light of the discussion ~~about delegation of responsibilties earlier~~ at the meeting. She was very concerned that the chapter on Wales should give a more positive slant to the introduction of self-governing hospitals and GP practice budgets, for example by introducing a planned timetable; and the rationale for these important developments should be brought in line with the rest of the White Paper. The three Secretaries of State ~~should provide the Secretary of State for Health with~~ revised texts of their ~~contribution, for incorporation in the new version of the White Paper which the latter would now prepare~~ chapters to the Secretary of State for Health who would have overall responsibility for preparing and circulating a complete new text of the White Paper, reflecting the discussion.

(I have elaborated her concerns more fully in my letter of 13 January.)

The Prime Minister invited

NEXT STEPS

Concluding the meeting, the Prime Minister invited the Secretary of State for Health to circulate the revised text of the White Paper to the group on Thursday 12 January, for discussion at ~~the group's~~ its meeting on Tuesday, 17 January. Thereafter, the proposals would be

considered by E(A) at the meeting arranged for Tuesday 24 January, and by Cabinet on Thursday 26 January. The aim would be publication on Tuesday 31 January.

I am copying this letter to the private secretaries to Ministers on the group, to Sir Robin Butler and to the others present.

SECRET

PRIME MINISTER

NHS REVIEW: MEETING ON 5 JANUARY

You were able to study the first draft of the NHS White Paper over the holiday. The meeting originally scheduled for 22 December will now take place tomorrow. We have allowed three hours.

There is a lot of paper to work through. I suggest you structure the discusison as follows.

The key handling paper is Richard Wilson's Steering Brief at Flag A. You have already seen this. It would be sensible to take the issues in the order he suggests, but you might like to divide the discussion into five separate agenda items. The relevant papers for each are in the dividers below.

ITEM 1 - OUTSTANDING REVIEW GROUP PAPERS

These are:

Flag B: HC 68. This sets out the agreed position reached by Messrs. Clarke and Major on drug budgets and control of GP numbers. It should be possible to take this as read.

Flag C: HC 69. This sets out the disagreed position between Messrs. Clarke and Major on GP practice budgets. Since this is the major outstanding policy issue I suggest you tackle it at the start of the meeting before we get into the detail of the draft White Paper. Your view is that the introduction of budgets for large GP practices is an important element of the review package; but that the present details as set out in chapter 3 of the draft White Paper are totally inadequate.

SECRET

b

ITEM 2 - DRAFT WHITE PAPER (EXCLUDING TERRITORIAL DEPARTMENTS

You have already seen all the following papers except for Flag E:

Flag D: the existing draft (HC 67).

Flag E: my letter dated 3 January in which I have sought to summarise your main reactions. (I thought it would be helpful to give members of the Group some flavour of your views before the meeting). You will want to glance through the letter to check that I have not misrepresented you on any particular points. – Yes – you have done a marvellous job.

Flag F: the Cabinet Office brief

Flag G: the Cabinet Office check list of outstanding points from the Review Group's discussions.

Flag H: Policy Unit brief

Flag I: Treasury comments on the draft

I suggest you start this item by considering whether the broad structure and order of the White Paper is what you want. Then you can steadily work through the draft chapter by chapter.

You will want to consider how critical to be about the detailed drafting at this stage. It might be best to handle this in a low key way at the start, stressing that the priority for this meeting is to make sure the broad coverage, content and structure is right. Then, towards the end of the discussion, you might like to call for a major effort to improve the style and drafting of the White Paper, perhaps with the Cabinet Office playing an active role in polishing the final text (as I gather you have discussed with Robin Butler).

Two other points:

- you will want to keep the Cabinet Office check list (Flag G) to hand to ensure that outstanding points of substance are covered as you work through the draft;

- we are still missing any contribution from the Treasury on tax relief at the end of Chapter 10. My intelligence still is that the Chancellor is minded at this meeting to reopen the decisions reached by the Group in the summer (which, for security reasons, were deliberately not recorded at that stage). I suggest you do not raise this issue until we get to Chapter 10; that will distance the discussion from that under Item 1 on GP practice budgets, and make it more difficult for the Chancellor to try to win concessions by looking at GP practice budgets and tax relief as a package.

ITEM 3 - TERRITORIAL DEPARTMENTS MATERIAL

The further papers here (all of which you have seen before) are:

Flag J: Scotland

Flag K: Wales

Flag L: Northern Ireland

Flag M: Cabinet Office

Flag N: Policy Unit

Page 4 of my letter at Flag E is also relevant.

