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From the Secretary of State for ~~Social Services~~ Health

COVERING SECRET

RA

Paul Gray Esq
Private Secretary
10 Downing Street
LONDON
SW1

30 September 1988

Dear Paul

NHS REVIEW: PAPERS FOR MINISTERIAL GROUP ON 4 OCTOBER 1988

I enclose the following papers for discussion at the meeting of the Ministerial group on the NHS review to be held on 4 October:

HC39	Self-governing hospitals
HC40	GP practice budgets
HC41	Merging FPCs and DHAs
HC42	NHS audit
HC43	Outstanding issues
HC44	Outline White Paper

I am copying this letter and enclosures to the Private Secretaries to the Chancellor of the Exchequer, to the Secretaries of State for Wales, Northern Ireland and Scotland, to the Chief Secretary, to the Minister of State and to Sir Roy Griffiths in this Department, to Professor Griffiths and Mr Whitehead in the No 10 Policy Unit, and to Mr Wilson in the Cabinet Office.

yours sincerely,

Geoffrey Podger

G J F PODGER
Private Secretary

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Copy No. 1 G

HC 44

NHS Review

OUTLINE WHITE PAPER

Note by the Secretary of State for Health

I was asked to circulate an outline White Paper. The attached draft does this. Each chapter deals with a major theme of our review.

2. The order of the chapters is provisional and depends very much on our general approach to the White Paper. So does the content and style of the introduction and conclusions, which I have deliberately left blank.

3. In writing up the White Paper we have a choice between:

First, a fairly detailed exposition of our thinking on the present position of the NHS, the analysis that lies behind that thinking and our proposals for the future. Most of the material would be in the White Paper though there could be supporting consultative documents; and

Second, a much less detailed document which focusses on the main themes and our conclusions. It would be supported by consultative documents which set out our detailed proposals.

4. A document on the lines of the first option would be seen to do most justice to the review we have carried out, which has attracted very considerable attention and a substantial contribution of ideas from outside Government. And the more detail we give, the less scope for our proposals to be misrepresented.

5. On the other hand, a shorter document might have more immediate impact and ensure attention was focussed on the major issues. It would also make it easier for us to issue the White Paper at an early date.

6. The choice between these options is finely balanced, but I incline to the second. It will be a more effective way of putting across our main messages.

7. There are three other general points which bear on the way we write the White Paper and in particular on the introduction and conclusions.

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8. First, we need to be clear about the main thrust we want to give to the White Paper. Much of our work has concentrated on getting the management and financial framework of the NHS right, particularly in relation to hospitals, whilst keeping organisational change to a minimum. But our fundamental objective, which our proposals are intended to achieve, has been a better deal for the patient - through competition and choice. It is essential that we get over the message that the Government has not been engaged in an arid exercise about money and management, but has been concerned first and foremost with the health care needs of patients. My aim is to bring this message out in the White Paper. One way would be to highlight in each chapter the impact of the proposed changes on patients and their families. A consumer guide to our proposals, in one sense.

9. Second, we also need to make it clear that, while the review was not itself concerned with other issues like services for the mentally ill or handicapped, health education or public health, this does not mean that the Government does not attach importance to them. We could strengthen that message by a short chapter detailing some of the other initiatives we have in hand - a specimen summary chapter is included in the annex. If the White Paper said nothing about this, it would certainly be picked up and criticised. It will be much better to defuse this issue in advance.

10. Third, we need to decide how far we produce a UK White paper. At present, the draft includes a separate chapter for Scotland, Wales and Northern Ireland. This would serve either to set out distinctive proposals for each country or simply to deal with aspects where, for good reason, the proposals were being modified for particular countries. My own preference would be the latter, but I would be ready to go along with the former if my health colleagues preferred it.

11. I invite colleagues, in considering the White Paper outline, to say:

- which type of document they prefer (para 3)
- whether they agree about the main thrust (para 8)
- whether they agree we should include a chapter about wider health issues (para 9)
- which approach they prefer to the Scottish, Welsh, and Northern Irish dimensions (para 10).

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OUTLINE OF DRAFT WHITE PAPER

A BETTER HEALTH SERVICE

Introduction

Chapter 1: Scope of review and summary of main proposals

This chapter will focus in particular on the impact on patients and their families.

Chapter 2: A better service

This chapter proposes a package of initiatives for improving the quality of services for the individual patient. The guiding principle is that the NHS should be more responsive to the needs of its customers. It covers:

- the development of a personal care and service programme in every hospital;
- better information for patients and visitors;
- more testing of consumer views;
- the regular review of complaints procedures;
- the introduction of more amenities for those wishing to pay;
- the development of clinical/medical audit and better ways of assessing the outcome of the treatment and the quality of care that patients receive.

Chapter 3: Choice and competition

This chapter is about funding. It covers the proposals in HC35 for replacing RAWP with a simpler system of resource allocation, for performance funding, and for contract-based funding; and the proposals in HC40 for budgets for large GP practices. More generally, this chapter can spell out the benefits of competition in improving performance and enchancing value for money, and stress the need to proceed on the basis of pilot schemes.

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Chapter 4: Managing resources

Introducing competition and improving incentives is of limited value if service providers have little control over, or information about, their resources. The Government therefore proposes to build on the introduction of general management by pushing down further decision making to the local level, including giving managers more flexibility in the use of capital and in setting the pay and conditions of staff. The chapter also encompasses the proposals for improving the flow of information to managers and their professional colleagues.

