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From the Secretary of State for Social Services

E7D (a-k)

SECRET

Paul Gray Esq
Private Secretary
10 Downing Street
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28 June 1988

Dear Paul,

NHS REVIEW

I enclose four papers for the meeting of the Prime Minister's group on the NHS Review which is to take place on ~~4 July~~ 30 June.

The papers are:

- Moving towards self governing hospitals
- Consultants
- Medical Audit
- Contracting out

Copies of this letter and enclosures go to the Private Secretaries to the Chancellor, the Chief Secretary, the Minister for Health and Sir Roy Griffiths; to Professor Griffiths and Mr O'Sullivan at the Policy Unit; and to Richard Wilson at the Cabinet Office.

Yours sincerely,

Geoffrey Podger

G J F PODGER
Private Secretary

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MOVING TOWARDS SELF GOVERNING HOSPITALS

Note by the Secretary of State for Social Services

The attached paper sets out a practical way forward towards our goal of giving hospitals greater freedom and responsibility for managing their own affairs. It differs in a number of respects from my earlier proposals for a buyer-provider model, particularly in the way that hospitals would continue to operate within the present framework of overall planning priorities and resource constraints set in general by the Government and in detail by health authorities. But it is still aimed at creating in due course the conditions in which hospitals operate within market disciplines rather than top down controls. This is the crucial change.

2. The main features of my revised approach are:

first, the emphasis is on building up the responsibilities and capabilities of the individual hospital for running its business and on involving doctors in the allocation of resources.

second, the process of change will take time. Hospitals generally have neither the necessary information nor the management capacity to move directly to self governing status.

third, as part of the process of change the present health authority structure would be slimmed down, so that overall we reduce bureaucracy.

3. It is important that we are able to fit GPs into the new arrangements. The proposals achieve this. I see no need for any reduction in the present freedom of GPs to refer patients to hospitals. Indeed they will have better information about where to refer patients. There will also be better local control of what is happening, because GPs will have a closer relationship with health authorities.

4. An important element in the process of change will be trying out the new arrangements on a pilot basis. I have in mind that we might:

* encourage a selected group of hospitals to apply for greater freedom e.g in staffing matters under the control of boards of management

* try out the "contractual" model of service planning in a selected number of district health authorities.

* invite a regional health authority to expand the trading of hospital services within that region.

June 1988

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MOVING TOWARDS SELF GOVERNING HOSPITALS

Introduction

1. This paper outlines a framework for giving hospitals greater freedom and responsibility for managing their own affairs, building on existing initiatives within the service. The paper puts forward a model for self governing hospitals as the end-point of an evolutionary process, and outlines an action plan for getting there. The paper sets out:

- the scope within the existing system for devolving more responsibility and freedom to hospitals, as a key precursor to self government;

- the consequential slimming down of the health authority hierarchy;

- the main features of self governing hospitals compared with the existing system; and

- a practical evolutionary path which leaves room for experiment and initiative, without imposing a monolithic solution.

Increased freedom and responsibility

Building up the hospitals

2. The present thrust of development in the NHS is to devolve management responsibility to the lowest level. This driving down of responsibility lies at the heart of the new framework for the hospital services. It needs to be continued and developed along three lines:

- build up the responsibility of hospital management (including clinical staff) and ensure that they have the information they need to control the resources they use;

- make specific services subject to "contracts" between DHA and unit;

- introduce greater flexibility and freedom for hospital management in the access to, and deployment of, the key resources, capital and manpower.

3. The first of these developments is already under way in the resource management initiative. The information aspects of the initiative will be described in more detail in a separate paper. The fundamental aim is to give clinicians, as the main users of NHS resources, responsibility for, as well as power over, those resources. This needs to be embodied in a new contract for consultants, which is discussed in a separate paper. Clinicians will therefore be accountable for the way resources are used, and will have detailed, timely and accurate information on patients and the costs attributable to their treatment. Thus, for example:

- doctors will be answerable for providing the most cost-effective treatment regime;

- managers will be able to identify the more efficient units for expansion;

- it will be possible to decide in a more informed way whether to provide a service in-house, or to buy it from a neighbouring hospital.

4. Secondly, the introduction of a "contractual" style of management between DHA and hospital would make more explicit the respective responsibilities of the DHA and the unit. This would build upon the availability of effective management information in the hands of those who actually deploy resources. For their local "baseload" services, hospitals would be committed to agreed performance targets in terms of the level and quality of the services they provide, including waiting times. Correspondingly, DHAs would be committed to a level of funding which reflected the targets set. "Contracts" with both the "home" and other DHAs - and with the private sector - could be introduced specialty by specialty for services beyond the "baseload", concentrating mainly on elective surgery. Thus for example:

- non-achievement of (or indeed exceeding) set performance targets would be apparent not only to managers on both sides, but also to GPs and patients;

- "contracts" would provide the basis on which hospitals, on their own initiative, could extend their services to other DHAs, or to the private sector;

- GPs' freedom of referral would be maintained within firm overall expenditure limits by retaining funds specifically for special or ad hoc referrals not covered by the main contract(s). Balancing GPs' freedom against firm management control is important, but in practice that freedom is already heavily constrained by growing reluctance to accept "out of area" referrals. The "market" approach will open up choices for GPs and patients.

