NOTES OF COMMENTS MADE AT CHEQUERS NHS SEMINAR ON SUNDAY 27 MARCH

Sir John Butterfield opened the discussion. He stressed the need to start by looking at patients as consumers. An increasing number in future would be in the older age bracket. Fortunately a large number had not troubled the primary health care sector and relied on self-treatment, visits to chemists, etc. Nonetheless, the hospital service still had to cope with 60 million out-patients a year, of which 25 million were new referrals.

He said that one of the difficulties for GPs was lack of an information system to enable them to refer patients to "vacancies" along the lines of an airline booking system; a current initiative in East Anglia was seeking to remedy this.

He stressed the importance of staff costs within total NHS budgets. For every doctor employed there were 20 other staff.

He suggested that much of the "noise" in the recent debate had come from the major teaching hospitals. He believed these institutions had been seriously underfunded since the days of Mrs. Castle.

Sir John Butterfield was also concerned that there was not an adequate career progress for good nurses. Consideration should be given to introducing a higher ceiling to which they could aspire.

Sir Arnold Elton made four points:

- initiatives (such as at Northwick Park) in the appointment of "bed managers" had been most successful. Even though beds had been closed, patient throughput had increased by mechanisms such as regular meetings with consultants and junior doctors. An extension of this trend was a move towards the

appointment of theatre managers to increase the throughput of operations.

- there were major advantages in formulating greater cross-boundary flow of patients. This would put into effect the concept of money following the patient and improve freedom of choice. Unfortunately, many health service administrators were discouraging the process.

- an important initiative in improving economy was the introduction of pilot studies of low cost post-operative beds. Once patients had adequately recovered from operations, there were substantial cost savings to be had from shifting patients to a lower cost care regime.

- perhaps too much attention was being given to alternative funding mechanisms. Greater attention should be given to unburdening the NHS through greater co-operation with the private sector.

Dr. Clive Froggatt stressed that attitudes were crucial. Many people believed there was an NHS problem only because NHS staff had told them there was. The key objectives were to match present needs for health care with the resources available; to improve the input/output relationship; and to reduce politicisation of health care provision.

He saw a number of key barriers to progress:

- poor relationships between health service workers and the Government;

- poor relationships between clinical/nursing staff and administrators;

- resentment by those in the hospital services at the resources being shifted to the primary care sector;

- tensions between different tiers of NHS management;

- insufficient incentives in the system for change.

Dr. Brian Crawley said the major problem was of expectations being greater than what could realistically be provided. This required patients to be made much more aware of costs, by divorcing health care from social security. The message to get over was that money had to come from the taxpayer. One way of doing this would be to bring payments nearer to the point of care, eg by giving the acute sector profit and loss accounts.

One of the obstacles was that NHS managers currently had more responsibility than authority, and little power; district health authorities did not delegate and their decisions were greatly affected by vested interests.

Professor Cyril Chantler said that the NHS was basically a good means of providing health care, which by international standards was relatively efficient. Hence the need was to remedy the problems in it rather than to destroy it.

The key requirement was that doctors should get much more closely involved in management; that was something that had to be done by NHS professionals rather than Government. One of the obstacles was confusion between representation and governance on health authorities and these two functions needed to be separated out. This might be achieved by giving the NHS management board a greater role and possibly doing away with regional health authorities, at any rate in their present form. In short, another major management change was required.

Another problem was the lack of freedom of choice in the NHS; this required mechanisms for competition and development of an internal market. Such a system could be introduced quite quickly (as was already being done at Guys) and then revised later.

Lord Trafford agreed that medical staff must get more involved in management. But management staff also needed to be beefed-up. At present, systems were insufficient and wasteful; in short, the NHS was administered but not managed. The key problem was the lack of authority of general managers.

Three separate health roles could be distinguished - to cure, care and prevent. The NHS was not the best mechanism for delivery of all three, and should focus on cure and prevention. A major problem for the acute sector was that it was being overloaded by referrals of non-acute cases by the primary health care sector. GPs referred far too many people.

Another hospital sector problem was gross under-capitalisation. The prospects of remedying this were worsened by the long planning cycle and the tendency for capital projects to be planned within a given total budget (which was always then fully spent) rather than by a bottom-up assessment of needs.

