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10 DOWNING STREET

LONDON SW1A 2AA

21 October 1988

From the Private Secretary

Dear Andy,

NATIONAL HEALTH SERVICE REVIEW

The Prime Minister held the thirteenth meeting of the group which is reviewing the NHS on 17 October. The meeting considered papers HC46 and HC47, 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 the CMO arrangements.

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

In discussion on self-governing hospitals (paper HC46) the following were the main points made:

(a) It was very important not to tie down self-governing hospitals with needless bureaucratic constraints. The proposals - for instance, that disposals of assets by self-governing hospitals would have to be approved by the Regions - needed to be looked at critically in that light. It was also important to ensure that self-governing hospitals were treated fairly by District Health Authorities when competing with hospitals run by the latter.

(b) The procedure whereby hospitals could become self-governing was too elaborate. The arrangements for consultation in paragraph 44 of the paper and the criteria set out in paragraph 45 might mean that in practice no hospital ever became self-governing, and were not acceptable. It was essential to avoid any consultation process which might in effect give a veto to those who were opposed to the policy. The important thing was to mobilise the support of local people and

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those who worked in the hospitals, perhaps through some active local grouping pressing for self-governing status.

(c) It was important to make early progress with the establishment of self-governing hospitals. Five or six by April 1991 and 30-40 by April 1994 was too slow. The question therefore was what could be done within existing legal powers. It was argued that these powers were too uncertain to be relied on and that action would have to wait until legislation had been passed. But against this there were strong attractions in starting with an existing legal model, such as Special Health Authorities, without waiting for legislation; and then using that legislation to develop the model and take whatever further powers or provisions proved necessary or desirable. This should be explored further.

(d) The concept of self-governing hospitals would need careful public and political presentation, to avoid the false impression that hospitals would be opting out of the NHS, and to retain the support of staff. This was another reason for building on an existing model like the Special Health Authority. The more that self-governing status could be publicly presented as the devolution of responsibility to the local level, the weaker the case would be for an elaborate process of local consultation.

(e) It was essential to make early progress with the discussion between the Treasury and the Department of Health on the treatment of capital. This was relevant to the proposal that self-governing hospitals should be subject to the market discipline of paying charges for their own assets. There was agreement that the hospitals should own those assets, maintain them and finance their depreciation. But the rationale for charging hospitals rent for assets which they already owned needed clearer explanation. It was another area where needless bureaucracy should be avoided.

(f) The proposal that the Government should match £ for £ any money raised locally for worthwile capital investment in a self-governing hospital should be considered further in the discussion on capital. On the face of it, this approach had disadvantages, not least that the Government's liability to contribute would be unlimited. Another approach which might be explored would be to put capital schemes out to auction; or to invite the private sector to build facilities and rent them to the NHS. Whatever approach was adopted, it was important to avoid subjecting capital plans to prolonged, detailed scrutiny by

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central Government.

(g) On consultants' contracts the proposal was that in general these contracts would continue to be held by Regional Health Authorities, but that where a hospital became self-governing the contracts would be held directly by the hospital. The mechanics needed to be carefully worked out. In particular it was not clear how on the one hand consultants would be employed by the hospital but on the other would have their pay determined by the Review Bodies. It ought to be possible, for instance, for consultants to contract to work a certain proportion of their time at a self-governing hospital, another proportion at a DHA-run hospital, and the rest in the private sector, and to be paid only for what they did.

(h) There needed to be discussions between the Department of Health and the Treasury about detailed pay aspects of the Review, both as regards consultants and more generally. It was for instance unsatisfactory that nurses benefited from having both a Review Body and a Whitley Council.

(i) The proposal that boards of management should include two non-executive members from the local community needed further thought. The important thing was to have boards which would ensure that the hospitals were efficiently managed. There was a risk that the proposals for community involvement would run counter to this. It might be possible to avoid the worst pitfalls by drawing the representatives from non-political organisations (e.g. the "Friends of the Hospital") and by specifying that there should be "up to" two representatives. But the responsibility for looking after the interests of patients rested ultimately with GPs who if dissatisfied could advise their patients to go elsewhere. There were objections to the idea of "hospital clubs" for similar reasons.

(j) It was essential that the board of management should include a strong financial director of the hospital. The appointment of executive directors should be a matter for the non-executive directors, not the board as a whole.

(k) The introduction of self-governing hospitals should lead to greater efficiency in running the hospitals and thus to a reduction, not an increase, in their costs. There was no presumption that self-governing status would require more money or more staff.

