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28 (A-B)

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P 03261

PRIME MINISTER

NHS MEETING: STEERING BRIEF

1. There are eight papers before the meeting. You may wish to accept Mr Clarke's suggestion that the Group should concentrate on four of them, in the following order:

1. Medical Audit
2. Funding
3. Reconstituting Health Authorities
4. Managing the Family Practitioner Service.

2. Full briefs on these papers are attached. All are important and you will want to take the Group through each of them. But the ones which probably need most attention are:

i. the paper on funding which raises some important and difficult issues which are central to the Review, in particular to 'the money following the patient';

ii. the paper on managing the Family Practitioner Service where the issues have been discussed before and need to be settled at this meeting, if possible.

3. A number of the papers quantify the costs of particular proposals and refer to the money which will be needed to implement them. We understand from the Department of Health that these figures are intended as an aid to decision-taking and not as bids for extra resources. You may wish to confirm this with the Secretary of State at the beginning of the meeting.

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4. If there is time at the end of the meeting you may want to spend a few moments on the four remaining papers (on which Mr Clarke has invited written comments). These cover:

Capital
A better service for patients
Public and private sector
Professional and employment practices.

5. You may wish to say that these will be taken at the Group's next meeting but invite any quick comments which can be made at this stage.

i. On capital you may wish to emphasise that the paper - which is long promised - must be at the top of the agenda for the next meeting and must be a full one. Discussions between the Treasury and Department of Health are continuing. The progress report gives an impression that the issues surrounding access to private sector capital are still unresolved.

ii. On professional and employment practices Mr Clarke is proposing a major inquiry into the best use of professional resources in the NHS. You may wish to ask whether, after such a long Review, this is necessary.

6. The Group will also soon need to start considering first drafts of parts of the White Paper. You may wish to ask Mr Clarke when he expects to circulate the first extracts. It will be important to get the style and tone right from the start: so it would be helpful if the Group could see at least a sample at its next meeting.

RTJW.

R T J WILSON
Cabinet Office
4 November 1988

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P 03260

PRIME MINISTER

RECONSTITUTING HEALTH AUTHORITIES

[HC52: Note by the Secretary of State for Health]

1. This paper spells out in more detail Mr Clarke's proposals for reconstituting District Health Authorities, slimming down Regional Health Authorities and revising the role of the NHS Management Board. His proposals reflect earlier discussion in the Group, but you may wish to run through the check list in paragraph 2 to make sure that you are content.

ISSUES

District Health Authorities (DHAs)

2. The Group agreed in July that there was a need to reconstitute DHAs so as to remove their political element. Mr Clarke proposes reducing their membership from 16-19 to 11 (5 non-executives, plus 5 executives, plus a non-executive chairman). Local authorities would lose their statutory right to appoint members. Points you may wish to explore include:

i. consultation. Regional Health Authorities are at present required by paragraph 1, Schedule 5, of the 1977 Act to consult a variety of bodies before appointing members of DHAs, including local authorities, trade unions of staff employed by the DHA and federations of workers' organisations. You may wish to ask Mr Clarke whether he intends to abolish this requirement;

ii. slimming down DHAs. There are 190 DHAs. The administrative costs of their headquarters operations

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totalled £317 million in 1986-87. You may wish to ask whether any savings are possible (eg following the establishment of self-governing hospitals).

Regional Health Authorities

3. Mr Clarke proposes that Regional Health Authorities should be slimmed down but retained to ensure that Ministerial policy is carried out and to oversee implementation of the Review's proposals. Their membership should be reconstituted on lines similar to DHAs. Their functions - other than head office function - should be slimmed down. Points you may wish to explore include:

i. slimming down headquarters. Mr Clarke says that the scope for savings in "head office" functions is modest. But the headquarters cost of all RHAs taken together totalled £110 million in 1986-87. The number of administrative and clerical staff totalled 7,800. You may wish to ask whether there might be rather more scope than he suggests, given that they are not actually delivering health care;

ii. slimming down other parts of RHAs. Mr Clarke says that scrutiny of RHA functions will produce many blocks of work which can be streamlined, delegated to districts or contracted out. You may wish to ask how, and by whom, the scrutiny will be carried out;

iii. net reduction. Mr Clarke says that overall he envisages a net reduction in the staffing and costs of RHAs. You may wish to ask how big a reduction;

iv. future of RHAs. At an earlier stage, the Group envisaged that Regions might ultimately become regional offices of the Department of Health, thus reducing one tier in the NHS. Mr Clarke wants to keep them as "an important buffer between Ministers and the operational level" (paragraph 11). Does the Group agree?

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NHS Management Board

4. The Group has not so far touched on the role of the NHS Management Board. Mr Clarke proposes that the Government should reject the case for an independent Board, divorced from his Department. Instead, he proposes that the Board should continue to deal with strategic and policy issues under Ministerial chairmanship; that the Health Services Supervisory Board should be abolished; that there should be an executive committee chaired by the NHS Chief Executive to deal with day-to-day issues; and that responsibility for the family practititioner services should be brought under the Board. You will wish to check that the Group are content. One important issue is membership of the Board, but you may wish to discuss this separately with Mr Clarke, not at this meeting.

R T J WILSON
Cabinet Office
4 November 1988

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P 03257

PRIME MINISTER

MANAGING THE FAMILY PRACTITIONER SERVICES
[HC51: Note by the Secretary of State for Health.
HC47 also relevant]

1. At the last meeting Mr Clarke was asked to produce a further paper which explained in more detail how he proposed to strengthen Family Practitioner Committees (FPCs) so as to ensure that they exercised tight control over GP practices which did not opt to have their own budgets. You also asked Mr Clarke to set out the alternative option of merging FPCs and District Health Authorities (DHAs) so that the merits of the two approaches could be weighed up. This paper is his response. His position is broadly the same as before. The paper elaborates his earlier proposals and strengthens them in one or two respects.

2. You may wish to take the issues in the order in which Mr Clarke sets them out in paragraph 2 of his paper: that is -

i. drug bills (paragraphs 5 to 10 of the paper). Mr Clarke is opposed to 'indicative' drug budgets for GP practices which do not opt to have their own budgets. He is also opposed to publishing comparative information about the drug bills of different GP practices. Instead, he proposes a regime based on education, better information for GPs and FPCs, an incentive scheme for FPCs, more medical manpower for FPCs and - perhaps the most important point - a power for FPCs to impose financial penalties on GPs who persistently over-prescribe. You will wish to decide whether to endorse this regime, or whether to press for indicative budgets;

why?

ii. referral rates (paragraphs 11 to 14). Mr Clarke proposes completion of a project on information systems in East Anglia over the next two years, which will then be ready for adoption by other Regions. His approach is

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primarily educational but he proposes that FPCs should be given powers to impose financial penalties in cases of persistent over- or under-referral. You will wish to decide whether to endorse this approach;

iii. drug budgets for GP practices which opt to have their own budgets (paragraph 15 iii). Mr Clarke proposes to stick to his earlier proposal that large GP practices which opt to have their own budgets should have a further option of having a drug budget too. The alternative, as discussed at the last meeting, would be automatically to include drugs within all budgets for large practices which opt to have them. You will wish to decide which approach to adopt;

iv. controlling GP numbers (paragraphs 16-22). Mr Clarke wants to wait and see how the profession react to the outcome of the Review before taking a final decision on whether to legislate to control GP numbers. Subject to that, he agrees in principle that the powers should be taken. You will wish to decide whether or not to include the proposed control in the White Paper;

v. strengthening FPCs (paragraphs 25 - 32). Mr Clarke repeats his earlier objections to merging FPCs and DHAs. Instead he proposes to strengthen FPCs by changing their constitution, improving their executive management and making them managerially accountable to Regional Health Authorities. You will wish to decide whether these measures, together with his proposals on drugs and referrals, add up to an acceptable package, or whether to pursue the idea of a merger.

ISSUES

Controlling the cost of prescriptions

3. The main issue for decision is whether the prescription costs of GP practices which do not opt to have their own budgets should be subject to some form of 'indicative' drug budget. Mr Clarke is opposed to this. He believes there would be 30,000 GPs

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and their patients protesting that their budgets were too small and that patients were being deprived of necessary medication. There might also be protests from the pharmaceutical companies. You may wish to explore the issues in the light of the following.

i. The scope for savings. The drugs bill is the largest single element (36 per cent) of Family Practitioner Service expenditure. It came to £1,375m in 1986-87, equivalent to £152,000 per practice or £28 per patient. It is expected to grow by 10% pa over the next few years. Visits by the Regional Medical Service to practices whose prescribing costs exceed the local average by 25 per cent have on average produced £10,000 per practice in the first year. Mr Clarke offered savings of £15m in 1989-90 and £20m in 1990-91 in PES. You may wish to ask whether his department should be aiming higher than this.

ii. Publishing information. Mr Clarke agrees that GPs and FPCs should be given information about prescribing, and he proposes to publish "league tables" of FPC prescribing costs. He does not however want to publish comparative information about the prescribing costs of different GP practices, because not only would the profession oppose it but some patients would prefer GPs who were ready to write a prescription. You will wish to decide whether you accept this argument. It is based on a pessimistic view of patients. Moreover, the question is whether publishing comparative information would have an effect on GPs themselves if coupled with other measures such as financial penalties. The fact that the profession would be opposed to publication of information suggests that they recognise that it would be a powerful weapon.

iii. Financial penalties. Mr Clarke is prepared to give FPCs power to fine GPs who persistently overprescribe. On the face of it this would seem to be open to the same objections as he makes against indicative budgets and publishing comparative information: namely, GPs would protest that their patients were being denied treatment and,

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if it became public (as it might), patients would find out which GPs were generous with prescriptions. Nonetheless financial penalties may well be part of the answer. You may wish to consider whether financial penalties would be more effective if coupled with 'indicative' drug budgets and publishing comparative information.

Referral Rates

4. Similar issues arise on referral rates, except that the problem is more difficult because information about referral rates appears not to be generally available at present. You may wish to concentrate on the following:

i. timetable. Mr Clarke envisages that completing the project in East Anglia will take about two years, by which time the information systems will be ready for adoption by other regions. You may wish to ask whether it is right that nothing should be done to introduce systems in other Regions until East Anglia has finished its work;

ii. educational. Mr Clarke says that the approach "must be primarily educational" (paragraph 14 ii). But the Group's discussion so far has pointed to FPCs operating as an effective discipline on GPs who do not opt to have their own budgets. You may wish to ask when he thinks FPCs are likely to exercise effective control over referral rates under his approach.

GP practices which do opt out

5. At its last meeting the Group saw strong arguments for including expenditure on drugs within the budgets of large practices which opted to have such budgets. Mr Clarke would still prefer to leave it as a further option which large GP practices would be free to take up only if they wished to. You will wish to decide whether to press the point again. The main arguments are:

i. greater flexibility. Including drug bills in all budgets for large GP practices would give them greater flexibility to vire betweeen different items of expenditure;

ii. cost-effectiveness. It would keep up the pressure for cost-effectiveness in the NHS;

iii. benchmark. It would help to establish new benchmarks which could be used in assessing the performance of GP practices which did not get to have their own budgets.

Power to control GP numbers

6. There are two points which you might wish to raise on Mr Clarke's proposal for controlling the total number of GPs:

i. trade restrictions. Mr Clarke points out that the proposal is arguably inconsistent with the Government's general approach to freeing trade restrictions. You might ask whether there would be a case for only controlling the number of GPs in practices which did not opt to have their own budgets. Those practices might tend to be below average in their cost-effectiveness and performance. It might also be a way of boosting the number of GPs in practices which opted to have budgets;

ii. handling. Mr Clarke appears not to want to announce his proposal to control GP numbers in the White Paper announcing the outcome of the Review. He wants to defer a final decision until he sees the reaction of the profession to the White Paper (paragraph 19). You may want to consider whether this would expose the Government to criticism for holding back part of its reform. The alternative would be to include it in the White Paper as part of a balanced package of reform.

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Strengthening FPCs or merging them with DHAs.

7. Mr Clarke repeats his arguments against merging FPCs and DHAs. It would look as though the Government did not know its own mind; this would be the fourth administrative upheaval in the NHS in a decade; there would be significant costs and no savings; and he wants to keep 'customers' and 'suppliers' separate, and not let hospitals dominate primary care. Instead he proposes to strengthen the management of FPCs, as follows:

i. composition. Membership of FPCs would be reduced from 30 to no more than, say 12, with a lay-chairman and only a minority of (four) professional members;

ii. executive management. A new chief executive should be appointed to each FPC;

iii. monitoring of FPCs. FPCs should be made managerially accountable to RHAs, instead of to the Department of Health.

8. The key question is whether these management reforms, together with Mr Clarke's proposals on drugs, referral rates and controlling the number of GPs, add up to a convincing and effective package for strengthening the control of FPCs over GP practices which decide not to opt for their own budgets. There may be some scope for tightening up the package on the lines indicated above: for instance by introducing 'indicative' drug budgets, publishing comparative information on GP practices and including the intention to control GP numbers in the White Paper. A further possibility, if the idea of merging FPCs and DHAs is ruled out, would be at least to impose cash limits on FPCs. These would give them a real incentive to manage their relationships with GPs effectively, without necessarily involving a cash limit for each GP.

RJW.

R T J WILSON
Cabinet Office
4 November 1988

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P 03258

PRIME MINISTER

Medical Audit

Paper by the Secretary of State for Health

HC 50

DECISIONS

In previous meetings the group has decided that satisfactory arrangements for medical audit are an essential part of the reform package. This paper discusses in detail, for the first time, exactly what form they should take. It points out that medical audit is, "by definition, primarily a professional matter" (paragraph 6) and emphasises the need to work with the professions. The main point on which you may wish to check in discussion is that the proposals ensure that medical audit is available to managers in hospitals and FPCs as a tool for getting the best out of professionals, and not just a comfortable arrangement which the professionals can keep to themselves.

2. For hospitals (paragraphs 3 to 18), Mr Clarke suggests the aim of introducing within two years a system of medical audit based on self-audit and peer review in every District and self-governing hospitals. He also suggests that management could initiate an independent professional audit. His proposals are based on the judgment that the professions themselves should be encouraged to take the lead in developing satisfactory arrangements. You may find this generally satisfactory, but there are points which you may want to raise:

i. confidentiality. The paper proposes that in the case of local audits "peer review findings would normally be confidential to the consultants involved" (paragraph 8 iii). You may wish to ask why local managements should not see the results;

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ii. audits by management. The paper proposes that local management should be able to initiate independent professional audits (paragraph 9). Another possibility would be to have arrangements to enable medical audit and management audit to work together in a joint exercise. You may wish to ask whether this could be done;

iii. consultants. The paper refers to the possibility of consultants refusing to participate in medical audit and proposes steps to deal with it (paragraph 11). You may wish to confirm that, as discussed earlier, participation in medical audit is to become one of the terms of consultants' contracts.

3. The position on the private sector (paragraphs 16 and 17) seems unsatisfactory. It is said for example that an untrained person can offer surgery, such as corrective surgery, and a laboratory can offer tests without quality control. Mr Clarke proposes to encourage the professions to ensure proper standards. You may want to ask whether there is any need for direct Government action, without bureaucracy.

4. The proposals for general practice (paragraphs 19 to 23) seem less fully developed, although admittedly the difficulties are greater. Here again it is essential that FPCs should be able to use medical audit as a management tool and have access to the results. You might ask Mr Clarke what timetable he has in mind for development of medical audit in general practice, and whether participation in such audit could be made a condition in GPs' contracts.

ISSUES

Medical audit and Management audit

5. The paper is primarily concerned with medical audit. On management issues the group has already agreed that the Audit Commission should provide an external audit. In practice, there is a considerable grey area between the two types of audit. As

paragraph 9 says, both management and medical issues could be involved in particular questions, and could point in different directions. The system for medical audit should not have the effect of leaving important management issues to be decided by the professionals. You may therefore want to ask whether any arrangement could be made for associating management audit with medical audit where management issues were involved. For example could the Audit Commission be associated with independent professional audits set up by management?

Publicity

6. Mr Clarke says (paragraph 8 iii) that peer review findings would normally be confidential to the consultants involved, unless they agreed otherwise, although the lessons learnt might be published more widely. You may wish to ask why local management should not have access to the findings, particularly if they have asked for the peer review (see paragraph 10).

7. You may also wish to discuss the general issue of publication of audit findings. For the more market-related approach which is at the heart of the reform package, information for patients and GPs is essential so that they can judge the performance of different providers. Perhaps it would be inappropriate to publish the outcome of audit of individual consultants, but you might ask what arrangements there would be for publishing the medical record of particular units or hospitals. And what does Mr Clarke have in mind as to publication of the results of the independent professional audits which management can initiate?

General practice

8. Mr Clarke's proposals for general practice are less stringent than those for hospitals in two ways which you may wish to probe:

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i. first, he suggests that the aim should be to have a system of medical audit in place for hospitals within the next two years. He does not propose a timetable for developing proper audit arrangements for general practice, and you might like to ask him what he has in mind;

ii. second, the Group has already discussed making a requirement to participate in medical audit one of the terms in consultants' contracts. You might wish to explore the possibility of a similar condition in GPs' contracts.

The private sector

9. Mr Clarke says (paragraph 16) that quality control is generally weaker in the private sector: for example, an untrained person could offer surgery. He also says that there is no legal framework within which the Government could impose standards. In the long run, greater competition should ensure that only qualified and efficient private sector providers survive. But the growth of the private sector may be slow unless patients have confidence in its medical standards. You will want to avoid a system of regulation and bureaucracy, but you could ask Mr Clarke if he sees any scope for more direct Government action to ensure adequate medical standards in the private sector.

R T J WILSON
Cabinet Office
4 November 1988

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P 03259

PRIME MINISTER

FUNDING ISSUES

Paper by the Secretary of State for Health

3 November 1999

HC49

DECISIONS

1. The Group has discussed funding before but Mr Clarke's paper elaborates the issues in more detail than hitherto, for decision. It is an important paper because it goes to the heart of the proposals for 'money following the patient' and abolition of RAWP; and also because it may affect the speed at which some key proposals can be implemented. Overall, you may wish to concentrate on exploring precisely what the proposals are, and what the thinking is behind them.

