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SECRET

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PRIME MINISTER

STEERING BRIEF: NHS REVIEW GROUP MEETING ON 24 NOVEMBER

AGENDA FOR THE MEETING

1. This meeting provides a good opportunity to deal with as many outstanding issues as possible and to clear the way for the drafting of the White Paper. You may want to cover the following:

i. Timetable. You may want to begin by spending a few minutes on the timetable for the Group's work between now and publication of the White Paper in January.

ii. Better Service to Patients (HC53). This is the note by the Secretary of State for Health which you discussed with him and Mr Mellor this morning, but have not discussed with the Group more generally.

FOLDER A

iii. Management of Capital (HC56): note by the Secretary of State for Health and the Chief Secretary.

FOLDER B

iv. Other Papers. It might be worth spending a few minutes on the two papers which Mr Clarke circulated for written comment:

a. Public and Private Sectors (HC54)
b. Professional and Employment Practices (HC55).

FOLDER C

v. Any other outstanding points. If there is time you may want to conclude with a round-up of outstanding points. One important area not yet discussed is Pay where the Secretary of State for Health and Chief Secretary are still in discussion. Also cover consultants contracts under this heading, and the NHS Chief Executive appointment. PRG

FOLDER D

SECRET

6

TIMETABLE

2. You decided this morning that the White Paper must be published before the first anniversary of the start of this Review. This means getting it out in the week of Monday 16 January 1989, or early in the following week: your interview on Panorama took place on 25 January 1988, and the first meeting of the Group was two days later, on 27 January. The timetable between now and publication might be as follows:

This reflects a talk I've had with Richard Wilson following our chat before lunch.
PRCG.

16 December: a meeting to deal with any issues still outstanding and to consider a first draft of at least part of the White Paper;

Week beginning 19 December: a further meeting to consider a full draft of the White Paper [possibly on 22 December];

Week beginning 2 January: meeting(s) as necessary to consider further drafts of the White Paper;

Week beginning 9 January: E(A) and Cabinet;
(or following week)

Week beginning 16 January: publication of the White Paper.
(or early following week)

3. You may wish to emphasise that the style of the White Paper needs to be crisp, readable and interesting (perhaps following the presentational style of the Broadcasting White Paper).

BETTER SERVICE TO PATIENTS (HC53)

4. You may want to run through the main points which emerged from your discussion with Mr Clarke and Mr Mellor.

i. The Review must produce specific benefits to patients, not vague initiatives or quality assurance programmes. Particular areas requiring action include:

- an appointments system which works;

- prompt information for patients about the results of X-rays and tests;

- better information about the availability of beds and about NHS services generally;

- shorter waiting times;

- the ability to change doctors, where a patient is dissatisfied with a GP;

- proper facilities for mothers and children in emergency departments;

- better complaints procedures.

ii. Improving the quality of service in 'acute' hospitals is a job for management, not for a new acute sector advisory body. The NHS Management Committee, and managers down the line in Regions and Districts, need to be on the look-out for things which are going wrong and may decide to send in teams to find out the reason. They may also want to commission medical or management audits of particular aspects of patient treatment such as appointments or waiting times. But none of this requires a separate body in the NHS. It is integral to management.

iii. Importance of sanctions. Where patient treatment is unsatisfactory it is important that managers have effective sactions to remedy it, for instance the power to hire and fire in self-governing hospitals.

iv. Health prevention and health indicators should not be a major feature of the White Paper. They can easily give the impression of treating patients as units and of the State

being responsible for each citizen's health. (The Chancellor too has reservations about giving emphasis to health indicators).

v. The whole purpose of the proposed reforms is to provide a better service to patients. The White Paper should bring this out and enlist their support. Its foreword should start with the theme of patient care, and each major reform in the text should be drafted to reflect it.

MANAGEMENT OF CAPITAL (HC56)

5. This paper is a very brief summary of the outcome so far of the discussions between the Chief Secretary and the Secretary of State for Health. The Secretary of State for Wales in his minute of 21 November argues the case for opening up the use of private capital, in particular through greater use of leasing arrangements in which the private sector builds facilities and the public sector leases them.

Capital Charging

6. Mr Clarke and Mr Major have reached agreement on the introduction of capital charges in the NHS. Under their proposals a system of charges will be introduced so that the users of capital assets will be required to meet the cost of these assets, as reflected in the current valuation (subject to normal depreciation). This regime will apply to all hospitals, whether or not self-governing. It will be introduced in three stages: first, valuation on an agreed basis; second, the introduction of 'notional' management accounts, to familiarise the NHS with such a system; and third, a move towards a fully effective system of real charges "as soon as reasonably practicable".

7. The principle that public sector hospitals, just like anyone else, should have to pay for the use of capital is important in order to enable there to be fair competition between the NHS and hospitals in the private sector. But there are two points you may wish to raise:

i. approval by the Regional Health Authority. The paper proposes that a self-governing hospital would need to obtain Regional approval before disposing of more than 5% of its total capital stock. This is an improvement on earlier proposals that all disposals by self-governing hospitals should require Regional approval. But you may nonetheless wish to ask why in principle there needs to be this sort of control over self-governing hospitals. Perhaps it would only apply to disposal of 5% in any one year? or would it be cumulative? is this bureaucracy necessary?

ii. length of transition. Experience with other management systems in the NHS suggests that they can take a long time to implement. It would be a pity if this initiative got bogged down in the second phase of notional management charges, before the third phase of real charges was reached. You may wish to ask what length of transition they have in mind. Would it be possible to go straight to ~~it~~ the third stage without the intermediate 'notional' stage? Might not real charges carry more conviction with hospitals which are to be encouraged to manage their own affairs?