Summing up this part of the discussion, the Prime Minister said that the Group had already agreed that the

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introduction of self-governing status for hospitals would be an important outcome from the Review. The detailed paper before the meeting had enabled them to make good progress in working out how the new arrangements would work in practice. The Secretary of State should now further develop his proposals in the light of the points made in discussion.

The Group attached great importance to ensuring that self-governing hospitals were free from bureaucratic controls. The proposals needed to be appraised carefully in that light. In particular the procedure whereby they became self-governing was too elaborate, an the Group were not convinced that the proposed consultation process was necessary. It was also important to make early progress with the development of self-governing hospitals. The proposal that five or six should be established by April 1991 was slow. The Group were strongly attracted by the possibility of starting with an existing legal model - probably the Special Health Authority - and using subsequent legislation to develop and add to that model as necessary.

Further work was needed on the treatment of capital. The discussions between the Treasury and the Department of Health should be completed with a view to bringing forward a paper for the next meeting of the Group, covering both self-governing hospitals and those which remained with District Health Authorities. There also needed to be discussions between the Treasury and the Department on pay aspects of the Review, including the position of consultants.

Finally, on the boards of self-governing hospitals the aim should be to create non-political bodies which could get on with the job of managing the hospitals efficiently within a clear financial framework and proper arrangements for medical audit, free from bureaucratic or other needless interference. It was essential that the hospital's finance director should be on the board. The non-executive directors should be the sort of people who could keep a critical watch on how things were going. The proposal for representatives from the local community needed further thought in the light of the discussion.

In discussion of paper HC47 on budgets for general practice, the following were the main points made:

(a) There were three main areas where action was needed to bring costs under control. One was outpatient referrals: the paper proposed that these should be included in GP practice budgets for those practices which opted out. The other two were expenditure on drugs and control over the number of GPs.

(b) The paper did not propose including drugs in GP practice budgets, but only that those practices which opted to have their own budgets should have the further option of a drug budget. The argument for not including drugs was that those who ran out

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of money would claim that they were being denied the resources to treat their patients. The proposal would also be opposed by the pharmaceutical companies. On the other hand, there were strong arguments for including drugs in GP practice budgets in the interests of better cost-effectiveness in the NHS. The right way to deal with GPs who over-prescribed was to publish the factual information about their drugs bill, with comparisons for other GPs in the same locality. This information was becoming available to Family Practitioner Committees (FPCs). There would be objections from the medical profession but the Government would have to make a stand.

(c) There was also a strong case for introducing a restriction on GP numbers. The arrangements would need to be worked out. It would for instance be important not to lock out bright new recruits to the profession. But in principle it was unacceptable that there was no limit on numbers.

(d) Another possible area for inclusion in GP practice budgets was expenditure on accident and emergency department spending. Although there was some uncertainty about practicability, there was scope for experiments to see how far this category of expenditure could be included.

(e) It was not clear how the arrangements for GP practice budgets would tie in with the proposals for 'top-slicing' aimed at reducing waiting lists for elective surgery. Discussion so far had been on the basis that this money would go to hospitals, but if GPs were to have budgets for elective surgery it could be argued that the money should go to them. More work was needed to clarify this point.

(f) There was a risk that the patients of smaller GP practices, not eligible for opting out, would spend longer on waiting lists. Large GP practices which opted out would be able to negotiate favourable waiting times in their contracts with hospitals, and other GP practices would suffer accordingly. There might need to be some protection against this. On the other hand, the effect in the longer term might be to encourage smaller practices to join together to form a larger practice with consequent gains in efficiency.

(g) It would be very important for the Government to present its proposals for GP budgets convincingly and to mobilise support for them. There would be attempts to misrepresent them; but, if properly explained, the public would welcome the benefits from greater cost-effectiveness.

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(h) There was a good case for allowing GP practices with budgets to carry forward overspends, as the paper proposed, but the arrangements for reconciling this with public expenditure controls needed further clarification. The important thing was to devise a system which was not too complicated and encouraged underspending, perhaps by allowing the GP to build up a reserve. Whatever the arrangements, the Department of Health would need to be prepared to find extra funds in the event of a real epidemic.

(i) It was likely that the practices which would apply for GP practice budgets would be the best and most efficient ones, and that FPCs would be left with a fair proportion of those which were less good. It was therefore important to have effective arrangements to enable FPCs to influence those practices which did not opt out. In this context paragraph 16 of the Annex was unclear and unconvincing. There needed to be some form of cash-limiting on FPCs, and effective powers for FPCs to pass on the discipline to those practices which remained under them. More work was needed on how this was to be done. The proposal for bonuses in paragraph 20 of the Annex was not acceptable.