2. You may wish to take the issues in the order set out in Mr Clarke's paper:

i. funding of Regional Health Authorities (RHAs, paragraphs 8 to 10). Mr Clarke proposes a new system to replace RAWP in 1990-91. It appears to comprise freezing existing Regional allocations at their present level, adding to them a percentage growth figure ('incremental growth money') adjusted for age and population growth, and adding a further special sum for 1990-91 to 'buy out significant under-resourcing'. It is not clear how this ties in with the capitation-based approach which the Group agreed earlier. You may wish to explore what the proposal is and what lies behind it. One important point may be who the gainers and losers would be with a straight capitation-based approach;

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ii. allocations to District Health Authorities (paragraphs 11 to 23). Mr Clarke proposes that, in allocating funds to Districts, RHAs should discontinue the use of sub-RAWP targets. But he is very concerned at the major shifts in funding between different Districts which would occur if there was an overnight switch to capitation-based funding on "buyers". He therefore proposes that the Regions should undertake a carefully managed transition - lasting beyond the next Election - to the new arrangements. Here again you may wish to explore Mr Clarke's thinking, including how long the transition would need to last and who the gainers and losers under the new arrangements will be;

iii. GP practice budgets (paragraph 24). There is a potential anomaly if budgets for large GP practices are funded on a capitation basis but their Districts are funded on a different, transitional basis. Mr Clarke proposes to leave it to the Regions, subject to central guidance, to decide what the allocation should be. You will wish to make sure that large GP practice budgets do not get squeezed unfairly by the arrangements for Districts;

iv. specialist services (paragraphs 25-26). Mr Clarke proposes that highly specialised hospital services should continue to be funded direct by the Department of Health, as now. You may wish to ask whether 'money following the patient' could be introduced, at least in part, for them;

v. interim arrangements (paragraphs 28 to 31). Mr Clarke proposes interim arrangements to allow cross-boundary flows to be better reflected in the present system. You may wish to ask whether it would be better to concentrate effort on implementing the new system than on modifying the present one;

vi. top-slicing (paragraphs 32-39). The paper returns to the proposals for top-slicing discussed earlier. They are designed to reward those hospitals which show the best gains in efficiency; reducing waiting times is mentioned only in passing. Mr Clarke also proposes to appoint 120 consultants

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over two years on a permanent basis: he is opposed to short-term contracts. You will wish to decide whether to endorse this approach. One alternative might be a simpler scheme designed solely to reduce waiting lists by awarding money to the most efficient hospitals, and appointing consultants on short-term contracts to assist them in the work.

Special waiting list money

ISSUES

Funding Regional Health Authorities

3. The Group has already decided that RAWP should be abolished. Mr Clarke begins with a reference to the simpler capitation-based approach which is to replace it, but then proposes a system under which the present distribution between the regions is preserved (paragraph 9 iii), all Regions are to receive an 'equivalent percentage growth figure', weighted for age and population (paragraph 8), and there is to be a special sum for some Regions in 1990-91 (paragraph 10). He sees considerable political and managerial difficulties in simply abandoning the present arrangements. You may wish to explore the thinking behind this.

4. In particular you may want to probe the distributional effects of the change. Mr Clarke says that it would 'preserve the redistribution of resources achieved over the last 12 years'. The approach seems to be that the RAWP redistribution will be frozen but taken no further. The practical consequences of this are not however clear. Does the present system mean that poorer Regions get above average allocations per head whereas the new system which he is proposing will mean that they will go on doing so, although without any further discrimination in their favour? Or does the new system mean that in future all Regions would get the same allocation per head weighted for the elderly, etc? Either could be controversial. You could ask for a clear statement of which Regions will be relative gainers and losers from the change.

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5. Mr Clarke suggests (paragraph 10) that a 'special sum' could be built into the allocations for 1990-91 for those regions significantly below their RAWP target. You may wish to ask how big this sum would be and whether total provision would have to be higher to take account of it.

Revenue allocation to districts

why?

6. Mr Clarke proposes that Regions should continue to decide on allocations to Districts but can, and should, end the use of RAWP targets. He then sets out the difficulties over switching quickly to funding District Health Authorities as 'buyers'.

i. Cross-boundary flows. In part the difficulty reflects the fact that some DHAs depend heavily on inflows of patients from other Districts (only 13% of patients treated in the Bloomsbury District are residents of Bloomsbury). There needs to be time to put contracts in place. You may wish to explore how long he has in mind.

ii. Use of hospital services. Districts differ in the extent to which their residents traditionally make use of hospital services. Mr Clarke gives some examples in Annex E. He proposes that this needs careful management by Regions over time. Here again, you may wish to explore what period he has in mind.

iii. Existing plans and commitments. Allocations to Disticts reflect plans for buildings and other schemes. Mr Clarke exphasises the need to avoid disruption, and proposes that Regions should take account of these plans in their allocations to Districts. Here again, how long will this need to continue?

7. All these factors lead Mr Clarke to propose a carefully managed transition which will extend beyond the next Election. In a sense the difficulties reflect the fundamental shift which the Group envisages from a centrally-directed system to one in which hospitals - and GPs - get rewarded for what they do rather than being there. One implication of this reform is that there should be a redistribution of funds: there would not otherwise be much

point in introducing it. The impact of the reforms will only be fully felt when Districts are funded as buyers. Mr Clarke is however concerned by the size of the shift which may occur between different Districts. Before deciding how fast the reforms should be pressed through, you may wish to ask for more information about their distributional effects and where the 'gainers' and 'losers' would be.

GP Practice Budgets

8. You may wish to ask about the basis of allocation to GPs who opt out. On the face of it, the allocations should be consistent with the basis of allocation to the districts from which the GPs opt out, since otherwise there would be some difference of treatment between those opting out and those staying in; but if District allocations vary, then so will allocation to opting-out GPs, and the inducement to opt out will vary from one part of the country to another. Mr Clarke proposes simply that Regions should 'earmark' funds for GP practice budgets. You will want to consider whether that is sufficient.

Interim proposals

9. Because of the need for a transition, Mr Clarke suggests interim changes:

i. to improve treatment of cross-boundary flows;

ii. to introduce top-slicing.

10. On cross-boundary flows, the present arrangements are unsatisfactory because:

a. they are based on average not actual costs;

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and b. they are based on past, not prospective, flows.

Mr Clarke in effect proposes an interim change to deal with (a) but not (b). He says (paragraph 31(i) that it would 'begin' to affect allocations in 1990-91. You might ask whether this change would divert effort from implementing the main decisions in the Review. If not, you might ask if it could not start to take effect in 1989-90, or at least could be complete in 1990-91.

Top slicing

11. The group has been attracted to the principle of 'top slicing' some money and paying it to hospitals reaching some specified standard. No decision has however yet been taken. Mr Clarke's proposals are designed to reward those hospitals which improve their efficiency. The following questions arise:

a. the group earlier thought a possible use of top slicing would be to encourage improvements in waiting times. This is not now mentioned, except in passing. Do the group still see that as desirable? Might it shift relative effort to treatment for which there are waiting lists, mainly cold elective surgery, away from treatment for more serious conditions?

b. would it be unfair to the most efficient hospitals? There would seem to be some risk that the money would go to those with the most room for improvement;

c. how much money would be available and where would it come from? Mr Clarke mentions £50m. Would this be seen as sufficient? He says he would need to bid for additional funds. You may wish to avoid any commitment to extra money.

As Mr Clarke says, top slicing would be only short-term until the new contractual arrangements were introduced. You will want to decide, depending on the answers to your questions, whether it is worthwhile. One possibility might be to have a simpler scheme at reducing waiting lists.

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12. Mr Clarke proposes that top-sliced funds could be used to appoint 120 new consultants, but on a permanent basis. You may wish to ask whether appointing them on short-term contracts, perhaps linked with a waiting-list initiative, would introduce a desirable element of flexibility in the management of consultants.

13. Mr Clarke argues against the suggestion made at the last meeting, that opted out GP practices might receive some top sliced money. There would be a specially strong case for this if top slicing was aimed at reducing waiting times, which are mainly for the cold elective surgery for which GPs will opt out. You may wish to consider whether some top slicing money would give opted out GPs an extra incentive.

Supra-regional services

13. Mr Clarke proposes (paragraph 26) that supra-regional services like those in Annex F should continue to be funded by central allocation from the Department of Health. You may want to question the implication that contract funding of these services might lead to duplication and make it harder to underwrite new developments. If subsidies are necessary, they could 'top up' a baseload provision derived from contracts. Some element of funding by Districts could make these services more responsive to customer needs.

R T J WILSON
Cabinet Office
4 November 1988

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23(A-B)

HC56

NHS REVIEW

MANAGEMENT OF CAPITAL

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

Introduction

1. This note records that we have reached agreement on the introduction of capital charges in the NHS; and on a programme of work on the scope for access to private capital. We invite colleagues to note this progress and the next steps which we have put in hand. We believe that the issues do not now need to be discussed within the Group meetings, but we will keep colleagues in touch with further work.

Charging for the use of capital assets

2. We consider that capital should not in future be regarded as a free good by the NHS. We believe that a system of charges can and should be introduced so that the users of capital assets are required to meet the cost of those assets, as reflected (subject to normal depreciation) in their current valuation. The introduction of such a system will enable:

- effective management information on the use and value for money of assets

- more cost-effective allocation of future investment

- clear signals on the need for replacement of assets

- a proper basis for charging between hospitals and between the public and private sectors.

3. The introduction of charges is intended to provide clear incentives for authorities and self governing hospitals to rationalise capital holdings, and to invest most effectively. These market disciplines need to apply equally to all public sector hospitals, whether run by health authorities, or self governing.

4. The capital assets used by the NHS are, and will remain, primarily public ones financed by public sector funds. As was recognised at the last meeting of the Group, no impression should be given that elements of the NHS may be alienated from this essentially public ownership. Health authorities need to have freedom to manage their assets - and we envisage self governing hospitals having greater freedom - but we must retain a broad lien on the major assets they use. A minimum requirement might be that disposals of more than 5% of a self governing hospital's total capital stock would require Regional approval.

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5. We see three stages in the introduction of a system of real charges. First, valuation upon an agreed basis. Secondly the introduction of a system of management accounts to enable the NHS to go through a process of familiarisation using notional accounts. Thirdly, and in the light of that experience, to move towards a fully effective system of real charges as soon as reasonably practicable.

6. Officials are working out the practical details of the system such as the definition of interest levels and depreciation schedules, the treatment of charges in the public expenditure context, and ways of achieving a smooth transition. We are confident that these are soluble, and invite colleagues to agree that we should continue to work these up, reporting back in due course. In the meantime, our White Paper should refer to the principles and objectives we have set out in this note.

Access to private sector capital

7. The issues here are more complex. We need to look at ways of enabling the NHS to work more closely with the private sector, which includes examining the scope for greater freedom of access to private capital, without losing expenditure control or being exposed to unacceptable risks with public money. A great variety of schemes may be possible, and the key issues can only sensibly be considered in relation to particular types of project. We have therefore asked our officials to prepare for us a series of key examples of schemes which have arisen in the past, and which might arise in the future, so that we can identify both the fundamental difficulties, and the scope for a more flexible approach. We shall report the results of this work to colleagues as soon as possible with the objective of making a general statement of our policy in the White Paper.

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Copy No. 1

HC 55

NHS Review

PROFESSIONAL AND EMPLOYMENT PRACTICES

Note by the Secretary of State for Health

1. This note responds to the Group's wish for a paper on "restrictive practices", which I have interpreted broadly to cover professional and employment practices generally in the NHS. It concentrates on doctors, nurses and the "professions supplementary to medicine" (physiotherapists, radiographers, chiropodists and so on).

2. In my judgement the most important requirement in this field is to tackle the rigidities caused by professional boundaries. The paper deals mainly with this issue, but also with employment practices. I have not addressed directly activities such as advertising and "price fixing", which are subject to wider legislation on fair trading which we should be ready to invoke as necessary; nor the scope for local flexibility on pay, which DH and the Treasury are to discuss further. The specific possibility of employing consultants on short-term contracts to reduce waiting lists is addressed in my paper on "Funding Issues" (HC 49).

3. In brief, I propose

(i) a major - but rapid and well-focused - inquiry into the best use of professional resources in the NHS.

(ii) reform of the national conditions of service of NHS staff, in the interests of greater flexibility.

(iii) further action on the efficient use of nursing staff.

I PROFESSIONAL BOUNDARIES

4. A note summarising the statutory framework for the main professions covered by this paper is at Appendix A. The health care professions are by definition self-regulating, setting their own standards for entry and training and thereby defining the scope of their work. As a result rigid professional boundaries have tended to grow up, both between the different professions and between professional and non-professional staff.

5. The problems are probably most serious where medical, nursing and social services are available in people's homes, aggravating the risk of the same patient being seen by

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different professionals for similar purposes. In hospitals too the existence of distinct professional roles can inhibit the deployment of less skilled staff and the use of one profession rather than another (such as the use of nurses or midwives to carry out tasks traditionally associated with doctors).

6. Any action in this area will need to take account of the following:

i. The NHS is a very large employer of (particularly female) school leavers with a reasonable level of academic qualification (5 GCSEs or more). This group is declining quickly in numbers and will continue to do so until the middle 1990s. There will be little recovery before the end of the century.

ii. It will be necessary to eliminate any unnecessary restrictions on entry to professional training, and to maximise recruitment from older age groups. It will also be essential to develop more flexible training patterns which allow non-professional staff to progress into professional training, and more flexible working practices.

iii. The "skill mix" between professional and non-professional staff needs further research to establish the optimum mix of staff in different circumstances.

iv. In community settings in particular the respective roles of different professional groups need review. This may mean identifying more positively those staff who have a primary diagnostic, caring or therapeutic role and those who, in effect, act more as consultants to patients' families and to other health care staff.

v. We need to explore to the full the scope for shared education and training.

Action in hand

7. Some small progress - no more - has been made on inter-professional issues. But a good deal of useful, collaborative work is under way with the professions to tackle the problem of boundaries between professional and non-professional staff.

8. Some examples are set out in Appendix B. A great deal of progress is being made with the nursing profession in the context of Project 2000, and also, for example, with occupational therapists and clinical phychologists. Others, such as physiotherapists and radiographers, are being more cautious, although constructive discussions are in hand. The spread of clinical budgets will put increasing pressure on the professions themselves to find more flexible ways of using staff; and some changes will be forced by demographic constraints on recruitment, even if the results are sometimes

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less than ideal. (A higher ratio of non-professional to professional staff is not necessarily either more cost-effective or in the interests of the patient; but nor are traditional role boundaries.

An inquiry

9. It will be important to maintain the momentum of these developments. Where we can make progress through collaboration between management and the professions we should do so. But much of our work so far has been opportunistic, and hence piecemeal. And progress is uneven.

10. The climate is right for a major, objective examination of professional boundaries. Many of the health professions are becoming more receptive to change as they recognise the likely impact of labour market developments in the 1990s. The Government has set the tone in other fields, most recently on the legal profession (although the parallel here is not exact): there could be no suggestion that the health professions were being unfairly singled out in our drive for greater flexibility.

11. We must proceed carefully nonetheless. For example, any legislative attempt either to curtail current restrictions on rights to practise or to redraw the boundaries around and between professions would be exceptionally contentious and fraught with definitional difficulties. Whether we need to legislate or not the ground must be carefully prepared.

12. If colleagues agree I propose to set up a small inquiry team consisting of, say, 3 or 4 lay people of suitable standing. Any attempt to make the team respresentative of the professions themselves would be impossibly cumbersome, but the inquiry could and should take evidence from all the relevant professional bodies, as well as from NHS management and other interested parties. It would be desirable to secure commitment to the inquiry's proposals from at least some of the professions involved.

13. It would be important to ensure that the inquiry was not seen as a crude attempt to "de-skill" health care but as an objective scrutiny of problems and solutions. Its task would be to examine, from first principles, the mix of professionally qualified and other staff required to deliver a given level of service safely and economically. It would be asked to take into account the labour market circumstances and other factors summarised in paragraph 5. Most importantly, its terms of reference should focus on how to make the best use of professional resources in the interests of patient care.

14. The inquiry should be free to make both general recommendations and recommendations which are specific to individual professions. It would need to examine

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- supply, training and education.

- personnel, employment and working practices.

- the substitution of technology or capital for labour.

- changes in the culture of the service and in professional attitudes.

- the consequences of the inquiry's proposals for patterns of service delivery.

- the management, financial and information implications.

15. We would need to guard against two, potentially serious, risks: first, that the sheer range of issues and professional interests would lead the inquiry to lack a clear focus; and, secondly, that the useful work already in hand would be stalled whilst the inquiry took place. To avoid these dangers I would propose asking the team to

i. take account of the wide range of projects already under way - as exemplified in Appendix B.

ii. let me have early proposals - within, say, two or three months - as to the issues on which they wished to focus their attention. I could then agree with them a more specific remit and timetable for the main part of their work. There might be advantage in seeking an early report on some issues and allowing more time for others; subject to that, the team might be asked to complete its work by, say, the end of 1989.

iii. concentrate not on producing a comprehensive and detailed report but on identifying areas where insufficient progress is being made and recommending solutions.

16. If colleagues are content with this proposal I shall work up the detailed arrangements - and try to identify a Chairman - so that we can move forward quickly after the publication of the White Paper.

II EMPLOYMENT PRACTICES

Terms and conditions of service

17. I suggest that the White Paper should also signal an intention to give managers greater flexibility to determine the conditions of service of NHS staff, which are currently determined mainly by national negotiation in the Whitley Councils. My proposals for self-governing hospitals envisage that these hospitals will be wholly removed from Whitley constraints. Leaving aside the issue of pay flexibility, that

still leaves room for the present detailed and prescriptive agreements on conditions of service to be replaced by arrangements which give health authorities generally scope for greater flexibility.