Professor Ian McColl felt that consultants had to share some of the blame for too many patients being referred into hospitals. Many consultants went out of their way to build up and hang on to patients in hospital-based clinics eg for diabetics. These were people whose needs could be met by health care in the community. He also felt the NHS should be looking much more at the quality of provision rather than quantity. There was no end to the potential number of operations; it was a nonsense that in America there was double the quantity of surgery, much of it unnecessary. In the United Kingdom, the fact that there were only a total of 960 surgeons did help to prevent unnecessary surgery.

In response to a query from the Prime Minister about medical audit, Professor McColl said that the Royal College of Surgeons had introduced a review procedure in all hospitals

which looked at cases where death or major complications had resulted. This was a useful form of "general confession".

In further discussion of the problem of large consulting clinics, Sir John Butterfield said that an initiative in Poole was under way to return diabetics' clinics to GPs premises. Lord Trafford pointed to a number of other similar initiatives involving consultants visiting clinics located in GPs' group practices.

Mr. Robin Touquet said that in an accident/emergency department there were immediate opportunities for some sort of medical audit; it provided a form of shop-window for the health service.

He believed that far too many tests and investigations were commissioned by junior hospital doctors, who had relatively little experience and who felt obliged to over-test in order to ensure that consultants had all conceivable information available when they made their tours. This pointed to the need for a relative increase in the number of consultants who would supervise the amount of work done and cut down testing.

As a former GP himself, he stressed that the minimum training time for a GP was now nine years - five years as an under-graduate, one as a houseman and three in some form of vocational training. If after that time GPs were not capable themselves of dealing with minor problems rather than referring to the hospital service it was a bad job. But at present the system did not provide sufficient incentive to GPs to do work themselves that they could do much more cost-effectively than hospital emergency services; so changes had to be considered in the GP system.

He agreed with comments by others that NHS administrators were ham-strung by left-wing health authorities - the reason for many empty beds in Paddington.

In response to a question from the Prime Minister Mr. Touquet said it would be helpful if hospitals were able to opt-out of DHAs. Sir John Butterfield mentioned that this was how teaching hospitals had been run until 1974.

Mr. Richard Packard agreed with earlier comments that doctors in hospitals were reluctant to take responsibility for decisions: it was for instance much easier first to tell someone to come back again after a period than to tell them not to come back again. He also agreed that consultants were the most efficient form of hospital doctor. Their throughput was greater and they were more likely to discharge patients quickly. At present, however, there was no financial incentive for consultants to treat more patients and to work harder; this had implications for the nature of the consultants' contract.

Professor Lee disagreed and argued that there were incentives for consultants to work hard. But one particular audit that was necessary was an investigation of where consultants were working; a significant number abused the NHS system by putting in minimal hours and concentrating their activities in the private sector. For this reason, he saw a strong case for maintaining a firm line between the private and public sectors, rather than allowing this to become blurred.

He thought the health authorities that worked well were those where doctors and administrators co-operated. He saw a case for spending more on administration in the NHS in order to secure an adequate flow of efficient cost information; he noted that in the private sector administration typically accounted for 10 per cent of costs as against only 3-4 per cent in the public sector. One way to improve cost-efficiency would be to have greater reliance in the NHS on centrally determined cost norms and formula.

Mr. Michael Dutt agreed on the need for better costing information and for managers to have greater authority. One

way the second point could be achieved would be to have more managers coming from a medical background.

He saw strong arguments for fundamental changes in the NHS financing system to get away from the present monopoly structure. He advocated a system of compulsory insurance with patients free to choose the level of cover they wanted. In considering this means of increasing freedom of choice, it might be appropriate to look at the German and French systems, while avoiding the problems experienced in those countries of over-provision.

Dr. Pereira Gray said that GPs were presented with a major opportunity for influencing the health of the population; on average every person consulted their GP four times a year. Although it might be true for the hospital service, he believed that in general practice there should not be a divorce between caring and curing. GPs had great opportunity to improve levels of preventative care.