Chapter 5: The central role of staff

The theme of this chapter is that, while it is managers who are ultimately accountable for the use of resources in their units, it is their professional colleagues whose decisions in practice determine the way resources are spent. This freedom brings with it responsibility and accountability which needs to be clarified. The chapter then spells out the proposals on consultant contracts (or, at least, the Government's broad objectives for managing the contract). In addition, the chapter covers:

- the need for a wider and more flexible basis for rewarding performance, ie current changes to the nurses' grading structure and future reform of consultants' distinction awards;

- the requirement of services and the market to have the right people in the right place at the right time, ie consultants' mobility; retaining contracts at regional level;and possibly a section on "restrictive practices";

- the need for an adequate supply of the right people, ie Project 2000 and medical education.

Chapter 6: Self-governing hospitals

The logical consequence of pushing down decision-making to the hospital level and introducing incentives to better performance is to allow hospitals effectively to become independent of their health authorities. The chapter sets out the Government's overall objectives in this area, including harnessing and encouraging the skills and commitment of people working in the NHS and restoring a sense of local pride in hospitals. It sets out how such a system might work, including proposals for pilot schemes.

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Chapter 7: A mixed economy of care

The theme of this chapter will be the benefits to the NHS of collaboration with the private sector; the greater choice to patients from the existence of a private sector; and, continuing the value for money theme, the benefits of extending competitive tendering and income generation. [Will this chapter also include fiscal incentives, or will these be dealt with separately by the Chancellor?]

Chapter 8: A better organisation

All these changes imply different roles for regional and district health authorities. This chapter sets out the Government's proposals for organisational change, including:

- changes in the role and functions of RHAs and DHAs;
- possibly, the amalgamation of FPCs and DHAs;
- consequent changes to the constitution, size and composition of RHAs and DHAs;
- possibly, changes in the role of Community Health Councils;
- possibly, changes in the role and composition of the NHS Management Board.

Chapter 9: Health services in Wales, Scotland and Northern Ireland

[Chapter 10: Wider health issues]

This chapter sets the specific proposals in the White Paper for improving hospitals' performance in the wider context of improving the nation's health. It covers:

- the proposals already published for improving primary care services;
- the relationship between primary care, hospital and community care services;
- action agreed following the Government's acceptance of the report "Public Health in England" which aimed to monitor the state of the nation's health and evaluate services for prevention and treatment and their impact on health including the control of communicable diseases;
- the development of health indicators;
- current initiatives to prevent illness and promote health including the importance of individual responsibility.

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Conclusions

The conclusions will pull together the range of proposals in the White Paper and map out a critical path for change, including the need for primary legislation and the timing of this and any necessary pilot schemes. The chapter will emphasise the Government's commitment to evolutionary change and its adherence to the underlying principles of the NHS.

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HC 43

NHS Review

OUTSTANDING ISSUES

Note by the Secretary of State for Health

1. The Group invited me to circulate a note summarising the state of play on those "areas for further work" which were listed in Annex A to the Cabinet Office paper on "The Overall Package" (HC32 revised) and which have not been covered in other papers. This note covers each of these areas and adds also medical audit, on which there was some discussion at our last meeting.

"Consultants' contracts"

2. To implement the improved arrangements we have agreed for managing consultants' contracts, I propose to:

* negotiate with the profession a more detailed, standard job description, to include responsibility for the management of resources and participation in the planning of service developments.

* within that framework, and whilst retaining contracts at Regional level, give DHAs clear responsibility for the day to day management and monitoring of contracts, free from Regional involvement or second-guessing.

* instruct Districts specifically to ensure that, where "maximum part-time" (10/11ths) consultants are not prepared to devote sufficient time to their NHS duties, they are transferred to a part-time contract for less than 10/11ths.

* give Districts more involvement in the appointment of consultants and change the appointments procedures to allow for, and to encourage where necessary, greater mobility.

* introduce improved disciplinary procedures to enable health authorities where necessary to take prompt and effective action against consultants who fail to meet their contractual commitments.

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3. On distinction awards, I propose to:-

* withdraw the lowest, "C" award and replace it with a reward by way of performance-related pay for those consultants who demonstrate not only the application of their clinical skills but also a clear commitment to the management and development of the service. It will be for general managers and senior doctors jointly to determine which consultants should be rewarded.

* restrict progression to the remaining three levels of distinction award to those consultants who have earned performance-related pay. These higher awards would, as now, reward clinical excellence, but we should ensure a stronger general management influence on the choice of award holders.

* ensure that new or increased awards are given only where the recipient can complete at least 3 years' further service.

* make awards, including performance-related pay, reviewable after 5 years, with some protection of pension rights.

These changes would not affect the existing entitlements of current award-holders.

"Charging for inessential treatment"

4. I recommend that we do not pursue further the possibility of charging for "inessential" treatment, or in any other way excluding particular treatments from NHS funding. There is very little money in the most obviously defensible candidates - aesthetic cosmetic surgery, for example - because the low priority accorded by clinicians to such treatment means that there is effectively little NHS provision. To try to draw the net more widely would lead us into difficult and contentious territory.

5. In short I do not believe that we could secure benefits on a scale sufficient to outweigh the political costs. I suggest that we should concentrate instead on developing clinical budgeting and medical audit as the key disciplines for avoiding "unnecessary" medical intervention, of whatever kind.

