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Prime Minister

"WORKING FOR PATIENTS" - A PROGRESS REPORT

file with.

You asked if I would circulate a progress report on the NHS reforms to members of the NHS Review Group.

Introduction

1. In the six months since "Working for Patients" was launched we have made considerable progress in:-

- arguing the case for reform of the NHS and the thinking behind the White Paper proposals; and

- turning the broad principles into a series of detailed organisational reforms.

My aim is to have the main elements of the internal market in place by April 1991. There is no practical reason which has so far emerged to cast doubt on that target date as a sensible possibility so long as it is understood that it will be broad brush at first and capable of sophistication in later years. Two key innovations, Self-Governing Hospital Trusts and GP Practice Budgets, have attracted most media attention as they are the most easily understood and interesting concepts in the White Paper. We are therefore devoting a great deal of attention to attracting interested volunteers in hospitals and practices who will pilot the first examples of self-government from 1991. However, these public activities have been underpinned by a detailed implementation programme within the Department and the NHS across the whole range of proposals. In the coming months, the emphasis will be on:-

- maintaining the case

  - winning the parliamentary and public debate about the need for and merits of the proposals. This must be done in as positive a way as possible but it must also continue to include defensive attacks on the truthfulness of the criticisms of our opponents for so long as they maintain strident high profile campaigns aimed at frightening the public into hostility to reform.

  - showing we can meet the legitimate concerns and aspirations of the medical profession without giving way to any general obstructiveness and getting across the right messages to NHS staff at all levels. A great deal of time has to be spent on campaigning inside the service because it is the doubts of the professional staff which are almost wholly responsible for the fears of the public.

- managing the implementation

  - working with management in the health service to evolve and adapt the financial, information and management systems to enable them to implement the proposals;

- legislation

2. My approach within the NHS has been to extend rapidly the areas in which policy is made clear in detail and procedures and techniques are firmly established. I have aimed to signal our determination - and ability - to deliver what we proposed in "Working for Patients", and to clear areas of uncertainty which would otherwise be fertile breeding grounds for scare stories based on extreme interpretations of our intentions.

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3. Our proposals are, of course, designed to produce a better quality of care by ensuring that we get better value for money and that decisions are taken as close to the patient as possible. But the techniques we must employ, relying as they do on better knowledge of what is being done and better ways of managing it, can look arid to those who actually deal with patients. So one of our continuing tasks must be to demonstrate that we have a firm commitment to the principles of the NHS and that we shall continue to provide the resources, as well as developing the systems, to make it attainable.

Responses so far

4. Responses to the White Paper have come from five main sources:-

- Parliamentary Even before publication the Opposition sought to establish a myth about privatisation. Other than that, they have no strong arguments of principle against the major White Paper proposals. Their own ideas - where they differ in substance - are uncosted and unspecific. As for the Social Services Select Committee, their main concerns relate to the need for piloting and the timetable for implementation. After the initial euphoria following the launch, our own backbenchers were then shaken by the vigour of the BMA campaign and the public response. The vast majority have remained supportive and become more confident in arguing the case and many have been stirred into vigorous support by irritation at the BMA's unscrupulous tactics. We can expect continuing pressure from our sensible supporters on some issues, such as expenditure controls on drug prescribing or restricting GP freedoms to refer, but support for the broad sweep of the proposals.

- NHS Management Health Authority Chairmen and General Managers at all levels of the NHS have, in general, been constructive and many are extremely enthusiastic in their support. Management support is essential if we are to create a

climate for change. Chairmen and managers have a key role in presenting the reforms positively to staff and public and have been kept up to date with information and presentational tools, re-inforced through national and regional meetings with Ministers and Management Executive members.

- The Medical Profession The public stance of the national representatives of the medical profession has been universally hostile from the very first. This conceals a considerable area of common ground. They support:

  - medical audit, provided it is properly resourced;

  - the development of better clinical, financial and costing information;

  - the greater involvement of clinicians in management;

  - funding arrangements to enable the money to follow the patient.