5. Thirdly, to match the greater control of resources flowing from better information, and the greater commitment to specific performance arising from the "contractual" approach, hospital management could be given more freedom, within a reformed Whitley system, to set local pay and conditions. Regional pay, and pay flexibility, are already under consideration; reform of the

consultants' distinction awards is discussed in a separate paper. Further detailed work will be needed on the extent of flexibility - especially over pay - which would be possible. However, for example:

- skilled staff could be deployed in new ways to meet service needs, and non-medical manpower could substitute for junior medical staff in supporting roles, subject to necessary professional, ethical and legal considerations;

- more flexible pay could be offered to attract or retain key staff involved in delivering important service "contracts";

- enable pay to match local labour market conditions, which might result in reduced costs.

6. The scope for increasing hospitals' freedom over capital is subject to further discussion between Treasury and DHSS officials.

Slimming down the health authorities

7. The devolution described in paragraphs 2 to 6 would represent a shift in responsibility from RHAs and DHAs to the hospitals themselves. As a result, DHAs would have fewer operational management responsibilities, and could concentrate more on the procurement of comprehensive hospital and community health services for their resident population - and for the GPs who refer patients to these services. This brings closer together the new functions of DHAs with the present ones of FPCs. It would therefore be possible over time steadily to reduce the number of DHAs by around a half, and to combine their functions with those of FPCs in a smaller number of geographically larger authorities. These combined authorities, referred to as "DHAs" for the rest of this paper, would contract with GPs much as the FPCs do at present.

8. RHAs too could devolve further responsibilities and contract out others. The net result might be that both RHAs and DHAs would each employ about half the number of staff. Most of the costs would devolve upon the hospitals in the first instance, but their concentration at that level, together with the scope for competitive tendering for a wide range of support services, should bring about significant net savings. RHAs would retain responsibility for health service planning and for ensuring the effective provision of specialised services, and of funds for capital investment. RHAs could ensure adequate provision of training posts by placing contracts with hospitals for specified training services, the price reflecting the overheads incurred. In addition, they would continue to serve as a bulwark against unnecessary Ministerial involvement in operational controversy. It might be possible over time to reduce the number of RHAs, perhaps to ten.

9. The resulting management regime needs to be considered from three viewpoints:

Funding would continue to flow from DHSS via RHAs to DHAs on a population-based formula. Most hospitals, and most services, would be planned, funded and managed by the DHA on the basis of "contracts" with the hospitals.

Capital would continue to be allocated by the health authorities according to their strategic plans, but if hospitals were required to meet capital costs this would both bring economic criteria to the fore, and involve hospital management more closely in capital planning. Any development of charging for capital would imply corresponding increases in revenue allocations recovered via receipts. Hospitals would have some scope for accumulating reserves which they could apply to minor capital projects.

Accountability for the use of resources, and for delivery of services, would continue to flow up the management line to the Secretary of State.

Self government

Statutory independence

10. Most of the initiatives described above are under way to some degree. They all develop, but remain within, the existing constitutional structure of the NHS, with hospitals (other than the London Post-graduate Teaching Hospitals) as operational arms of the DHAs, both being subordinate to the RHAs. The key break with the existing pattern of health service management would be to form each hospital into an autonomous organisation - a self governing hospital.

11. This would require the creation of a statutory Board of Management for each hospital. The Board of Management could comprise the key members of the hospital management team, plus two or three "non-executive directors" drawn from business and the community. Further consideration would be needed as to whether the Secretary of State should have a role in the appointment of board members, in particular the chairman.

12. The board of management would be a formal legal entity which would be empowered to employ staff, enter into contracts with health authorities and private health insurance companies etc, and hold financial reserves. By comparison with the developments described above, the self governing hospital would, for example:

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- in principle, be free to grade, deploy and pay its staff - including consultants, who would also be hospital employees - as the board thought fit, bound only by arrangements to safeguard training to ensure a continued supply of skilled professional staff. However the need for additional constraints on pay would need further detailed consideration;

- be free to enter joint capital ventures with the private sector, and to allocate the funds earned through contracts to "revenue" or "capital" expenditures at will;

- be free to develop new packages of services which take advantage of technological advance, or meet new demand.

- be free to sell their services to whichever DHAs (or RHAs, for regional specialties) needed them, or to private sector health insurance companies;

13. Thus for fully self governing hospitals:

Funding would flow from DHSS to RHAs on the basis of their resident population. RHAs would allocate funds to the DHAs according to strategic plans. At both stages, funds for supra-regional and regional contracts with self governing hospitals would be held for payment direct to the hospitals. DHAs would use funds to provide those services for which they remained operationally responsible, and to finance their contracts with whichever self governing hospitals could provide the best packages of services. Contracts would be contestable by other public and private sector hospitals.