18. Following a recommendation of the Griffiths Inquiry, the Department last year commissioned a radical review of conditions of service by a seconded NHS personnel specialist. His report is due by the end of the year and will provide the basis for a programme of reform. I propose that the White Paper should state our intention to carry through these reforms. To do so it will be necessary to amend the relevant Regulations, which at present severely restrict our scope for progress other than by negotiations through established machinery.

Efficient use of nursing staff

19. At our last meeting the Group also raised the issue of working patterns in nursing.

20. The NHS Management Board has devoted considerable effort recently to improving health authorities' capacity to plan the demand for nursing staff. Most authorities now use one of a number of recommended methodologies.

21. Staff must also be deployed and used to best advantage. A whole range of measures is needed here, from reducing wastage and absenteeism to restructuring the workforce to produce taut, effective management structures and the best possible grade mix. Some of the relevant work in hand is among that referred to in Appendix B. As soon as the initial pay assimilation process is completed I shall be taking steps to ensure that authorities use the restructuring opportunities created by the new clinical grading structure.

22. An area particularly needing attention is matching staffing levels more closely to workloads. This includes the elimination of shift overlaps which are not justified by peaks in activity levels. Authorities are beginning to use computerised work scheduling systems, and the resource management initiative will give these a considerable boost. Progress is not, however, dependent on information systems, and while some authorities have made good progress others still lag behind.

23. I am considering how to give greater focus and impetus to the considerable range of work which is going on in this whole field. I should be happy to bring forward proposals for inclusion in the White Paper if colleagues agree that that would be appropriate.

November 1988

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APPENDIX A

THE STATUTORY FRAMEWORK

Professional self-regulation

1. The statutory framework for doctors, nurses and the professions supplementary to medicine is founded on the principle of self-regulation. For some at least of these professions the activities of the statutory and/or professional bodies may encompass, among other things:

(a) maintaining a register of qualified members - only those on the register may practise the profession.

(b) protecting the profession's title.

(c) establishing codes of professional conduct and removing members from the register in the event of breaches of the code or unfitness to practise.

(d) controlling entry standards for, the content and length of - and sometimes the numbers in - training,

(e) through a combination of (a),(c) and (d), determining the role of the profession, including the role of non-professional support staff.

(f) determining staffing and other criteria for suitable clinical placements during training.

(g) specifying mandatory refresher training.

Doctors

The General Medical Council

2. The General Medical Council is an independent statutory body whose constitution and functions are regulated by the Medical Act 1983. The general duty of the Council is to protect the public and uphold the reputation of the profession. Specifically its duties cover registration; standards of education and experience; standards of professional conduct and medical ethics; and professional discipline.

3. The Council consists of 97 members, of whom 50 are directly elected by registered practitioners, 34 appointed by universities with medical schools and by the Royal Colleges, and 13 (including 11 lay members) nominated by the Privy Council. It elects a President from among its members.

The Royal Colleges

4. There are seven English Royal Colleges (Surgeons, Physicians, Psychiatrists, Radiologists, Pathologists, Obstetricians and Gynaecologists, and General Practitioners), each established by Royal Charter. Together with similar bodies covering other specialties (such as the Faculties of Anaesthetists and Community Medicine), they have the general aim of promoting standards of excellence in their respective specialties, for example by providing courses, promoting research and publishing reports. In practice they control the standards and content of specialist training, by conferring post-graduate qualifications (diplomas, memberships and fellowships) and through a system of regular inspection of all junior medical posts. In these ways they have considerable power to shape specialist practice. There is machinery for co-ordinating College views, but it is weak.

Nursing

The United Kingdom Central Council for Nursing, Midwifery and Health Visiting

5. The United Kingdom Central Council is an independent, statutory body set up by the Nurses, Midwives and Health Visitors Act 1979. The Council's functions cover registration; standards of training and professional conduct; and professional discipline. Each of the four National Boards (see below) nominates seven members, and 17 are appointed by the Secretary of State. The Council elects its own Chairman.

The National Boards

6. Four National Boards - for England, Scotland, Wales and Northern Ireland - have been set up under section 6 of the 1979 Act. The job of each Board is to ensure that pre-qualification training courses are provided and examinations held, and that the courses meet the requirements of the Central Council as to their content and standard. The Boards also carry out preliminary investigations of cases of alleged misconduct. The majority of the members of the Boards are directly elected by members of the professions, the remainder being appointed by the Secretary of State. A majority of appointed members are nurses, midwives or health visitors appointed to ensure that all branches of the profession are adequately represented. The Boards elect their own Chairmen.

Professions Supplementary to Medicine

7. Machinery for the state registration of a range of health professions was set up under the Professions Supplementary to Medicine Act 1960. The seven professions currently within scope of the Act are chiropodists, dietitians, medical laboratory scientific officers, occupational therapists, orthoptists,

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physiotherapists and radiographers. State registration under the Act is a pre-requisite for employment in the NHS.

8. There is a separate Board for each profession, whose membership is drawn mainly from that profession, and which is responsible for maintaining the register and for the regulation of professional education and conduct. The Boards approve courses, curricula and institutions as suitable to lead to state registration in their respective disciplines. In the majority of the professions the qualification so approved is the diploma of the professional body concerned.

9. The Boards are supervised and co-ordinated by a Council for Professions Supplementary to Medicine. The Council may comment on, but not veto, the Board's recommendations, which are submitted to the Privy Council for approval. The Health Ministers appoint either directly or indirectly (by advice to the Privy Council) seven of the Council's 21 members and its Chairman. A further seven members are appointed by, and represent, the individual Registration Boards. Most of the remaining members are appointed by medical colleges.

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APPENDIX B

PROFESSIONAL BOUNDARIES

1. A substantial programme of action is either planned or in hand concerning the boundaries of professional practice in health care, both between professions and between professionals and their non-professional support staff. Among this work is the following:-

a. Project 2000. The Government's acceptance in principle of the Project 2000 reforms of nurse education and training depends on developing the role of non-professionally qualified support workers to nurses and the possibility of progression from support work into professional training. The UK Central Council has work in hand to identify vocational qualifications, as well as academic qualifications which might satisfy the entry criteria to nurse training; and is also looking at alternative entry procedures for potential mature students.

b. Nursing. Following up a current, small-scale study at the University of Warwick on skill mix within the acute ward team, concentrating on the role of ward clerks, the University has been commissioned to undertake a major two year study of cost-effectiveness and skill mix within nursing.

c. Nursing and technicians in high technology care. A short study of possible overlap between the roles of nurses and technicians in high technology care has been completed. This identified overlap in many areas of work. We plan to follow this up shortly with a larger study which will encompass the deployment and training implications of these findings.

d. Occupational therapy. A report on skill mix and manpower requirements for occupational therapy in the NHS and local authorities is expected by autumn 1989. This work will form part of a longer term project which will continue with a review of competencies and training requirements.

e. Physiotherapy. A study of workload measurement and supply is in hand. This work is expected to lead on to an examination of skill mix.

f. Clinical psychology. We are planning a study to identify common or core skills; to determine the levels of staff and skill mix required; and to examine both the possibility of introducing supporting staff and the feasibility of delegating tasks to, or sharing them with, other groups.

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g. Pathology. A recent report on pathology service staffing has suggested that there is scope for greater use of non-graduate laboratory assistants.

h. Speech therapy. We are funding a study of skill mix in speech therapy, and in particular the role of speech therapy helpers.

i. Shared training. Examples of current initiatives include significant progress towards shared training between nurses and social workers in the field of mental handicap, and a joint working party of the Royal College of Nursing, the College of Occupational Therapists and the Chartered Society of Physiotherapy on the scope for joint working, including shared training, between the three professions.

2. Action is also in hand on nurse prescribing. Outside the hospital service the ability to prescribe and/or supply drugs and medicines is limited to preparations ordered by a medical or dental practitioner. The Cumberlege Report on Community Nursing recognised that in practice community nursing staff were frequently operating in circumstances that required them to supply a limited range of preparations to patients with whom they were in direct contact. The Report recommended that nurses should be able to prescribe and/or supply a limited list of preparations, and also, in carefully defined circumstances, to control and vary drug dosage.

3. The Government has made clear its general support for this recommendation. The Department has established a small working group, including all the professional interests involved, to examine the professional and ethical issues. These issues range from the nature of prescribing and the appropriate categories of nurse to engage in it, through the types of items which might be covered and the financial and legal consequences. There are related questions of security, training and personal liability. The Group expects to complete its work by June 1989.

4. The Group will confine itself essentially to the Cumberlege recommendation, which was limited in scope. The consultation exercise which followed Cumberlege gave the other professions the opportunity to voice their concerns, but it was recognised that to a large extent the recommendation would regularise existing practice and opposition from other professions was limited. Any attempt to go further would be fiercely resisted. Primary legislation may nonetheless be needed to achieve the necessary changes.

21 (A-C)

Copy No: 1

HC 54

NHS Review

THE PUBLIC AND PRIVATE SECTORS

Note by the Secretary of State for Health

1. This note

   * assesses the impact of the review on the distinction between public and private health care; and

   * makes specific proposals for carrying forward the competitive tendering of pathology and radiology services.

2. In summary, the key elements are:

   i. blurring the distinction between public and private sectors.

   ii. enabling the private sector to trade and compete freely and on a fair basis.

   iii. extension of competitive tendering, to the clinical as well as non clinical field.

Blurring the distinction

3. One of the key objectives of the review has been to blur the distinction between the private and public sectors in health care. Taken together, many of the reforms we are planning will achieve this in the most effective way possible: by helping the private sector to trade and compete freely with the public sector.

4. In presenting our conclusions, especially to those who are looking to the review for a boost to private health care provision, I suggest we emphasise three points in particular:

   (i) we are building in strong incentives for health authorities and, especially where they have their own budgets, GPs to look to private as well as public sector providers for the best available deals, especially in elective acute services.

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(ii) we are breaking the monolith of public provision by enabling self-governing hospitals to operate much more like private sector hospitals, but within the public sector.

(iii) we are "levelling the playing field" so that public and private sector hospitals can compete on equal terms.

5. My discussions with the Chief Secretary on charging for capital are particularly relevant to (iii). More generally, we must ensure that the new funding arrangements set out in HC49 are developed in a way which does not build in significant advantages or disadvantages to NHS providers - in terms of training costs, for example.

6. There are two other changes which would help further to blur the distinction:

(i) easing the constraints on the access of public sector providers to private capital. This too I am discussing separately with the Chief Secretary.

(ii) making progress towards the competitive tendering of pathology and radiology. The remainder of this note makes specific proposals to this end.

Competitive tendering

7. We have made good progress in recent years in the competitive tendering of non-clinical support services. My paper on reconstituting health authorities (HC52) suggests that we accelerate the contracting out of other non-clinical functions at Regional level. For clinical services generally, and elective surgery in particular, the new funding arrangements we propose will themselves generate more competition.

8. As we have acknowledged, the main outstanding area to address is the potential for competitive tendering of clinical support services, particularly pathology and radiology. We must not overlook the importance of excessive demand from clinicians for diagnostic tests, whether or not these tests have been contracted out: we must continue to tackle this through the resource management initiative, and medical audit will also be relevant. But that need not prevent us from addressing the need for competitive tendering. My proposal here, which I outlined in an earlier paper, is that we proceed by fostering local initiatives.

9. There is clear scope for competitive tendering of pathology and radiology, for example to reap the full benefits of economies of scale and to make the most effective use of expensive capital equipment. The routine processing of samples in chemical pathology is one example. There is considerable scope for the

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private sector to respond. But there are also legitimate professional concerns: that we must secure proper quality control; and that clinicians do not lose their ready access to the expert advice of pathologists and radiologists.

10. In the light of these concerns the profession have been assured, for example in a letter from John Moore to the Royal College of Pathologists last November, that we have no plans for a "central initiative" in this field. But initiatives by individual health authorities are not ruled out, as long as the views of the profession are taken into account.

11. It should not be difficult to foster local initiatives of this kind, and to learn from early experience how best to meet the profession's proper concerns. This is the course I recommend. If colleagues agree I shall draw up and implement an action plan along these lines. The White Paper will need to be drafted in terms which leave the way open but which are also consistent with the assurances the profession have been given.

November 1988

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HC 53

NHS Review

A BETTER SERVICE TO PATIENTS

Note by the Secretary of State for Health

Introduction

1. We are agreed that, in presenting the outcome of the review to the public, we shall need to be ready with a convincing package of expected benefits to patients and to the public generally consistent with the impact on doctors and managers.

2. I propose to deal with this in three ways:

first, by presenting our proposals throughout in the White Paper in a way which brings out the patient's perspective and underlines the improvements being made for the benefit of patients. I will also emphasise that while much of our work has concentrated on financial and managerial issues, underlying this is our objective of securing a better service by giving patients and their GPs a greater say in where they will be treated and by encouraging greater competition in the provision of services.

second, by a package of measures to improve both service to patients and the quality of clinical care.

third, by a number of initiatives to emphasise our aim of improving health as well as the treatment of those who need care.

3. In summary, my key proposals on the second and third points are:

i. a national initiative to put better service to patients at the top of the agenda. The key to this will be a quality assurance programme in every District.

ii. specific proposals for making the service more personal, including proposals on waiting times for outpatients' departments and for diagnosis and treatment.

iii. much better information provided by hospitals, e.g. leaflets, better telephone service, periodic reporting to the public.

iv. more emphasis on the quality of clinical care through better information about clinical outcomes, medical audit and monitoring of health outcomes.

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v. an action plan on quality assurance programmes.

vi. a major training initiative to back up these plans.

vii. a new acute sector advisory service to monitor the quality of service in acute hospitals.

viii. a focus on better health, through more public awareness, monitoring health, measuring the outcome of health services and a new initiative to encourage health promotion and disease prevention.

ix. one element of this focus would be the development of a portfolio of health indicators.

A national initiative

4. There is already a lot of good work going on in the field. A number of Regions, notably Trent and Wessex, have set up comprehensive programmes aimed at improving the quality of service to patients. We now need a national initiative to ensure that every health authority puts the issue at the top of the agenda.

5. The key to change is to get a quality assurance programme up and running in every District. The objectives of each programme will be:

i. to treat people as people by giving a more personal service and offering them a wider choice of amenities,

ii. to inform and consult people so that they are less daunted by hospitals and feel they can have a say about the way services are delivered to them,

iii. to maintain and improve the quality of clinical treatment that patients receive by encouraging professionals to review systematically their procedures and the clinical outcomes.

6. The review offers us the ideal opportunity to launch such an initiative. But we should not overplay the role of central Government. We need above all to change the attitudes and commmitment of the people working in the NHS, and the experience of large private corporations has shown that this takes time and resources in education and training. Any national initiative must also be flexible enough to accommodate a potentially enormous range of local initiatives. I therefore envisage the programme being driven by local management with the full involvement of the professions.

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Making the service more personal

7. The most visible impact of a district programme on the public will be in making services more personal. Some health authorities are already alive to the need to change both their image and their practices, but this attitude should be the norm and not the exception.

8. I have considered whether we should set specific targets from the centre for improving customer service, but it would not be easy to monitor and risks crowding out other worthwhile, local initiatives. In the White Paper we can however give examples of the kind of improvements we expect to see health authorities introducing. I have in mind:

i. ensuring that all the patients are properly welcomed to the clinic or ward,

ii. providing facilities for patients, or their relatives who are distressed, to recover or be counselled in private,

iii. ensuring that a full range of optional extras are available for patients who are willing to pay an extra charge. These could include more elaborate meals, colour TVs, hairdressing services and so on.

9. Considerable irritation and inconvenience is also caused when, having arrived for an appointment in a clinic or an outpatients' department, a patient is kept waiting to see the doctor for long periods without any explanation or apology. A more personal service would tackle this, too. I would expect all health authorities to review their appointments procedures, to make sure that every patient is given a specific appointment time and, as far as possible, is seen within a reasonable period of that time; in Peterborough, for example, all patients are expected to have been seen within 20 minutes of their appointment time. Where there are unavoidable delays, patients should be given an apology and told what has gone wrong.

Waiting times

10. The White Paper will also need to deal with the more intractable problem of long waiting times for diagnosis and treatment. We shall also need to draw out the ways in which our proposals for greater competition and moving money with the patient will serve the objective of reducing waiting times. Our current national waiting list initiative, our proposals for rolling it forward in 1989/90 - for which resources have already been earmarked - and my proposals on "performance funding" (HC 49), can be presented as interim solutions until the full effects of our proposals work through.

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Information

11. I also want to see a much better flow of information between hospitals and their customers. Again, there are a number of basic rules which I would expect all health authorities to follow, such as:

i. sending all prospective hospital patients a leaflet telling them what they need to know about coming into hospital - how to get there, what to bring, and other relevant information. Brighton have produced some very attractive and informative booklets,

ii. making sure that telephone calls are answered promptly by the hospital switchboard. This is a good example of a basic improvement where targets can be set and progress monitored.

12. Further, I expect all health authorities to keep their customers informed about past performance and future plans through periodic reports, annual meetings open to the public and regular publicity in the local media.

Improving the quality of clinical care

13. Quality assurance programmes are not just about improving hotel and support services. These are important - and highly visible to patients - but all health authorities should be satisfying themselves that they have adequate mechanisms in place for monitoring and improving the quality of clinical care. In the past, this has been inhibited by the absence of a reliable information base and the technology which enables the complex range of clinical and personal data to be processed quickly at ward level. We are now well on the way to overcoming these problems and have more "computer literate" doctors and nurses wanting to develop this aspect of care.

14. My separate paper on medical audit (HC 50) suggests how we can ensure that every doctor is involved in securing high-quality cost-effective clinical care. The same principles apply to all the professional groups. Nurses, for example, are leading a number of initiatives for improving standards of care. The acceleration of the Resource Management Initiative will provide an added stimulus and context for the developing quality assurance on a national scale.

15. Health authorities must also be able to focus on areas of particular concern. Monitoring the health of the local population will continue to be a key role of all DHAs. Health authorities will need to satisfy themselves that what they are buying offers not only value for money but also a high quality service which is effective in improving the health of its resident population. In this regard, the work currently under way to devise better measures of health outcomes (para 27-28

below) will be particularly valuable. Health authorities must also learn to listen to their customers, and surveys must be an integral part of the district's monitoring role.

