PRIME MINISTER (1)

I passed on to Kenneth Clarke's office your message when you learned that he had been planning to stay in Spain until the end of next week.

I understand that Mr. Clarke now intends to be back in this country on Sunday 28 August. He and Mrs. Clarke would thus be available to come to lunch at Chequers on Monday 29 August if you still wished. Although he has not of course had a chance to talk to the various contributors to the NHS review since taking up his new job, I understand he took a lot of the papers with him on holiday and has fairly clear in his own mind his reaction to the ideas which have so far been floated.

On that basis do you want me to extend again the invitation to Mr. and Mrs. Clarke to come to lunch at Chequers on Monday?

Yes

DOMINIC MORRIS

24 August 1988

re draft JLR 11 August 1988

INTRODUCTION

1. A three-year experiment in the USSR, launched in April 1988 as part of the effort to promote Health for All, concerns the financing of health care services in three locations, one of which is the City of Leningrad. The aim is to improve the quality, effectiveness and efficiency of the public system of health care by means of economic incentives.

In this experiment the City health budget is allocated to the primary care polyclinics, according to the number of people living in their territories. Out of this budget the polyclinics provide their own primary care services and pay specialized polyclinics, emergency services and hospitals for their services according to price lists negotiated with the City health department.

The specialized care institutions, therefore, do no longer receive a budget of their own but receive income as they provide services to the primary care system. Otherwise the system of health care provision itself is unchanged and continues to adhere to the Leninist principles of public health.

The experiment concerns the public sector, where services are rendered without charge to the population. It does not yet include the workplace based services nor the maternal and child health services which are organised separately in the USSR.

The experimental system was examined by a WHO expert team involving discussions at the All Union Ministry of Health and the Public Health Department of Leningrad, and through visits to hospitals, polyclinics and emergency services in Leningrad. A seminar for All Union and Republic ministers of health was briefed on the findings of the WHO team and raised some questions regarding the adaptability of the experiment to all other parts of the country.

The experiment is a major innovation in health care financing in Europe that will attract considerable international interest. It also gives rise to certain issues if the experiment is to achieve fully its intended results in improved quality and efficiency of health care and better health for all people.

The Leningrad experiment: major aspects

2. The Soviet Union has built a national health care system based on Leninist principles: it is free of charge and generally accessible to the public, it emphasizes

prevention, it is based on the unity of science and practice and it solicits the active participation of society in health development.

The Leningrad experiment, covering a region of about 5 milllion population, introduces "supply side" incentives and prices for services that will continue to be provided publicly and free of charge. The aim is to make every nurse, doctor and administrator conscious of the cost and quality of services. The original Leninist principles are fully maintained.

In parts of the USSR system not included in the experiment, local health departments allocate budgets to polyclinics, hospitals and emergency services (See Fig. 1). The existing system has succeeded in providing a comprehensive health service to all sections of the community. However, certain issues have arisen within the general framework of perestroika.

The traditional system tends to encourage polyclinics to refer more patients to hospital than is necessary. There is also little economic incentive in hospitals and polyclinics to review the quality and effectiveness of care. Neither polyclinics nor hospitals gain financially from reducing the cost of treating individual patients. This situation can lead to inefficient use of, and continued excess pressure for, resources such as beds, staff, equipment and buildings.

Polyclinics may ask patients to come back more often than is necessary and hospitals may keep patients unnecessarily long in bed. Health departments may be so busy with routine managerial issues that they have little time to deal with longer-term Health For All strategies. Systematic incentives in favour of prevention and promotion are weak.

The Leningrad experiment introduces a new financing system (Fig.2): the primary health care polyclinics receive a Capitation based budget i.e. directly related to the number of inhabitants in their territory. For any patient referred to hospital the polyclinics pay the hospital a price according to an established list of prices per admission; no extra price is paid for readmissions to hospital that are due to low quality of hospital care.

Emergency ambulances are similarly paid on a fee-for-service basis. The present price list for inpatient care covers 37 medical specialties and a few separately identified high-cost cases; it is under continuous review by the health department and a list for day surgery has also been drawn up. In the near future there will also be price lists for payment to the

specialized polyclinics covering places of work and providing services beyond their immediate local population and to some other specialized institutions.

Once the experiment is fully implemented, the primary polyclinics will receive virtually all of the funds which the health department has at its disposal. 74 Roubles per person per year in 1988/89, which conforms to the national average. The hospitals which previously received about 80% of the city health budget, and the other specialized services, no longer have a budget allocation of their own.

The experiment was prepared carefully, with discussions, negotiations and briefing sessions with all concerned, including the population, 5-6 months prior to its official start in April 1988.