This will be a tricky discussion in which you need to bring Mr. Walker back more closely in line with the English position. I have sought to put the Welsh Office on notice by

d

the comments in my Flag E letter.

ITEM 4 - PLANS ON PRESENTATON

There are no further circulated papers on this, but I suggest you work through the points set out in paragraph 3 of Richard Wilson's Steering Brief at Flag A.

ITEM 5 - TIMETABLE

The comments in paragraph 4 of Richard Wilson's Steering Brief are now overtaken. We have now arranged further meetings on the lines you agreed just before Christmas, ie:

- final meeting of Review Group on Tuesday 17 January.

- E(A) meeting on 24 January (conceivably this may need to be put off for a day if the Gorbachev visit proves to be from 22-24 January).

- Endorsement by Cabinet on Thursday 26 January.

- Publication by 31 January.

I suggest you stress the importance of sticking to this timetable, and of ensuring that the next draft of the White Paper is circulated by by mid-day on Thursday 12 January so that members of the Group have the chance properly to study it before the 17 January meeting. And in view of the publicity on this morning's "Today" programme about the likely contents of the White Paper you might also stress the importance of tight security over its contents.

PACG.

PAUL GRAY

4 January 1989

P.S. The Treasury has just submitted some ~~visit~~ introductory draft material on "An Efficient Health Service", together with a paragraph on the public expenditure implications of the Review. I have put this at the end of Folder 2 as a new flag "O".

SECRET

SL3BGI

chex.ps/mw/41 SECRET

CEBP

2 Ab a-g

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

4 January 1989

Paul Gray Esq
10 Downing Street
LONDON
SW1

Dear Paul,

NHS REVIEW: DRAFT WHITE PAPER

The Chancellor has asked me to circulate to the Review Group the attached draft chapter entitled "An Efficient Health Service", which was promised in the Chief Secretary's letter of 22 December to the Secretary of State for Health. Although it is cast in the form of a separate chapter, the Chancellor thinks it could as easily be combined with some of the material now in the present draft chapter 2 to form a new chapter on the general objectives of the Review, in line with the Prime Minister's comment that chapter 2 needs to say more about better value for money in the health service.

file on BUP

The Chancellor and Chief Secretary also feel that the White Paper will need to mention the public expenditure implications of the Review, although it is for consideration where such a reference should be placed. I attach their suggested paragraph. We understand that the Secretary of State for Health is considering the detailed expenditure implications of the proposals. The Chancellor suggests that he might discuss these bilaterally with the Chief Secretary.

I am copying this letter and enclosures to the Private Secretaries to the Secretaries of State for Health, Scotland, Wales and Northern Ireland, the Minister for Health and Sir Robin Butler, and to Sir Roy Griffiths, Mr Wilson (Cabinet Office) and Mr Whitehead (Policy Unit).

Yours,

Moira.

MOIRA WALLACE

b

DRAFT

AN EFFICIENT HEALTH SERVICE

One of the Government's main concerns is to ensure that the public gets the best possible value for the considerable sums of money the taxpayer puts into the health service, which will in real terms be 37 per cent higher next year than in 1978-79. Greater efficiency and cost-effectiveness can significantly improve the quality of the service given to patients, which is the prime objective of the health service. Moreover, the more that staff can feel they are contributing to a well run organisation, the better their motivation to give of their best in serving the patient.

2. The Government remains committed to keeping the health service largely free at the point of use. This means however that the normal market mechanisms which encourage suppliers of services to do so in the most efficient manner are absent. It is therefore all the more important that other ways are found of ensuring the resources made available by the taxpayer are used to the best effect. The delivery of health care must be structured in a way which actively promotes efficiency. This becomes even more vital as the demands on the health service continue to grow. So a recurring theme of this White Paper is how to ensure the best possible value for money in all the health service does.

C

Responsibility and accountability

3. The health service has evolved as an organisation controlled from the centre through a series of detailed rules and guidance going out through a hierarchy of authorities. These frequently have little relevance to the day to day work of doctors and nurses in clinics and on wards. In the past, responsibility has been diffuse, and managers' accountability for the use of resources has been divorced from clinical decisions which have in large measure committed them. Where decisions are taken which affect the use of resources, there needs to be full accountability for the expenditure so incurred. And those who manage the organisation need to have more influence over the way resources are used. In other words, management responsibility and accountability for resources must go together.

4. Following Sir Roy Griffiths' report in 1983 on the management of the health service, reforms were made, including the introduction of general managers with overall responsibility for management decisions. These were important first steps. The time has now come to carry this process a stage further.