However there is deep suspicion about the Government's intentions and many of the profession's concerns are based on deeply felt concerns about the effects on the quality of health care. These concerns are in my opinion largely based on fanciful fears and worst case scenarios but we have to continue to give strong public reassurances on many details. The BMA also play on the fears of the profession about a managed system and the introduction of more personal responsibility and accountability. They are determined to defend their national role in negotiating terms and conditions of service. There will be continuing battles and the BMA will continue to exploit public confidence in the profession and to use mis-information to further their cause. Some of the medical professional bodies, notably the Royal Colleges, do not approve of the BMA's 'shroud waving' approach but they are ultra-cautious about reform and remain obstinately hostile to self-governing hospitals and the contract system in particular.

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- The Nursing Profession The nurses' unions' opposition to the reforms has been less publicised but they share many of the fundamental concerns of the doctors. Their leaders are in the same position as the BMA's in wishing to defend their national role in negotiating terms and conditions of service and to maintain the maximum influence over management. They are the largest health professional group, the most powerful lobby with the public and we will need to handle their concerns positively and sensitively.

- General Public We have achieved recognition that reform of the NHS is necessary - as a Daily Telegraph poll made clear. Media coverage of the developing White Paper proposals has been extensive but generally neutral, some supportive. Yet the headline news is the mud thrown by the Opposition and the medical profession and that has continued to stick. There is no doubt that the campaign has bewildered the general public about the purpose and detail of the White Paper proposals. The pressure on postbags is easing now and I would not expect it to increase again before the Bill is introduced. It should then be different in character. We have taken - and will continue to take - every available opportunity to explain "Working for Patients", stressing the impact it will have on patient services

Annex A sets out the main comments received from the professions on the White Paper, as a reminder of the range of issues to be addressed.

5. In practice the public response of the NHS interest groups has had little impact on progress on implementation. Yet it causes uncertainty and anxiety. We need to win the presentation battle, despite the vested interests rather than with them. We will of course provide a steady flow of information about policy and implementation to the public through speeches, press notices and, where useful, - and we are finding that they are - roadshows.

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6. The BMA are able to finance a multi-million pound professional media advertising campaign which is guided by no rules or constraints whatever. The Advertising Standards Authority will not intervene in what they regard as a political arena. No member has yet challenged their legal right to conduct political campaigning without having a political fund as required by Trades Union legislation. Their message is intrinsically more newsworthy and sensational than the Government's in any event. The Government is constrained by our rules on the use of taxpayers' money for campaigning purposes and by the style and tone we are expected to adopt in official pronouncements. Since the old GLC first set the new pattern for big spending media campaigns, this is becoming an increasing problem with lobbies of all kinds and the BMA have moved on to new ground.

7. We need to continue targetting opinion formers, including leaders of the medical profession. We will continue meeting the leaders of the key health professions and others to make sure that they fully understand the objectives of the reform. Where they have legitimate concerns, we will reassure them to the extent possible. A key meeting with over 100 medical opinion formers took place on 10 July at which most present adopted a positive, if cautious, approach. We will build further on that developing understanding, tackling the genuine concerns and rebutting the spurious. Presidents of the Royal Colleges, academics and opinion formers generally tend to take the opportunity to lobby for familiar interests of their own and the reward for listening carefully to them is benevolent neutrality in public debate. It would be a serious mistake to imagine that any will or could be persuaded to offer vigorous public support for the Government against the BMA.

Managing Implementation

8. Under my supervision, the Department and the NHS Management Executive have developed a project approach to implementing the White Paper proposals covering:-

- policy development, transforming the principles of the White Paper to a more specific and detailed framework to cover every aspect of the health service;

- identifying and working up the legislative implications (see paragraphs 15-17 below);

- the management, information, and operational implications of the proposal.

A network has been produced to ensure that we do not lose sight of the complex interdependencies between the projects and to produce an overall timetable for implementation within the Department and the health service (see Annex B). Each project is working closely with a designated Regional General Manager selected for his ability who will ensure that we meet the practical requirements of management in the service.

9. Duncan Nichol, the Chief Executive of the NHS Management Executive, is leading an Implementation Group which:-

- has identified the key priority requirements for management action centrally, regionally and locally and is then making sure that necessary action is taken at the right time, at the right level;

- is channeling and focussing information for NHS management.

That Group has successfully achieved a managed approach to implementation of the White Paper.

Feasibility

10. The work of the NHS Management Executive, which takes account of the views of NHS Regional Chairmen and General Managers, has shown that the timetable set out in the White Paper is tight but readily feasible. The White Paper set out our broad policies and principles, leaving the detailed implementation - of which there is much - to be done in conjunction with the health service. That process is going well.

