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NHS REVIEW

Outstanding Points from Ministerial Group

Other than on capital and pay

Self-governing hospitals

Use of the existing power to set up Special Health Authorities was 'worth considering as a first step' (15th meeting).

The application of end-year flexibility to self-governing hospitals remained to be settled, but there was a strong case for it (15th meeting).

Proposal that representatives of the local community should be on hospital boards 'needed further thought' (13th meeting).

GP practice budgets

Secretary of State to 'revise and develop' his proposals for GP practice budgets in the light of the discussion at the 13th meeting.

Two particular points mentioned in this connection at 13th meeting:

a. There was scope for the inclusion of expenditure on accidents and emergencies.

b. The proposals on overspending and underspending should be 'developed' in the light of the need to ensure that the system was simple and workable.

HC 51, on managing the FPS, said that the Secretary of State was working up separately his proposals on detailed aspects of GP practice budgets.

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Effect of top slicing on GP practice budgets 'needed clarification' (13th meeting). This may drop in view of later developments on top slicing.

Other FPS questions

Secretary of State to prepare a note about timetable for getting information about the proper level of referrals and prescribing, and basing budgets on it (15th meeting).

Secretary of State to 'consider what could be done' on providing incentives to GPs (15th meeting).

Audit

Secretary of State to check that arrangements already agreed would expand Audit Commission's role to cover FPS as well as hospitals (15th meeting).

Reconstituting Health Authorities

'Further thought to be given' to case for giving RHAs guidelines for the exercise of their power to appoint members of DHAs (14th meeting).

Private Sector

The possibility of Government action to ensure that the private sector had adequate medical standards 'should be further considered' (14th meeting).

Number of consultants

HC 49 proposed using some performance funding to provide for more consultant posts. This was also mentioned in HC 58. The proposal was not discussed by the group.

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PRIME MINISTER

NHS REVIEW: DRAFT WHITE PAPER
[HC67: Paper by the Secretary of State for Health]

1. This is a workmanlike first draft but it will need quite a lot of sprucing up before it is ready for publication. You may wish to concentrate on the main points of substance, rather than a line-by-line analysis. Particular points on each chapter are set out below.

CHAPTER 1: FOREWORD

2. The main question on the foreword is whether it strikes the right note and is substantial enough. More than any other part of the White Paper it needs to catch attention. You may feel that the present text, although making roughly the right sort of points, does so without much conviction. You will wish to invite views on this. One possibility might be to say rather more sharply not only that the Government is committed to preserving the NHS and the good things about it but also that there are weaknesses on it, as many patients know, which the Government is determined to put right. Some of the material at the beginning of Chapter 2 might also be brought into the Foreword to demonstrate the Government's commitment to the NHS. There is also the question who should sign the foreword: a decision on this will be needed fairly shortly.

CHAPTER 2: DELIVERING A BETTER SERVICE

3. This is the key chapter which should establish from the outset the rationale for the reforms and how they are all designed ultimately to result in a better service for patients. You may wish to comment on the following:

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1. benefit to patients. You confirmed on 24 November that the White Paper should include a package of practical improvements in the NHS of direct benefit to patients. The White Paper is however rather tentative, with the main description tucked away in paragraph 2.15, beginning "The practical improvements that may often be needed include..." You may feel that these points should be brought forward in the chapter and put more convincingly;

ii. changing doctors. There is no reference in this chapter to improving the procedure for allowing patients to change their GPs although there are proposals in paragraph 8.29. You may want to suggest that there should be some mention of them in this chapter;

iii. waiting lists. The passage on waiting lists in paragraph 2.14 says rather lamely that the problem of waiting lists remains, even though paragraphs 7.31 and 7.32 deal more fully with the position. Here again, the chapter might be strengthened;

iv. Value-for-Money. Improving the NHS is not only a question of making the NHS more businesslike, but also of getting better value for money for the huge sums poured into it. It is not reasonable to expect the taxpayer endlessly to provide more money without some assurance that present expenditure is being properly used. There is no flavour of this in the present text. You may wish to consider whether there should be.

