SECRET

PRIME MINISTER

NHS REVIEW

I was, of course, unable to attend the meeting of the Ministerial Group of the review on 5 January but I have now seen the minutes and a copy of your Private Secretary's letter of 3 January 1989 which conveyed your views about the first drafts of White Paper material. In view of the tight timetable for completing our work, I am writing to record the points of major concern to me.

2. I am enclosing with this note a revised text of the Welsh Chapter which I believe reflects the distinctive needs and circumstances of Wales, as well as dealing with the points in the earlier text on which you commented. I note that at the meeting on 5 January it was agreed that there should be separate chapters covering Northern Ireland, Scotland and Wales. These need to follow a broadly common format, although they need not, of course, have the same detailed content. I have not produced an introductory section on distinctive achievements of the NHS in Wales in the belief that early in the main body of the White Paper we would put across stongly our record of achievement for the UK as a whole since 1979. But if a nation by nation approach were preferred, I could provide additional text quickly.

3. Turning to the White Paper material produced by the Department of Health and discussed on 5 January, I am pleased to note that it is to be made clear what passages apply to England and what to other parts of the the UK. This could be achieved by expanding the paragraph 2.16 which ends Chapter 2 as follows:-

"The Government has prepared detailed proposals for making the NHS more sensitive to the needs of patients, more efficient in the use of resources and better able to provide quality care. Chapters 3 to 10 set out these proposals in full for England. Chapter 11 summarises these and gives an action timetable and Chapters 12 to 14 set out how the general proposals are to be translated into detailed programmes of action pertaining to the particular needs and circumstances of Scotland, Wales and Northern Ireland."

4. Also in Chapter 2, the last inset paragraph in 2.12 it should make it clear that it refers to the national management of the service in England.

5. Turning to Chapter 4, I believe it is important to make it clear that there will be a guarantee of adequate service coverage. Already our opponents are saying that self-governing hospitals will concentrate on the most profitable lines and neglect other services. We must find an emphatic statement, such as that I have proposed in the Welsh Chapter, which sets out clearly our reply to this accusation.

..../6.

b

6. On Chapter 5, throughout our discussion I have expressed my very real concern that we have not given the priority we should to obtaining a much higher quality of general and financial managers. In other parts of the White Paper we do acknowledge that these skills will be crucial to the success of the reforms we propose. I do consider it essential to express stongly our intention of having top standards of financial and general management and that means seeing that people of the quality desired get their appropriate reward.

7. Last, I return to Chapter 1 - the foreword. I believe that we would set the right climate by restating unequivocally our sole objective that everybody, no matter what their means, should be entitled to a higher standard of health care, and that the treatment of major disease and illness will and must remain available to everybody. This would, of course, be linked with our having made available vastly increased expenditure for the NHS.

8. I am sending copies of this minute to Nigel Lawson, Kenneth Clarke, Malcolm Rifkind, Tom King, John Major and David Mellor; to Sir Roy Griffiths, Professor Griffiths and Mr Whitehead in the No 10 Policy Unit; and to Mr Wilson in the Cabinet Office.

11 January 1989

PW

CONFIDENTIAL 2ND DRAFT 10.1.89

DRAFT OF WELSH CHAPTER FOR NHS REVIEW WHITE PAPER

Introduction described in previous chapter

1. The people of Wales will benefit fully from the improvements which will flow from the Review, and which will make the NHS more responsive to the needs of patients. There are distinctive health care needs and circumstances in Wales. This Chapter describes these and the distinctive programme of action for the Principality.

2. There is no regional health authority in Wales. Some of the functions of the regional health authorities in England - such as the holding of medical consultants' contracts - are the responsibility of district health authorities in the Principality. Others are carried out on authorities' behalf by the Welsh Health Common Services Authority (WHCSA), and there is the special remit of the Health Promotion Authority for Wales, which works in co-operation with the DHAs and other interests, to ensure that ill health is prevented and better health promoted.

3. Other regional functions, such as determining the capacity, location and funding of regional services (such as renal dialysis) resource allocation, regional manpower planning and strategic investment in information systems and technologies, are the direct responsibility of the NHS Directorate. The NHS in Wales works under the strategic direction of the Health Policy Board, which is chaired by the Secretary of State. An Executive Committee of the Board is led by the Director of the NHS in Wales and is responsible for carrying into effect the decisions of the Board. The Director is also the Chairman of WHCSA. These arrangements, which were introduced following the NHS management inquiry of 1983, have proved their worth and will continue. They will be focused to ensure the delivery of the programme of action described in this ~~Chapter~~ Review. A full corporate strategy for the NHS in Wales will be published in 1992.

