PRIME MINISTER

11 May 1990

IMPLEMENTING THE NHS REFORMS

Implementing the NHS reforms is a high-risk business. As we approach the next election, it is vital that we give as few hostages to fortune as possible - even though our opponents, both within the NHS and politically, will be eager to exploit mismanagement.

Particularly vulnerable to adverse press comment would be:

- a self-governing NHS hospital which ran into financial trouble;

- a GP practice which ran out of funds;

- a switch of referrals through the new contracting system which left say a major teaching hospital with only half the number of patients or a major provincial hospital with increased queues and a large rise in its charges.

Should there be pilots or phasing?

The risks in implementation could be tackled either by introducing the reforms in a limited number of pilots or by introducing the reforms throughout the system as a whole but in a number of distinct phases, which could even differ from region to region.

Kenneth Clarke clearly prefers phasing to pilots. His reasons are that:

- we must not dampen the enthusiasm shown by hospitals applying for self-governing trust status and GP practices willing to manage their budgets;

- the Regional Authorities and the NHS Management Executive both advised strongly against pilots because the NHS is such an interdependent nationwide system;

- a momentum for reform has been generated among NHS managers, which would be lost if they were unable to start implementing the reforms throughout the system.

The major argument in favour of pilots is that the system is unprepared: either through lack of IT or through lack of management expertise.

Sophisticated IT, while desirable and even possibly necessary to ensure that the reforms are able to work in toto, is not however critical for the reforms to work, providing the reforms are introduced in a phased way. Similarly, while the NHS could do with more commercially minded and experienced management, there are sufficient effective managers within the system at present to make the introduction of reforms across the Service feasible.

My personal view is that Kenneth Clarke's judgement is correct and that we should not go for pilots but for the introduction of the reforms across the board, but in a number of distinct phases.

How would phasing work?

This is where Kenneth Clarke's paper is rather weak. He seems to suggest the following:

Phase 1 : Commencing April 1991

- 40 - 60 self-governing hospitals to be set up;

- 400 GP practices to become fund holders;

- introduction of first stage of contracting.

Both the establishment of self-governing hospitals and the establishment of GP budgets in the first phase of the reforms will have clear benefits - hospital management, doctors, nurses and GP's will have greater freedom over the way they do things, which they will value. Hopefully these will also feed through into improved patient care. Meanwhile providing the NHS Management Executive has done a thorough job of vetting potential applicants, there should be very little risk from these changes.

Question 1 **How can we ensure that the benefits from these changes result in greater patient care and are well publicised?**

The more tricky question concerns contracts. Introducing contracts introduces considerable risks. Here the Secretary of State is vague: "the first series of contracts will be framed in broad terms and simply replicate existing patient and financial flows."

He needs to be pressed at this point.

Question 2 **Will the first series of contracts be 'shadow' contracts? If so, how precisely will these work? Will they produce real change or are they just a dress rehearsal?**

Question 3 **Are contracts sufficiently different, so that self-governing hospitals might be allowed one kind of contract which other hospitals are not?**

Question 4 **For a self-contained RHA, could phase 1 be extended in terms of the contracts they could use?**

Phase 2

If the reforms are to be phased the Secretary of State should at

least say something about the second phase.

Question 5 **When will Phase 2 start? Is it pre or post-election?**

Question 6 **Will Phase 2 be an extension of Phase 1 (a) additional self-governing hospitals and GP budget fund holders, b) more elaborate contracts) or is there anything else?**

Question 7 **What is the target time period it will take to implement the whole of the reforms?**

Problem of London

Everyone accepts that London is a special problem and that its hospitals are very vulnerable to a loss of patients to the provinces due to the introduction of contracts.

Question 8 **What steps does the Secretary of State propose taking to prevent serious problems developing in London?**

Conclusion

Kenneth Clarke's instinct of wanting to capitalise on the enthusiasm for reforms which exists within the NHS must surely be right.

The details he gives of how this might be done however is rather vague. He seems to be saying "I know introducing the reforms is a complex business, but just trust us to get it right." To which the response must be, "of course we trust you, but our trust is that much firmer the more information you give us of what precisely you intend doing."

This he has yet to do.

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Draft

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IMPLEMENTING THE NHS REFORMS

Implementing the NHS reforms is a high-risk business. As we approach the next election it is vital that we give no hostage to fortune - even though our opponents, both within the NHS and politically, will be eager to exploit any sign of mismanagement. Particularly vulnerable to adverse press comment would be:

- a self-governing NHS hospital which ran into financial trouble;

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strongly advised against pilots because the NHS is such an independent nationwide system;

- a mommentum for reform has been generated among managers of all levels within the Service, which would be lost if they were unable to start implementing the reforms throughout the system.

The major argument in favour of pilots is that the system is unprepared: either through lack of IT or through lack of management expertise.

Sophisticated IT, while desirable and even possibly necessary to ensure that the reforms are able to work in toto, is not however crucial if the reforms are introduced in a phased way. Similarly, while the NHS could do with more commerically minded and experienced management, there are sufficient managers within the system at present to make the introduction of reforms across the Service feasible.

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Question 1 **How can we ensure that the benefits from these changes result in greater patient care and are publicised?**

The more tricky question concerns contracts. Introducing contracts also involves considerable risks. Here the Secretary of State is vague: "the first series of contracts will be framed in broad terms and simply replicate existing patient and financial flows."

He needs to be pressed at this point.

Question 2 **Will the first series of contracts be 'shadow' contracts? If so how precisely will these work? Will they produce real change or are they just a dress rehearsal?**

Question 3 **Are contracts sufficiently different, so that self-governing hospitals might be allowed one kind of contract which others are not?**

Question 4 **For a self-contained RHA, could Plan 1 be used and go further in terms of contracts?**

Phase 2

If the reforms are to be phased then while we do not expect an elaborate plan for the next ten years, the Secretary of State should at least say something about the next phase.

Question 5 **When will Phase 2 start?**

Question 6 **Will Phase 2 involve additional (a) self-governing hospitals, (b) GP budget fund holders, (c) more elaborate contracts?**

Question 7 **What is the target time period it will take to implement the whole of the reforms?**

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