11. I have consistently rejected proposals for a scientific "pilot" approach to reform, by which the BMA mean an approach under which we set up a few jointly selected experiments, have them evaluated by disinterested academics, and do nothing more until the evaluation is complete. Quite apart from being too slow, I dispute the validity of the approach to achieving management and cultural change. I continue to insist that implementation generally will be evolutionary, proceeding at a purposeful pace and learning the practical lessons of experience as we go along. The first Self-governing hospitals and GP practice budgets will be pilots in effect but enthusiastic volunteers will develop them and experiment with methods of managing them to produce a model for later expansion.

12. Examples of how this approach will work in practice are:-

- A significant number of hospitals are on course to achieve self-governing status in April 1991, and more will come on stream later learning from the experiences of the first.

- A reasonable number of GP practices are already considering seeking their own budgets and we will identify the volunteers once the contract dispute is behind us. Later waves will learn from the first.

- The successor funding arrangements replacing RAWP will come in on schedule next April and a system of contract funding of hospitals will be in place in many districts by April 1991. Most will initially concentrate on block contracts and will largely reflect existing patterns of health services. This means we will avoid sudden upheavals in referral patterns in 1991. Health authorities as they come to grow into their role as purchasers of health care will bring into play more sophisticated contracts better suited to their needs, and developing over time.

13. The implementation timetable we have set is very demanding. But managed in this way there will be no sudden transition or disruption of services, and the key elements will be in place by April 1991.

Progress on the ground

14. Details of progress on the major proposals are summarised in Annex C. This shows that the Department and NHS Management Executive working with NHS Managers have made significant progress in implementing the White Paper reforms. This is most visible for the development of self-governing hospitals. The annex shows clearly, however, that on all projects we have developed a detailed and specific work programme.

Legislation

15. Many, though not all, of the White Paper proposals will require primary legislation. Policy instructions have now been sent to Parliamentary Counsel. The Lord President has agreed that the NHS Review Bill should be introduced at the beginning of the next session. To achieve that we hope to have a first draft of the Bill this summer. Inevitably there will be supplementary Instructions but any relating to the Review will be kept to a minimum and should be available to Parliamentary Counsel very shortly.

16. Treasury and the territorial departments have been kept closely in touch with the preparation of legislation.

Conclusion

17. We knew when we launched the White Paper that the reforms would not be welcomed by the medical profession. I remain quite convinced that our reforms will raise standards of patient care and produce a

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better NHS giving much better value for money. But the reforms represent a radical change from a health service largely dominated by uncoordinated clinical decisions, to one which is managed much more effectively. It is inescapable that that means altering the balance of power between doctors and managers. Doctors should not feel threatened so long as they are prepared to involve themselves in management issues and accept reasonable personal accountability and responsibility. This is a cultural change for most doctors which is causing great anxiety - unnecessary but understandable. People worried by change are easily persuaded to believe perverse misconceptions which have been re-inforced by BMA and Opposition propaganda. But the opposition to the reforms is mainly wind and fury which has had amazingly little effect on progress towards implementation. Health Service Chairmen and Managers - upon whom the reforms depend are supporters. A steadily growing number of doctors in the NHS are beginning to understand what we are doing and why and to back all or part of it. The more we can do to provide further detailed explanations and reassurances the more apparent their support will become to the public. Our aim should be to tackle head on - and meet - the legitimate concerns about standards of care while continuing to see off the myths, fantasies and half-truths based upon vested interest.

18. I remain quite confident that the whole climate of debate will change when most of the service feel involved in preparation for the reforms in their own units and practices. At this stage, apparent wavering in our purpose would only demoralise the many enthusiastic managers who are putting their heads above the parapet in their own authorities. The BMA are in no mood to compromise at all at the moment as they are cock-a-hoop about the Government's standing in the polls and what they wrongly believe are concessions to the lawyers and the brewers. At the moment they would only offer token support to face-saving and meaningless compromise in exchange for expensive commitment to tackle the "under-funding" which they claim is the root of all problems. They are about to see their position

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transformed as we continue to make excellent progress with implementation and legislation. If we maintain our present progress, the patient will begin to see tangible benefits and improvements in the quality of service well before 1991. Only when we reach that stage of benefits to the public will success be assured.