"A package to improve the treatment of patients"

6. My suggested outline for the draft White Paper (HC 44) includes a chapter on "A Better Service", and I am working on the ideas summarised there. I suggest that the Group can best address the substance of these ideas when we consider the relevant draft chapter.

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"Restrictive practices"

7. A number of changes already agreed by the Group, notably the more effective management of consultants' contracts, will make for the more flexible deployment of staff. There are other changes we could make to loosen the remaining rigidities in professional and employment practices in the NHS. I see these changes falling under three heads:

* increasing employer and consumer influence over professional decisions.

* breaking down rigidities caused by professional boundaries.

* removing restrictive employment practices.

8. Action under the first head would involve legislation. Progress under all three heads implies firm management action.

"The role of the NHS Management Board"

9. I shall bring forward proposals on this and related organisational issues as soon as possible.

"Competitive tendering"

10. The Cabinet Office paper on "The Overall Package" includes (paragraph 12(iii)):

> "extending contracting-out to clinical work as well as laundry cleaning and catering. Competitive tendering will initially cover clinical support services such as pathology but the scope for further extension (eg to certain types of elective surgery) will also be considered."

The idea of "competitive tendering" for elective surgery has in effect been subsumed in our further work on funding. The main outstanding issue is the competitive tendering of clinical support services, in particular pathology and radiology.

11. I suggest we proceed by fostering and evaluating local initiatives in competitive tendering for pathology and radiology. It will be important to test out how best to secure quality control and to ensure that clinicians do not lose their ready access to the expert advice of pathologists and radiologists. I propose to reflect this approach in preparing the draft White Paper, and to work up the detail accordingly.

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"Information technology and the Resource Management Initiative"

12. I have examined carefully our current programme for securing better information, and especially better cost information, for health authority management. Subject to the outcome of the current PES round, I propose to implement a revised programme as follows:

i. to develop a system of "tariffs" as a guide to budget-setting and trading. The aim would be for all 260 major acute hospitals to have locally based tariffs in place by early summer 1989, giving estimated annual average costs by diagnosis related group (DRG). A brief programme of research and development will be needed.

ii. to implement the more comprehensive resource management systems being developed in the present pilot sites, enabling managers and clinicans to use current, local data.

iii. in parallel with (ii), to develop and implement the information technology and interrelated systems needed both the strengthen the operational efficiency of acute hospitals and further to improve the quality of the information available to management.

Medical audit

13. Building in John Moore's earlier proposals, I suggest that we should

* press the medical Colleges to make participation in medical audit a condition of a unit being allowed to train junior doctors.

* use medical audit (together with outcome measures) as a tool in securing the accountability of consultants for the quality of their work.

* ensure that our other proposals serve to embed medical audit into the system, for example through the criteria for hospitals to become self-governing (and, I would add, through contract and performance-based funding).

* invite the profession to participate in a national initiative to support and monitor the development of medical audit locally.

Other issues

14. I am conscious that there are a number of issues, such as detailed changes in the role and composition of health authorities, which will need to worked up in more detail in the light of conclusions reached by the Group on other papers to be discussed on 4 October. I shall bring forward proposals as soon as possible, in whatever form seems sensible in each case.

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HC 42

NHS Review

NHS AUDIT

Note by the Secretary of State for Health

1. There are currently three layers of audit in the NHS: internal audit within health authorities and Family Practitioner Committees (FPCs), which is sometimes contracted out to private firms; the Department's statutory external audit of health authorities and FPCs (also in part contracted out to private firms), which is responsible to me; and audit by the National Audit Office (NAO).

Proposals for change

2. The Group are already agreed that the present arrangements for external audit by the Department should be changed. Our objectives are to have an NHS audit body that, whilst appointed by and reporting to me, is independent of the Department of Health and the NHS and whose reports will be published. Two options have been identified: to transfer the function of external audit from the Department of Health to the Audit Commission; or to establish a new independent audit authority.

3. Officials were instructed to draw up a list of the criteria for an acceptable NHS independent audit authority, and to identify whether or not the Audit Commission could fulfil this role. The attached note, prepared by officials, sets out these criteria. They have been discussed with Howard Davies, the Controller of the Audit Commission, who has expressed the view that the Commission could take on this task without weakening its local authority effort and that the transfer of NHS audit would strengthen the Commission's ability to encourage more efficient and effective management of local public services.

4. Peter Walker is content in principle that the Commission should take on this role, although he notes that, given the status of the NHS, further consideration will need to be given to the arrangements for publishing audit reports and to the Commission's relationship with me as Secretary of State. Nicholas Ridley's views are awaited.

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Conclusion

5. Colleagues are invited:

i. to agree in principle that, subject to Nicholas Ridley's views, the external audit of health authorities and FPCs should, in principle, be transferred to the Audit Commission; and, if so,

ii. to agree that officials should explain to the National Audit Office what is proposed and to discuss with them the relationship between the NAO audit and the work of the Commission, emphasising that there will be no change in the NAO's role.

September 1988

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NHS AUDIT

Note by Officials

Current arrangements for NHS audit

1. There are currently three layers of audit function in the NHS:

(a) internal audit within health authorities and Family Practitioner Committees (FPCs);

(b) the Department of Health's statutory external audit of health authorities and FPCs, which reports to the Secretary of State; and

(c) audit by the National Audit Office (NAO).

(a) Internal audit

2. The NAO reported on internal audit in the NHS in April 1987, concluding that, whilst considerable progress had been made since their 1981 study, shortcomings remained in audit planning and execution and coverage of FPCs and computer systems.