Both polyclinics and hospitals will now have a strong incentive to produce a surplus (the income of the institution minus its expenditure), since they will be allowed to retain these funds for staff bonuses and improvement of staff facilities. Thus any increase in outpatients and inpatients staying excessive periods, will now constitute higher costs rather than an excuse for requesting increased budgets.

It is expected that polyclinics will become more self-sufficient, increase their own ambulance services, strengthen services for the elderly and chronically ill, and introduce out-patient surgery. Hospitals are expected to receive fewer patients that are more severely ill or require more specialized care, reduce the length of patient stay and strengthen day surgery, and give better quality of care to avoid re-hospitalization.

Surprisingly, the discussions leading up to the experiment and its very start have already achieved appreciable improvements in efficiency. The decreased number of hospital referrals and the decreased length of stay (from 17.6 days including psychiatry to about 12 days) have made about 7000 beds redundant and have allowed the transfer of some staff to polyclinics. Polyclinics in turn have been merged into bigger units.

These changes are not required to be approved at the Republic or All Union levels as the polyclinics and hospitals have delegated powers.

Physicians at different levels are already deeply immersed in negociations regarding patients, prices and costs. Participants in the experiment appear to be quite enthusiastic, while aware of the difficulties ahead.

LOCAL HEALTH CARE IN THE USSR

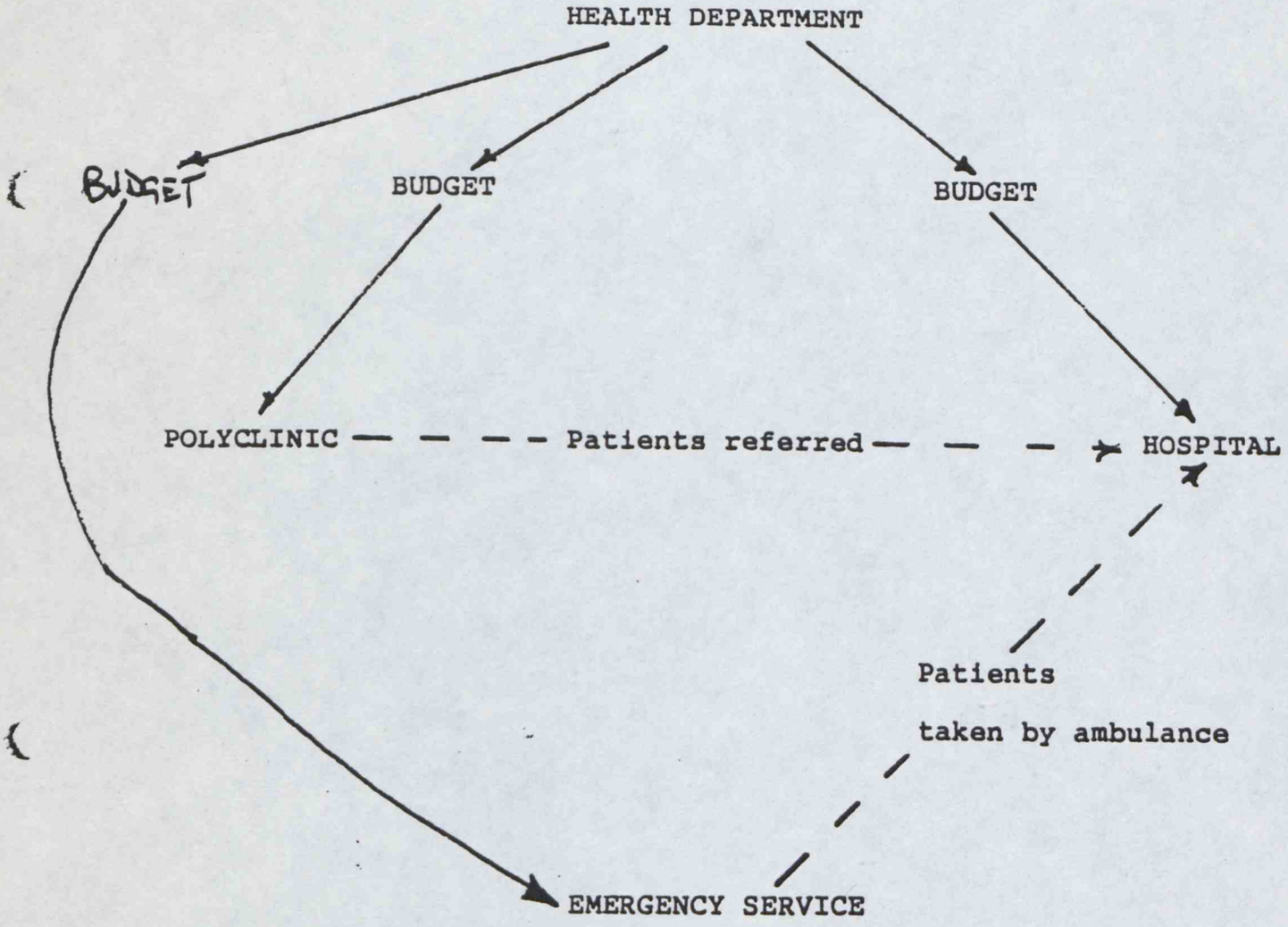

Fig. 1

HEALTH CARE IN THE LENINGRAD EXPERIMENT

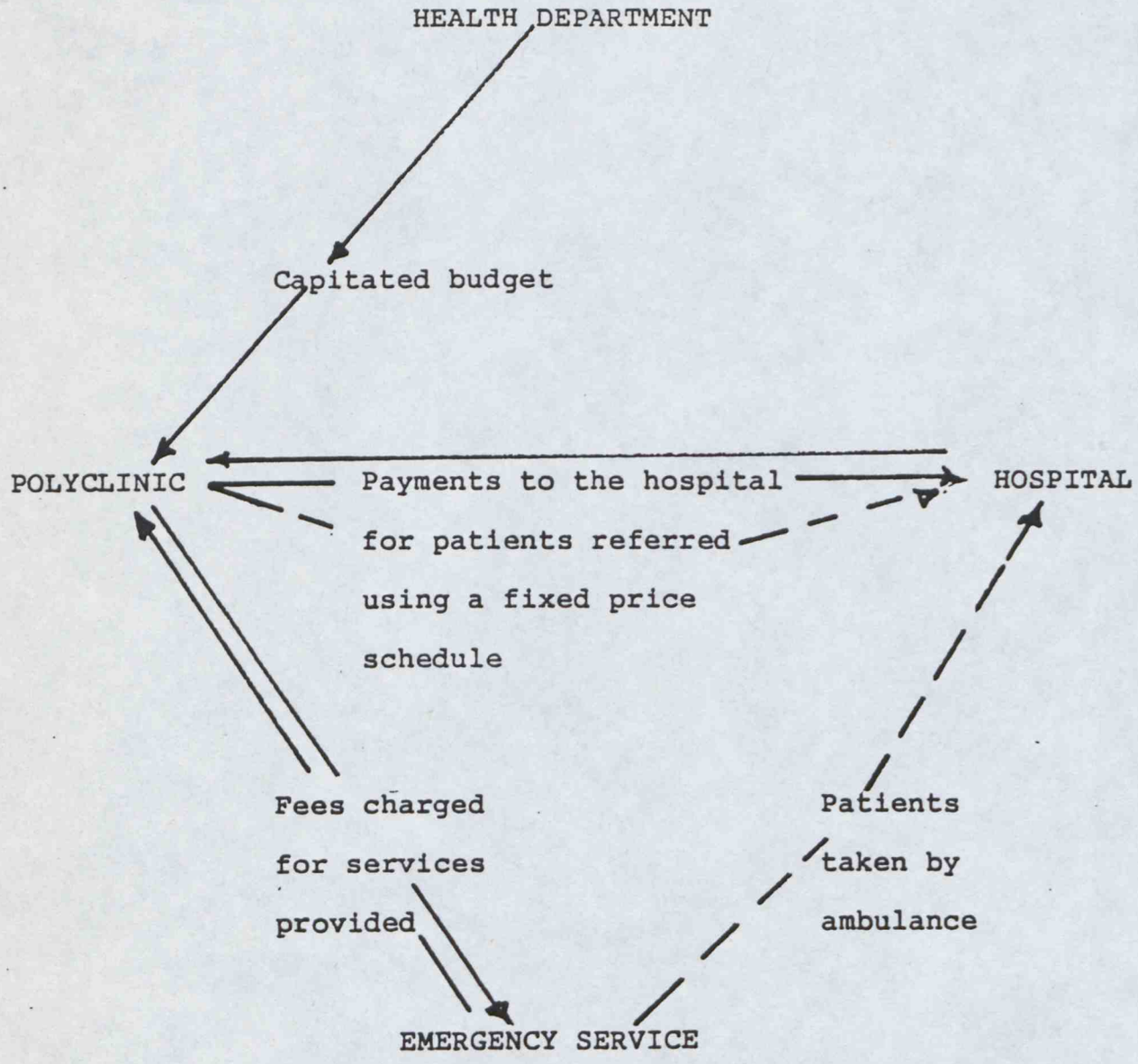

Fig. 2

The experimental system provides many advantages over the previous arrangement, but attention needs to be given to the following issues:

* gaps in the provision of the system as a whole;

* financial arrangements for budget control and management in hospitals, polyclinics and in emergency services;

* planning for the development of future patterns of servics and their volume and quality;

* education, training and research requirements for the future, especially for the extension of the service beyond the experimental areas; and

* international collaboration to assist the experiment, the evaluation and dissemination of its results, and for further research and development.