Capital assets used by a self governing hospital would remain in public ownership. The hospital would charge through its contracts for its use of these assets. Subject to RHA approval (to prevent asset-stripping) the board of management could dispose of assets and re-invest the proceeds in new developments. Funds for new investment would be available from the RHA's capital programme, according to priority, and

to meeting the capital charges from their own resources. Self governing hospitals would also be free to allocate their own resources from contract income to capital investment.

Accountability for the delivery of services would flow from the self governing hospital to the DHA or other authority which placed the contract for the services. The hospital would be subject to the usual market disciplines. As regards the hospital's use of public assets, the board of management would be answerable via the RHA to the Secretary of State.

14. Not all the 1800 hospitals in England would be suitable for self governing status. 750 of them have fewer than 50 beds, and many are in practice closely interdependent. The hospitals fall within 600 or so management units. Some units could become self-governing as they stand; others might sensibly be subdivided. Yet others would not fit the self governing mould, and DHAs would be likely to retain operational responsibility for their services, perhaps especially community and public health functions and at least some psychiatric services. DHAs would also need to ensure, both by operational management (where appropriate) and by contract planning, that the necessary integration of hospital and community-based services was not undermined. The DHAs would deal with self governing hospitals on the same basis as they would with private sector hospitals: as contractors providing a service. They would nevertheless be expected to plan local services in close cooperation with the boards of management, and might need reserve powers for use if necessary to ensure that a basic range of core, local services were maintained.

Legislative implications

15. Although existing legislation provides for special health authorities to be created by Order of the Secretary of State (and this is the constitutional model of, for example, the London Post-graduate Teaching Hospitals), it would be preferable to introduce into primary legislation the new statutory model for the hospital management boards. This would set them apart as entirely new bodies, and in particular, would avoid the presumption

of direct funding by DHSS. Primary legislation would also be needed to empower health authorities to cross-charge for services, and thus to establish the scope of the "internal market".

16. Minor changes to the health authority network - for example amalgamating authorities - could be made by secondary legislation. However, more radical change, such as combining the functions of FPCs and DHAs would require primary legislation, as would changes to the representative nature of membership of DHAs (for example, local authority members).

17. It follows that the gradual or experimental introduction of the changes proposed in this paper would need to be carried out - and would be best understood - within the framework of enabling primary legislation which would open up an evolutionary path for the new NHS.

A practical evolutionary path

18. Having set out the main features of self governing hospitals, and the freedoms and responsibilities they would enjoy, the task is to plan a practical evolutionary path towards that goal. It would not be possible, nor sensible, to attempt this in one step; an evolutionary approach would be essential. This requires the staged implementation of the various changes outlined above.

19. The risks of such a staged process of change would lie in giving some hospitals additional freedoms (say over pay levels, or over selling additional services) but not others. This could harm the competitive chances of the non self governing hospital eg because they lose their key staff to competing hospitals. Careful planning and regulation would therefore be necessary during the transitional period. The risk of unfair competition would be lessened by introducing full self government in discrete "blocks". Regions would offer the most appropriate framework for such staged implementation, and RHAs would have a key role in planning region-by-region changeover.

20. Managing the transition would be made more difficult by the fact that, under the existing system, hospitals have no "personality" at all. There would therefore be no formal "body" which, at the outset of transition, could participate (on the hospital's side) in the orderly introduction of full independence. It might therefore be advantageous to introduce the Boards of Management early in the process. In this way, the hospitals could be "up and running" in a constitutional sense, during the "building up the hospitals" phase described in paragraphs 2 - 6, but before they achieved full self government. RHAs would then be dealing with experienced and semi-autonomous bodies during the region-by-region implementation of fully self governing hospitals. A further advantage of early introduction of Boards of Management would be that it would be a visible and popular signal of change.

21. In summary, an action plan for the development of self governing hospitals might be in four overlapping phases:

Phase 1: complete the introduction of devolved management and information systems.

Phase 2: create Boards of Management for all hospitals.

Phase 3: allow regions to introduce the "contractual" model of service planning and management, applying it first to "baseload" services for the "home" DHA and then extending specialty by specialty to elective surgery for other DHAs. Hospitals would win funds according to their performance under these "contracts", in line with an internal market.

Phase 4: allow regions successively to implement self governing status for their hospitals, ensuring an orderly introduction of greater freedom to deploy their resources as they judge appropriate. For these hospitals the contractual framework would become the means by which DHAs paid for hospital services.

22. The path through these steps might well be quicker in some regions than in others - and in any case the phasing would necessarily overlap. The key would lie in appropriate experimentation, rather than the "big bang" introduction of a new system.