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(b) Statutory external audit

3. The Department's Audit Directorate audits 221 health authorities, 90 FPCs and 40 other bodies. Some 15% of these audits are performed by private sector firms. Of the Directorate's staff of about 210, 59 are qualified accountants/auditors and a further 104 are engaged in external training for qualifications. The Directorate's regularity audit provides, inter alia, the basis for the NAO audit of the NHS consolidated accounts. Some 10% (and increasing) of the Directorate's audit effort is devoted to VFM audit. It is currently engaged in a number of VFM studies; for example of health authorities' cost improvement programmes, medical and nursing staff levels, and hospital pharmacies. These studies are reported in the Director of Audit's annual report to the Secretary of State who makes it available to Parliament and to the NHS. All of the Directorate's audit reports are used as appropriate by NHS management to help increase internal pressure for management improvements.

(c) NAO audit

4. The National Audit Act, 1983, provides statutory authority for the C&AG to carry out VFM audit examinations. The NAO audit the NHS consolidated accounts, not the accounts of the individual health authorities. They devote some 60% of their work to VFM performance in the NHS. Over the last 18 months they have published reports on the employment of professional and technical staff; competitive tendering in the NHS; usage of operating theatres; care in the community; estate management; and FPC management. Current studies include the quality of care in NHS hospitals; heart disease; oversight of hospital building in England; and financial control in the NHS.

Criteria for new statutory external audit arrangements

5. Any new independent audit body to replace the Department of Health's Audit Directorate's work on the statutory external audit of the NHS should:-

(i) be so empowered under statute; primary legislation would be needed;

(ii) be appointed by, and report to, the Secretary of State for Health (who would of course be separately advised by his own officials on the product of the audit body);

(iii) provide technical and regularity audit support to the Accounting Officers.

(iv) agree in advance with the Secretary of State its annual programme of work, covering:-

(a) regularity audits of the 350 individual health authorities and FPCs mentioned above, including certification of their accounts;

(b) value for money audit of the individual health authorities and FPCs, either self-standing or following upon and based on the studies at (c) below;

(c) special VFM studies of particular aspects of health authority and FPS work, including both clinical and support services;

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(v) establish a data base for its work (agreed with NHS Management);

(vi) establish a mechanism for avoiding errors of fact: clearance with the authorities upon which it is reporting would seem the simplest and most appropriate mechanism;

(vii) publish its reports (see below);

(viii) produce an annual report on its activities, to be presented to Parliament by the Secretary of State.

6. The reports at (iv)(b) and (c) above would include recommendations for VFM improvements in individual health authorities and would, as required by the Secretary of State or on the audit body's own initiative, report on a wide range of VFM issues in the NHS. The reports would also have to take into account the fact that value for money in the NHS is not a function solely of costs but of achieving the highest quality of health care at the most cost-effective price. When examining clinical areas the body would have to work in multi-disciplinary teams or have access to qualified medical advice in order to judge the quality of medical care. In addition the body would be required to produce rigorous and systematic comparisons of aspects of efficiency and effectiveness between different health authorities in order to encourage the less efficient to match the performance of the best.

7. These criteria need of course to be geared to the structures and funding of the NHS emerging from the health review: the criteria may need to be adapted. But for as long as the NHS continues to be funded mainly from

taxation, and its management continues to be devolved in part to some structure of health authorities, the above criteria should serve in broad terms.

Publication of reports

8. The audit reports produced by the new body would simultaneously be submitted:-

- to each health authority for consideration by the authority;

- to the Secretary of State for Health for any management action required by the Department.

9. To be independent of the Department and the NHS, the new audit body would have to report direct to the Secretary of State. In the process of producing its reports, and before submitting them to the Secretary of State and publishing them, it would have to check facts with the health authorities concerned, and reveal to them the deductions it wished to make from the facts and the options it wished to express. Further consideration needs to be given to how far it should clear its reports with the Department before publication: there is a case for saying that the reports under 5(iv)(a) and (b) above should be published by the audit body without the need for the Secretary of State's approval, but that the studies under 5(iv)(c) should be published by the Secretary of State, with any response which he felt he wished to give. On the other hand, since the NHS is virtually 100% vote funded and accountable to the Secretary of State, it is arguable that he should retain a degree of

control of the publication of all audit reports and of the way in which the audit findings are expressed. The formal position of the Accounting Officers would also have to be safeguarded.

Relations with the NAO

10. As with the present Departmental Directorate, the new audit body would also need to act as secondary auditors for the NAO. And to allow the NAO to test the effectiveness of the audit process it would as now be necessary for the NAO to retain the right to all audit files relating to Departmental votes and to examine audit processes and systems.

Current role of the Audit Commission

11. The Audit Commission is responsible for the audit of local authorities in England and Wales and reports to them. Some 30% of local authority audits are contracted out to private sector firms. The Commission devotes some 40% of its audit effort to VFM work. It instructs its auditors in the course of their audit to gather figures for specific activities. It then assembles and compares these figures and produces models of best practice.

12. We understand that the Audit Commission produces broadly three types of reports:-

(a) Annual audits of individual local authorities, including certification of their accounts. When the auditor wishes to raise matters of concern he writes a private management letter to the members of the local authority. When the auditor discovers matters of wider concern he may make a public interest report to the authority; there is a

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requirement for the local authority to consider it as a publicly available document. Such reports are sent to all members and they generally receive local publicity.