Health care system and organization

3. The Leningrad experiment could increase the positive impact of incentives by further improving its organization of health services. It is suggested that the primary polyclinics should provide family practice, community medicine and community nursing (see especially Finland, United Kingdom, Norway).

This would increase considerably the incentive for the primary polyclinic to keep the population from falling ill or from exposure to health risks. Health promotion (including co-ordination of the various efforts of industry and other sectors) and disease prevention, as well as basic curative and rehabilitative services, should be the major priorities (see, for example, the North Western Region in the United Kingdom).

The secondary level of polyclinics (territorial or work-based) then could act as a first-referral level, depending on the nature of health risks and problems. Specialist staff could also hold regular clinics at the primary polyclinics (see United Kingdom and Ireland). This secondary level has at present little financial incentive to reduce unwarranted referrals to hospitals, since it is not they but the primary level clinics who pay for these cases. There are several options for overcoming this problem:

* specialized polyclinics could phase in savings from

reduced hospitalization (see Bavarian example in Federal Republic of Germany);

* specialized polyclinics could be integrated into the accounts of hospitals (see outpatient departments in France, Netherlands, Sweden, Finland);

* or secondary polyclinics could be paid according to price schedules which would include an element to cover possible subsequent referral to hospital (see contracts of some hospital maintenance organizations (HMO) with outpatient departments in the United States).

There is in addition a need for better collaboration between work and territory-based polyclinics (see the Gabrovo experiment in Bulgaria). At the moment, hospitals do not sufficiently take into account subsidies received from outside sources such as for research, training and special equipment. Doing so would strengthen the diversification of the hospital system, with higher prices being paid for more specialized care (see Netherlands).

The shift to polyclinic surgery and shorter length of outpatient stay will necessitate good quality control measures regarding procedures, patient satisfaction and health outcome (see Netherlands, Belgium). The emergency ambulance service sector should also be reviewed. The present system relies heavily on specialized physicians going out on the vehicles to attend to patients in the community.

Experience in other countries (Federal Republic of Germany, France, United Kingdom) shows that very few calls really benefit from physician presence if the non-medical attendants are properly trained and equipped. Moreover, the present ambulance system has an incentive to make a large number of calls and hospital referrals without financial responsibility for them.

In many countries (Spain, France, United Kingdom,) ambulance emergency services are part of the hospital sector. In this case, the cost of transportation need not be itemized but would be included in the overall hospital prices. In other countries (example Denmark) they are linked to municipalities, and may be paid a yearly subscription per "standard" inhabitant.

In the present system, direct incentives could be given for admissions to polyclinics or for first aid at home where appropriate. Bonuses could also be given for meeting target response times and for maintaining the survival rate for life-threatening conditions.

Financial aspects

4. In order to control and monitor the Leningrad experiment the financial information system at the hospitals and polyclinics need to be developed. Information on quality of care and outcome also needs to be collected routinely to assess performance.

National health systems generally in the Soviet Union and elsewhere have not previously considered it important to trace the cost of a treated patient with a specific disease; appendicitis, acute myocardial infarction, inguinal hernia. The hospitals have had annual budgets to be spent regardless of the kind of patients treated. But many national health services are now developing diagnostic related financial information systems.

The Leningrad experiment requires the hospitals and polyclinics to develop better methods of costing patient care and measuring service requirements (lab tests, X-ray, nursing days, drugs, procedures etc.) for each patient.

A rather new development in this respect is the so-called diagnosis-related groups or DRGs, which is a way of classifying patients according to the types and quantities of hospital service required. Each category of cost (or DRGs) represents a class of patients requiring similar sets of hospital services.

The standard DRG system consists of about 475 different DRGs. In a great number of European countries there is a strong interest to study this approach towards a better output measurement (SWE, FRA, POR, UNK, IRE, NOR, FIN, DAN, AUS, CAN).

It should be noted that the DRGs could be used for different purposes: planning, budgeting, review of clinical activity and as a basis of payment.