19. I am copying this report to Nigel Lawson, Peter Walker, Tom King, Malcolm Rifkind, John Major, David Mellor, Sir Roy Griffiths, Sir Robin Butler and Ian Whitehead.

July 1989

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ANNEX A

REACTION OF PROFESSIONAL GROUPS TO WHITE PAPER

1. The professional reaction to the White Paper has come from medical and nursing bodies. This paper is an objective description of the reaction putting the points in terms which the professions themselves would agree with and use.

MEDICAL REACTION

2. Responses have been received from the British Medical Association, General Medical Services Committee, General Medical Council, Medical Research Council and the Joint Consultants Committee and the individual Royal Colleges and Faculties. The overall reaction has been negative and hostile heavily based on irritation that there was no formal consultation with the profession during the Review. There are indications, however, that some of the Royal Colleges are uneasy about the BMA's advertising campaign and approach to the discussions and there could be scope for shifting the balance of opinion in the medical profession. There is <u>support</u> for a number of key issues:

* Medical Audit, provided it is properly resourced

* the steady development of RMI

* the greater involvement of clinicians in management

* the funding arrangements to enable the money to follow the patient.

There are <u>major reservations</u> on:

* the implementation timetable

* the lack of pilot projects

* the need for the fundamental shift to a purchaser/provider system

* whether IT systems and appropriate support staff can be in place in time

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* whether adequate funds for implementation will be provided or will be poached from patient care resources (and whether the resources themselves will keep pace with demand).

The main specific concerns are on:

* safeguards for medical education, research and manpower planning, especially in self-governing hospitals

* the role of self-governing hospitals (SGHs), the extent of their freedoms and responsibilities and the extent to which clinicians are being involved in local discussions on candidacy for self-governing status

* the freedom for SGHs to determine pay and conditions of service for doctors

* the lack of specification in the White Paper about a medical presence on HAs, and concerns on how health authorities will obtain professional advice

* the definition of "core" services and the scope for SGHs to cease providing important services

* what is seen as an unethical financial incentive to GPs in the context of GP Practice Budgets

* objections to sanctions in relation to indicative prescribing budgets

* the reduction in the number of GP members on FPCs from 8 to 1.

* constraints on GP freedom of referral.

Overlaying these concerns has been the row over the GP's contract. The agreement reached with the profession's negotiators was a step in the direction of defusing this, even if it is still necessary to impose a new contract following the current ballot of all GPs.

DISCUSSIONS WITH MEDICAL PROFESSION

3. Progress is being made in discussing review issues with the official representatives of the profession. Secretary of State and other Ministers have had positive meetings most notably with the Joint Consultants Committee (JCC) and the BMA. A major meeting with over 100 medical opinion formers about our plans to safeguard medical education and training, research and manpower planning took place on 10 July. Officials have had more detailed discussions as follows:-

Family Practitioner Service

The uncertain position over the GPs' contract has impeded progress on the FPS issues. There have been two formal meetings with the General Medical Services Committee concentrating on working papers 3 (Practice Budgets), 4 (Indicative Prescribing Budgets) and 8 (FPS Implications).

Hospital and Community Health Service Issues

There have been five formal meetings at official level with the JCC and further meetings are planned.

The main areas covered so far are:

- the allocation of funds to health authorities;

- contracts for hospital services;

- the composition of health authorities;

- self-governing hospitals.

- medical manpower planning, medical education and research.

The JCC have tended to use the meetings to probe areas of detail rather than offer new alternative ideas. (This is not entirely unhelpful since it displays policy areas where more work is needed). Copies of the minutes of these meetings have been sent to the other UK Health Departments.

Consultant Contract Issues

Officials have had 2 meetings to date with the Joint Negotiation Committee (Senior) on Consultant Contract Issues. The first meeting was procedural and the second covered disciplinary matters. Further meetings are planned.

Medical Audit and RMI

Separate discussions are taking place with the JCC over a longer timescale on medical audit and resource management.

NURSING REACTION

4. Comments have been received from:

* Royal College of Nursing

* Royal College of Midwives

* Health Visitors Association

* Joint Committee of Professional Nursing, Midwifery and Health Visiting Associations

* Standing Nursing and Midwifery Advisory Committee

* English National Board

* Association of Radical Midwives

* Joint British Advisory Committee on Children's Nursing.