(j) It was also important to strengthen the composition of FPCs, and to give them adequate managerial staff, to make sure they could do their job properly. Reducing the professional representation to a clear minority would be controversial but was essential to avoid the conflict of interest inherent in the present system. The other members of the FPC would need to be of sufficient calibre and independence to stand up to professional interests when necessary and to take a tough line with inefficient GP practices. More work was needed on who these people would be, and how the strengthening would be brought about in practice. There was also the question of what arrangements there would be to ensure that FPCs were operating effectively, and perhaps to hear appeals from GP practices which believed they had been unfairly treated.

(k) Overall, the proposals gave a key role to FPCs and in effect were creating a third tier in the structure of the NHS. It was questionable whether this was the right approach. The alternative was to merge FPCs and DHAs, as the Group had discussed earlier. The merits and practicability of the two approaches needed to be weighed up carefully.

Summing up this part of the discussion, the Prime Minister said that the Group were in favour of allowing large GP practices to opt to hold their own budgets, and agreed that these budgets should include the categories of

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treatment set out in paragraph 3 of the Secretary of State's paper.

There were however a number of aspects which needed further work. In particular, there were strong arguments for including expenditure on drugs in all GP practice budgets, with arrangements to publish management information where appropriate. It also appeared that there was scope for experimenting with the inclusion of expenditure on accidents and emergencies. These points needed to be considered further. There were strong arguments for introducing restrictions on the number of GPs: more work was needed on this. It was not clear how the arrangements for 'top-slicing' would take account of GP practice budgets: this needed clarification. More generally, it was essential to devise a system which worked in practice and was not needlessly complicated: the proposals in the paper on overspending and underspending, for instance, needed to be developed in the light of this. It would also be important to prepare the ground carefully for public presentation of the proposals and to mobilise support for them. The Secretary of State should arrange for his proposals to be revised and developed in the light of the discussion.

On Family Practitioner Committees, the proposals gave FPCs a much bigger and more important role than they had had hitherto. They would be responsible for allocating funds to those GP practices which did not opt to have their own budget, monitoring them and calling to account those which were inefficient. The Group were not yet satisfied that the proposals would achieve this. A paper was needed for the next meeting which explained in more detail how the FPCs would be strengthened and would exercise effective control over those GP practices which did not opt out; and which also set out the alternative option of merging FPCs and DHAs.

In further discussion the Group considered what other issues were still outstanding on which decisions were needed. The main areas were as follows:

(a) Medical audit. The importance of medical audit had been a consistent theme of the Group's discussion. A paper was needed on who would carry it out and how it would work. It would also need to deal with the problem that at present consultants could refuse to take part in medical audit.

(b) A package to improve the treatment of patients. The Group had agreed on 8 July that the White Paper should include such a package.

(c) Organisational issues, in particular reconstituting District Health Authorities, Regional Health Authorities and the role of the NHS Management Board. It had already been agreed

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that DHAs and RHAs should cease to have political representation; and there were attractions in using Community Health Councils as a channel for local politicians if the latter no longer held a place on DHAs. The aim was to make the Authorities executive bodies. Amendment of the Public Bodies (Access to Meetings) Act 1960 would probably not be necessary.

(d) A greater role for the private sector. Another theme of the Group's work had been the need to encourage the private sector and blur the distinction between public and private. Competitive tendering (e.g. for clinical services such as pathology and radiology) was one example.

(e) Restrictive Practices. There were many ways in which the NHS was fettered with restrictive practices. The introduction of short-term contracts for consultants in order to reduce waiting lists was one possibility with considerable attraction, as discussed earlier: it needed to be worked up. More generally, there were many areas where changes were needed: for instance, the training of nurses and their working patterns.

(f) Remaining funding issues. The details of 'top-slicing' needed to be worked out. Cross-boundary flows was another important topic.

Summarising this part of the discussion, the Prime Minister asked that papers on these subjects should be prepared for the next meeting of the Group, in addition to the papers on treatment of capital and on Family Practitioner Committees mentioned above.

The next meeting would take place in early November, and the papers for it should be circulated by Wednesday 2 November. The aim thereafter would be to draft the White Paper and submit it to E(A), followed by the Cabinet, before Christmas with a view to publication in mid to late January. The White Paper would need to be a document of some detail which would do justice to the thoroughness of the Review. The treatment of Scotland, Wales and Northern Ireland could only be decided when a draft of the text was available.

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

Yours ever,
Paul Gray

PAUL GRAY

Andy McKeon, Esq.,
Department of Health.