In the Leningrad experiment a price-list of 37 patient classifications has ben developed. The prices, which at the moment are based on the average length of stay, are a promising and important first step towards a better cost accounting system. The prices vary from 17 Roubles for an abortion to 550 Roubles for orthopaedic patients. It is understood that the current price-list is not considered fair for certain diseases. One notable example of this was the cost of a patient with extensive burns which cost much more to treat than the price allowed in the current price-list.

A good way to elaborate a revised price-list would be to consider the DRGs as a basis for payment.

In order to get the price system accepted it is very important that both those who pay and those who provide care consider the prices as fair. To achieve this the prices have to be negociated with the medical staff both at the hospital and polyclinic level.

The final adjustments would have to continue to be decided by the Department of Public Health to provide some standardisation, but competition between hospitals could be encouraged especially where spare capacity allows a hospital to develop a marginal pricing system to use up that capacity.

DRGs permit a number of relevant management activities, e.g.:

Economic

* utilization review (explanatory)
* cost control
* hospital budgeting
* hospital planning

Medical

* profile analysis (review of care and service required by patients)
* retrospective monitoring of utilization patterns.

Financial

* prospective reimbursement by fixed cost per DRG.

Other issues to be considered include the following:

1) There is an urgent need for polyclinics to monitor the cost of their own services (FRA, ITA)

2) Medical records need to be kept and accounts need to be related to these, so that prices charged for inpatient services can be checked against the records of patients to whom they relate. Independent audit may be required (USA).

3) How often should prices be changed? (annually, see USA)

4) The DRGs could be used in programming budgets (e.g. DRGs belonging to cardiology could be lumped together (NET), DRGs including programming budgeting

could be integrations into medical care programmes, or medical care protocols (all Scandinavian countries).

5) How to cope with external funding for certain capital equipment. Ideally it should be included in the health budget (FIN).

6) Internal pricing. With programme budgets, ancilliary services such as X-ray, laboratories and intensive care are not allocated a budget of their own. This is sometimes called a zero-based budget. It means that the clinical services, which are allocated budgets buy services from the ancillary departments.

7) Developing budgets on these lines requires the involvement of accountants and economists working with the hospitals and the polyclinics.

Development of services

5. The basis incentives to improved efficiency at hospital and polyclinic level will need to be supplemented by continual review of the effectiveness of care and equality of access (See UK, Sweden, France)

Criteria for measuring quality and effectiveness should be established in a way which is acceptable to clinical staff. Criteria should be agreed for each of the different specialty and diagnostic groups that are separately identified in the pricing schedules. The criteria coulld include case fatality rates, wound infection rates, and other case morbidity characteristics. Eventually the criteria should include case survival rates with measures of the quality of life enjoyed by patients as a result of the medical care received. Quality-adjusted life years, QALY's, are one index which might be applied (See the UK).

The monitoring of health care services should be undertaken within the context of monitoring community-wide mortality and morbidity from specific diseases. The potential for preventing disease and promoting health to avoid unnecessary demand for costly health service provision, should become a normal part of the system, directly used by polyclinics in management and in the setting of priorities.

Option appraisal should be used to review choices in using any surpluses achieved by polyclinics and hospitals when planning the use of liberated resources.

Proposals for expanding the range and quality of services

should be similarly appraised using economic and health criteria, taking into account national and local priorities.

Consumers have an interest in health service efficiency. Their views have not been adequately included in the experiment so far. This will require different approaches in different parts of the country to ensure that local perspectives can lead to te kinds of services that local people would like to see.

How far polyclinics can jointly plan their health services with other sectors of the community will need to be explored. Joint planning should be undertaken with factories, offices and other places of employment, but also with those producers of goods and services which affect health.

Incentives, penalties and systems of re-charging, may need to be introduced as a means of reducing the ill health produced by other sectors. With the experimental system in Lennigrad such influences on health will be seen by the health services as a preventable cost. Health needs to be given a higher priority in other sectors. They have an important contribution to make to the prevention of disease and the promotion of health. The health services, especially the polyclinics, should seek to stimulate and perhaps co-ordinate a new attack for the prevention of disease and the promotion of community health (See UK, Canada, Australia, Norway, Finland, France).

Training, education and research

6. The main training and education needs arising from the Leningrad experiment are:-

* Technical training in financial accounting, record keeping and statistics for the staff involved in the pricing system, charges, and referrals, employed in the polyclinics and hospitals (See USA, France. Sweden-after 1989)

* Training for medical and non medical staff in the interpretation of management accounting information (See USA, France, UK)

* Training of academically trained economists at all levels of the new service to increase and improve their contribution to the efficient working of the system (See Netherlands, UK)

* Medical education and re-education in the clinical aspects of the impact of the system on medical

practice and the pattern of care (See Sweden, UK)

* Management training and health economics training to assist in the dissemination of the system to other parts of the country (See Pan-America, Sweden, UK). A teaching package with case study material based upon experiences from the experimental locations should be produced

* Publicity should be produced for international dissemination of the material and ideas (See Australia, UK, USA)

Research should concentrate on:-

* Measures of quality and effectiveness (See France, Sweden and the UK)_

* Efficiency of incentives and the points at which they produce diminishing returns (See UK and USA).