Delegation and efficiency

5. The Government believes that most decisions are better taken at local levels. Increased delegation of responsibility is

therefore proposed. A series of detailed proposals is set out in chapter [5]. This will include delegation of functions from regions to district, and from district to hospital. Detailed decisions about pay and conditions of service can be devolved much more to local level. New arrangements will be introduced to encourage the efficient use of capital assets, incorporating financial incentives for those authorities who make best use of them.

6. Those hospitals with the capacity to do so will be able to opt for a new "self-governing" status within the National Health Service, described in more detail in chapter [4]. This will free them from many of the detailed financial controls which apply to them now. They will also have the opportunity to enjoy greater freedom over employment and staffing matters. They will directly benefit according to their ability to offer the best service to patients on the most cost-effective terms to health authorities. These hospitals will express the Government's determination to devolve responsibility and give local managers full charge of, and full accountability for, the resources under their command.

7. The greater local accountability for using and managing resources will be further extended and reinforced by a new system of funding health authorities. This will enable money to follow

patients more directly than now. It is described more fully in chapter [7].

8. The Government proposes an important change in the audit of health authorities and other NHS bodies. The work at present done by auditors employed in the Department of Health will be transferred to the Audit Commission, who will, for this purpose, report to the Secretary of State. There will be more emphasis on value-for-money audit. The Audit Commission has already made a valuable contribution to the audit of local authorities, especially through its comparative value for money studies, and it will bring this expertise to its new role in the field of health care. The role of the National Audit Office, in auditing the consolidated accounts of the NHS and more particularly its very important value-for-money studies, will be unchanged.

9. The Government also intends to give doctors greater responsibility for the resources available to them, so that they can be applied for the benefit of patients. As an important first step, the Government will begin next year to extend to all major acute hospitals the resource management initiative, pilot experiments in which exist at a small number of sites. These systems will give doctors for the first time comprehensive information about the care patients are receiving, and its costs.

f

They will enable medical staff to play a much fuller day-to-day role in the management of hospitals.

10. The Government attaches great importance to medical audit, and the continuing review of doctors' clinical practice and quality of care by their professional colleagues. It will therefore be seeking the introduction of comprehensive arrangements as soon as possible, building on the best practice now current. The consultants' distinction award system will be reformed in order to improve the incentive it gives for consultants to contribute to better medical care and better management, and to remove some unsatisfactory features of the present system. There will be new budgeting arrangements for GPs.

11. Taken together these reforms will enable the Health Service to use the resources at its command to provide the most efficient and high quality service to its patients. The following chapters describe the proposals in more detail.

9

DRAFT

Public expenditure

The reforms in this White Paper will enable a higher quality of patient care to be obtained from the resources which the nation is able to devote to the NHS. The provision for spending on health in the coming financial year, 1989-90, announced in the Autumn Statement already included provision for the likely cost of preparing for the reforms and for the legislation which will give effect to them. In subsequent years such extra costs should soon be offset by the improved efficiency which will stem from them. The total provision for spending on health in those years will take account of the progress made in implementing the reforms, and will be determined in the regular annual public expenditure surveys, having regard to the priority to be attached to this and other spending programmes.

NAT HEALTH: Enf and Effmncy

Pt 16

PA - NHS

Prime Minister
Of background interest for tomorrow's NHS Review meeting.
RACG
4/1

PRIME MINISTER

4 January 1989

GALLUP POLL ON THE NHS

Gallup have just completed a poll for Central Office of the views of consultants, GPs and general managers on the funding of the NHS.

Its major conclusions are interesting: the perception of lack of funding is disappointing but on structural change there is a good deal of support for the direction in which the Review is moving.

Key conclusions

Four out of five general managers believe that the quality of care in the NHS has improved in the last ten years, but only one in three consultants and GPs hold this view.

All three groups agree that in real terms the level of funding of the NHS has declined over the last decade. ???

Apart from insufficient government funding all three groups recognised that increased demand for health services, developments in the medical field, the ageing population, and higher public expectations were factors influencing the shortage of financial resources in the NHS.

For all three groups, only one in three believe that more money is the solution to the problems of the NHS. A majority recognise that reorganisation and more efficient resources is needed, as well as an increase in funding.

Apart from increased taxation as a method of increasing funding, there was substantial support for a national lottery and patients paying for "extras" such as a better room and a choice of food. There was some support for tax relief for private health schemes, but there was strong opposition to health voucher schemes, charging for out patient attendance and routine treatments.