5. The organisations concerned have tended to focus on the various aspects of the White Paper that were of particular relevance to them, or their particular clients.

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6. The main nursing concerns are:-

* Lack of a clear definition of core services (particularly relevant to midwifery)

* Difficulties in assuring continuity of care between hospital and the community, or indeed even between different aspects of community care. May lead to fragmentation of care.

* Concern as to how strategic planning, particularly in relation to nurse manpower is to be handled and co-ordinated in the future.

* Medical Audit broadly welcomed, but felt to be too restrictive a concept. Multi-disciplinary clinical audit is seen as the way forward.

* Access to health care facilities and fears about excessive travel.

* Opposition to tax relief for people over 60.

* the freedom for SGH's to determine pay and conditions of service for nurses.

OTHER REACTIONS

7. These cover a diverse group of professional/staff groups, consumer groups, bodies with specific interest in education and research, the private and voluntary sectors. Few of the responses give unequivocal support but some do give a <u>general welcome</u> to the proposals, whilst entering caveats on specific points.

8. On specific issues there is <u>broad support</u> for:

* Medical audit - provided it is geared to quality not just cost control.

* RMI

Most responses include reservations about:

* the implementation timetable - though, encouragingly a key group (NHS Directors of Finance) see the implementation task as achievable.

* the lack of pilot projects

* the internal market and its effect on quality, access to services, research etc. (However, the National Association of Health Authorities and NHS managers support internal market proposals.)

* resources - the most commonly held view of all about the White Paper is that the Review does not address NHS underfunding and concern about where funding for implementation will come from.

9. Specific concerns common to several groups are:-

* SGHs - will be reluctant to take on cases requiring expensive treatments
  - will exacerbate recruitment and retention problems in the rest of the NHS.

* definition of "core" services

* GP practice budgets - will discourage GPs from registering patients who require expensive treatment

* Indicative prescribing budgets - will encourage doctors to prescribe on basis of cost rather than patient need

- pharmaceutical industry concerned that it may stifle flow of new medicines.

* capital charges - will provide an incentive to sell off land and buildings leading to reductions in the "less profitable" services

ANNEX A1

REVIEW WORK OF A GENERAL NATURE: 30 JANUARY - 3 JUNE 1989

Ministers Correspondence (Letters from MPs about the Review)	3,400)	(some 35% of (Departmental total)
General Correspondence (Letters from the General Public)	5,200)	
Parliamentary Questions (Many of which were oral)	150	
Major speeches	10	
Invitations	25	
Major briefing packs	3 packs maintained	
Debates	3	
Statements	2	
Secretary of State's appearances before the Social Services Select Committee	3	

These figures only relate to activities undertaken by the Review Implementation branch of the Department which deals with general review issues. Much similar work on specific issues has been undertaken by the relevant lead branches. This does not include the political work of Ministers and the Special Adviser or the nationwide staff communication exercise which Ministers and the Management Executive have undertaken with conferences, roadshows and communication material.

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ANNEX B

MANAGEMENT OF IMPLEMENTATION EXERCISE

1. White Paper implementation is being handled in 34 projects over the period from the launch of the White Paper to April 1991 and beyond. A list of projects is attached at appendix A.

2. Within each project there are three main categories of work the balance of which varies between projects:

- policy development
- input to legislation
- implementation arrangements.

3. A common feature of this work is the high level of mutual dependence between projects. This means that the progress of projects towards milestones in line with objectives set by Ministers and made public (ie SGH Trusts in operation by April 1991) is built upon and dictated by progress in other projects. The diagram at appendix B provides for one project a useful representation of the extent and critical nature of this dependence.

4. Because of the complexity of project activity a 'networked' approach has been adopted to monitor, co-ordinate and control Departmental and NHS action. Implicit in this is a system to identify changes to plan and have them approved in the light of their implications for other dependent projects.

5. The 'network' of activity has been produced on the basis of assessments by project teams each of which involve a designated lead Regional General Manager (RGMs). The input of RGMs ensures that the networked activity is complete, realistic and achievable from the point of view of NHS implementation. A series of meetings have also been held with one RHA team working on the White Paper at local level to put the network under further scrutiny.