* Robustness and adaptability of the system to other parts of the Soviet Union.

* Impact on staff recruitment and attitudes.

* Acceptability of the system to local people and to patients (See UK).

* Impact of the system on clinical care and the training implication for doctors and nurses (See Denmark and UK)›

International collaboration

7. It is suggested that it would be worthwhile to establish a USSR/WHO Project to help the development of the international aspects of the Leningrad experiment and the other pilot projects being undertaken in the Soviet Union. The use of Leningrad as a "pilot region for the management of policies for health", could serve to focus and enrich overall WHO collaboration with the USSR.

The aim would be to promote scientific and practical solutions to the challenges identified in the experiment within the context of the promotion of the policy of HFA 2000 in the USSR.

Collaboration would encompass:-

* research studies

* exchange of scientists and managers (utilising

Leningrad's network of twin cities in Europe)

* health economics education and training for staff in the Ministry of Health and in the Leningrad Department of Public Health.

* participation in expert seminars organised with WHO in the USSR and elsewhere

* exchange of information

Finally, it is recommended that a similar team of experts participate in the overall evaluation of the experiment in 1989-90 and advise on the best ways of adapting the experiment to meet the needs of other parts of the USSR and other parts of Europe.

JLR redraft
August 1988.

Summary of conclusions and principal recommendations

1. The experiment in Leningrad is one of major international significance in the testing of health care finance and management ideas.

2. The use of economic incentives to stimulate health service staff to make the best use of resources and to improve the quality and efficiency of services, appears to be working well; it adheres to both Leninist principles and to the new policies on restructuring and delegation of responsibilities away from the centre and to local people.

3. The senior staff at the polyclinics and the hospitals that we visited are keen on the new system and well briefed on the way in which it is intended to work. They want to see it succeed.

4. The experiment does not provide any new incentives for encouraging local people to keep themselves fit, to avoid preventable disease, or to use the health services efficiently.

5. The continuing arrangements for the emergency ambulance services are an anomaly in the experimental services: the polyclinics pay for these services but have no means of controlling them.

6. The new system puts fresh responsibilities on senior staff for the management of the business aspects of the services: they are committed to making the new system work, but they have had no training for the important new tasks which they have to undertake. There are particular problems for them in developing:- economics, accountancy; service planning; manpower planning; training; redeployment of staff; organisation development, etc.

7. The evaluation of the experiment presents formidable challenges. Judgement about its success will need to depend upon many views; its extension and modification to suit other parts of the USSR and perhaps countries beyond will depend upon local perspectives, assisted by some further independent advice.

8. It was not clear to us how local consumer views were being brought into the management and planning process. They should be a vital part of the evaluation. We were impressed by the way in which consultation before the start of the experiment hed involved local people and that there are some current examples of patient satisfaction surveys going on.

Principal recommendations

The WHO mission make the following principal recommendations drawn from the many comments and suggestions in the body of the report:-

* The pricing system for hospital services should be extended on the lines of the Diagnostic Related Index used in other countries (DRGs)

* Programme budgets should be introduced to assist in the management of hospitals and polyclinics

* A new financial information system should be developed for the experiment with a view to subsequent use throughout the USSR. It should relate expenditure to individual patients and DRGs; it should be used as part of utilisation review, which should be adopted for all services

* Polyclinics should have financial information systems for reviewing the efficiency of their services; similarly this should be based on patient records and patient related service expenditure.

* Consideration should be given to bringing the emergency ambulance service under the management of the polyclinic directors; the extent of specialisation in the emergency service should be reviewed; international comparisons should be helpful.

* Internal pricing of services within facilities should be introduced; competitive pricing between facilities should be considered; the use of marginal pricing should be tested to use up short term under-used capacity.

* Social surveys on the health and health behaviour of local people should be introduced as a routine planning and evaluation tool; they would be useful for detecting unmet need and for assessing patient satisfaction and community opinion of the new services.

* Option appraisal techniques should be developed to assess the best use for liberated staff and other resources arising in the new system.