(b) Reports which look at particular services across local authorities. The study team analyse the way the activity is tackled in a number of local authorities thereby identifying the elements of good management practice. The names of authorities taking part may remain confidential, and commonly do when the findings are critical.

(c) Reports on the impact of central government on value for money in particular areas of local government work. The Commission can point out conflicts between different central government policies as they bear on local authorities.

13. The Commission operates as a statutory independent body; it often consults Departments at draft stages of the reports and endeavours to agree facts, but may not always be amenable to changes suggested by Departments to its reports, which are of course not concerned with Departments' direct expenditure but with that of the local authorities to whom the Audit Commission reports.

14. The audit regime which the Audit Commission provides to local authorities would not be appropriate to the case of the health authorities and the FPCs, which are not separately elected bodies but part of central government and accountable to the Secretary of State. The statutory external audit of the NHS must also recognise that the Accounting Officers are accountable to Parliament for the financial propriety and regularity as well as for the prudence, economy and value for money of voted expenditure.

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15. It is possible that the Secretary of State's and the Accounting Officers' audit requirements could be met by the Audit Commission but the two separate sets of audit requirements laid on the Audit Commission might not sit easily side by side. (See, for example, current pressure by the Audit Commission on the local authorities for increased expenditure on highway maintenance).

16. On the other hand, the Audit Commission has considerable experience and expertise in areas of work closely related to that of the health authorities. In particular, it is accustomed to working in multi-disciplinary teams with professionals looking at professional services. It might therefore start work, and make an impact, on the NHS audit requirements set out above, more quickly than a new audit body created from scratch. A new body could however subcontract some work to the Audit Commission.

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Copy No. 129(A-H)

HC 41

NHS Review

MERGING FPCs AND DHAs

Note by the Secretary of State for Health

1. This note responds to colleagues' wish to consider further two issues:

* whether Family Practitioner Committees (FPCs) should be merged with District Health Authorities (DHAs); and

* whether, and if so how, the Family Practitioner Services (FPS) should be cash-limited.

I. FPC/DHA AMALGAMATION

Reforming FPCs

2. At the Group's last meeting I argued against the merger of FPCs with DHAs. I remain of the view that merger would not materially assist the key structural changes we seek - new funding arrangements, self-governing hospitals, GP practice budgets, and so on - and would tend to divert effort away from their achievement.

3. What would help - and is needed anyway to implement the Primary Care White Paper - is the more effective management of the FPS. To this end I suggest that we:

(i) free management to manage by altering the composition of FPCs to reduce the influence of the professions. The simplest approach would be to remove the contractor professions entirely from membership of FPCs, whilst ensuring that adequate professional advice remained available.

(ii) strengthen the ability of FPCs both to manage their contracts with the professions and to support GPs in the task of securing cost-effective hospital services for their patients.

4. These changes may not of themselves be enough to ensure that change happens. For the Department itself to drive change forward through 90 FPCs is neither effective nor efficient. I therefore propose to make Regions our agent of change in this field, as in the field of hospital services. This relatively limited addition to their present functions would not prevent us from slimming down the regional function overall, and would make good management sense.

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Disadvantages of merger

5. These changes are not incompatible with merging FPCs and DHAs, and merger would have the further advantage of removing an administrative tier. But there are three further - and I believe compelling - arguments in favour of keeping FPCs in being, at least for the time being.

6. First (and if the introduction of general management into the hospital and community health services is included in the reckoning), merging FPCs with DHAs would be the fourth administrative upheaval within a decade. As an indication of the disruption involved in merging 90 FPCs into 190 Districts:

* 56 FPCs relate to more than one District.

* Of these 56,

  - 26 have boundaries which cut across those of their related Districts, and

  - 17 cover part or all of at least four Districts.

There would be significant costs - in additional computers, in reorganising FPC registers and in additional staff - but only minimal financial savings because the bulk of the work undertaken by FPCs (for example in administering contracts and payments) would continue as before. In short I believe that we should stick to our intention to go for evolutionary change.

7. Secondly, merger could easily be portrayed as indicative of a Government which does not know its mind. FPS and hospital administration were merged from 1974 until 1985, following the 1974 reorganisation. It was this Government which detached them again, not least because we judged that health authorities had not earned a good track record in their administration of the FPS, and since 1985 there has been real progress towards more effective management.

8. Finally, I believe that we can inject competition into the NHS more effectively by keeping "customers" and "suppliers" separate and by ensuring that the interests of hospitals do not dominate those of primary care. This is still more true if we are to develop GP practice budgets.

Reaction of the professions

9. The GPs, dentists, opticians and pharmacists would all oppose strongly the changes suggested in paragraph 3, especially altering the composition of FPCs. But they would be at least as strongly opposed to merger, and if we are to have a row with them I would rather it were about effective management control than about administrative reorganisation.

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Conclusion

10. I recommend that we do not pursue the merger of FPCs with DHAs, and that we adopt instead the reforms outlined in paragraph 3.

II. CASH LIMITING THE FPS

Cash limits and expenditure control

11. Any system of cash limits presupposes that those to whom the cash is allocated can control expenditure. In my view cash-limiting the FPS is not a matter of principle but a matter of ensuring that we can put adequate, and acceptable, controls in place.

12. These controls in turn must leave unaffected the patient's entitlement to

* access to professional time when they need it;
* any necessary treatments in the surgery; and
* any necessary prescribed medicines.