CHAPTER 3: GP PRACTICE BUDGETS

4. This is the chapter with which the Treasury seem likely to be in most disagreement. The central point must be to ensure that the Department of Health have a scheme which will work and that they know the answers to the main questions which are likely to be raised. Points which you may want to test out include the following:

i. accident and emergencies. The Group asked Mr Clarke on 17 October to consider the scope for experimenting with the inclusion of expenditure on accidents and emergencies in budgets. You may wish to ask Mr Clarke what conclusion he has come to;

ii. overspending and underspending. The Group asked Mr Clarke on 17 October to devise simple and workable arrangements for dealing with overspends and underspends. The arrangements outlined in paragraph 3.19 have square brackets round the key numbers. You may wish to ask whether this is backed up with detailed proposals. Is Mr Clarke satisfied that there is no danger of GPs lining their own pockets at the expense of patient care, under the arrangements for ploughing back underspends into the practice? You may wish to ask what will be done about auditing GP practices.

iii. drugs. The text accurately reflects the decision that GP practices which opt to have their own budgets should have a further choice as to whether or not to include prescribing costs in their budget (paragraph 3.10). It has now been decided that all GP practices should have indicative drug budgets. You may wish to ask whether this further option should therefore be dropped. Would it not be better to include prescribing costs in the budgets of all practices which choose to have them?

iv. negotiating budgets. The draft proposes that GP budgets should be settled by a process of negotiation between the practice in question, the Regional Health Authority and the Family Practitioner Committee. This could be a lengthy process, particularly if the FPC wanted to give the practice as small a budget as possible (as they would have every incentive to do). And it would be difficult for the GPs in the practice to know whether they wanted to apply for their own budgets if they had no idea how much money

they were going to get. You may wish to ask whether it is really right to rule out a straightforward formula for setting the budget, so that everyone knew where they stood;

v. aim. The draft says that the Government aims to encourage a substantial number of GP practices to apply to manage their own budgets with effect from April 1991 (paragraph 3.21). Mr Clarke will be asked how many he has in mind. You may wish to ask him what he will say.

CHAPTER 4: SELF-GOVERNING HOSPITALS

5. This chapter explains the Government's proposals on self-governing hospitals. Much of its content has already been thoroughly discussed by the Group. You may wish to concentrate on the following:

i. composition of the board (paragraph 4.5). The Secretary of State was asked to give further thought to a proposal that representatives of the local community should be on the boards of self-governing hospitals. The draft proposes that "at least two" of the five non-executive members should be drawn from the community, for example from the League of Friends, and that they should be appointed by the Regional Health Authority (unlike the other non-executives who will be appointed by the Secretary of State). None will be an employee of the hospital or health authority, or trade union with employees in the NHS or a major contractor or supplier. You may wish to ask why the list of exclusions does not extend to local authorities and all trades unions;

ii. accident and emergency. You may wish the draft to reassure readers that very urgent treatment, for example for accidents, will continue to be available from the nearest hospital. Paragraph 4.10 mentions that the point will be covered in Chapter 7. Should it be covered in this Chapter?

iii. number of self-governing hospitals. The Government will be pressed on how many self-governing hospitals it expects to set up. You may therefore wish there to be a clear and unequivocal commitment on this point. The nearest to this in this chapter is in paragraph 4.23 which refers to the establishment of Trusts. You may wish to ask Mr Clarke what he will say when he is asked how many he has in mind.

iv. role of the regions. There is a reference to the Regional Health Authorities "establishing the precise range of services and facilities" for which self-governing hospitals will be responsible (paragraph 4.22). You may wish to probe what lies behind this. The paragraph refers to RHAs putting forward the formal applications for self-government: is it the intention that they should be the only source of formal applications?

v. closures. The White Paper rules out self-governing status for any hospital which the Secretary of State believes should be closed (paragraph 4.20). You may wish to consider whether this negative note is the right one to strike.

CHAPTER 5: MANAGING THE HOSPITAL SERVICE

6. This chapter brings together a variety of important issues to do with the management of the NHS. The role of the NHS Management Board, slimming down the Regions, devolving management responsibility to hospitals, making better use of staff, introducing information systems, improving pay negotiations, changing the rules on capital (public and private) and extending the role of the Audit Commission: all of these are dealt with here, mostly quite briefly. You might raise the following:

i. accountability to Parliament. At the last meeting you asked that the White Paper should remove from Ministers responsibility for answering detailed questions about pay in

Parliament. Mr Clarke said that this would require legislation and that any reduction in accountability would be controversial. The point was not resolved.