* Retraining and education of staff is a major priority if the new system is to realise its full potential and if those in the Leningrad experiment are to assist in the next stages of its development to other parts of the USSR

* Further public education will be important as the new system creates the opportunity for major changes in the pattern

of local services. People will need to understand the reasons for changes and will want to contribute to the debate about the options for the future

* Information about serrvices across the Soviet Union and in other Eastern European countries will be helpful in further education of staff and in the promotion of changes elsewhere relevant to local circumstances; investment now in gathering such comparative data will be an key element in such processes.

* Incentives and penalties should be considered to encourage health cosciousness and initiatives in disease prevention in other sectors of the community whose activities affect health

* Training in health services management should be extended to all people with a managerial role; opportunities for career development should be created early for potental top managers.

* Research should be established into the quality and effectiveness of services and the results used in the management training programmes.

* International colla boration should be fostered; there is much to be gained by all parties; there will be considerable international interest in the experiemnts in the USSR and the impact of this should be anticipated.

* Further international assessment and support for the experiemnt and its extension across the USSR should be developed with WHO, as part of a broader system of collaboration in health service matters.

The members of the WHO mission would like to record their thanks to all those in the USSR who asisted in the visits and discusions upon which this report is based. We were made most welcome and given every possible assistance in our work. The quality of the interpreting service so readily provided was particularly helpful and appreciated by us all.

JLR
Aug 1988

Encl 5

PTO

CLINICAL GRADING STRUCTURE FOR NURSES

GENERAL

The Management Side of the Nursing and Midwifery Staffs Negotiating Council very much regret the attitude of the Staff Side and, in particular, their refusal to continue discussions in the Joint Negotiating Council on the implementation of the new clinical grading structure for nurses. They believe the Staff Side action to be both premature and unnecessary, since no final grading returns have yet been received from Regions, and one that can only do harm to the implementation process. They remain ready at any time to resume discussions.

The structure was negotiated and agreed jointly by the Management and Staff Sides. As the Prime Minister and Health Ministers have repeatedly emphasized, the Management Side's main concern has been to ensure the fair and consistent application of the new structure within both the spirit and the letter of the agreement. That remains the position. There is no question of betrayal or sabotage, or of selling nurses short. The Government have provided the full amount - £803 million - of the estimated cost of the Review Body's recommendations and have allocated this to the Regions. This huge sum is specifically for nurses' pay.

The Managemnet Side are determined to press on with the successful completion of this exercise. It is designed to provide nurses - particularly those in clinical areas - with a proper career structure and with the rewards their skills and responsibilities merit. These objectives remain crucial to the interests of nurses, patients and the Health Service as a whole.

Numbers of sisters going into each grade

The position which the Staff Side are now taking up is at odds with the RCN's own evidence to the Review Body which said:

> "It is likely, however, that a significant proportion of ward sisters will be placed in Grade F and that this will become one of the key career grades"

The position now adopted by the Staff Side would mean that very, very few sisters would be in F.

The Health Departments' evidence was that most sisters would go into G. We are confident that that will in fact be the outcome because:

*in most wards it is clear who is the senior sister and she will be graded at G;

*most posts in the community carry continuing responsibility for a caseload and they will be graded at G;

*It is not just posts that carry continuing responsibility that will get graded at G. There is also provision for clinical specialists for example in high tech areas to be graded at that level;

*All the early returns we have seen suggest that our original estimates were right and a majority will be in G.

No sister will be graded lower than F - none will go into E as some people have tried to suggest.

Range of increases

- wide range of increases covered by average 15.3% award.
- range is 4.2%-33.6% but over 9 out of 10 nurses likely to get between 6.3% and 33.6%.
- the substantial additional funding was made available precisely to cover the cost of a major restructuring of the grading system.
- at the heart of that restructuring is the need to distinguish more clearly between different jobs.
- in the past a vast range of jobs were graded at the same level, particularly at staff nurse and sister level.
- the new agreement means that nurses' grading will more accurately reflect and reward different levels of skill and responsibility.
- clearly this will mean that nurses who in the past have been similarly graded may not all be on the same grade under the new structure and that some will benefit more than others.

Continuing responsibility

The Management Side is in no doubt that the agreement reached with the Staff Side makes - and was intended to make - a clear distinction between the senior sister who has full responsibility for the running of a ward and the nurse who takes charge while she is off duty.

Our interpretation of "continuing responsibility" is that this applies to the person who is responsible for making sure the ward is properly staffed, even when one is not on duty and who sets the policies and procedures which apply throughout the week, across all shifts. There can only be one person who carries this sort of accountability for clinical management and administrative arrangements on a ward, otherwise the term continuing becomes meaningless.

The Staff Side have taken the view that where there are a number of sisters on a ward and no sister post carries the full responsibility, all sisters should receive the higher grading. The Management Side cannot accept that this is what was intended or that it would be in the best interests of the health service or nurses themselves.