13. In theory the merger of FPCs with DHAs would help, by creating a larger budget within which to vire spending. But the main short-term levers at the disposal of health authority managers - closed wards, mothballed developments and increased waiting lists - could not be defended as a response to, say, over-spending by dentists. Whether or not we merge FPCs with DHAs, I do not believe we should move to cash-limiting unless and until we have sufficient, sensible controls in place within the FPS themselves.

The present system

14. The main elements of spending as a proportion of total FPS expenditure are set out in the following table:

	Gross cost 1987-88 U.K. (£ billion)	% of total FPS (approx.)
General medical services	1.50	30
General dental services	0.96	20
General ophthalmic services	0.18	4
Pharmaceutical services (other than medicines)	0.53	10
Medicines	1.91	36

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15. The general ophthalmic services have now been opened up to competition, and the remuneration system for opticians is under review. The remuneration system for pharmacists is also under review, and we now have powers to control the number of new pharmacies under contract to the NHS; by far the most important component of pharmaceutical service costs is that of the medicines themselves, where spending flows from the number and cost of doctors' prescriptions. The remainder of this paper concentrates, therefore, on the general medical and dental services, and on the drugs bill.

16. The remuneration system for doctors and dentists is based on a "cost-plus" contract under which each profession is entitled to a reimbursement of NHS expenses and to an average net income per practitioner.

17. The average net income is determined by the Government in the light of recommendations by the Doctors and Dentists Review Body (DDRB). The DDRB is influenced primarily by two factors:

* a general view of the relative standing of the professions in the pay league; and

* an assessment of their NHS workload (and, for doctors, their overall responsibility for patients) as it changes from year to year.

The average workload for doctors was determined through a survey in 1985, and a further survey is scheduled for 1989. Dentists are paid on an item of service basis, but item of service payments constitute only 10% of GPs' gross income.

18. The reimbursement of expenses operates as follows:

* for GPs, some NHS expenses - mainly on premises and ancillary staff - are reimbursed directly by FPCs; and spending on staff and improvements to premises is to be cash-limited under the Health and Medicines Bill. Their remaining NHS expenses - about half of the total - are reimbursed on an average basis through GPs' fees and allowances. Each year the DDRB estimates those NHS expenses which are to be reimbursed, using Inland Revenue sample data.

* for dentists, all NHS expenses are reimbursed on an average basis through their fees and allowances. In their case expenses are agreed by the two Sides in the Dental Rates Study Group - which has an independent Chairman - again using Inland Revenue sample data.

19. Once the Government has adopted a particular level of remuneration, the total pool of money to be made available for the year is calculated by reference to the number of practitioners. The fee structure is then fixed so as to deliver the set level of gross remuneration (excluding directly reimbursed expenses), given assumptions about the incidence of patient demand for services delivered on an item of service basis. Within the year, an unexpected level of patient demand will cause the pool to be under- or over-spent, as the case may be. But between years any discrepancy will be taken into account in setting the size of the pool for the following year.

20. Leaving aside the relatively small element of GPs' expenses which are directly reimbursed but will not be cash-limited under the present Bill (mainly the running costs of premises), the main determinants of in-year expenditure, and therefore the main factors which we need to consider controlling if we are to move towards a cash-limited system, are:

* the number of practitioners.

* item of service payments.

* the drugs bill (both the number of prescriptions and the unit cost).

The number of practitioners

21. The Government have not so far taken powers to control the numbers of GPs, although the statutory Medical Practices Committee (MPC) regulates the geographical distribution. I believe we should take such powers at the right time, and am currently considering how the control might best be effected. My initial inclination is that we should set a ceiling on the total number of GPs in each year, and distribute this allocation to FPCs in a way which takes into account FPCs' own judgement of how many GPs they need. One corollary of this would be the abolition of the MPC, which I believe we would need to reform anyway to reduce its domination by the profession. Any new system of controls, and any reform or abolition of the MPC, would be hotly contested by the profession and would place the Government in the firing line over the way the system works in practice. In my judgement the changes are nonetheless necessary and must be made at some time. We have to consider whether we wish to add this battle with the GPs to our other controversies in the review.

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22. There are no direct controls on numbers of dentists. We are currently working to limit the number of places in dental schools, and are taking powers to introduce a compulsory age of retirement for NHS dentists. These measures may prove sufficient. If they do not I would be prepared to consider introducing controls similar to those I propose for GPs, although we would need to secure a better geographical distribution of dentists as well and I would prefer to avoid the administrative costs of a control system if we can.

Item of service payments

23. Item of service payments exist for two main reasons:

* to encourage GPs to carry out important preventive treatments such as immunisation and cervical screening.

* because dentists (like opticians and pharmacists) do not have a "list" and therefore cannot be paid on a capitation basis.

24. In principle there are three ways of removing the uncertain effects of item of service payments on in-year expenditure:

* ration services when budgets run out, thus transferring the risk to the patient. This would be feasible in theory: each contractor would know how many items were to be made available, and would cease supply thereafter, rather as for elective hospital treatments. But I do not think this approach would be defensible.

* vire funds from elsewhere when budgets run out, thus transferring the risk to lower priority services. This would be feasible only if the relevant FPS budget-holder also held other budgets. One way of securing this would be to amalgamate at least some HCHS budgets with FPS spending, but as I have argued in paragraph 12 this would carry major political risks.

* switch entirely to capitation-based remuneration, thus transferring the risk to the contractor.