You may wish to consider returning to this important issue in the context of paragraph 5.2. The role of Government is not only to set objectives and priorities, but also to decide how much money the nation can afford for the NHS, to provide financial disciplines to make sure that it is well spent and to monitor performance. Within that framework it is the job of managers to manage. You may wish to discuss whether this should be embodied in legislation. The reference in paragraph 9.8 to Ministers being "fully accountable" to Parliament is also relevant. It seems to imply continuation of the present arrangements;

ii. Resource Management Initiative (paragraphs 5.16 to 5.19). The draft commits the Government to pressing on with the centrally driven RMI, with the aim of extending it to all 260 acute hospitals by the end of 1991/92. In parallel, there will be "regional information strategies" (paragraph 5.19) prepared by May 1989 which will cover all 260 hospitals by March 1993. You may wish to ask how these timetables fit in with the arrangements for setting up self-governing hospitals. Might it not be better to let the hospitals get on quickly with whatever information systems they think they need?

iii. pay. The section on pay is headed "Pay flexibility" but begins with the statement that the Government remains committed to a central framework for pay determination in the NHS (paragraph 5.21) and puts the main paragraph on flexibility, paragraph 5.24, in square brackets. There are no doubt important sensitivities on this. But you may wish to consider whether the text gets the balance right. Does there need to be such a resounding commitment to central negotiation?

CHAPTER 6: THE WORK OF HOSPITAL CONSULTANTS

7. This chapter mainly sets out the decisions taken by the Group on hospital consultants, but you will wish to probe two points where these decisions have been modified:

i. distinction awards. The fourth inset in paragraph 6.20 says that new or increased distinction awards should be pensionable only if a consultant continues working in the NHS for at least three years. The proposal agreed by the Group (set out for example in Mr Clarke's letter of 21 November to the Chancellor) was that awards should only be payable if the consultant continued working for three years. This seems a significant change and you will wish to question it;

ii. eligibility for distinction awards. The first inset in paragraph 6.20 says, as agreed by the Group, that 'C' distinction awards will be replaced by performance related pay, for which eligibility will be jointly decided by general managers and senior doctors. It also refers to "a small number of exceptions" for consultants whose jobs have only a limited management content. We understand that Mr Clarke has in mind medical school staff for example. The reference to exceptions may be justified but it has not been put to the Group before and you may wish to ask about it.

8. There is also an important point on consultants' remuneration. Mr Clarke proposed, and the Group agreed, that where a consultant worked only X sessions a week for the NHS he should be paid only X/11ths of a full-time salary. This is not mentioned. We understand that Mr Clarke may say that it is covered by the general reference to the consultants' job description in paragraph 6.13. But such flexibility in pay arrangements for full-time consultants is unusual, and you might ask whether it would be better to say explicitly that the Government intends to make more use of it.

9. There is also one point on audit. The Group agreed that there should be provision for joint enquiries covering both medical and

management audit in cases where both types of issue are involved. This does not seem to be mentioned and you may wish to ask about its absence.

CHAPTER 7: FUNDING HOSPITAL SERVICES

10. This chapter sets out the new arrangements for funding hospital services, and in the main follows what the Group has agreed. You may however wish to raise the following.

i. RAWP. There appears to be a change in the new system to replace RAWP for allocation to RHAs. HC58, which was agreed by the Group, mentioned a differential of 3% in favour of the Thames regions (paragraph 12). You might ask why the White Paper (paragraph 7.8) now mentions 2%, given that even a 3% differential would have meant losses for the northern Thames regions.

ii. Allocations to districts. No timetable is given in paragraph 7.13 for the new method of allocation to districts. Instead the Government is to discuss implementation with RHAs. This may be right and is not contrary to earlier decisions by the Group, but you may wish to be satisfied that there is no needless uncertainty.