Two out of three general managers believe the Health Service to be efficient. Consultants and GPs are fairly evenly divided on their views and are concerned about waste and administration costs.

Whereas more than two out of three general managers believe that the NHS is as efficient as the private sector, only a minority of consultants and GPs believe this.

There was considerable support for generating more funds for the NHS through increased co-operation between the public and private sectors.

The selling of laundry, pharmacy and pathological services, as well as providing screening and x ray facilities to the private sector, were strongly supported as methods of increasing resources for the NHS.

There was also considerable support for leasing spaces in hospital shopping mall, offering franchises, and selling catering and laundry services. A majority of general managers and consultants approved of private beds and amenity beds.

A majority of all three groups thought the NHS should be administered at the district level, but one in four consultants favoured regional administration and one in five consultants and GPs favoured hospital level administration.

More than two out of three of all those surveyed supported the notion of a much greater degree of self government to be given to individual hospitals, and two out of three consultants favoured taking responsibility for their own budgets.

BG.

BRIAN GRIFFITHS

SECRET COPY NO. 13 OF 13 COPIES

E
MJ2
File
18a-e
cc Ian Whitehead
(Policy)

10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

3 January 1989

Dear Andy,

NHS REVIEW

The Prime Minister has had the opportunity over the holiday to consider the papers prepared for the meeting of the Review Group originally scheduled for 22 December which had to be cancelled. It may be helpful in advance of the reconvened meeting on 5 January if I record her main reactions to the papers, and in particular the first draft of the White Paper.

I should be grateful if you and copy recipients would ensure that no further copies are taken of this letter without authority from this office.

The Prime Minister recognises that a lot of further work will be necessary on refining the drafting and presentation of the White Paper, and her initial comments therefore focus on important points of substance.

Chapter 1 and 2

The Prime Minister is concerned that, as presently drafted and structured, chapters 1 and 2 do not strike the right opening note for the White Paper. She thinks it would be preferable to include some of the thoughts in the present chapter 2 in the opening chapter of the White Paper, and considers that the model set in the draft contribution by the Secretary of State for Scotland should be closely followed. The key points to be got over include:-

- From many viewpoints the NHS has been a major success story. The task of the Review has been to keep the best but to make improvements where the past record has not been satisfactory.

- We now have figures showing great differences in performance between similar hospitals, along with the initial results of the Resource Management Initiative. These, together with experience since the Griffiths Report, enable the Government now to put forward proposals for the future.

b

- The impact of demographic change, and changes in medical techniques and the benefits from research, should be fully brought out.

The Prime Minister also has some more detailed comments on the material presently in chapter 2:

- The package of practical improvements of direct benefit to patients should be put forward more convincingly.

- There should be some mention at this point in the White Paper of improving the procedure for allowing patients to change their GPs.

- In paragraph 2.9 the order of the first two indents should be reversed.

- There is not sufficient emphasis on the importance of getting better value for money from the enormous sums already spent on the NHS.

Chapter 3

The Prime Minister thinks that the introduction of GP practice budgets is an important element of the White Paper proposals; it is integral to the general approach of dispersing and delegating greater responsibility. However she does not think that the present detailed proposals for operating GP budgets are workable, and feels in particular that the material on negotiation of budgets (paragraph 3.12) needs to be changed. She has commented that a straightforward formula for setting the budget, based on that for allocations to districts, might be more appropriate.

On more detailed points:-

- Since it has now been decided that all GP practices should have indicative drug budgets, the comment in paragraph 3.10 that practices will be able to choose whether or not to include prescribing costs in their budget would seem to have been overtaken.

- In paragraph 3.19 the Prime Minister has asked whether the square bracketed figures for possible overspends are backed up by detailed proposals.

- In paragraph 3.21 the Prime Minister wonders when it is proposed to publish the proposed discussion document.

Chapter 4

The Prime Minister thinks it would be helpful at an appropriate point in this chapter if the distinction between self-governing hospitals and DHA-managed hospitals, and the greater flexibility available to the former, could be brought out more clearly.

On more detailed points, the Prime Minister has noted that

consideration needs to be given to the position of local authorities and the generality of trade unions in relation to the composition of Hospital Trusts (paragraph 4.5); and she sees advantage in stressing in this chapter that accident and emergency treatment will continue to be available to patients from the nearest hospital.

