PRIME MINISTER

13 January 1989

NHS WHITE PAPER: SECOND DRAFT

The draft White Paper is much improved. But it is crucial that a number of points - mainly presentational - are addressed in the meeting:

- A single clear chain of command between the Regions, NHS Management Board and Secretary of State should be stated explicitly (Chapter 2).

- Self-Governing Hospitals should not be limited to the major acute hospitals (Chapter 3).

- Chapter 5 is stilted and clumsily written.

- The chapter on GP budgets needs more discussion (Chapter 6).

- The Welsh contribution is still extremely disappointing.

CHAPTER 1 - A Better Health Service for Patients

This introductory chapter is much better. But the section 'the need for change' should bring out far more clearly one of the main reasons for the Review: long waiting times for out-patients and in-patients.

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CHAPTER 2 - Managing the Hospital Service

Para 2.4 Central Management of the NHS

The paper now distinguishes more clearly between policy formulation and operational management. But there is one glaring omission in this section. What is the precise reporting line?

A few days ago, I was not surprised to hear that top DH officials are more concerned over the drafting of this section than any other in the White Paper. In the past, department officials have filled the gaping holes created by unclear lines of accountability. One such hole appears in the last sentence in the paragraph 'For that reason, the Board has to be part of the Department of Health.' In practice, the Board will be located in the same building as officials. But there is no need to state this in the White Paper. This sentence should be taken out.

Strong leadership of the NHS is fundamental to the success of the reforms. It is essential that the NHS Management Board is given clear responsibility.

This section of the paper should incorporate a statement that Regions will be accountable directly to the NHS Management Board and the Management Board will be accountable directly to the Secretary of State.

CHAPTER 3 - Self-Governing Hospitals

Para 3.1 Self-Governing Hospitals.

The paper proposes that self-governing hospitals will be limited to the major acute hospitals - "major" defined as having more than 250 beds. This is far too restrictive. Should we discriminate against a well-run 100 bed hospital?

In the recent Gallup Poll for Central Office, more than two out of three of all those surveyed supported the notion of greater self-government for individual hospitals. This positive response was not just limited to areas where a substantial cross-boundary flow of patients can be expected. In Wales and Scotland, over three-quarters of the consultants sampled supported self-governance.

A number of key figures have expressed to me their concern about this issue:

Sir Roy Griffiths has noted that there is no reason why smaller hospitals should be excluded. He is particularly concerned that this restriction will substantially reduce the potential impact of this reform.

Duncan Nichol, the new Chief Executive of the NHS Management Board has spent many years working in the health service. He has also expressed strong reservations about this restriction.

John Redwood does not have a major acute hospital in his constituency. But he has expressed his hope that a local cottage hospital will be given the opportunity to apply for self-governing status.

Many small independently-run private hospitals manage their services very efficiently with far fewer beds than the 250 bed minimum proposed by Ken Clarke.

Examples in London include:

	Number of Beds
The Lister	106
Clementine Churchill	114
Harley Street Clinic	115
Princess Grace	119

In conclusion, there is no valid reason why this central reform should be restricted to large hospitals only. Kenneth Clarke should be asked to place no restriction on the minimum size of a self-governing hospital.

CHAPTER 4 - Funding Hospital Services

Para 4.22 Other services.

This paragraph states:

> 'DHAs will want to keep a relatively small sum for buying services case by case, at a price quoted by a hospital. This opens up the scope for buying services at marginal costs as hospitals try to use spare capacity'

The words 'relatively small' should be excluded. In practice, such a statement may apply in many cases but we should avoid being either too restrictive or too prescriptive.

CHAPTER 5 - The Work of Hospital Consultants

In general, chapter 5 is stilted and clumsily written. The change in style is immediately apparent.

Para 5.1 The Work of Hospital Consultants.

The sentence 'the reforms proposed by the Government in this White Paper will make it easier for consultants and their colleagues to get on with the job of treating patients' is far too vague as an introduction.

We will need to make a clear statement that whereas many consultants provide a high quality service for their patients, there is a wide variation in performance.