He agreed strongly with the need for medical audit. The Royal College of General Practitioners had been the first to support this system, but help was needed to get it going. This included keeping GPs in touch with latest developments in medical research and development. Another desirable trend was the adoption of micro-computers by GPs which would build on the medical information benefits provided by the UK registration system (which few other countries had). He also pointed to the importance of the development of team practices, which greatly increased the opportunity for the primary care sector to avoid referrals to hospitals.

Mrs Packard made the point that not all doctors were good at research, or needed to be good at it. The important thing was to keep them up-to-date with the latest developments.

Dr. Froggatt agreed with the importance of increasing output from the primary care sector. Steps could be taken to widen the scope of GPs' responsibilities and so achieve their full

potential. Much of the material in the Primary Care White Paper was helpful in this direction, although it would be difficult to implement because of the strength of anti-Government feeling. He thought that the links between GPs and hospitals could be improved by greater devolving of responsibilities and removing steps in the hierarchy. He thought the idea of an independent medical audit authority should be considered.

The Secretary of State for Health invited further comments about the present nature of the consultants' contract - was the principle of tenure right?

Professor McColl and Sir John Butterfield thought that tenure should be abolished and agreed with the Prime Minister's suggestion of a rolling five year contract. (No one demurred at this suggestion.)

Sir Roy Griffiths said that the NHS depended on a consensus view of what it was expected to deliver; that was now breaking down. It was therefore necessary to clarify what the NHS should provide.

He noted that the NHS management enquiry had not been invited to make any recommendations which had legislative implications. But he thought it was too easy to talk about the advantages of eliminating tiers of management. The NHS was a very big business and he doubted whether RHAs could be removed. But he agreed it was certainly necessary to look at levels of authority and delegation. Attitudes had to be changed, although it was a time-consuming business. In response to a query from the Prime Minister, Sir Roy Griffiths said that the special targeting of funds through waiting list initiatives was an example of how management should work more generally in the NHS.

On the opting-out of hospitals, Mr Packer commented that if people felt that the local hospital was theirs, they would take much more interest in it and its running.

Mr. Robin Touquet said that he supported the notion of money following the patient. But it was important to follow this to its logical conclusion that, if hospitals failed adequately to serve their local GPs, then money should be taken away from them.

The Prime Minister asked if there was strength in the argument put to her that it was necessary to retain private patients in NHS hospitals to safeguard the teaching function. Mr. Dutt said this was only partly true; NHS hospitals could for example rotate different types of work through private hospitals.

Professor Chantler said he had been struck by just how primitive most existing budgeting systems were. It was essential to move to a system where every budget was the responsiblity of one individual. This is what had been achieved at Guys on the basis of a relatively simple system. The basic accounting requirements for such systems could be spread quite quickly, and there was nothing to prevent it being done.

PRCG.

PAUL GRAY

27 March 1988

PMMAUP

Mr. Denis Thatcher

LIST OF GUESTS ATTENDING THE SEMINAR FOLLOWED BY LUNCH ON SUNDAY, 27 MARCH 1988
SEMINAR STARTS AT 11.00 AM

The Prime Minister	Mr. Thatcher attending lunch
Rt. Hon. John Moore, MP	
Rt. Hon. John Major, MP	
Rt. Hon. Antony Newton, MP	
The Lord Trafford	
1 ✓ Sir John Butterfield	
2 ✓ Sir Arnold Elton	
5 ✓ Professor Ian McColl	
7 ✓ Mr. Richard Packard and Mrs. Packard	
3 ✓ Dr. Clive Froggatt	
Dr. Denis Pereira Gray	Royal College of General Practioners
6 ✓ Mr. Robin Touquet	Accident/Emergency Department, St. Mary's Hospital, Paddington
✓ Professor H.A. Lee	Southampton.
4 Dr. Brian Crawley	Chairman, Department of Anaesthesiology, Kent and Canterbury Hospital
✓ Professor Cyril Chantler	Paediatrician, Guy's Hospital
Mr. Michael Dutt	St. Albans City Hospital
Sir Roy Griffiths	
Mr. Richard Wilson	Cabinet Office
Mr. Paul Gray	
Mr. John O'Sullivan	