Chapter 5

The Prime Minister has commented in relation to this chapter and chapter 9 that a clear distinction must be drawn between ministerial responsibility for setting broad policy, strategy and the level of funding; and the responsibility of NHS managers to manage. Against that background, she does not consider (paragraph 9.8) that Ministers should be fully accountable in detail to Parliament for the management of the Service.

On more detailed points:-

- The Prime Minister has asked how the proposed timetable for the Resource Management Initiative (paragraphs 5.16-5.19) fit in with the arrangements for setting up self-governing hospitals.

- The Prime Minister is struck by the fact that paragraph 5.21 gives a firm commitment to the continuation of a central framework for pay determination in the NHS, and wonders whether such a resounding commitment is appropriate.

Chapter 6

There are two points which the Prime Minister feels should be made more explicitly in this chapter. First, the agreement that there should be provision for joint enquiries covering both medical and management audit in cases whether both types of issue are involved. And second, the proposal to make greater use of the flexibility that where a consultant works only X sessions a week for the NHS he should be paid only X/11ths of a full-time salary.

Chapter 7

In paragraph 7.8 the draft White Paper refers to a differential of 2 per cent in funding per head of population for the Thames regions; the Prime Minister recalls that the group had previously agreed on a 3 per cent differential.

In paragraphs 7.12-7.13 the Prime Minister has asked what timetable is now envisaged for the introduction of changes to allocations to DHAs.

Chapter 8

The Prime Minister has noted that, although paragraph 6.8 refers to access for management to the results of medical audit in hospitals, there is no similar reference in Chapter 8 to access for FPCs. She believes that paragraph 8.4 should include an additional point indicating that the FPC should have access to the general results of medical audit of GPs.

d

In paragraph 8.7 the Prime Minister has asked why it is not possible to aim to raise the average remuneration of GPs accounted for by capitation to 75 per cent rather than 60 per cent.

The Prime Minister agrees with the Chancellor's comment on paragraph 8.18 that a change of name to FPAs could lead to confusion with the Family Planning Association.

Chapter 9

The Prime Minister's principal point on this chapter is covered by the comments above on chapter 5. But she has also asked on paragraph 9.6 whether it would be appropriate for guidelines to be given to RHAs covering the appointment of non-executive members of DHAs.

Chapter 10

The Prime Minister's main comment on this chapter is that the commitment to wider use of competitive tendering should be strengthened, with mention of specific possibilities. She has noted that a Treasury contribution following paragraph 10.3 is awaited.

Territorial Departments

The Prime Minister has noted that it will be necessary to decide how best to organise the material covering the territorial departments, for example whether they should be merged into one rather than three separate chapters.

On the present contributions, she is struck by the contrast between the Scottish and Welsh material in relation to the development of self-governing hospitals and GP practice budgets; she thinks these developments should be given a more positive slant in the Welsh material, for example by introducing a planned timetable.

The Prime Minister's other comments on these contributions are:-

- The Northern Ireland section might start with material on past NHS successes.

- She wonders whether the timetable for the first GP practice budgets in Scotland (1992) should be slower than in England (1991).

- Paragraph 4 (iii) of the Welsh material promises to publish a "wider programme of quality assurance" in Wales; the Prime Minister has noted that the Group rejected a rather similar proposal for England.

- In view of the position in relation to merger of FPCs and DHAs for England, consideration needs to be given to whether paragraph 4(viii) should indicate that there are "strong arguments" in Wales for bringing together the hospitals and FPS "under common management and leadership".

Timetable

As you will be aware, we have now arranged that, following the meeting of the Group on 5 January, the Group will next meet on 17 January. This is to enable sufficient time for a full redraft of the White Paper, in the light of the 5 January discussion, to be circulated during the week beginning 9 January, so that members of the Group have good time to consider it in advance of the next meeting. But the Prime Minister continues to attach importance to publication of the White Paper still taking place by the end of January.

I am copying this letter to Allex Allan (HM Treasury), Stephen Williams (Welsh Office), Mike Maxwell (Northern Ireland Office), David Crawley (Scottish Office), Carys Evans (Chief Secretary's Office), Jenny Harper (Minister for Health's Office), Sir Roy Griffiths (Department of Health) and Trevor Woolley and Richard Wilson (Cabinet Office).

Yours,

Paul

Paul Gray

Andy McKeon, Esq.,
Department of Health.

PART Part 17 ends:-

Ch Ex to SS/Health 23/12/88

PART Part 18 begins:-

PG to DoH 3/1/89

IT8.7/2-1993
2009:02

Image Access

IT-8 Target

Printed on Kodak Professional Paper

Charge: R090212