Implementing quality assurance programmes

16. We cannot rely solely on exhortation to ensure that all health authorities introduce a quality assurance programme. Following the publication of the White Paper, I suggest that all health authorities should be required to draw up plans in 1989/90 for implementation from 1990/91. Progress on preparation and delivery will be monitored through the performance review process. I propose to consolidate this by including improvements to quality of service and clinical care as one of the criteria against which general managers' performance will be assessed. I also believe that the increased competition that will result from our other proposals will act as a spur to a systematic improvement in quality.

Costs

17. Quality assurance programmes themselves need not cost a great deal to introduce. In Wessex, for example, the initial work is costing about £0.75m a year, excluding training costs. But a major training initiative is also vital. British Airways, for example, invested £25 million over 3 years to retrain their 40,000 staff. Given the size of the NHS, even a basic training programme would cost at least £10m a year in the first two years that the programme was launched. We are therefore talking of £20 million a year over 2 years to launch a comprehensive quality assurance initiative.

An acute sector advisory service

18. I have also given some thought to whether we should establish a national body to monitor the quality of services in acute hospitals. A number of the organisations who have made submissions to the review have advocated some form of hospital inspectorate, and the Social Services Committee endorsed the idea in their report on the future of the NHS. We shall therefore need to be ready to give our views when the White Paper is published, even if we do not make specific proposals ourselves.

19. A monitoring body could take various forms. I am not proposing an organisation that is independent of Government and could develop into yet another lobby for more resources. For this reason, I have rejected the models adopted in the United States and Canada under which an independent body formally accredits hospitals against a set of national quality standards. I am however attracted to the idea of an advisory body that is ultimately answerable to Ministers but whose main function is to offer a source of independent advice to local management on a consultancy basis.

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20. The model I have in mind is akin to the existing NHS Health Advisory Service (HAS). The HAS was established in 1970. It is professionally led and monitors, on my behalf, the provision of services for the mentally ill and the elderly. An acute sector advisory service might similarly consist of a small, central group of staff with perhaps a doctor as its director. For each visit it would appoint a multi-disciplinary team drawing on a group of practising professionals who could command the respect of colleagues. The membership of the team would of course need to reflect the nature of the service being reviewed. The inspectorate would be self-financed mainly through fees from health authorities and hospitals being visited.

21. I have considered the option of extending the remit of the existing HAS into the acute hospital sector, but I have concluded that acute hospital services are sufficiently different to merit a separate body. More importantly, unlike the HAS which sets its own programmes, I see the acute sector advisory service as essentially a tool of local management, with the bulk of its work programme being determined in the early stages by Regions and later by Districts. It would also be available to - but would not be imposed upon - self-governing hospitals. There may however be occasions where difficulties arise of sufficient importance for Ministers to ask the service to investigate a particular area of work or a particular hospital. As with HAS reports, the new advisory service's reports should be published. Not to do so risks charges of excessive secrecy.

22. The concern of the advisory body would be mainly the quality of clinical services. It would in some circumstances be an imposed peer review. Thus when a local manager, unhappy at the quality or performance of a particular specialty, called in the advisory body, the key part of their visit would be the review of local professional work by other doctors in that specialty. In this way, it would complement the other work being undertaken in the hospital either in the context of value for money initiatives or as part of a medical audit programme. The multi-disciplinary composition of the team and its independent status would however enable it to take a wider view of service provision, including the targets and priorities that a hospital had set itself and to act as an outside stimulus to change.

23. The follow up to an advisory report would in the first instance be the responsibility of local management, who would need to have regard to the wider resource and policy implications. But an adverse report would also be picked up by the RHA as part of the performance review process. Failure to take action on a report would be one of the criteria against which the general manager's performance was assessed. At national level, advisory reports would be one of the sources of information against which regional performance was assessed.

24. I believe that an initiative of this kind would be widely welcomed. The UK is one of the few countries not to have some

form of national body that is capable of assessing the quality of acute hospital services. My proposals do not go as far as some have argued, not least because we must avoid a heavy-handed, bureaucratic approach. But they would help to reassure the public and the professions that the review is not simply about value for money, and, in my judgement, are the minimum we can put forward in the White Paper.

Better Health

25. I have dealt so far with the scope for improving services for patients who need treatment. We must also do more to reduce the numbers who do need treatment. I propose to focus on four developments in the White Paper:

First, building on our successful efforts to convince people that by taking sensible measures e.g. on diet, exercise, smoking and alcohol they can help to improve their own health.

Second, improving our ability to monitor health and to identify areas of concern e.g. adverse changes in the patterns of disease so that we can respond to them effectively and in good time.

Third, measuring the outcome of health services.

Fourth, developing new initiatives to prevent illness and to promote health.

26. Public awareness Our emphasis here should be on providing better information so that people can make their own choices. This will be consistent with our emphasis elsewhere on the importance of choice.

27. Monitoring health Following discussions between my predecessor and the Chancellor, my officials have agreed with Treasury officials the basis for developing a portfolio of health indicators, which will be published regularly. The indicators will enable us to chart improvements in health and to identify potential areas of concern. We would also, if we so wished, be able to quantify what we wanted to achieve e.g. a reduction in alcohol misuse.

28. Measuring outcome of health services The health indicators will also enable us to provide data for the first time on the benefits to quality of life by treatment in the NHS. In so doing, we shall be able to set out much more clearly the beneficial impact of our NHS funding. This will enable us for example to put into proper perspective the issue of those waiting for treatment as compared to those already successfully cured.

29. Health promotion and disease prevention. I propose to take a major new initiative with Regional Health Authorities to encourage the development of new ideas in this field. The aim

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will be to build on local enthusiasm, as has been successfully done with the Welsh campaign "Heartbeat Wales" and the English campaign "Look After Your Heart". There are two main elements:

First, and more important, incentives for developing new initiatives in disease prevention and health promotion, e.g. the detection of congenital deafness and treatment of undisclosed high blood pressure as well as new health education programmes. These would be funded from regional allocations by agreement with Regional Chairmen.

Second, prizes for those who have already run successful disease prevention or health promotion campaigns. The prizes would be funded privately by charitable foundations (I already have one potential backer) or leading local firms.

We would be able to link this initiative to the development of new health outcome indicators, since these would help us to identify areas where incentives were most needed. The amount of money involved, particularly in the prizes would be small. But it should provide very good value. It will also help us to respond to public concern that we do not pay as much attention to the prevention of disease as to its cure.

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HC 52

NHS Review

RECONSTITUTING HEALTH AUTHORITIES

Note by the Secretary of State for Health

Introduction

1. We are agreed that we should review the constitution of health authorities in the light of our review proposals, with the aim of making them excecutive bodies. This paper sets out my proposals for achieving this. It also considers the implications of our review proposals for the NHS Management Board.

2. In summary, the key proposals are:

(i) District health authorities (DHAs) would devolve more functions to hospitals but retain responsibility for directly managed services and for monitoring and planning local services. As buyers, they would be accountable to Regional Health Authorities (RHAs) and Ministers for services provided for their residents.

(ii) To minimise disruption, boundary changes would be kept to a minimum. But where DHAs become too small to be viable, for example when hospitals become self governing, mergers may be necessary.

(iii) DHAs should be reduced from their present 16-19 to 5 non executive and 5 executive members plus a non executive chairman.

(iv) Appointment procedures would remain broadly as they are. But local authorities would no longer be able to appoint members.

(v) DHAs would continue to meet in public, with private sessions where necessary.

(vi) No change would be made to Community Health Councils (CHCs).

(vii) Slimmed down regional health authorities would have a continuing role in ensuring that Ministerial policy is carried out and in overseeing the implementation of the review proposals.

(viii) Membership of RHAs should be similar to that of DHAs.

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(ix) RHAs would be streamlined by delegating or contracting-out existing non head office functions e.g. hospital design and computer and legal services.

(x) The NHS Management Board (NHSMB) under Ministerial chairmanship would continue to be part of the Department of Health (DH), not divorced from it.

(xi) The Board would focus on strategic and policy issues. The present Health Services Supervisory Board would go.

(xii) Day to day operational issues would be handled by an executive committee, chaired by the Chief Executive.

District health authorities

(a) Existing responsibilities

3. Annex A lists current DHA responsibilities. Briefly, these are to assess the health needs of the local population and monitor the effectiveness of the services provided; to manage health services in the district, including the provision and development of community health services; to integrate, with primary care and social services, the planning of general hospital services and services for the priority groups - the elderly, mentally ill and mentally handicapped; and to provide clinical facilities for medical education.

(b) Future role

4. One of the themes of the White Paper will be the need to build on the introduction of general management into the hospital service by pushing down further decision-making to the unit level. I shall need to scrutinise their functions to make sure this is done to the fullest possible extent. The proposals in HC46 for introducing self-governing hospitals will accelerate the process in those DHAs where the main acute hospital becomes self-governing. DHAs will however retain responsibility for the management of the remaining services, including hospitals for the priority care groups and their key responsibility for monitoring and planning the provision of services in their locality. Crucially, as the buyers of services for their resident population, they will also continue to be accountable to RHAs and Ministers for the quality and cost-effectiveness of the services provided for their residents.

(c) Size of districts

5. While these changes will signal a major shift in responsibilities in all DHAs from the health authority to the hospital unit, it is in the smaller, single DGH districts where the impact will be greatest. It may therefore be desirable to merge some of the smaller districts in order to create a viable health authority. District mergers are disruptive and can cause considerable controversy locally. I would therefore want to keep

the number of boundary changes to the minimum necessary. In putting forward proposals for self governing hospitals, RHAs should be asked to consider the options for sensible mergers as part of their submissions.

(d) Membership of DHAs

6. Annex B sets out the present constitution and membership of health authorities and their statutory basis. It is clear from this that health authorities are not presently constituted as management bodies. As a result, they do not always supervise their managers adequately. Neither does the size and membership of DHAs lend itself to crisp decision-making. In recent years, there have been many examples of health authorities becoming bogged down in local politics. I therefore propose that DHAs should be reduced from their present 16-19 members to 5 (non executive) members and 5 executive members plus a non-executive chairman. The non-executives would be chosen in particular for their managerial and financial skills and there would no longer be any local authority members as of right. DHAs that covered a teaching hospital should include a representative of the medical school. The executive members would include the general manager and up to 4 other officers. This would enable the district medical, nursing and finance officers to be included.

7. The basis for the appointment of DHA members is set out in the 1977 NHS Act and we shall need primary legislation to amend this.

(e) Members' appointment procedure

8. As I have indicated, a central role of the newly-constituted DHA will be to act as the buyer of services on behalf of its resident population. It is therefore operating in effect on behalf of the local community. The removal of local authorities' (LAs) statutory right to appoint members directly will be highly contentious and will need careful presentation, not least to some of our own supporters. RHAs should retain the right of appointment of DHA members in order to avoid complaints about excessive centralised patronage. In future RHAs would not be bound by the LAs' recommendation but where there are good candidates, they would be appointed on their merits. DHA Chairmen would continue to be appointed by the Secretary of State.

(f) Community Health Councils

9. Because of the sensitivity of the DHA membership issue, I am not proposing any changes in the LA membership of Community Health Councils (CHCs). At present, local authorities appoint half of the CHC membership. The remaining third are appointed by the voluntary organisations and a sixth by RHAs. While this

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inevitably politicises many CHCs, DHAs are experienced at dealing with them. I therefore see no need to alter the membership of CHCs or make any other changes to their role. In the White Paper we can stress their continuing importance as the local consumer watchdog.

(g) DHA meetings in public

10. As we recognised at our last meeting, there is no need to make any change in the existing requirement under the Public Bodies (Access to Meetings) Act 1960) for health authorities to hold their meetings in public. Authorities already have some discretion under this Act to exclude the public e.g. because of the confidential nature of the business to be transacted.

Regional health authorities

(a) Role and functions

11. Annex C lists current RHA responsibilities. I believe that a slimmed down regional tier should continue to be the main vehicle for ensuring that Ministerial policy is being carried out on the ground. RHAs will also have a crucial role in managing the changes brought about by the White Paper. In my view the size and nature of the management task are such that these changes could not be managed by regional arms of the Department. RHAs contain the necessary local knowledge and act as an important buffer between Ministers and the operational level. The changes I propose below in the membership of RHAs will strengthen them for their task of ensuring that our proposals are carried out in the most efficient and effective way.

(b) Membership of RHAs

12. Membership at regional level should match that at the district level. That is, RHAs should comprise 5 non executive members and 5 executive members plus a non executive Chairman. It would be desirable for medicine, the relevant university and FPC interests to be represented if the latter are made accountable to RHAs. As at present, members and Chairman would be appointed by the Secretary of State.

(c) Reducing the size of RHAs

13. Following the introduction of general management into the NHS, RHAs are already signed up to devolving as many functions as possible to districts and their units. But I have no doubt that there is further scope for reductions in RHAs' staffing and costs. It is important however to distinguish the "head office" functions invested in RHAs - principally the development and monitoring of services and the allocation of resources - from RHAs' current responsibilities for providing certain technical and support services such as computers and supplies.

14. The scope for savings in RHAs' "head office" functions will be modest, if they are going to manage districts effectively and spearhead the introduction of many of the reforms which will emerge from the Review. But I am convinced that scrutiny of the remaining RHA functions will produce many blocks of work which can be streamlined, delegated to districts, or contracted out altogether. Indeed many Regions have already begun the process, so the scope for action varies from Region to Region. The work which can be streamlined or disposed of includes management services, design of hospitals, storage and distribution of supplies, computer services, and legal services. The effect of these proposals on the size of RHAs will vary from region to region but I would expect to see a significant reduction. My aim is that, after taking account of the additional work Regions take on in implementing our proposals, there should be a net reduction in their staffing and costs.

The role of the NHS Management Board

15. There are many people and bodies within the NHS who demand that the NHS Management Board should be divorced from my Department, under independent chairmanship. Although the distancing of NHS management from Ministers clearly has some attractions, the disadvantages are even greater. I do not think so large and politically sensitive a public service, which is going to continue to be overwhelmingly vote financed, can in practice be separated from the political process. A separate Board would resemble nothing so much as the Board of a nationalised industry. Parliament would not tolerate Ministers trying to hide behind the Board to avoid responsibility for key issues. An independent Board would quickly become an extra tier in the management chain between Ministers and the real health services and, almost certainly, a new lobby for more public money. I believe therefore that we should use the opportunity of the White Paper to refute the case for separating the NHS Management Board from Ministers and the Department of Health.

16. We would however streamline management arrangements within the Department by giving the Board a clear role in major NHS strategic issues.

17. I propose four main changes:

first, responsibility for the family practitioner services will be brought under the Board. The better integration of primary care with hospital services is an important objective.

second, the Board, - as now under Ministerial chairmanship - would deal with strategic and policy issues, as well as the more critical operational matters. The Board would be reduced in size and reconstituted to contain a higher proportion of non-executive members appointed from the commercial and industrial worlds.

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third, as in most companies, much of the day to day work would be handled by an executive committee of the Board chaired by the Chief Executive.

fourth, the Health Services Supervisory Board would no longer have a role to play and would go.

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ANNEX A

THE RESPONSIBILITIES OF DISTRICT HEALTH AUTHORITIES

The functions of DHAs are as follows:

1. Promoting health, preventing illness and planning services

   - review the status of health of the population and assess needs;
   - develop strategic and operational plans;
   - implement plans;
   - liaise with local authorities; FPCs and voluntary sector;
   - produce guidelines for local service developments;
   - evaluate outcome.

2. Performance and review

   - setting objectives and targets for units;
   - monitoring and reviewing performance against targets.

3. Provision of Patient Services

   - hospital and other accommodation;
   - medical, dental and nursing services;
   - facilities for the care of expectant and nursing mothers and young children;
   - facilities for the prevention of illness, including health education and promotion;
   - arrangements for surveillance, prevention and treatment of communicable diseases;
   - arrangements for the proper care of persons suffering from or recovering from illness or disability;
   - other services required for the diagnosis and treatment of illness including domiciliary nursing and other forms of care provided in the community, including collaboration with local authority;
   - medical and dental inspection and treatment of school children;
   - family planning advice, treatment and supplies;

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- facilities for private patients.

- services to local authorities to enable them to carry out their social services and education functions;

- facilities for clinical teaching and research;

- health centre accommodation;

- assistance in the conduct of relevant research.

4. Finance

- provide management accountancy function;

- analyse financial data including identification of potention over/under spends;

- ensure DHA financial strategy is achieved.

5. Personnel

- reconcile units' collective demand with national etc policies and estimate impact of local authority, private or voluntary sector requirements; determine manpower requirements for District functions; reconcile collective demand with resource assumptions;

- identify sources of supply for staff groups where district can be self sufficient (e.g technical and nursing staff);

- establish policies and targets for recruitment, retention, return, deployment; monitor performance; establish manpower targets (where relevant, eg. (Administrative and Clerical);

- monitor effective skill mix;

- promote image of NHS as employer locally; maintain contact with local education system, careers service, Department of Employment.

6. Building and Estates

- management of delegated capital budgets;

- procurement of minor health building schemes;

- monitoring of unit compliance with fire, health and safety standards; etc

- control of smaller disposals and Joint planning with local authorities and FPCs on estate matters;

- monitor cost effectiveness of unit based maintenance staff.

7. Support Services

- ambulances;
- transport;
- sterile supply;
- laundry.

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ANNEX B

CONSTITUTION AND MEMBERSHIP OF HEALTH AUTHORITIES

Regional and District Health Authorities

1. It is the duty of the Secretary of State by order under Section 8 of the NHS Act 1977 to establish Regional and District Health Authorities for such regions and districts as he may specify. Under Schedule 5 to the Act, the Secretary of State may specify how many members shall constitute a RHA or a DHA. The chairman and members of a RHA shall be appointed by the Secretary of State, as shall the chairman of a DHA. The Secretary of State shall consult on the appointment of members of a RHA except in some prescribed circumstances. A specified number of members of a DHA shall be appointed by the relevant local authority and the remainder by the relevant RHA, either after consultation with or on the nomination of various other bodies, including any university whose medical school is associated with the district. There are limited exceptions to the RHA's duty to consult.