6. The resulting network in a regularly updated form is provided to RGMs on a routine basis. This allows them to:

- keep in touch with the progress of projects

- plan and monitor their own Regional activity against the network plan

- identify potential problems where networked objectives are unrealistic or unachievable.

7. Information from the Departmental and NHS monitoring exercise is fed into the Chief Executive's Implementation Group to ensure that a managed approach to implementation is achieved.

July 1989

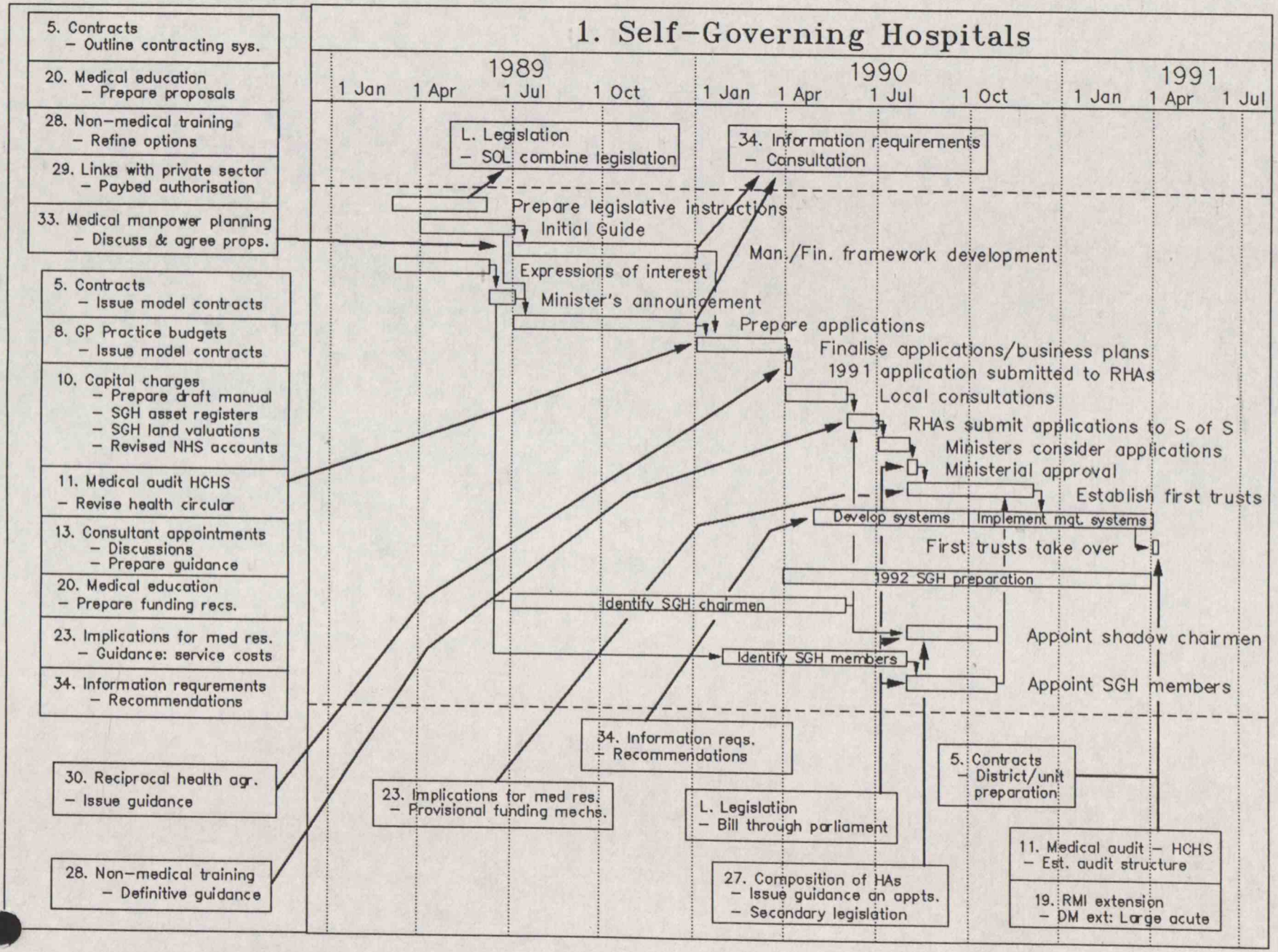
APPENDIX A

NHS REVIEW IMPLEMENTATION: PROJECTS

Project

1. Self-Governing Hospitals
2. Revenue Allocations to Regions
3. Revenue Allocations to Districts
4. Cross Boundary Flow Adjustments (Regions)
5. Contracts for Hospital Services
6. Use of Private Capital
7. Cash Flow Funding
8. GP Practice Budgets
9. GP Prescribing Budgets
10. Capital charges
11. Medical Audit (HCHS)
12. Medical Audit (FPS)
13. Consultants Contracts
14. Consultants: Distinction Awards
15. Additional Medical Consultants
16. Implications for FPCs
17. Delegation of Functions to the HCHS
18. Quality of Hospital Services to Patients
19. Extending the Resource Management Initiative.
20. Medical Education
21. Financial Audit
22. Pay Flexibility
23. Implications for Medical Research
24. Outcome Information
25. Information Technology
26. Role of DHAs
27. Composition of Health Authorities
28. Nursing and PAM Education and Training
29. Links with the Private Sector (including standards)
30. Reciprocal health Agreements
31. Oversight of Development Projects in Regions
32. Making the best use of Nursing (and Midwifery) Resources
33. Medical Manpower Planning and Post-graduate Training
34. Information Requirements

APPENDIX B


1. Self-Governing Hospitals
1989
1990
1991
1 Jan
1 Apr
1 Jul
1 Oct
1 Jan
1 Apr
1 Jul
1 Oct
1 Jan
1 Apr
1 Jul
5. Contracts – Outline contracting sys.
20. Medical education – Prepare proposals
28. Non-medical training – Refine options
29. Links with private sector – Paybed authorisation
33. Medical manpower planning – Discuss & agree props.
5. Contracts – Issue model contracts
8. GP Practice budgets – Issue model contracts
10. Capital charges – Prepare draft manual – SGH asset registers – SGH land valuations – Revised NHS accounts
11. Medical audit HCHS – Revise health circular