Putting the patient first: the programme for action

4. i. Increased autonomy for hospitals - The introduction of general management at all levels of the NHS in Wales has already brought a significantly improved focus on quality of care and cost effectiveness. Unit general managers have been appointed to run hospital and

allocated. Money must move with the patient so that hospitals which are efficient and effective, and attract more work, get the resources they need. Detailed proposals will be the subject of consultation.

iii. Assuring quality of care - The Welsh Office will work jointly with the other UK Health Departments and the professions to introduce as rapidly as possible a comprehensive system of medical audit. There will be close working with the professions and the representative bodies in Wales to build on the work which has already been done. The NHS in Wales will embark upon a programme to improve the quality of acute care and other services, commencing with proposals in 1989 for better ways to inform patients about services and to take account of patients' views in the development of services.

iv. Closer involvement of doctors in management - Wales is well advanced in developing the role of clinicians in management, in particular through the pilot resource management project and the development of costings for individual treatments. This work will be accelerated, so that information systems to enable doctors to work with general managers and ensure the most cost-effective use of resources are in place throughout Wales by 1992.

v. Developing the role of the GP - The NHS in Wales has taken the lead in securing the closer involvement of GPs in the planning and development of hospital services, through an experiment under which the decisions of GPs about where patients receive hospital treatment will be reflected in the DHA's planning and budgeting. The results will be used to extend the influence of GPs in such decisions across Wales.

There is already a sustained drive to equip GPs with the management systems and technologies they need to make effective referrals to hospital services. The central elements are information about waiting lists, waiting times and the costs of treatment. This programme will be accelerated so that by 1992 all GPs in Wales will have up-to-date information on which to base their decisions.

As these initiatives take effect, and as GPs are able to demonstrate their management capacity in these new

community services at local level and given clear responsibility working in co-operation with medical, nursing and professional staffs, for budgets and results. Wales is in the vanguard of the UK-wide drive to introduce the information systems and technologies which are needed to show what medical treatments cost.

The managerial autonomy of hospitals will be further enhanced and hospital management and clinical staff will be given direct responsibility for the services they provide. They will move as quickly as possible to a position where they are, in effect, contracted to provide a given level, range and quality of service.

There are 17 major acute hospitals in Wales, ie with 250 or more beds, many of which serve widely dispersed populations. It will be possible by the early 1990s for a major acute hospital that so desires to become self-governing provided that it shows clearly that it will have the capacity to provide efficiently and effectively an adequate range and depth of services to the population it serves.

ii. An open market in health care - These changes in the management of hospitals will take place against a wider background of the creation of an open market in health care.

Private sector hospital care is relatively poorly developed in Wales, with just 215 in-patient beds. And there are just 54 pay beds in NHS hospitals. These facilities will need to expand to increase patient choice.

Health authorities in Wales have begun to purchase private sector care where this represents the best deal for patients. These initiatives will be built on to lead a sustained drive to reduce waiting times. Special consideration will be given to the establishment of treatment centres to ensure the rapid turn-round of cases, with direct referrals by GPs for key disabling conditions where waiting times are too long, such as hip and knee replacements, cataracts, varicose veins and hernias.

The drive to open up the market in health care for the benefit of patients will be supported and encouraged by changes in the way in which resources are

ways, the programme to enable GPs to hold budgets for their expenditure, and those of key areas of hospital services, will be extended to Wales. At first, practices with lists of at least 11,000 will be eligible to apply to hold budgets; this represents about 30 practices in Wales. Details of the scheme will be set out in the discussion document which the Secretary of State will publish following the Review. Subject to suitable arrangements being worked out with the appropriate health authorities, the Government would like to see a number of GP budgets in operation by 1992.

vi. Promoting better health - There is far too much avoidable illness and premature death in Wales. Levels of coronary heart disease, strokes and most forms of cancer are significantly higher in Wales than on average in the United Kingdom. A sustained drive to tackle these problems is central to the future of a prosperous Wales. The Secretary of State has set up the Health Promotion Authority for Wales to lead this drive, building on the success of Heartbeat Wales. Detailed proposals for action will be published later this year.

vii. The health authorities - Health Authority memberships will be reconstructed with the creation of new style boards on which the non-executive members, including the Chairman, will be appointed by the Secretary of State. There will be a strong emphasis in these appointments on leadership and top level management qualities. The Secretary of State will continue to appoint at least one member to each authority in Wales as a representative of the University of Wales College of Medicine. The executive directors of the board will include the district general manager and the medical, nursing and finance directors. The non-executive directors will form a majority.

The new boards will sharpen the focus on the delivery of cost effective services and the quality of care, through the development of the DHAs' role as enablers and purchasers of services, rather than simply as direct providers.

The Secretary of State will be examining the arguments, in the circumstances of Wales, for bringing the hospital and community services (currently the responsibility of the district health authorities) and

the family practitioner services (currently the responsibility of the FPCs) under common management and leadership.

viii. The consumer voice - There are 22 community health councils (CHCs) in Wales. Their memberships come from the voluntary sector, the local authorities, and by direct appointment by the Secretary of State. In the light of the new style boards of DHAs, there is a strong case for there being one CHC for each DHA area, to represent the consumer voice in a clear and more focused way. The Secretary of State will publish proposals along these lines for consultation.

ix. All of these proposals are aimed to secure better patient care and to see that the maximum benefit is obtained from the large resources that will be available. To help authorities achieve targets for cost improvement programmes and the generation of income, a value for money unit will be set up under the NHS Directorate.

NOT HEALTH: Exp + Efficiency P.7

8