2. RHAs are constituted and their regions specified under subordinate legislation (SI 1981/1836 and SI 1975/1100). The constitution of DHAs and the districts for which they are to act are specified in SI 1981/1838 and SI 1981/1837. Under these provisions, 14 RHAs and 190 DHAs have been constituted. These each consist of a chairman and between 16 and 19 members. The composition of DHAs is set out in the appendix.

3. SI 1983/315 provides for the appointment and tenure of office of chairman and members of RHAs and DHAs and for the procedures of those authorities. Terms of office shall not exceed four years. The procedural requirements include rules as to meetings and proceedings of authorities, disability on account of pecuniary interest and the appointment of committees and sub-committees.

Special Health Authorities

4. The Secretary of State has discretion to establish Special Health Authorities by order under the NHS Act 1977 to carry out such functions as he shall direct. The Secretary of State specifies by order the number of members who shall constitute each SHA and appoints the chairman and members. There are regulations governing the procedures of SHAs and the appointment and tenure and office of their chairman and members.

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APPENDIX

COMPOSITION OF DISTRICT HEALTH AUTHORITIES

1. The membership of DHAs is governed by Schedule 5 to the NHS Act 1977, the NHS (Constitution of Districts) Order (SI 1981/1838), and by Departmental guidance (Health Circular (81)6). The position is as follows:

Chairman

Appointed by the Secretary of State who is not required to consult before doing so.

Membership

There are 16-19 members per DHA. On average 12 are appointed by the RHA and 4-6 by relevant local authorities. The membership is comprised as follows:

Appointed by RHA

(i) one hospital consultant (ii) one general medical practitioner (iii) one nurse, midwife or health visitor.	The Act only requires RHAs to consult appropriate medical and nursing bodies before making appointments. These specific appointments are required under HC(81)6.
(iv) a nominee/s of the appropriate university medical school (1-3 members)	The Act requires the RHA to appoint a university nominee - Teaching Districts and those with a dental school have additional members under SI 1981/1838
(v) On average 8 generalists including members drawn from the wider TU movement	The number of generalists is prescribed in the constituting SI 1981/1838 but under the Act the RHA has to consult "any federation of workers organisations who appear to be concerned". There is no TU place as of right.

Appointed by Local Authorities

(vi) 4-6 LA members	The Act gives LAs direct right of appointment. The RHA has no leverage here whatsoever. The

Constitution Order (SI 1981/1838) specifies the numbers of members which relevant LAs can appoint to each District. Maximum 4 year term, but LAs decide expiry date.

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ANNEX C

THE RESPONSIBILITIES OF REGIONAL HEALTH AUTHORITIES

The functions of RHAs are as follows:

1. Planning, Performance and Review

   - establish regional strategic and operational plans;
   - management of capital programme;
   - management of performance and accountability review process;
   - facilitation of joint planning.

2. Finance

   - allocation of resources to districts;
   - monitoring of spending against operational objectives;
   - monitor cost improvement and other VFM activities;
   - manage funds for regional specialties and capital programme.

3. Personnel

   - guidance to districts on personnel and industrial relations;
   - hold medical consultants', registrars' and senior registrars' contacts.

4. Building and Estates

   - provision of design services;
   - provision of specialist technical services;
   - advise on disposals;
   - provision of technical advice/skills on estate matters.

5. Managed services

   - manage

     blood transfusion service

     ambulance service

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- provide services to districts

  central stores

  computing services

  management services

  legal services

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18(A-P)

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HC 51

NHS Review

MANAGING THE FAMILY PRACTITIONER SERVICES

Note by the Secretary of State for Health

1. This paper addresses three related issues arising from the Group's discussion of budgets for general practice (HC 47):

* the management of contracts with GPs.

* the number of GPs.

* the role and constitution of FPCs.

I am working separately to develop our proposals on GP practice budgets in the light of our discussion.

2. In brief, my proposals are that

i. on prescribing costs, we should

a. pilot an incentive scheme for FPCs on drug spending.

b. enable FPCs to buy in the medical manpower they need to follow up their monitoring.

c. take powers for FPCs to impose financial penalties on GPs who persistently over-prescribe .

ii. we should give a high priority to improving the information available to GPs and FPCs about referral rates and costs, and give FPCs the capacity and powers they need to follow up their monitoring of referral rates.

iii. subject to an assessment of the overall impact of the review on the medical profession, we should take powers to control GP numbers; and should in due course reduce the retirement age from 70 to 65.

iv. we should keep FPCs separate from DHAs, but

a. strengthen their non-executive leadership by changing their composition.

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b. introduce a tougher, and better resourced, executive management.

c. make FPCs accountable to Regions.

Medical audit in general practice is dealt with in paper HC 50.

I MANAGEMENT OF CONTRACTS WITH GPs

Context

3. Leaving aside the number of GPs, we have identified two main respects in which further action may be needed to secure greater cost-effectiveness in general medical practice: prescribing habits; and referrals to hospitals. GP practices which opt to have their own budgets will have a strong incentive to act cost-effectively. We must therefore address the position of GPs who are not covered by the practice budget scheme. In my view the right way forward is to build on our existing policy of tightening the GP contracts and giving FPCs the powers and capacity they need to manage the contract effectively.

4. The terms of service of GPs are set out in Regulations. These Regulations, along with the current fees and allowances, constitute the basis of each GP's contract with his or her FPC. The main obligations which the terms of service place on GPs, and the main controls and sanctions which are available to FPCs, are summarised in Appendix A, along with examples of the action we have in hand to extend these obligations and controls following the Primary Care White Paper. The following paragraphs set out how these contractual arrangements can - and should - be used to secure cost-effective prescribing and referrals, and how they will need to be reinforced to make them effective for this purpose.

Prescribing costs

5. We have already discussed the possibility of trying to control prescribing costs through cash limits or "indicative" drug budgets. As I have argued in previous papers, I believe that an approach along these lines would be fraught with political difficulty. There would be potential for 30,000 GPs to protest - and encourage their patients to protest - at the perceived inadequacies of their budgets. We would be bombarded with stories of individual patients deprived of necessary medication by the effects of "cash limits".

6. Some FPCs are already monitoring and advising on prescribing habits, but this function has hitherto been carried out primarily by doctors from the Department's Regional Medical Service (RMS). This approach is relatively limited in scale: the RMS visits practices whose prescribing costs exceed the local average by 25%. But these visits -

which are educational, not punitive - are effective enough to save on average around £10,000 per practice in the first year. We are doubling this RMS activity from 1989-90.

7. We are already intending to ensure that FPCs themselves take a more active role from now on. We should not underestimate the potential impact of this. In particular:

i. the experience of some FPCs which are already active in this field suggests that the essential first step is to educate GPs, for example in the use of practice formularies (short lists of drugs selected on the basis of economy and efficiency); the scope for generic prescribing; or systems for helping GPs to for control and reduce repeat prescriptions. We shall be ensuring that in future all FPCs give a strong local lead in educating GPs, so that no doctor can claim to be ignorant of what can be done to control prescribing costs.

ii. we shall also inform - both GPs themselves, so that they can audit their own prescribing, and FPCs, so that they can monitor the performance of their GPs. And I shall be arranging for the publication of "league tables" of FPC prescribing costs. A description of the new "PACT" information system, appended to HC47, is attached again as Appendix B. Despite strong opposition from the profession, we shall be making this information available to FPCs from next year, and all FPCs will be covered by the system from 1990-91. In anticipation of the impact of this information, and of the related FPC and RMS activity, my PES bid offered savings of £15 million and £20 million in 1989-90 and 1990-91 respectively.

8. As I suggested in HC 47, I believe we should explore the scope for reinforcing these initiatives with some incentives. The scheme I set out in that paper was one in which an FPC could be set a target level of spending on drugs, with a proportion of any savings being returned to them to finance primary care initiatives in their area. Involving the GPs themselves would help to secure their commitment to the scheme. I hope colleagues will agree that I should pilot this proposal with the help of a willing FPC.

9. Effective though I believe they will be, our current plans would still leave FPCs with two important handicaps: a shortage of resources with which to follow up their monitoring; and, since a requirement to prescribe economically does not figure in the contract, a lack of effective sanctions. I propose to overcome these handicaps as follows:

i. for most GPs the most effective response to evidence of over-prescribing will be pressure and advice from their peers. We should therefore give FPCs the medical manpower with which to follow up their monitoring, and not only when costs are 25% or more above the local

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average (which is all the RMS is resourced to do). The most practical approach, at least initially, would be to expand the RMS and charge FPCs for the use of RMS doctors. I am confident that the resulting savings would outweigh the manpower costs by a wide margin.

ii. we must enable FPCs to impose financial penalties where GPs persist in over-prescribing. Current Regulations provide only for Local Medical Committees (LMCs), which represent the GPs themselves, to investigate excessive prescribing, at the request of the Secretary of State. This provision is ineffective, and has fallen into disuse. I suggest we seek to amend the Regulations to enable an FPC to investigate on its own initiative and to fine GPs who persistently refuse to curb excessive prescribing. This power would be subject to the normal right of appeal to the Secretary of State. GPs' terms of service would also be amended to require doctors to answer questions from their FPC about their prescribing patterns.

10. I have considered further colleagues' suggestion that we should publish comparative information about the prescribing costs of different GP practices. Aside from the certain opposition of the profession there is a fundamental problem: the evidence - from FPC performance reviews, for example - suggests that at least in some areas patients tend to prefer doctors who are more ready to write a prescription. If this is so, publicity could have precisely the reverse effect of the one we intend. It might be more profitable to experiment with publicity campaigns to educate patients not to put pressure on their doctors to prescribe indiscriminately, although I understand that experience of a campaign of this kind in Northern Ireland is not encouraging.

Referral rates

11. We are less well prepared to tackle referral rates. We lack both information and experience in this field. Medically, inefficient referral patterns are more difficult to spot than excessive prescribing. We need to curb over-referral, but we must also guard against the under-referral of patients who need specialist attention.

12. The essential first step is to improve the information available to both GPs and FPCs. There are a number of useful local initiatives, including examples of GPs keeping records of their own referral rates. But the most important development is a project in East Anglia, based at the RHA and part-funded by the Department. This project is tackling three problems, with extensive co-operation from the Region's GPs:

i. developing an information system to identify the decisions being made. The first phase of the project has shown that it is possible to trace the patient and the

referring doctor using existing data, although some difficulties remain to be resolved. (For example, the GPs referring the patient may or may not be the GP with whom the patient is registered, and it is the latter who tends to be recorded.) The next phase, now in hand, is to develop and program a regional computer system.

ii. developing techniques for linking costs to these decisions. Information about the cost of out-patient work is currently poor. It will be important to develop a system which takes account of case mix, as do diagnosis related groups (DRGs) for in-patient costs. We are planning soon to test through the project the use of an adapted version of "ambulatory visit groups" (AVGs), an out-patient equivalent of DRGs being developed in the USA. Linked systems will be needed to cover in-patient and diagnostic costs, and we shall need to ensure compatibility with the resource management initiative. All this work will also be an essential input to the development of GP practice budgets.

iii. learning more about what constitutes a "good" referral decisions in terms of cost effectiveness. The Region have initiated useful work here, too, for example in encouraging GPs and consultants jointly to draw up "protocols" covering particular conditions such as diabetes. But this approach can be fully effective only when adequate information is in place to support it.

13. Our current estimate is that it will take about two years to reach the point at which the information systems at (i) and (ii) will be fully in place in East Anglia and ready for adoption by other Regions. It might be possible to accelerate this programme given additional resources.

14. In the meantime, as for prescribing costs, we must ensure that FPCs will have the capacity and powers to make effective use of referral information when they get it. To this end:

i. FPCs are to contract with independent medical advisers - drawing on academic medicine, the RMS and other sources - to encourage good practice in the referral of patients to hospital. This capacity will be built up steadily over time. Among the other effects of this work should be a reduction in waiting times.

ii. although the approach must be primarily educational, I suggest that FPCs are given powers to impose financial penalties in cases of persistent over- or under-referral, as for over-prescribing. But it will be some time before FPCs have adequately robust criteria against which to use this power.

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Relationship to practice budgets

15. I am confident that the measures outlined in paragraphs 7-14 will be not only effective in themselves but also more than sufficient to avoid giving large GP practices a disincentive to opt for their own budgets. Without going into detailed aspects of practice budgets, which I have been asked to work up separately, it may be helpful to make three further points:

i. the main incentives for a practice to take its own budget are that it

- enables them to back their choices with money, and
- opens up the possibility of generating funds for their practice through virement.

In both respects it offers the potential for attracting more patients. All these incentives apply whether or not other practices are brought under effective pressure to curb prescribing and referral costs.

ii. if practice budgets are calculated in the way I proposed in HC 47 only practices which beat the average, or believe they can do so, will have an incentive to opt into the scheme. This in turn means that practices which would like to join the scheme will have an incentive to beat the average first.

iii. colleagues have questioned my proposal in HC 47 that practices opting for a hospital service budget should have the option of having a drug budget too. The logic of this proposal is that, if drug budgets were a compulsory element of the scheme, practices which would like a hospital service budget but do not (at least yet) beat the prescribing costs average would be deterred altogether. I believe this logic holds good, and that we should proceed accordingly. I would rather they at least began with a hospital services budget to get them into the scheme. They would then have a strong incentive to bring down their prescribing costs so that they could safely opt for a drugs budget and thereby increase their scope for virement. (They might choose to vire into drug spending, of course, where they judged this more cost-effective than using hospital services.)

II CONTROLLING GP NUMBERS

16. Recruitment into general practice is buoyant. The number of GPs in Great Britain has increased by nearly 20% over the past decade, to nearly 30,000. The increase in the year to October 1987 was 1.8%. In 1987 the average GP had less than 2,000 patients on his list, compared with nearly 2,300 in

1977. There is a strong demand to fill practice vacancies even in traditionally unattractive areas. Excluding the cost of drugs and hospital referrals, but including practice expenses, the average GP costs the Exchequer £56,000.

17. Aside from the normal immigration controls, the Government has no power to restrict the entry of suitably qualified doctors to general practice. The only "de facto" control is that exercised by the statutory Medical Practices Committee (MPC), which regulates the geographical distribution of GPs. Under present arrangements a doctor who wishes to set up in practice in an area with an average list size of 2,100 patients or less must apply to the MPC for admission to the relevant FPC's "Medical List". The power to change this criterion to a different average list size rests with the MPC itself. The MPC is empowered to refuse an application from a suitably qualified doctor only where the number of doctors in the area is "already adequate".

18. Controlling the total number of GPs would require primary legislation. I continue to see some difficulties in this. Limiting the number of independent practitioners (small businesses, in effect) is arguably inconsistent with our general approach to freeing trade restrictions (although we have done it for pharmacists); and public reaction to limiting the number of GPs might well be unfavourable. It would be opposed by the profession, whose declared aim is an average list size of 1,700 (although in private many would see controlling the numbers as helping to maintain their incomes). Abolishing the MPC, or substantially constraining its role, would also be strongly contested by the profession.

19. For these reasons I suggest we defer a final decision until we are in a position to assess the reaction of the profession to the review package as a whole. Subject to that, I agree in principle that we should legislate to take the necessary powers.

20. I shall give further thought to how these controls should work and to the nature of the powers we shall need, so that we are ready with detailed proposals when the White Paper is published. I see two basic approaches, each operating within a ceiling - set by Government - for the total number of GPs in any one year:

i. we could empower the Secretary of State to direct the MPC - or a successor body - as to the manner in which, and criteria on which, it exercises its existing functions.

ii. allocations within the ceiling could be made to FPCs, either directly by the Department or, preferably, by Regions. The MPC would be abolished.

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21. The main advantage of option (i) is that it distances Government from potentially contentious allocation decisions. It could work well if we changed the composition of the MPC, or replaced it altogether, to remove its current domination by the profession. On the other hand option (ii) arguably makes more management sense because it enables allocations to Regions and FPCs to be directly related to other priorities and resource allocation decisions. I should like to give a little more thought to this.

22. As we discussed at our last meeting it will be important to ensure that we do not deter good, young doctors from entering general practice. I shall need to give further thought to this, too. The best approach might be

i. to reduce from 70 to 65 the retirement age for GPs which we are introducing through the Health and Medicines Bill, this reduction to take effect when the new manpower controls are established.

ii. to ensure that, when filling single-handed practice vacancies, FPCs give priority to younger doctors who are keen to work as members of primary health care teams.

I am looking at ways in which FPCs could have more influence over the filling of vacancies in partnerships.

III THE ROLE AND CONSTITUTION OF FPCs

Need for change

23. There is a clear need to strengthen the management of the FPS. In particular, we must

* complete the substantial body of changes set out in the White Paper, including the implementation of legislation.

* secure much more effective local management of contracts with independent practitioners. Appendix A outlines some of what is involved for GPs (and GPs with their own budgets will, of course, remain in contract with FPCs and subject to the same basic terms of service).

* implement effectively the measures proposed in parts I and II of this paper.

24. The key management changes we need are

i. a strong, non-executive leadership devoted specifically to the management of the FPS locally.

ii. tougher, and better resourced, executive management of the FPS.

iii. firmer monitoring and accountability of local FPS management.

My proposals under these three heads are set out more fully in paragraphs 27-32 below.

Merger with DHAs

25. The changes in paragraph 24 will be needed whether or not FPCs are merged with DHAs. DHAs could not simply absorb either these new management tasks or the existing administrative functions of FPCs, and they would lack the experience which FPCs have been building up since 1985.