Access to private sector capital

8. The paper makes no proposals on access to private sector capital. It simply says that the issues are complex, that they have asked officials to identify cases which have arisen in the past to enable them to identify the scope for a more flexible approach and that they will report the results to colleagues as soon as possible "with the objective of making a general statement of policy in the White Paper".

9. You may wish to invite Mr Clarke and Mr Major to report progress, including:

i. the scope for greater use of leasing. The annex to Mr Walker's minute of 24 November lists specific areas where private sector finance could play a part in the NHS. These include the design, building and possibly running of

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hospitals; the design, installation and maintenance of information technology systems (with DHAs being able to fund leasing and contractual arrangements out of revenue expenditure); the leasing of medical equipment from the private sector, particularly in high-risk short-life technologies; energy management contracts (typically, the private sector make the investment in energy efficiency and share the savings from lower fuel bills); and "factory" style treatment centres specialising in particular operations (eg hip replacement) to reduce waiting lists. You may want to ask whether these ideas can be followed up.

ii. Capital allocations within the private sector. The paper on Funding Hospital Services said only that capital allocations would be based on capitation weighted by age and morbidity and that land sales would continue to be retained for developments within regions (paragraph 23). You may want to ask what the arrangements will be for capital allocations to self-governing hospitals.

TWO OTHER PAPERS

10. Mr Clarke has invited written comments on two other papers.

The public and private sectors (HC54)

11. This paper rightly stresses the importance of blurring the distinction between the two sectors. But you may wish to consider whether more could be done to achieve this.

i. One possibility would be to make more optional extras available at a charge to NHS patients. Amenity beds are the most obvious example.

ii. Another possibility would be for the NHS to contract out more clinical as well as non-clinical services where the private sector can provide them more cheaply. Mr Clarke's paper suggests the need for local initiatives on contracting out of pathology and radiology. The Chancellor in his

SECRET

comments on this regrets the fact that assurances which Mr Moore gave last November rule out a stronger steer from the centre on promoting competitive tendering but in the circumstances reluctantly agrees with what Mr Clarke proposes. You may wish to endorse the case for local initiatives at least.

Professional and employment practices (HC55)

12. The Group earlier asked for a paper on restrictive practices in the health professions. This is the outcome. Its main proposal is that there should be a major inquiry into the role of the professions and boundaries between them. The Group will want to consider whether it would be right to set up another inquiry after the main Review has lasted a year, and when it would prolong uncertainty until the end of 1989. The Chancellor is opposed: he thinks the inquiry could well get into territory covered by the Review (eg on consultants) and give the impression of muddle, with the criticism that if the Government is prepared to have an inquiry on this point, why not on other aspects of the Review. Mr Walker on the other hand supports the proposal for an inquiry.

13. For the rest, Mr Clarke mentions a number of exercises which he has in hand, in particular on the terms and conditions of NHS staff (paragraph 18) and on the deployment of nursing staff (paragraph 21), without giving very much detail. You may wish to ask him to include any positive proposals emerging from this work in the forthcoming draft of his White Paper, where it can be seen in context.

ANY OTHER OUTSTANDING POINTS

14. One area where disagreement between the Treasury and the Department of Health needs to be resolved is pay, in particular the extent to which self-governing hospitals should be responsible for their own pay arrangements as well as for the hiring and firing of staff. The Secretary of State for Health and the Chief Secretary are due to circulate a joint paper but have not yet done so. You may wish to ask for a progress report.

SECRET

SECRET

15. Another area where Mr Clarke has been asked to do more work is consultants' contracts and how they are to be better managed. His letter of 21 November to the Chancellor sets out his latest thinking. Much of it is in tune with the Group's earlier discussion: for instance, involvement of District General Managers in appointments, the introduction of budgets for which consultants are responsible and putting a time-limit on disciplinary proceedings. But there are still points to be clarified. You may wish to ask the Chancellor whether he has comments and raise the following points:

i. part-time contracts. The simple question is: why should not a consultant contract to work for five-elevenths of a full-time job and be paid five-elevenths of a consultant's salary for it? The letter appears to envisage continuation of the present "maximum part-time" arrangements under which consultants agree to devote substantially their whole time to their professional duties but subject to that are free to undertake unlimited private practice for 10/11ths of a whole-time salary;

ii. distinction awards. Mr Clarke refers to the "changes we propose" to the distinction awards system. What follows is then a summary of what Mr Moore proposed last July (HC36). You may wish to ask what approach he has in mind in his reference to widening the criteria for these awards;

iii. self-governing hospitals. Mr Clarke refers to the process for appointing consultants which is in the hands of professional Advisory Appointment Committees. You may wish to ask what arrangements will apply in self-governing hospitals.

NEXT MEETING

16. For the next meeting on 16 December, the Group may wish to consider:

SECRET

i. the further work commissioned at this week's meetings;

ii. the joint paper on pay by the Secretary of State for Health and Chief Secretary;

iii. a first draft of at least part of the White Paper including perhaps the chapter on self-governing hospitals.

RTJW.

R T J WILSON
Cabinet Office
23 November 1988