13. Consultant appointments – Discussions – Prepare guidance
20. Medical education – Prepare funding recs.
23. Implications for med res. – Guidance: service costs
34. Information requrements – Recommendations
30. Reciprocal health agr. – Issue guidance
28. Non-medical training – Definitive guidance
L. Legislation – SOL combine legislation
34. Information requirements – Consultation
Prepare legislative instructions
Initial Guide
Man./Fin. framework development
Expressions of interest
Minister's announcement
Prepare applications
Finalise applications/business plans
1991 application submitted to RHAs
Local consultations
RHAs submit applications to S of S
Ministers consider applications
Ministerial approval
Establish first trusts
Develop systems
Implement mgt. systems
First trusts take over
1992 SGH preparation
Identify SGH chairmen
Appoint shadow chairmen
Identify SGH members
Appoint SGH members
34. Information reqs. – Recommendations
23. Implications for med res. – Provisional funding mechs.
L. Legislation – Bill through parliament
27. Composition of HAs – Issue guidance on appts. – Secondary legislation
5. Contracts – District/unit preparation
11. Medical audit – HCHS – Est. audit structure
19. RMI extension – DM ext: Large acute

Annex C

PROGRESS ON THE GROUND: KEY PROJECTS

1. CAPITAL CHARGES

1.1 The scheme as proposed has generally been well received by managers in the NHS. Many managers are actively involved in Departmental steering groups and sub-groups formed to develop the technical details of the scheme.

1.2 A further Working Paper has been published explaining how capital charges will flow through funding arrangements. The basis of valuation for land and buildings has been agreed, and arrangements made for District Valuers to carry out the necessary work between September and December this year.

1.3 Officials have established good communication systems with the NHS on this issue. A regular series of Capital Charges Updates is being published to clarify points of detail. Seminars to explain the scheme have been arranged in many places, and for a wide variety of NHS managers.

1.4 Most health authorities are now ready to start work on the preparation of asset registers, a necessary prerequisite for capital charges. Most authorities are expected to have these ready to introduce the scheme in shadow form for 1990/91.