26. I remain of the view, therefore, that we should not merge FPCs with DHAs, for the reasons I gave in HC 41. In short:

i. I believe we can inject competition into the NHS more effectively by keeping "customers" and "suppliers" separate and by ensuring that the interests of hospitals do not dominate those of primary care. This is still more true if we are to develop GP practice budgets.

ii. merger could easily be portrayed as indicative of a Government which does not know its mind. FPS and hospital administration were merged from 1974 until 1985, following the 1974 reorganisation. It was this Government which detached them again, not least because we judged that health authorities did not have a good track record in their administration of the FPS. Since 1985 there has been real progress towards more effective management.

iii. if the introduction of general management into the hospital and community health services is included in the reckoning, merging FPCs with DHAs would be the fourth administrative upheaval within a decade. Of 90 FPCs, 56 relate to more than one District and 17 cover part or all of at least four Districts. Further reorganisation would tend to divert effort away from more important objectives.

iv. there would be significant costs - in additional computers, in reorganising FPC registers and in additional staff - but only minimal financial savings because the bulk of the work undertaken by FPCs would continue as before.

Composition of FPCs

27. FPCs currently consist of 15 members from the professions and 15 lay members. All the members are appointed by the Secretary of State. The professional members are drawn from Local Representative Committee (LRC) nominees. Four of the

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lay members are drawn from DHA nominees, and a further four from local authority nominees. The Chairman may or may not be lay - we have been steadily reducing the proportion of chairmen drawn from the contractor professions - but the professional members tend to dominate the proceedings.

28. Not surprisingly, some Committees regard the support of the contractors as more important than service to the customers. There is a general tendency to shrink from proper enforcement of the contracts, and I see changing the constitution of FPCs as essential to strengthening the management of the FPS. There will be strong opposition from the contractor professions, particularly the doctors, but I believe we should face this.

29. I propose that the composition of FPCs should in future be as follows:

i. there should be no more than, say, 12 members in total.

ii. there should be a lay chairman, appointed by the Secretary of State.

iii. there should be a clear minority of professional members - one from each of the four contractor professions. The professional members could be nominated by anyone but would be appointed by the RHA.

iv. the chief executive (paragraph 31 below) should always be a member of the committee. (There are no equivalents of the other executive members I propose for DHAs - see HC52.)

v. the remaining members - all lay - would be appointed by the RHA and chosen for their experience and personal qualities. No places would be reserved for DHA or local authority nominees.

vi. the currently extensive sub-committee structure should be radically slimmed down, and many decisions currently taken by sub-committees devolved to officers. The reduced size of the membership should then suffice.

Executive management

30. The typical FPC has about 50 staff, most of whom are engaged in the routine work of paying practitioners and maintaining records. Computerisation has enabled staff savings to be made and released resources for strengthening middle management. But this is not enough.

31. I believe we must now appoint new chief executives to all FPCs, by open competition. The salaries offered will need to be good enough to attract quality managers from both inside

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and outside the NHS. Essentially the same level of administrative support should remain, with the chief executive supplying the drive and managing the many changes that will be needed. I estimate the costs at around £3 million a year.

Accountability

32. Since April 1985 the 90 English FPCs have reported direct to the Department. Although a good deal has been achieved by way of setting objectives for the Committees and giving them a sense of direction, it is impossible to monitor all FPCs as closely as we would like. As they take on new responsibilities it will be necessary to assess their performance more regularly. I therefore believe that FPCs should be made managerially accountable to RHAs, who would carry out much more frequent performance reviews than the four-yearly formal reviews carried out by the Department now. This relatively modest addition to the functions of Regions will be more than offset by the overall slimming down I propose in HC52.

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APPENDIX A

GENERAL PRACTITIONERS' CONTRACTS

The contract with the FPC

1. GPs are independent contractors. Their contract with the FPC is governed by Regulations which include their terms of service. The main obligations placed on the GP are:

- to render to his patients all necessary and appropriate personal medical service.
- to do so in suitable surgery premises or at the patient's home.
- to refer the patient to other parts of the NHS if necessary.
- to prescribe whatever medicines are necessary.
- to provide 24-hour cover either personally or through a deputising service.
- to provide (if he so contracts) maternity services, contraceptive services, cervical cytology and vaccination and immunisation.

Controls and disciplinary procedures

2. FPCs have the following powers

- to refer a complaint about unsatisfactory treatment to a Service Committee. This is set up by the FPC under lay chairmanship with, additionally, three GPs and three other lay people.
- to receive and act on recommendations from the Service Committee as to whether or not there has been a breach of the GP's terms of service.
- to fine the GP if he is in breach, subject to the Secretary of State's agreement. Fines of £500-£1000 are not uncommon. There is a procedure for the GP to appeal to the Secretary of State.
- to refer more serious cases (eg repeated breaches) to the NHS Tribunal, which is a statutory body with an independent chairman appointed by the Lord Chancellor; and to remove a GP from the FPC's list if so instructed by the Secretary of State in the light of the NHS Tribunal's decision. This is also subject to an appeals procedure.

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Additionally, an FPC can refer a case to the General Medical Council, which can remove a GP from the Medical Register and therefore from the right to practise altogether.

3. An FPC can also

- check that premises are up to standard and, if not, withhold reimbursement of rent and rates.
- withhold fees or allowances if the specified conditions are not satisfied.
- approve consultation hours.
- approve and oversee use of deputising services.

Current plans to tackle weaknesses

4. The weaknesses of these arrangements are

- poor leadership in some FPCs.
- domination of FPCs by the professions.
- limited FPC resources to take necessary follow up action.
- lack of specific requirements in the terms of service (eg. no reference to health promotion).
- patients ill informed of rights and service availability; patients' expectation are low.
- inadequate flow of information about GPs' activities.
- the complaints procedure is cumbersome and insufficiently consumer friendly.
- quality of care is not monitored.

5. Following the Primary Care White Paper, the Government intends to:

- make the remuneration system performance related.
- increase competition and consumer power through better information about local services and greater emphasis on capitation fees.
- cash limit and target expenditure on premises improvements and practice team staff on those premises and practice teams where the need is greatest.
- retire elderly doctors.

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- enhance the role of FPCs and their management.
- make GPs' terms of service more specific.
- streamline the complaints procedure.

6. In addition, FPCs will be required to:

- submit service development plans for improving services where most needed.
- set targets for GPs in receipt of vaccination and immunisation and cervical cytology fees.
- monitor performance of GPs using outcome measures, performance indicators and consumer surveys.
- exercise leadership in improving the cost effectiveness of prescribing.
- in due course apply similar arrangements to hospital referrals.
- exercise more vigorously their powers to inspect records.
- use existing Service Committee and Tribunal powers to raise and maintain standards.

APPENDIX B

GP PRESCRIBING - INFORMATION PROVIDED TO PRACTICES

The Prescription Pricing Authority has developed a 3-level reporting system based on data taken from prescriptions dispensed by community pharmacists (shortly to be extended to dispensing doctors):

* Level 1 reports are sent quarterly to each GP practice and within 3 months of the period measured. Each report compares the practice prescribing costs (calculated at list price) with the FPC average and the national average. It also compares the prescribing pattern with the FPC average in each of the 6 highest-cost drug categories (e.g. cardiovascular). The report gives information on the prescribing of individual GPs within the practice and about generic prescribing habits.

* Level 2 reports are sent automatically within a week of the level 1 report to practices whose costs exceed their FPC average by 25% or more and to those whose costs in any of the 6 major cost categories exceed the FPC average by 75%. Level 2 reports are sufficiently detailed to identify areas of high cost down to individual drugs. Tables show how individual GPs stand in relation to the practice as a whole, and how practices stand in relation to the FPC overall, in terms of

    - numbers of items prescribed
    - total cost (at list prices)
    - average cost per item

* Level 3 reports are available on request for those wishing to carry out a detailed audit. It provides a full catalogue of items prescribed. Analyses of prescribing can be provided in terms of

- overall pattern
- 6 major cost groups
- all other drug groups
- appliance and dressings
- other preparations

2. The system is under continuing review. A leaflet explaining its methods and purposes has been sent by the Department to all GPs and group practices.

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HC 50

NHS Review

MEDICAL AUDIT

Note by the Secretary of State for Health

1. This paper sets out my proposals for securing the accountability of doctors for the quality and cost-effectiveness of medical work.

2. In brief, I propose that we work with the medical profession, nationally and locally, to establish

* a system of medical audit in every District and self-governing hospital, based on self-audit and peer review and with a facility for management to initiate an independent professional audit; and

* a parallel system for general practice.

I HOSPITALS

Context

3. A major objective of the review is to ensure that consultants take more responsibility for the management and delivery of hospital services, and are more accountable for the quality and cost-effectiveness of what they do. There are two main aspects of this:

i. on primarily management issues, such as whether doctors are putting in the hours they are contracted to work, accountability will be secured through the management of consultants' contracts, supported by financial and VFM audit as appropriate. We have agreed on the steps we must take to make both the management of contracts and VFM audit more effective.

ii. on primarily professional issues, such as whether a doctor is using the most appropriate procedures for diagnosis and treatment, we need to secure accountability through medical audit. Medical audit will need to cover both the clinical treatment of individual patients and services to the population (cancer screening programmes and child development surveillance, for example).

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4. This paper is concerned mainly with (ii) - although we must also ensure that nothing falls into the cracks between (i) and (ii). The main focus is on the quality of medical care, which stands up well in comparison with other countries but remains, in places, uneven.

Medical audit in practice

5. Medical audit is a systematic, critical analysis of the quality of medical care, including the procedures used for diagnosis and treatment, the use of resources, and the resulting outcome for the patient. It necessarily requires both a specialised knowledge of current medical practice and access to medical records (which are the medical audit equivalent of accounts). I suggest that we should aim to have a system of medical audit in place, within the next two years, in every District and self-governing hospital.

6. It would be a mistake to prescribe precisely what each system should look like: medical audit is, by definition, primarily a professional matter, and it cannot be implemented by Government without the active participation of the profession. We also need to recognise that

i. medical audit is a relatively recent development in this country. Opinions about its use and value vary, and knowledge of its aims, scope and methods is thinly spread. Yet we need all hospital doctors to be intellectually convinced of its validity.

ii. medicine is an inexact science. Every diagnostic technique and treatment has an inherent element of risk. Medical audit must not encourage doctors to be reluctant to take on difficult but essential clinical work.

iii. we lack comprehensive, robust and professionally acceptable measures of the outcome of the work of individual doctors or of services.

7. In my view, therefore, we must consult the profession nationally about exactly how medical audit would work, and how prescriptive we (or they) should be, so that we can carry them with us. But we must do so on the basis of the kind of system we have in mind. I envisage a two-part approach: medical audit as a regular part of local medical practice; and a system of independent medical audit which can be initiated by management.

8. Subject to the outcome of consultation, I see regular, local audit working along the following lines:

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i. every consultant would be expected to participate in a locally agreed form of medical audit, covering both self-audit and peer review. Accountability for the quality of work would be built into the standard job description for all consultants. Medical audit would become a fundamental element of continuing medical education.

ii. District management would be responsible, and accountable, for ensuring that this system was in place; that the work of each consultant's team was subjected to peer review at whatever regular, frequent intervals were agreed locally; and that there was a rolling programme under which the treatment of particular conditions was reviewed by the relevant doctors collectively at regular intervals.

Publication? Debate on individuals

iii. the system itself would be medically led. One approach might be for local practice and procedures to be overseen by a hospital or District medical audit advisory committee, chaired by a senior clinician. Peer review findings would normally be confidential to the consultants involved, unless they agreed otherwise, not least to avoid the risk of exposure to legal action. But it would be all the more important for the lessons learned to be published more widely, as the profession is already beginning to do.

iv. there would probably be a similar advisory committee or equivalent at each Region: partly to oversee the medical audit of less common specialties where a Regional approach seemed sensible; and partly, when necessary, to help doctors at District or hospital level to find consultants from outside the locality to help with peer review.

9. The ability of management to initiate an independent professional audit will be particularly important in the grey area between "management" and "professional" issues (paragraph 3(i) and (ii) above). Typical examples might be an unusually low proportion of day surgery or an unusually high rate of diagnostic tests: both might consume more resources than management believed to be necessary, yet either might be justified by the consultant concerned on clinical grounds. An independent audit could also be important where there was cause to question the quality of a service (for example evidence of unexpected outcomes such as a high death rate), or where the quality of a service was being examined in relation to its cost.

10. The fuller integration of consultants into hospital management should help considerably in such circumstances, but it will remain essential for management to be free to call on some form of peer review. This might often be done through any local advisory committee (8(iii) above), and there might

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also be advantage in a formal mechanism for approaching the Region - preferably with the agreement of the local advisory committee chairman. A District general manager should, I think, be free to invoke such a procedure either in respect of a District service or in respect of a self-governing hospital with which the District has a contract.

11. In both routine medical audit and independent professional audit the best results will be achieved where the system works on the basis of consent, both as between doctors and as between clinicians and management. Nor should we underestimate the impact on a doctor of praise, advice or criticism from his peers. But there remains a risk that some consultants would refuse to participate in whatever form of medical audit was agreed locally, or decline to act on the findings of an independent professional audit. I propose we deal with this as follows:

(i) The General Medical Council (GMC) is likely to recommend soon that the medical records of all patients treated within the NHS should in principle be available for peer review, and that audit of medical work should be an obligatory element in continuing medical education. This will be more acceptable, and at least as effective, as any management attempt to enforce participation, and I suggest that we encourage the GMC to proceed accordingly.

(ii) Where a consultant refuses to act on the findings of an independent professional audit, management should invoke the normal disciplinary procedures, on grounds of professional incompetence.

(iii) The quality of medical work should be taken into account in the criteria for distinction awards.

12. An effective system of local medical audit needs strong leadership. This in turn requires time and - experience suggests - some secretarial support (for example to collate and present relevant data). More generally, all hospital doctors will need to devote a significant proportion of their time to taking part. Even assuming every consultant devotes just one-twentieth of his week to medical audit the cost in consultants' time would be around £25 million.

Other Action required

13. If we are to put in place arrangements of the kind described in paragraphs 6-12 of this paper, and are to do so within the two years I suggest, we need to build on the current growth of interest and experimentation within the profession itself. For example:

i. The Confidential Enquiry into Perioperative Deaths (CEPOD), a major study of all deaths within 30 days of surgical operation in 3 Regions, showed that in a small proportion of deaths there were preventable factors. This study is now to be extended nationally, with DH funding, and will be run by the Association of Surgeons, the Association of Anaesthetists, and the Royal College of Surgeons.

ii. The Royal College of Surgeons is now insisting that medical audit is a prerequisite for recognition of a unit for training purposes.

iii. A Royal College of Physicians Working Party will shortly publish a report commending the need for audit and requiring it as a prerequisite for the approval of training posts. They will also publish guidelines on how to undertake audit.

iv. Medical audit is already widely practised in many branches of pathology, where the quality and accuracy of the work is more readily measurable than that of other disciplines. The Royal College of Pathologists have developed protocols for checking standards.

14. Action by Government must be carefully judged to go with the grain of these developments. Our aim must be for Government and management to be supporting, using and reinforcing procedures developed by doctors themselves. There is nonetheless much we can do to generate still greater momentum by working with the profession nationally. In particular:

i. I have asked the statutory Standing Medical Advisory Committee, which represents the full range of authoritative medical opinion, to consider and report on how the quality of medical care can best be improved by means of medical audit, and on the development of indicators of clinical outcome.

ii. we should press all medical colleges to make participation in medical audit a condition of a unit being allowed to train junior doctors, by an agreed date.

iii. we should invite the profession to take part in a national initiative to support and monitor the development of medical audit locally. This might build on existing inspections of training posts, carried out nationally by the Royal Colleges. It might also be possible for each College to establish guidelines for the diagnosis and treatment of common conditions.

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iv. we should encourage the further development by the profession of national audit schemes such as CEPOD.

15. I believe we should also insist that a hospital has an acceptable system of medical audit before we can agree to self-governing status. I am considering how best to reduce to a minimum the criteria for self-governing status, but I suggest that adequate medical audit remains one of them. This should prove a useful, additional incentive. Districts buying the hospital's services will no doubt wish to ensure, through their contracts, that an effective system of medical audit remains in place subsequently.

The private sector

16. In principle, medical audit should apply to private as well as public sector hospitals. At present quality control is generally weaker in the private sector: for example, an untrained person can offer surgery, such as cosmetic surgery; and a laboratory can offer to undertake tests, or to provide a service such as breast cancer screening, without any quality control. Medical records tend to be relatively scanty.

17. There is no legal framework within which the Government could impose standards or require the adoption of medical audit. I suggest that the best approach would be to

i. encourage the profession nationally to extend medical audit into private practice. One example of this approach is a current Royal College of Pathologists' proposal to establish an accreditation scheme for private sector laboratories.

ii. encourage the GMC to make peer access to medical records obligatory in the private sector too.

iii. ensure that Districts which buy services from the private sector insist on adequate medical audit being in place before they do so, just as I am suggesting where they buy services within the public sector.

18. These measures, taken together, should prove an effective stimulus to the development of medical audit in private sector hospitals, and should also help further to blur the distinction between the public and private sectors.

II GENERAL PRACTICE

The problem in general practice

19. The circumstances of primary care differ from those in the hospital service in several ways which bear on the nature of medical audit. For example:

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i. care is delivered in more places - 10,000 surgeries, plus patients' homes.

ii. periods of treatment are less well defined, so that record and audit systems must handle continuing care, perhaps over many years.

iii. medical records are usually less detailed.

iv. monitoring the work of independent contractors is different in principle from - and potentially more difficult than - monitoring the work of salaried doctors in hospitals.

20. Nonetheless, as in the hospital service, there is a range of problems varying from the almost entirely professional to the mainly organisational. For example:

i. Are we diagnosing breast and bowel cancer early enough? Are referrals to hospital always appropriate, and are all those who need referral referred? Are drugs used effectively and efficiently?

ii. Does the coverage of clinics, and do clinic times, suit patients? Should doctors in partnerships have separate or merged lists of patients. Are relationships between doctors, community nurses and health visitors satisfactory? Is night and weekend cover arranged satisfactorily?

As with hospitals, we need to take primarily management action to deal with (ii), and also ensure that the profession itself takes action on (i) in a way which enables FPCs to invoke peer review procedures whenever necessary.