The Staff Side interpretation would mean that there would be no financial incentive to take on extra responsibility. That cannot make sense.

More Money?

- An extra £566m (UK) - over half a billion pounds - has been made available for the nurses award this year. This money has already been voted and allocated to authorities. [Total estimated cost, including amount included in original cash allocation £803m];

- This was and remains our best estimate of the additional cost. No better estimate is currently available, despite speculation in various quarters. District returns are still being scrutinized by Regions. Regional returns will be scrutinized by Department. [When that process has been completed, we should know whether our estimates were correct];

- Would be quite wrong to have given authorities an 'open cheque'?

CHANGE OF TIMETABLE

- initial deadline set for completing exercise - 31 OCTOBER - remains ie grading decisions taken and individual nurses informed by that date;

- timetable for regions to submit preliminary returns to Department has been brought forward from end to beginning of September. This is to enable them to be scrutinised for fairness and consistency, and to ensure grading criteria properly applied;

- nothing sinister in this. Designed to meet Staff Side concerns that criteria being misused by some authorities to save money;

- Department's central implementation team will be visiting regions during August to help with their consideration of provisional District returns in interests of fairness and consistency;

Statistics Out of Date

- Review Body estimates take as their baseline health authorities own estimates of numbers of staff in post at 31 March 1988. Similarly the baseline for the funding for agency paybill was health authorities own estimates of what that paybill would be on 31 March 1988. It is hard to see how we could have got more up-to-date figures for a pay award whose operative date was 1 April.

- Estimates do not take account of movements since 1 April 1988 - no provision for growth in the extra money we provided because this is provided for separately in NHS funding.

Encl 5

PSA

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- wide range of increases covered by average 15.3% award.
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- the substantial additional funding was made available precisely to cover the cost of a major restructuring of the grading system.
- at the heart of that restructuring is the need to distinguish more clearly between different jobs.
- in the past a vast range of jobs were graded at the same level, particularly at staff nurse and sister level.
- the new agreement means that nurses' grading will more accurately reflect and reward different levels of skill and responsibility.
- clearly this will mean that nurses who in the past have been similarly graded may not all be on the same grade under the new structure and that some will benefit more than others.

Continuing responsibility

The Management Side is in no doubt that the agreement reached with the Staff Side makes - and was intended to make - a clear distinction between the senior sister who has full responsibility for the running of a ward and the nurse who takes charge while she is off duty.

Our interpretation of "continuing responsibility" is that this applies to the person who is responsible for making sure the ward is properly staffed, even when one is not on duty and who sets the policies and procedures which apply throughout the week, across all shifts. There can only be one person who carries this sort of accountability for clinical management and administrative arrangements on a ward, otherwise the term continuing becomes meaningless.

The Staff Side have taken the view that where there are a number of sisters on a ward and no sister post carries the full responsibility, all sisters should receive the higher grading. The Management Side cannot accept that this is what was intended or that it would be in the best interests of the health service or nurses themselves.

The Staff Side interpretation would mean that there would be no financial incentive to take on extra responsibility. That cannot make sense.

More Money?

- An extra £566m (UK) - over half a billion pounds - has been made available for the nurses award this year. This money has already been voted and allocated to authorities. [Total estimated cost, including amount included in original cash allocation £803m];

- This was and remains our best estimate of the additional cost. No better estimate is currently available, despite speculation in various quarters. District returns are still being scrutinized by Regions. Regional returns will be scrutinized by Department. [When that process has been completed, we should know whether our estimates were correct];

- Would be quite wrong to have given authorities an 'open cheque'?

CHANGE OF TIMETABLE

- initial deadline set for completing exercise - 31 OCTOBER - remains ie grading decisions taken and individual nurses informed by that date;

- timetable for regions to submit preliminary returns to Department has been brought forward from end to beginning of September. This is to enable them to be scrutinised for fairness and consistency, and to ensure grading criteria properly applied;

- nothing sinister in this. Designed to meet Staff Side concerns that criteria being misused by some authorities to save money;

- Department's central implementation team will be visiting regions during August to help with their consideration of provisional District returns in interests of fairness and consistency;

Statistics Out of Date

- Review Body estimates take as their baseline health authorities own estimates of numbers of staff in post at 31 March 1988. Similarly the baseline for the funding for agency paybill was health authorities own estimates of what that paybill would be on 31 March 1988. It is hard to see how we could have got more up-to-date figures for a pay award whose operative date was 1 April.

- Estimates do not take account of movements since 1 April 1988 - no provision for growth in the extra money we provided because this is provided for separately in NHS funding.