25. It would be feasible to abolish item of service payments for GPs in favour of capitation income, perhaps coupled with an explicit contractual requirement to provide the services concerned. The main disadvantage of such a move is that it would remove the direct incentives for preventive work which are the nearest we have in the present system to a performance-related element in GPs' remuneration. Abolishing item of service payments for GPs would help to resolve the unpredictability of general medical services expenditure; but, depending on the outcome of negotiations with the GPs, it would not necessarily reduce the level of spending overall.

26. Experiments are under way to explore the introduction of capitation-based remuneration for children's dentistry. I shall need to consider the next steps in the light of the outcome.

The drugs bill

27. The growth in expenditure on the drugs bill is largely, but not entirely, the result of GPs prescribing newer, more expensive drugs, rather than an increase in the number of items prescribed. The danger of cash limiting the drugs bill is that patients might not receive essential and urgent treatment. This in turn would lead to the additional costs of otherwise avoidable treatment, and would risk deaths and litigation. The average drug budget per GP practice would be about £170,000, but there are currently wide variations in spending. This variability would pose severe problems of adequacy and equity on the ground.

28. Controlling the drugs bill is much the most important and difficult problem to tackle if we are to move towards cash-limiting. I suggest that our approach should be to develop our use of existing levers until drug expenditure is sufficiently predictable for cash limits to be considered. The main levers are:

- the Pharmaceutical Price Regulation Scheme (PPRS)
- the Selected List
- generic prescribing
- feedback to doctors on the number and cost of their prescriptions.
- peer review.
- visits by the Department's Regional Medical Service to high-cost doctors.

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29. I am considering how best to make progress in this field. This includes developing the enhanced management role for FPCs outlined in the Primary Care White Paper. Our planned rate of progress will need to take into account the terms of that White Paper, which said:

> "The Government has no plans at present to extend the selected list scheme into other therapeutic areas or to introduce compulsory generic prescribing or substitution. In reaching this decision the Government has noted the willingness of the medical profession to achieve more economic and effective prescribing by voluntary means and will be seeking clear evidence that such measures yield positive results."

Controls over the drugs bill would also have implications for the PPRS, which would have to be renegotiated with the pharmaceutical industry.

The politics of cash-limiting

30. There is a major political risk embedded in the approach set out in this paper. It would not be difficult for our opponents to represent a policy of cash-limiting the FPS as one which posed a serious threat to the currently unrestrained access of patients to their GP and to primary care services generally. Technical counter-arguments about how the system would work in practice would cut little political ice. Many GPs would share such fears, and all would have an interest in reinforcing them.

31. Even if we are ourselves convinced that cash-limiting is a workable objective for the medium to long term, therefore, it would be a grave misjudgement to declare it. The row it would provoke would swamp the rest of our package of reforms. It would be represented as reneging on a clear undertaking, given to Parliament during the passage of the Health and Medicines Bill, that the Government has no plans to use the Bill's cash-limiting powers other than in respect of GPs' premises improvements and practice team staff. We must progress step by step, putting each building block in place as we are able and ready to do so.

Conclusion

32. Cash-limiting the FPS should be our medium to long term aspiration. But we should proceed pragmatically. The next step is to draw up detailed proposals for controlling the number of GPs, and to consider further what practical steps we can take to extend capitation-based remuneration and control expenditure on prescribed medicines. I see this work proceeding outside the compass of our published conclusions on the review. I invite colleagues to agree that I should proceed accordingly.

28 (A-F)

Copy No: 1

NHS Review

HC 40

GP PRACTICE BUDGETS

Note by the Secretary of State for Health

1. At our last meeting I was asked to submit a paper giving further details of the practical arrangements for optional budgets for GP practices.

Scope of the scheme

2. The main elements of my proposal are:

basis of scheme - GP practices which met the qualifying conditions would be able to opt to have a budget of their own covering a defined range of services. For all other practices, DHAs (or perhaps FPCs, if they remain in being) would secure services on their behalf, reflecting referral patterns in their placement of contracts.

scope of budget - the budget would cover out-patient services and a defined group of acute elective inpatient and day case treatments, together with that proportion of FPS spending which is to be cash-limited (paragraph 4 below).

calculation of budgets - on a weighted population basis.

participation - restricted to large practices with list sizes of more than twice the national average. This is equivalent to 9% of practices nationally, or just under 90% of practices with 6 or more doctors.

ability to manage budgets - participating practices must have in place the necessary IT to support monitoring of contracts and budgets.

budgetary flexibility - (1) practices will be able to carry forward any underspend in their budgets, consistently with current carry forward arrangements for the hospital and community health services (HCHS), and to vire within the scope of their budgets.

(2) DHAs will hold an exceptional "backstop" reserve fund. Advances will be secured against the following year's allocation and accompanied by peer review of referral patterns.

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contracts - participating practices will enter into contracts with hospitals for the supply of out-patient services and "elective" treatments.

3. Sir Roy Griffiths has suggested that, in addition, we should consider allowing smaller practices, which wish to group together in order to qualify, to take part in the scheme. He has also suggested that we should be ready to extend the scope of the scheme to cover areas of hospital expenditure like accident and emergency work if GPs so wish. I am very ready to try these suggestions out as well, as they are fully consistent with my main proposal.

4. The Group have also identified the desirability of extending budgets to cover elements of primary care expenditure under the control of GPs, for example practice expenses and drugs. I suggest that, at least to begin with, we include premises improvements and practice team staff, on which spending will be cash limited under the Health and Medicines Bill. Limiting budgets to areas of expenditure which are already cash limited would be the most practical approach. It is also the approach most likely to attract support from the GPs themselves, whilst providing a secure foundation on which to build.