Action required

21. Again there are valuable professional initiatives on which we can build. The Royal College of General Practitioners (RCGP), in its "Quality Initiative", has shown the way. The Joint Committee on Postgraduate Training in General Practice audits practices in which young GPs are trained. There is also an increasing amount of self-audit, the launching of the new national prescribing information system (described in HC 51) being a recent example. We must press the RCGP to continue to develop and encourage medical audit, and the inspection of training practices and development of criteria of care by the profession will provide useful foundations.

22. Unlike the hospital service, the FPS has little by way of an organisational framework for a universal system of medical audit to fit into. Again the precise arrangements would need to be subject to consultation, but I envisage something along the following lines:

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i. the GMC should be encouraged to require peer review access to GP as well as hospital consultants' medical records.

ii. medical audit locally would be based primarily on self-audit by GPs and GP practices. Local practice and procedures would be medically led, supported and encouraged by a medical audit advisory committee established by each FPC.

iii. each FPC would establish a system for identifying possible signs of poor quality care. Many different indicators could be relevant: inadequate records or equipment; inappropriate referrals; emergency admissions resulting from poor health surveillance or failure to refer sooner; avoidable deaths; and so on. Local clinical protocols could be developed on a selective basis (setting out the action required during antenatal care, for example), and clinical records assessed against these protocols. The local advisory committee would help to arrange an external audit of a GP or GP practice where necessary.

iv. each FPC, in consultation with its GPs, would set up a small unit of doctors and other staff to support and monitor the audit procedures of contracting practices. The unit would be accountable to the FPC manager and work under the guidance of the local steering committee. The staff costs and travelling expenses each FPC's unit might average as much as £100,000 a year, or approaching £10 million for England as a whole.

23. In short, as with hospitals, I would suggest a system which is based firmly on the principles of self-audit and peer review but in which action can also be initiated by management.

November 1988

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16(A-2)

Self-governing hospitals

Copy No. 1

HC 49

NHS Review

FUNDING ISSUES

Note by the Secretary of State for Health

1. I was asked to submit a note describing how cross-boundary flows will be funded in the future and how our proposals on rewarding performance by allocating an element of "top-sliced" money will operate. Discussion of these topics necessarily draws us into future funding arrangements generally and the timetable for change, and I have therefore taken the opportunity to outline my proposals on transitional arrangements.

2. In summary, the key proposals are:

(i) the replacement of RAWP in 1990/91 as the basis for financial allocations to Regions, to be replaced by a simpler system of distributing incremental growth money.

(ii) sub-Regional RAWP targets to be discontinued as indicators for financial allocations to Districts.

(iii) a carefully managed transition to funding Districts as "buyers", on a weighted capitation basis.

(iv) from 1990/91, changes to the present arrangements for funding cross-boundary flows, to make them reflect the work carried out more accurately pending the full implementation of (iii).

(v) a short-term, performance funding scheme to allocate very small £50m of "top-sliced" money on the basis of a proven track record of efficiency or to encourage targeted improvements in output, including additional consultant posts.

Funding cross-boundary flows

3. One of the key themes of the review is that hospitals should be rewarded for their success in attracting business. This means that money must follow the patient.

4. Under present arrangements, cross-boundary flows of inpatients between Regions are reflected retrospectively in the RAWP formula. The adjustments affect targets - and hence Regions' distances from targets - and so the impact on allocations is indirect. Quite significant changes in flows may

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have little or no immediate effect on allocations. Other disadvantages of the present system are:

(i) the adjustments are based on past data, so can never be less than a year out of date.

(ii) the adjustment to reflect casemix - and hence the costs of flows - is too broad adequately to reflect the costs associated with treatment.

(iii) the costs used are national averages, and so give no incentive to the "exporting" authorities to shop around.

(iv) neither "exporters" nor "importers" can control flows.

5. At Regional level, net cross-boundary flows represent a relatively small proportion of targets, as Annex A illustrates. Flows are much more significant between Districts. Arrangements for allocations to Districts vary from Region to Region, but are likely to reflect planned rather than actual flows. Districts which exceed their planned inflow will not necessarily receive additional funding for the extra business undertaken. So the disadvantages in paragraph 4 apply generally to flows between Districts also.

6. Paper HC35 outlined proposals for the future funding of hospital and community health services (HCHS). In particular it proposed a move towards a contractual approach to the management and funding of services, differentiating DHAs as buyers of services from hospitals - DHA managed, self-governing or private - as providers. Our proposals on GP practice budgets are a further development of this approach.

7. Under these proposals Districts would receive an allocation which would be used to fund services for their resident populations. In some cases GPs would be responsible. The present system for funding cross-boundary flows would be phased out, since these flows would be funded directly by the "buying" authority and by "buying" GPs, under contracts with hospitals outside their own District boundaries. A model contract developed by my Department and MoD earlier this year as a framework for health authorities to buy services from MoD service hospitals provides one example of this approach, although by no means a fully developed model (Annex B). The following paragraphs set out how the new financial allocation system might work and how we might manage the transition.

Allocations to Regions

8. HC35 proposed a simple capitation based formula with adjustments to reflect geographical variations in input prices and the numbers of elderly people. For allocations to Regions, I suggest that:

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(i) all Regions would receive an equivalent percentage growth figure, subject to:

(ii) extra funding for those Regions which had a relatively fast-growing population or a particularly rapid growth in the number of elderly people. (Annex C presents population projections by Region.)

Funding in respect of medical teaching, together with other "top-sliced" money, would be handled separately.

9. This approach has many attractions:

(i) simplicity: the complicated adjustments in the current formula for assessing "relative need" would be abandoned on the grounds that over time these are relatively stable between Regions. The relative position of Regions would not change rapidly. We would have to examine this assumption periodically, however.

(ii) it avoids the distinction between target and actual allocations, the differences between which always provoke rows.

(iii) it emphasises the fact that RAWP has largely fulfilled its objective of redressing geographical imbalances in funding, and that we can now draw a line under it by preserving the redistribution in resources achieved over the last 12 years. Eleven of the 14 Regions are now within 3% of target.

10. However, there would be considerable political and managerial difficulties in simply abandoning the present arrangements. Over half the country would be up in arms, regarding themselves as having been robbed of their due under the RAWP equalization process. It would in any case be impractical to try to implement the proposed new system for the next financial year. It should be possible to build into the allocations for 1990/91 a special sum for those Regions who are significantly below their RAWP target in order to "buy out" significant under-resourcing.

Allocations to Districts

Funding authorities as buyers

11. Under the contractual approach to funding services outlined in HC35, Districts as "buyers" should in principle be allocated the funds they need - no more and no less - to buy services for their resident population. The location of services would be irrelevant. Districts using their own services would "buy" them through management budgets, but would be free to buy them from other Districts, from self-governing hospitals or from the private sector.

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12. For the reasons set out below, these proposals imply much more significant changes in allocations to Districts than to Regions. We cannot move as quickly to capitation-based funding without causing far more turbulence than we could justify. We therefore need a carefully planned transition, managed by Regions.

The present position

13. Allocations to Districts are a matter for Regions. Regions have been expected to follow the general principles of RAWP, but in recent years we have encouraged a more flexible system in which allocations reflect service plans, including the revenue consequences of capital developments. RAWP targets at District level are now used mainly as indicators for planning purposes.

14. Districts exhibit more variation against target than Regions. The existing range is -38% (Milton Keynes) to +37% (Riverside), compared to -4% (East Anglia) and +7% (North East Thames) at Regional level. Bringing all those Districts currently below target closer to targets, as I suggest for Regions, is not a practical proposition. Apart from the cost, many Districts would be unable to use the money because of a lack of capital development. Regions can and should discontinue the use of sub-Regional RAWP targets, even just as planning indicators, but they will have to manage the transition in a different way.

Managing the transition

15. There are four main reasons why the transition to funding Districts as "buyers" must be managed carefully over a period of time:

(i) the scale of cross-boundary flows.

(ii) variations in the use of hospital services.

(iii) existing plans and commitments.

(iv) less crucially, variations in input costs.

16. Even at Regional level there are significant differences in net cross-boundary flows, as Annex D shows. The impact of paying directly for these flows will be much more marked at District level. Annex E shows how, for selected Districts in SE Thames, funds would flow between Districts if Districts were to be responsible for funding cross-boundary flows out of their allocations.

17. One part of the problem is the scale of the "trading" involved. Funding Districts only for "home" patients means that hospitals will need separate contracts or other reimbursement arrangements for "imported" patients, often involving a

significant number of different authorities as Annex E illustrates. To cite a more extreme example, Bloomsbury DHA accepts annually 100 or more patients from each of 50 of the 57 Districts in the Thames Regions; only 13% of the patients treated are residents of Bloomsbury.

18. Another part of the problem is the scale of the potential changes to individual Districts' allocations. Of the three Districts illustrated in Annex E, Table 1, one (Bromley) would get 17% more money and another (Tunbridge Wells) 16% less.

19. Districts will need to enter into discussions with each other on the costs of cross boundary flows, concentrating initially on the major flows. Once agreed, Regions can reflect these in their allocations to Districts. Regions would act as facilitators and, where necessary, arbitrators. These revised allocations will initially reflect existing patterns of service delivery and cross-boundary flows; subsequent changes in patterns of "trading", as they begin to bite, will then have an incremental effect, year-on-year, on a hospital's funding.

20. Regions will also need to take into account variations in the use of hospital services by different Districts' resident populations. For example, residents in Districts with a historically high level of provision typically use hospital services more, and variations of this kind may also reflect the relative strengths and weaknesses of primary health care services. Examples of variations in "utilisation rates" are given in Annex E. Of the three Districts illustrated there, the utilisation rate for the resident population of Lewisham and North Southwark is significantly higher than those for Bromley and Tunbridge Wells, even when the population is "weighted" for age, sex and marital status.

21. Funding Districts according to current rates of service use would minimise the risk that hospitals under contract with local Districts would be suddenly unable to maintain their current levels of service provision. But such a policy would enshrine current inequities into future funding arrangements. In SE Thames, for example, this would tend to disadvantage the home counties and south coast towns. Regions will need to ensure that such disadvantages are minimised, if not removed, over time, but that this process too is carefully managed to prevent the disruption of services and to take into account the adequacy of the primary health care available.

22. Regions will also need to take account of existing plans and commitments. For example, current building schemes reflect assumptions about future allocations of funds to Districts. We must avoid unexpected changes which would disrupt building programmes and service provision. We do not want new hospitals to be unable to open because of an unforeseen reduction in funding.

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23. Similar considerations apply to the extent to which allocations reflect geographical variations in input costs, for example due to "market forces" or London Weighting, of the kind which will feed through into the prices charged by hospitals. Where a District is effectively constrained to buy locally, for example emergency services, they will need to be compensated for the higher prices they will have to pay. But Regions will also need to take a view on the extent to which Districts should be compensated in this way, bearing in mind the need to preserve incentives to shop around to secure the best deals.

GP Practice Budgets

24. Our proposal to allow large GP practices the opportunity to have their own budgets means that funds for these budgets must be split away from the balance of HCHS allocations at some point. It does not seem defensible to vary capitation payments to GP practices according to the District in which the patient happens to live, at least not until the District itself is funded purely on a weighted capitation basis. I propose that the earmarking is best left to Regions, on the basis of central guidance over the scope of GP practice budgets.

Specialist Services

25. HC35 recognised the need for separate funding arrangements for highly specialised hospital units which provide services to patients from a wide catchment area. Many of these services have been developed on a supra-regional or regional basis, for example heart transplantation and neonatal care respectively.

26. The current central funding arrangements for supra-regional services are outlined in Annex F. I propose that these arrangements should continue. It is particularly important to avoid wasteful duplication of these often expensive services, and to be able to underwrite important new developments like heart transplantation as they get off the ground.

27. The current approach to regional services differs between Regions. Some Regions, for example Yorkshire, are already exploring the use of a contractual approach to the planning, management and funding of "multi-district services", under which Districts enter into prospective service agreements with providing Districts on the elements of service to be provided. I expect our proposals on the funding of services to give further impetus to such developments.

Timetable for implementation

28. For the new funding arrangements we envisage to be put in place, a number of other things are needed:

(i) primary legislation is needed to permit cross-charging between health authorities (Annex G). We are planning

legislation for the 1989/90 session giving authorities the necessary powers to cross charge from autumn 1990.

(ii) both "buyers" and "providers" must be in possession of better cost and activity information. As outlined in HC43, we are planning an accelerated programme for implementing the resource management initiative (RMI); in the meantime improved information is available following the implementation of the Korner recommendations, and further improvements will flow naturally at local level in response to the demands of an increasingly contractual approach to management and funding.

(iii) we must attract into the service finance and other staff capable of negotiating, monitoring and controlling contracts. This will have implications for pay levels and the costs of management, and will take time.

(iv) direct funding for the training of medical, nursing and other staff. Under current arrangements DHAs bear a considerable proportion of the costs of training (Annex H). Training is generally undertaken on behalf of either a group of authorities or the NHS as a whole. Hospitals providing training should not be at a cost and price disadvantage when competing for business; Districts buying services should not be expected to bear an undue proportion of the training costs incurred on behalf of other authorities; and self-governing hospitals, many of whom will be teaching hospitals, will need contracts in respect of their teaching activities. Non-medical training will need to be planned, as now, on a Regional or, exceptionally, national basis.

29. We will clearly not be able to introduce our funding proposals universally until after the next General Election. Rapid implementation without adequate attention to the management infrastructure and to the underlying arrangements for transferring funds between buyers and providers will fail.

Interim Proposals

30. During this interim phase we must make the present arrangements for funding services work better. In accordance with the outline proposals in HC35, I intend to:

(i) amend the present arrangements for funding Regions in respect of cross-boundary flows to ensure that changes in flows have a more immediate impact on allocations to hospitals; and

(ii) introduce a performance funding scheme for allocating an element of "top-sliced" money on the

basis of either a proven track record of efficiency or in order to encourage targeted improvements in efficiency or output.

Cross-boundary flows

31. On cross-boundary flows I propose the following steps:

(i) Regions should enter into discussions with each other during 1989/90 to establish the appropriate sums for "exports" and "imports", concentrating on the major flows. We could then begin to reflect these agreements in allocations for 1990/91. The initial sums would be based on the estimated actual costs (to the providing authority) of recent cross-boundary flows.

(ii) until legislation to permit cross-charging was available, the Department would make any necessary adjustments to cash limits as agreed between Regions.

(iii) as cross-charging became possible, allocations would need to be adjusted so as to relate primarily to resident populations (though Regions might initially still be required to provide services for "de minimis" flows, from within their allocations, so as to avoid unnecessary bureaucracy).

Whilst these changes will not address all the disadvantages of the present system, they will ensure that authorities are compensated more accurately, albeit still on the basis of past flows, for the work carried out.

Performance Funding

32. Once fully implemented, our approach to funding services on a contractual basis, in combination with a more competitive environment, will provide the necessary incentives for hospitals to improve their efficiency; money will also flow to those hospitals successful in attracting business. I therefore regard any scheme which allocates an element of "top-sliced" funds in accordance with actual or potential performance as short term only, on the principle that the new funding arrangements should make redundant any "top-down" performance funding scheme.

33. Measurement of performance is difficult. Ideal measures of effectiveness - based on health outcomes - and efficiency - relating outcomes to inputs - are not available. Assessment of performance requires taking account of a range of performance measures. A mechanistic approach would cause public complaint; and reliance on only a few indicators might distort behaviour and focus activity narrowly on improving the indicators chosen. Local management judgements will be needed. There should be no presumption, however, that all Regions will receive similar amounts, pro-rata to their main allocations.

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34. Possible indicators of efficiency and effectiveness include:

* changes in "cost weighted activity" in relation to expenditure;

* throughput per bed;

* waiting times for inpatient and outpatient treatment;

* percentage of treatments on a day basis (a cost effective form of treatment for many conditions);

* percentage of unplanned admissions;

* significant changes in avoidable mortality.

The Group will be familiar with many of these. Annex I provides a further description of "cost weighted activity" and avoidable mortality.

35. The emphasis within the scheme will be to reward those hospitals which have demonstrated recent improvements in efficiency, having regard to the scope for further improvements. Hospitals which have already secured significant improvements in efficiency should still be in a position to be rewarded for further, albeit smaller, improvements. There should also be scope for Regions to allocate funds in a more targeted manner, for example where allocations would secure improvements in waiting times and permit additional patients to be treated. This involves an element of prospective funding, but I suggest that this should be permitted only if the recipient has already demonstrated improvements in efficiency; we must avoid allocating funds solely to hospitals which, by dint of their poor track record on efficiency - as reflected, say, in long waiting times - have the greatest potential for improvement.

36. Even if the scheme is short-term there could be some overlap in time with the beginnings of self-governing hospitals and GP practice budgets. It would seem sensible in these circumstances for the money to go directly to "providers" - that is to self-governing hospitals but not to GPs - since it is on providers that the scheme's incentives are intended to operate.

37. Performance based allocations will be funded out of "top-sliced" money. I propose a sum of £50m a year for the duration of the scheme. I would need to make a bid for additional funds. The merit of keeping the scheme modest is that it enables a simple method of allocation and it would be easier to justify why some Districts receive no additional funding. Allocations in respect of improved performance would be built into baselines for future years.

38. Paper HC36 discussed the feasibility and cost of establishing additional consultant posts in acute specialties.

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These posts could be funded out of performance based allocations; Regions would be informed of the number of additional posts they could create. The use of funds in this way would introduce an element of inflexibility into the scheme; and the costs would be uncertain, varying by specialty and location. Nevertheless, I am pursuaded by the argument that additional posts will act as a counterweight to other changes which the profession will find less attractive. I propose therefore, a target of an additional 120 consultant posts over 2 years, 60 each year. This would cost around £15m a year after year 2, assuming (perhaps conservatively) that the average cost - including associated staffing and facilities - was £250,000 a post. An increase of this order would be feasible in terms of the availability of qualified senior registrars.