iii. Contracts between buyers and providers. This chapter goes into some detail on the forms of contracts between buyers and hospitals. Paragraph 7.18 for example says that contracts for core services will be based on fixed payments, and paragraph 7.22 that those for elective surgery will be "cost and volume" contracts, with some buying on a case by case basis. You may wish to ask whether it is necessary to go mnto this degree of detail before consultation, when other important topics have been dealt with relatively briefly.

iv. Waiting times. The Group earlier said that the White Paper should give some detail on how a reduction in the waiting list for operations would be achieved. You may wish to consider whether paragraph 7.31 gives enough detail on this important topic.

v. Appointment of more consultants. The draft proposes a scheme for increasing consultant numbers (paragraph 7.32). This was originally the Chancellor's idea but no final decision about it was ever taken. You may wish to confirm that the Group agree to its insertion in the White Paper.

CHAPTER 8. MANAGING THE FAMILY PRACTITIONER SERVICES

11. On medical audit, the White Paper does not contain a clear statement that management, in the form of the FPC, should have access to the general results of medical audits of GPs. The Group attached importance to such access in the case of medical audit in hospitals, and a reference appears in paragraph 6.8. You might ask whether there should be a similarly explicit reference to management access in the case of audit of GPs. Other points which might be raised are:

i. GPs' Pay. Paragraph 8.7 mentions the decision to increase the capitation element in GPs' pay so as to exert downward pressure on numbers. A firm target of 60% is however new and you will wish to consider whether you are content with it. Mr Clarke may want to reconsider it following his meeting yesterday with Mr Major;

ii. control of drugs. The last two sentences of paragraph 8.11 say that the new controls over prescribing costs will do no more than moderate their rise. You may wish to ask whether the White Paper really needs to accept further increases in public expenditure in this area;

iii. change of name. The White Paper also contains (paragraph 8.18) the new proposal that FPCs should be re-named Family Practitioner Authorities. You might ask whether this change of name is necessary.

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CHAPTER 9: BETTER DECISION-MAKING

12. This rather thin chapter deals with the reconstitution of health authorities and the new arrangements for the NHS Management Board. You might raise the following:

i. local authorities. There is a reference in square brackets to consulting local authorities about the appointment of members of District Health Authorities (paragraph 9.6, sixth indent). You will wish to consider whether this should be in;

ii. guidelines for RHAs. On a minor point, Mr Clarke was asked at the 14th meeting to consider further whether to give guidelines to RHAs about how they exercised their power to appoint members of DHAs. You might want to ask what conclusion he has come to;

iii. NHS Management Board. The draft firmly restates the responsibility of Ministers for directing and controlling the NHS. The Secretary of State will chair a Policy Board; the new Chief Executive will run the Management Board. You may wish to ask about membership of the latter. The present Management Board has considerable representation from the Department of Health: will this continue? If there is to be a clear separation between responsibility for strategy and responsibility for management, should not the role of the Department be to concentrate on strategy, and keep out of management?

CHAPTER 10: WORKING WITH THE PRIVATE SECTOR

13. This chapter seems very thin. Two points arise:

i. can it be strengthened? You may wish to ask Mr Clarke to consider whether it could be made more specific. For instance, the Group has agreed that the Government should encourage local initiatives on competitive tendering for such clinical services as pathology: is there any reason why this cannot be mentioned specifically?

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ii. tax. The weakness of the chapter makes it all the more important to include some reference to the decisions on tax agreed in July. The Chancellor may still be considering coming back to you on them: we do not know. You may simply wish to ask him where the Treasury passage is, and how he plans to handle the announcement. The best course might be a Parliamentary Answer by the Chancellor in parallel with publication of the White Paper which would include a short passage on what is proposed.

CHAPTER 11: HEALTH SERVICES IN SCOTLAND, WALES AND NORTHERN IRELAND

14. See separate brief.

CHAPTER 12: SUMMARY AND TIMETABLE FOR CHANGE

15. It may be best to come back to this chapter when the rest of the White Paper has been polished. It is not completely clear what purpose the chapter serves. In particular the introduction appears to duplicate the foreword and some of the early chapters; and the timetable seems sketchy (eg it makes no reference to the Audit Commission or medical audit, or to the new funding arrangements). You may wish to ask Mr Clarke to have another look at it.

RTJW

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21 December 1988