Para 5.18 Disciplinary procedure.

There is a danger that consultant dismissals will continue to drag on for years, using up valuable management time and substantial amounts of money. The final sentence in the paragraph 'the Government therefore welcomes the Working Party's proposal for a timetable which should normally lead to concluding an appeal within nine months of the dismissal' is meaningless. This could be a recipe for the status quo.

Ken Clarke should be asked to redraft this paragraph and give a more positive statement of Government policy.

CHAPTER 6 - GP Practice Budgets

Para 6.7 In view of the limited impact of this reform, it would be helpful to incorporate a line from the Scottish Chapter (Chapter 10, Para 10):

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'Smaller practices (in Scotland) will however be able to group together if they wish to do so in order to opt for GP practice budgets.'

Para 6.8 Determination of budgets

The sentence 'GP practices within the scheme will receive their budgets from the relevant DHA, which will in turn need to consult the practices FPC' is imprecise. The tripartite discussions between the GP, DHA and FPC will be never ending. In practice, many large GP practices may decide not to bother applying. Furthermore, the statement in Para 6.9 'There are social and other local features which affect usage of hospital services, and these will be reflected in the budget' is bound to lead to endless discussion and more bureaucracy. Inevitably, the further we move away from a simple formula, the more discretion will be available. There is a significant danger that any budget which is not based on a simple 'per capita funding' will benefit the inefficient GPs.

Ken Clarke should be asked to simplify the budget determination.

Para 6.13 Scope for flexibility

The second sentence states:

'The Government intends that they (the practices) should be free to spend up to 50% of any savings as they wish, with the balance reverting to the DHA'.

How is this 'freedom' reconciled to the rather vague statement in the next sentence 'This flexibility will allow them to plough money back into improving their practices and offering more and better services to their patients'. How will this proposal work in practice?

I am certain that this airey fairy proposal will be impractical to operate.

CHAPTER 7 - Managing the Family Practitioner Services

Para 7.3 The proposed procedure for medical audit of GP practices is likely to be ineffective. Peer review and self-audit sound too cosey. It is essential that an external peer review is carried out every 2 to 3 years. The phrase "where necessary' in the fourth indent is meaningless.

Para 7.8 Choosing a doctor

The sentence 'GP practices will be encouraged to produce and distribute information about the services they offer' lacks any teeth. If we hope to give patients better choice, good information will be crucial. Ken Clarke should be more positive.

Para 7.15 Indicative drug budgets

Again, the phrase 'DHAs will set drug budgets for each FPC on the basis of reasonable assumptions about prescribing costs in the FPC area' is too open. And the next statement 'FPCs will then set indicative budgets for each practice in discussion with the GPs themselves' is again too discretionary. In practice, it is probable that inefficient GPs will not be penalised for poor performance.

Ken Clarke will need to simplify the process and eliminate any room for endless discussions.

CHAPTER 10 - SCOTLAND

Para 5. This paragraph suggests that 'at least 2 major acute hospitals might attain self-governing status by 1992'.

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This time horizon should be brought forward to 1991 in line with the overall target in Chapter 3 Para 22.

CHAPTER 11- WALES

This draft is still very poor. It is badly written and lacks any conviction.

Para 3. This paragraph is too bureaucratic and uninteresting. As in the previous draft, Peter Walker is clearly setting his own agenda. The last sentence 'a full corporate strategy for the NHS in Wales will be published in 1992' should be taken out.

Section 4(i) Final Paragraph. He needs to be far more upbeat about self-governing hospitals.

Section 4(ii) Final Paragraph. He plans to merge DHAs and FPCs unilaterally. This sentence should be excluded.

CHAPTER 12 - Northern Ireland

Para 12.10 Tom King is also too tentative. The statement 'will facilitate progress towards self-governing status for a small number of hospitals' is weak.

Para 12.17. To be consistent with the rest of the country we should not say that District Councils will no longer be represented on the Boards. We should say that there is no longer any automatic right to appointment of local councillors.

Ian Whitehead

IAN WHITEHEAD