39. I propose that these additional posts should be permanent. We have discussed in the past the possibility of short term appointments as a means of making an impact on waiting lists without incurring long term costs. I am not persuaded by this argument because:

(i) except under rather unusual circumstances, an additional consultant surgeon will need additional supporting facilities which would become redundant after his appointment was terminated.

(ii) short term appointments are likely to attract lower quality applicants.

Short term appointments would necessitate amending the Regulations on the appointment of consultants.

November 1988

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Annex A

NON-PSYCHIATRIC PATIENT FLOWS AS A PERCENTAGE OF POPULATION OF EACH REGION (1988/89 ALLOCATIONS)

NORTHERN	- 0.38
YORKSHIRE	- 0.04
TRENT	- 4.45
EAST ANGLIAN	5.70
NORTH WEST THAMES	- 13.64
NORTH EAST THAMES	4.60
SOUTH EAST THAMES	0.78
SOUTH WEST THAMES	- 11.65
WESSEX	- 1.10
OXFORD	- 1.55
SOUTH WESTERN	0.56
WEST MIDLANDS	2.04
MERSEY	- 0.73
NORTH WESTERN	3.08

1. "-" Signifies a net outward flow.

2. Figures include cross-boundary flows into and out of Scotland and Wales.

3. The patient flows for North West and South West Thames Regions are more marked because of the number of patients treated by Special Health Authorities on their behalf.

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ANNEX B

MOD/DHSS FINANCIAL ARRANGEMENT FOR NHS USE OF SERVICE HOSPITALS

1. The Ministry of Defence and DHSS have agreed revised arrangements for the treatment of NHS patients in Service hospitals in the United Kingdom.

2. Service hospitals are established to train Defence medical staff in all aspects of their work so as to fulfill their roles in periods of tension or war. To meet that training requirement, the hospitals, in peacetime, treat Service personnel and NHS patients, which includes Service dependants, mainly free of charge.

3. Under the new arrangements, NHS patients will continue to be treated, mainly at MOD expense, within a baseline which reflects the training requirement. Beyond that level, any spare capacity will be offered to Health Authorities on marginal cost recovery terms to help relieve NHS waiting lists and maximise the Service hospitals' contributions to civilian health care. Under the new arrangements, provision is also made for planning agreements where defence and health facilities can be rationalised or integrated to mutual local advantage.

4. The intention is that the implementation of the arrangements should rest at local levels and negotiations take place directly between Health Authorities and individual Service hospitals who will need to convert the national principles into contracts and planning agreements to reflect local needs.

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ANNEX C

POPULATION PROJECTIONS 1985 - 1995

Total Population (thousands)

Region	1985	1986	% change
Northern	3,086	3,038	- 1.6
Yorkshire	3,599	3,635	1.0
Trent	4,625	4,741	2.5
E Anglian	1,965	2,149	9.4
NW Thames	3,482	3,589	3.1
NE Thames	3,751	3,832	2.2
SE Thames	3,602	3,743	3.9
SW Thames	2,962	3,061	3.4
Wessex	2,854	3,093	8.4
Oxford	2,437	2,678	9.9
S Western	3,150	3,345	6.2
W Midlands	5,183	5,265	1.6
Mersey	2,423	2,379	- 1.8
N Western	3,992	3,982	- 0.3
Total	47,112	48, 530	3.9

Population 75+ (thousands)

Region	1985	1995	% change
Northern	185	210	13.5
Yorkshire	234	253	8.0
Trent	282	328	16.5
E Anglian	134	167	24.7
NW Thames	206	227	10.4
NE Thames	243	263	8.2
SE Thames	273	302	10.7
SW Thames	220	239	8.1
Wessex	210	244	16.3
Oxford	128	155	20.8
S Western	243	284	16.8
W Midlands	290	340	17.1
Mersey	146	162	10.8
N Western	259	269	4.1
Total	3,051.9	3,441.0	12.7

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ANNEX D

FUNDING FOR RESIDENT POPULATION: IMPACT ON ALLOCATIONS

Region	Existing RAWP allocation (1988-89)	Allocation adjusted for cross-boundary flows	Difference (%)
Northern	735	731	-0.5
Yorkshire	830	834	+0.5
Trent	1010	1034	+2.4
East Anglian	438	426	-2.7
North West Thames	808	837	+3.6
North East Thames	1007	987	-2.0
South East Thames	898	905	+0.8
South West Thames	746	754	+1.1
Wessex	615	625	+1.6
Oxford	482	494	+2.5
South Western	732	721	-1.5
West Midlands	1186	1174	-1.0
Mersey	586	583	-0.5
North Western	1005	972	-3.3

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ANNEX E

FUNDING DISTRICTS AS "BUYERS": ILLUSTRATIVE EFFECTS

Cross-boundary flows

1. Comprehensive data on cross-boundary flows between Districts in respect of all services are not available but cross-boundary flows for local acute services in the SE Thames Region and three districts within that Region have been used to illustrate the effects of these flows on District allocations:

* Table 1 shows the broad financial implications for three Districts of changing to a system of funding Districts on the basis of resident populations: Lewisham and N Southwark, an Inner London Teaching District; Bromley, an Outer London non-teaching District; and Tunbridge Wells, a Shire District.

* Table 2 shows the patient flows in respect of Tunbridge Wells DHA.

Utilisation Rates

2. Hospital utilisation rates vary between Districts due to differences in "need" and the availability of services. Simply to illustrate this point, the table below shows the utilisation rates on a resident population basis for acute in-patient treatment for (the same) three Districts in SE Thames. Also shown are the rates that would be "expected" on the basis of age, sex and marital status of the population.

District	Utilisation Rate (%)	
	Actual	"Expected" (i)
Lewisham & N Southwark	12.2	10.4
Bromley	8.8	9.1
Tunbridge Wells	8.8	9.8

Notes:

(i) "Expected" on the basis each of age, sex and marital status group having the national average utilisation rate for that group.

(ii) Difference between actual and "expected" rates will reflect the influence of supply on service use and the omission of additional factors known to impact on the "need" for services beyond that captured by demographic characteristics.

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TABLE 1

ILLUSTRATIVE REVENUE PATTERNS FOR SERVICE PURCHASED BY CONTRACT [1988/89 ALLOCATIONS]

	Lewisham & N Southwark (£m)	Bromley (£m)	Tunbridge Wells (£m)
1. Inflow of contracts to treat non-resident patients	36.2	9.8	16.1
2. Allocation for Service Increment for Teaching	13.2	-	-
3. Spending on local treatment of residents	71.0	43.4	34.4
4. Outflow spent on contracts for treatment of residents outside districts	30.0	18.8	8.0
	150.4	72.0	58.3
(a) Resources spent on treatment provided in district (1+2+3) (current allocation)	120.4	53.2	50.5
(b) Resources spent on purchasing services for residents (2+3+4)	114.2	62.2	42.2
(c) Change in allocation $\frac{(b) - (a)}{(a)}$	- 5%	+17%	-16%

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TABLE 2

TUNBRIDGE WELLS HEALTH AUTHORITY: FLOWS OF RESIDENT AND NON-RESIDENT LOCAL ACUTE INPATIENTS, 1985

	Inflow of non-residents	Outflow of residents
South East Thames Region		
- Brighton	21	10
- Eastbourne	2,841	9
- Hastings	498	188
- S E Kent	71	42
- Canterbury	11	11
- Dartford	125	31
- Maidstone	1,118	142
- Medway	26	10
- Bexley	10	34
- Greenwich	10	59
- Bromley	63	1,536
- W Lambeth	5	143
- Camberwell	6	63
- Lewisham	8	373
SETRHA sub-total	4,813	2,651
North West Thames	16	188
North East Thames	39	295
South West Thames	1,716	145
TOTAL	6,584	3,279

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ANNEX F

DESIGNATIONS OF SUPRA-REGIONAL SERVICES

1. Supra-regional services are those clinical services that in order to be clinically effective or economically viable, need to be provided by centres, each serving a population significantly larger than that of a single health service region. The criteria for selecting services to be funded supra-regionally are:

* The service should be an established clinical service, not a research or development activity (for which alternative sources of funding exist).

* There should be a clearly defined group of patients having a clinical need for the service.

* The benefits of the service should be sufficient to justify its cost when set against alternative uses of NHS funds.

* The cost should be high enough to make the service a significant burden for the providing regions.

* Supra-regional funding, as opposed to regional or sub-regional development, should be clearly justified either

  a. by the small number of potential patients in relation to the minimal viable workload for a centre, or

  b. by the economic and service benefits of concentrating the service in fewer and larger units shared between regions (this does not include services organised mainly at regional level in which two regions agree on joint provision as a matter of mutual convenience), or

  c. as an interim measure, by the scarcity of the relevant expertise and/or facilities.

* The units to be designated should be capable of meeting the total national caseload for England and Wales.

2. Supra-regional services are funded directly by the Department of Health. Applications for supra-regional designation and funding are made by Regional and Special Health Authorities. These are considered by the Supra-regional Services Advisory Group, which consists of representatives of the medical profession and NHS management and is chaired by a Regional Health Authority chairman. The Group makes recommendations on the identification of services to be funded supra-regionally and on the appropriate level of provision. Supra-regional status is not guaranteed permanent, but is reviewed regularly.

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The designations for 1988/89 are as follows:

Service	Number of Centres	Central Funding £000s	
		Revenue	Capital
Craniofacial	2	376	
Chorioncarcinoma	2	563	
Endoprosthetic Services for Bone Tumours	2	1732	
Heart Transplantation	5	6778	877
Liver Transplantation	4	5038	358
National Poisons Information Service	1	316	113
Neonatal and Infant Cardiac Surgery	10	8933	133
Psychiatric Services for Deaf People	2	1260	
Specialised Liver Services	4	2112	
Spinal Injury Services	8	13734	
		40842	1481

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ANNEX G

CROSS-CHARGING BETWEEN HEALTH AUTHORITIES

1. The essential principle of trading within the NHS is that one health authority should be able to recoup the costs of treatments provided on behalf of another.

Existing practice

2. There are four means by which a health authority may presently recover the costs it has incurred in providing goods and services for another authority:

(i) By adjustment to cash limits effected by a superior Authority tier or by the Department. An example of this is the London Ambulance Service, administered by the South West Thames Region on behalf of all four Thames Regions.

(ii) By the system known as Inter-Authority Non-Cash transfers. Under this, authorities issue one another with cross-accounting vouchers in respect of the cost of services provided to one another. The vouchers are copied to and used by the Department to allow authorities to draw either more or less than their cash limits, but without formal adjustment to the cash limits as such. An example of this is the payment for central supplies provided by Mersey RHA for other authorities. The gross value of transfers in 1986/87 was £3,813m.

(iii) By direct payment between authorities using commercial bank accounts.

(iv) By direct payment between authorities using the Paymaster General Accounts system. Under this, cash never leaves the Exchequer, and the charges are in effect book transfers.

Legislative Implications

3. The requirement that "money flows with the patient" implies a move towards more explicit cross charging between authorities than hitherto. Only direct payment - methods (iii) and (iv) - would seem to satisfy this requirement. This requires primary legislation.

4. Section 16 of the NHS Act 1977 permits authorities to carry out functions on behalf of another but does not provide for charging. This is only permitted where functions are contracted out to the private sector (Section 23). The Act is also quite specific about the source of authorities' money for treating patients: the Secretary of State. It may be inferred, therefore, that authorities cannot expect to receive money from other authorities for treatments on out-of-area patients.

ANNEX H

PRESENT ARRANGEMENTS FOR THE FUNDING OF TRAINING

Medical

1. Responsibility for the management, organisation, funding and provision of medical undergraduate education is vested in several bodies - the Health Departments, the Committee of Vice-Chancellors and Principals, the UGC, the NHS and the GMC. Similar arrangements exist for dental education.

2. Under current funding arrangements the UGC is responsible for student support and the employment of clinical academics and support staff. Nevertheless, clinical academics and NHS doctors carry out a similar mixture of tasks - clinical teaching, patient care and research. There is no precise accounting for the sharing of costs which are borne on a "knock for knock" basis. Within the revenue allocations to RHAs is an allowance - Service Increment for Teaching (SIFT) - for the additional service costs incurred by teaching hospitals in respect of their teaching duties.

Nursing Staff

3. At present the English National Board (ENB) holds responsibility for approving courses of education and training leading to the admission to the register; and for post-registration courses in clinical nursing skills. All pre-registration and most post-registration nurse training takes place in the NHS. There is a very small element of post-registration in the private sector and discussions are taking place on increasing this proportion.

4. Save for the 200 or so students undertaking pre-registration nursing degrees who are maintained by the DES, student training allowances and salaries are paid by the DHA's who have control over the numbers, and the range of specialist training programmes. In addition, DHAs are financially responsible for the cost of nursing school premises and the provision of supervision during clinical placements. The ENB funds the tutor posts and some teaching resources. Oversight of ENB funds is provided by Regional Educational Advisory Groups.

5. Project 2000 is beginning to change this pattern. Some authorities have already started to make arrangements for students to undertake degree courses, with support either coming from DES awards or via current health authority training allowances.

6. The arrangements for post-registration training are similar to basic nurse training in that the health authority is responsible for student salaries. For student midwives, the ENB provides for teachers' salaries etc. For training which takes place within the higher and further education sector, for example

Health Visitor, health authorities pay fees. All other forms of post-registration training are entirely the financial responsibility of health authorities in terms of student salaries and teaching costs.

Para-medical staff

7. Most para-medical professions receive their predominantly non-degree training either in higher education or NHS schools. Student support is predominantly via NHS grants save those on degree courses where support is provided by DES awards. Accreditation for the most part is by the Council for the Professions Supplementary to Medicine (CPSM). The CPSM has no direct funding responsibilities so the costs of teachers, accomodation etc are funded via the UGC and NAB or fees paid by the NHS or both. In all cases health authorities remain responsible for supervision during clinical placements.

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ANNEX I

PERFORMANCE FUNDING: DEFINITION OF INDICATORS

COST WEIGHTED ACTIVITY

1. The Department of Health calculates each year a cost-weighted activity index for the NHS as a whole. The index aggregates different types of service activity by weighting by the relevant unit costs. Table 1 lists the components of the index.

2. The index provides a broad estimate of what activity in a given year would have cost had there been no change in unit costs. Setting this against actual expenditure (adjusted for HCHS pay and price increases), provides an indication of changes in overall efficiency.

3. The indicator as presently constructed is not particularly sensitive to casemix variations, quality of care, or policy. It is proposed that for the purposes of performance funding, the following improvements are made:

* separate inpatients, day cases, outpatients and A&E activity;

* disaggregate inpatient activity by specialty and apply specialty specific unit costs available from Korner;

* for long stay specialties such as Mental Illness and Mental Handicap, adopt a measure of activity other than Deaths and Discharges which reflects workload more accurately, for example inpatient days.

* use of Regional (and District), rather than national unit cost weights, in order to take into account regional variation in input prices.

4. In addition to providing an indication of movements in "efficiency" over time, the indicator can be used to illustrate the relative unit costs of Authorities. Table 2 provides illustrative figures by Region.

AVOIDABLE MORTALITY

4. For a small number of disorders mortality rates can be used as indicators of the success of the health service in curing disease. These are the potentially "avoidable causes of mortality" where clinical treatment is most likely to save life and normally does so in younger patients under 65. Table 3, taken from last year's Health Service Annual Report, shows the record over the last 5 years at a national level. Potentially "avoidable deaths" account for just under 3% of all deaths, but one in every eight deaths before the age of 65.

5. Avoidable mortality rates are already included in the Health Service Management Centre's Performance Indicator dataset for Districts, although the data is "pooled" from a number of years

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due to the small number of observations for some conditions. At Regional level this would be unnecessary, particularly if attention was concentrated on the overall rate and some of the major components - e.g. Hypertension/Cerebrovascular disease and Perinatal mortality.

6. Changes in avoidable mortality will depend both on the effectiveness of primary and secondary care and is arguably, therefore, more applicable to the health service in general than Health Authorities in particular. There may also be time lags. Nevertheless, in the absence of alternatives, its use as a broad indicator of effectiveness can be defended, particularly when used in conjunction with other indicators.

Table 1

Components of National HCHS Cost Weighted Activity Index

Inpatient plus Day Cases (Inpatient Discharges & Deaths and Day Cases)

Outpatient plus A & E (Attendances)

Day Patients (Attendances)

Health Visitng (People visited)

Home Nursing (People treated)

Ambulances (Cases carried)

Blood Transfusion (Bottles of Blood issued)

Table 2

ILLUSTRATIVE CALCULATIONS OF RELATIVE UNIT COSTS

RELATIVE UNIT COSTS 1985/6

NORTHERN	94.6
YORKSHIRE	91.1
TRENT	92.7
EAST ANGLIAN	97.5
NORTH WEST THAMES	116.8
NORTH EAST THAMES	114.4
SOUTH EAST THAMES	105.8
SOUTH WEST THAMES	116.3
WESSEX	94.7
OXFORD	94.4
SOUTH WESTERN	97.9
WEST MIDLANDS	100.4
MERSEY	98.5
NORTH WESTERN	89.5
TOTAL	100.00

Notes:

1. Relative unit costs: actual expenditure divided by estimated expenditure using national cost weights.

2. Variations will reflect, in part, the effects of regional variations in input prices - London Weighting etc.

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Table 3

'Avoidable Causes of Mortality'
Percentage Changes in SMRs 1981-86[3], England and Wales

Cause	Age Group	Percentage Change 1981-86
Perinatal deaths	-	-19
Tuberculosis*	5-64	-36
Cancer of the Cervix	15-64	- 1
Hodgkin's Disease	5-64	-22
Chronic Rheumatic Heart Disease	5-44	-47
Hypertension/cerebravascular Disease	35-64	-18
Surgical deaths[2]	5-64	-11
Respiratory Disease	1-14	-56
Asthma	5-44	0
Total of above	as above	-16
All causes except those shown above	all	0
All causes	all	0

*Omits late effects of tuberculosis

[2] Appendicitis, choleolithiasis, cholecystitis and hernias

[3] SMR for 1981 equals 100 SMR = Standardized mortality ratio; a measure of the death rate which takes account of changes in the age structure of the population

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