2. SELF-GOVERNING HOSPITALS

2.1 Development of the policy framework for self-governing hospitals (SGHs) is now well advanced. Working Paper 1 was supplemented last month by the publication of "Self-governing Hospitals: An Initial Guide". This guide gave detailed guidance on the freedoms and requirements of SGHs and on their financial regime, as well as more information about the operating principles for contracts, some teaching, research and personnel issues; and the key features of the application process.

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2.2 An invitation for units to express interest in becoming self-governing resulted in 178 replies by May. While the quality of the bids varies, I am content for all but 6 of these to consider making a formal application next year. To further discussion of the issues, I held a National Conference in London on 20 June for representatives of all interested units. In addition, Ministers have undertaken 8 Regional Conferences to allow more staff from each unit to participate.

2.3 The process of identifying the likely first wave of candidates for 1991, and of putting in place the supporting management arrangements, is now in hand. While formal decisions on applications must await legislation, much of the preparation can begin now.

3. FUNDING AND ALLOCATIONS

3.1 1990-91 will see the first step towards a simpler system of funding Regional Health Authorities and, for the first time, Regions will pay each other directly and in full for those of their residents treated outside their administrative boundaries. Guidance on identifying and costing such cases has been issued and Regions have been asked to reach agreement on payments in time for us to make adjustments to 1990-91 allocations (for 1991-92 and thereafter Authorities will of course have powers to charge each other directly).

3.2 A funding mechanism has been agreed for meeting the extra service costs incurred by those hospitals which support undergraduate medical education and research, to ensure that the hospitals concerned are not put at a competitive disadvantage.

4. INFORMATION NEEDS AND INFORMATION TECHNOLOGY

4.1 Working for Patients will have a major impact on information needs and information flows as the distinction between service providers and service purchasers becomes apparent. Work is in hand to identify those aspects which require a nationally consistent approach to:

* hospitals (SGH, DHA managed and private) as service providers

* RHAs, DHAs and GP Practice Budget Holders as service purchasers.

4.2 Working groups will be looking at particular aspects of NHS activity (such as waiting times, community health service, out-patients and accident and emergency) to determine the new information needs in particular - to identify the direction, nature and content of data flows between different parts of the NHS. An implementation process will then be defined for the recommended changes. The aim is to complete this preliminary work by the end of October 1989.

4.3 An Information Technology strategy for the NHS should be completed by the same date. This NHS-wide strategic approach is needed, because only a national perspective will ensure that the necessary IT infrastructure is in place to permit a co-ordinated interworking between different parts of the NHS - in particular where contracts are operating. A number of IT initiatives are currently under way which will contribute to the overall framework required for Working for Patients adapted and extended as necessary (and in some cases this has already happened). These include the development of computing capacity in GP surgeries, improved computing facilities in hospitals to calculate the costs and prices of services and to provide referral information to GPs, and a nationwide data communications network to support the efficient and timely exchange of information.

5. PRACTICE AND INDICATIVE PRESCRIBING BUDGETS

5.1 Officials have entered into discussions with the GMSC on the implementation of both GP practice and indicative prescribing budgets and other FPS issues. A series of meetings has been arranged, and two have already been held.

5.2 The Department is also working closely with the NHS on the implementation of the proposals. Two joint steering groups - one for practice and one for prescribing budgets - have been set up and useful meetings been held. Both practice and prescribing budgets will require legislative backing and instructions to enable Parliamentary Counsel to draft the necessary provisions in the Bill are virtually complete.

5.3 Secretary of State intends to discuss with Regional Chairmen [on 19 July] the launch of a prospectus on practice budgets in late October/early November directed at prospective budget holders. This will give further details of the operation of the scheme and of the arrangements for eligible practices to notify RHAs of their interest in becoming budget holders.

5.4 On indicative prescribing budgets Secretary of State has announced that the PACT prescribing information system already in operation will be speeded up and enhanced so as to provide all GPs, FPCs and RHAs with monthly budgetary statements from April 1991. This follows feasibility studies by the Department and the Prescription Pricing Authority. This decision will take away from GPs the burden of paperwork which might otherwise be associated with the introduction of the scheme.

6. **FPCs**

6.1 A pay package for the new General Manager appointments was issued in May, and RHAs and FPCs placed advertisements at the beginning of June. Short-listing has been virtually completed for all 90 posts, and 12 appointments have already been made.

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