5. Pilot schemes will be mounted to test the detailed arrangements. Annex A gives examples of where I expect pilot schemes will lead to refinement of my proposals.

Contractual arrangements

6. I expect contracts for out-patient services to be of the "block" variety whereby hospitals would get an annual fee in return for providing services to all patients referred. Contracts for inpatient and day case treatment may need to be more tightly defined in terms of waiting times, volume, casemix and costs per case for a variety of conditions. Annex B deals with the nature of the contracts in more detail.

7. GP referrals to hospital are initially for diagnosis by a specialist. On referral, the clinical responsibility for the patient is transferred to the consultant who will determine the diagnosis, urgency and management of the case. The essential feature of the contractual arrangements I have outlined is that they do not cut across this clinical decision-making process, but still enable GPs to back their choices with money. "Block" contracts in respect of out-patient services permit GPs to refer as necessary. From the consultant's standpoint, GP contracts will define the level of resources which the practice is willing to commit whilst leaving the consultant free to exercise clinical judgement at the level of the individual patient. This is similar in principle to the extension of clinical budgeting which we expect to follow the greater use of management budgeting, contract funding and the implementation of the Resource Management Initiative.

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Budgetary Constraints and Waiting Lists

8. It is essential to address what happens if a practice reaches its budget limit before the end of the year. Referrals for urgent cases must not be delayed by budgetary problems.

9. The key to this problem is unconstrained access to out-patient services for diagnosis. Large budgets and the ability to vire expenditure within them should ensure that GPs do not delay urgent referrals on budgetary grounds. Where "block" contracts have been negotiated, non-urgent cases would still be referred. I do not envisage GPs having waiting lists for non-urgent referrals.

10. Referred patients diagnosed as not falling within the scope of practice budgets will be treated in the same way as now. By definition, this will mean that urgent cases are treated. Cases diagnosed as being suitable for "elective" treatment will be placed on the consultant's waiting list, with the waiting list being managed with regard to clinical priority and overall resource constraints.

11. I expect that, as good budgetary practice, GPs will hold an uncommitted proportion of their budget in reserve. Where contract limits are in danger of being breached, the existence of such a reserve will enable practices to cope with modest year-on-year fluctuations in demand. This reserve could then be used for one-off purchases of treatment, opening up the possibility of GPs securing treatment at marginal cost as hospitals attempt to utilise spare capacity.

Conclusion

12. Offering large GP practices the opportunity to manage their own budgets will reinforce our policies on:

* patient choice;
* making hospitals responsive to the needs of GPs
* dispersing responsibility to as low a level as is reasonably practicable.

13. GPs can choose whether, when and where to refer, a choice which they exercise on behalf of patients. To make hospitals respond to that choice requires money to follow the patient. GP budgets provide such a mechanism whilst giving GPs direct responsibility for controlling the expenditure which their referral decisions generate.

14. I invite colleagues to endorse my proposals and to agree that I should now ask officials to begin work on designing pilot schemes.

September 1988

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ANNEX A

PILOT SCHEMES

Pilot schemes will be mounted to enable policy to be refined before extending the scheme on a national basis. Pilot schemes might be expected to lead to refinements in the following areas:

* Size of participating practices

  Large budgets provide practices with sufficient flexibility to cope with fluctuations in demand. Pilot schemes will initially restrict participation in the scheme to those with list sizes larger than twice the average (11,000+). The pilots will be designed to explore alternative thresholds.

* Calculation of budgets

  Practice lists differ in their composition with respect to a number of factors, not least age and sex. Budgetary allocations will initially be on a fairly crude age and sex weighted population basis. Pilot schemes will highlight whether such an approach is sufficiently sensitive to the health care needs of practices and what alternative factors might be taken into account.

* Coverage of budgets

  The 20 most common "elective" operations include procedures, such as mastectomy and termination of pregnancy, which are subject to time constraints. Pilot schemes will need to test the feasibility of including such procedures within the scheme, and more generally to help define precisely the treatments to be covered.

* Information requirements

  Participating practices will need access to data on waiting times and on the costs of different procedures for a comprehensive range of hospitals. Pilot schemes will explore ways of giving GPs access to such data. The use made of the information will be monitored in order to provide practices with a guide to the minimum information requirements needed to underpin decisions on referrals and the placement of contracts.

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ANNEX B

CONTRACTUAL ARRANGEMENTS

Type of contract

1. At least three types of contract can be identified:

* "Annual fee": hospitals would agree to provide an agreed range of services in respect of all cases referred. Out-patient services are likely to be covered by such contracts given the need for unconstrained access for diagnosis.

* "Cost and volume": the contract would specify the number of cases (minimum and maximum) to be treated, likely casemix, cost per case by condition and maximum waiting times. Payment would be on the basis of work done, subject to the minimum volume being referred. Such contracts provide flexibility with expenditure control. Contracts in respect of most "elective" treatments are likely to take this form.

* "Cost per case". Contracts would be negotiated on a cost per case basis plus maximum waiting times, but without any volume commitment. Treatments funded from the budget reserve and in response to unanticipated increases in demand are likely to take this form. This form of contract is likely to be attractive to hospitals seeking to use spare capacity and offers the GP the opportunity to negotiate contracts at marginal as opposed to average cost.

Prices

2. Prices charged need not reflect the actual costs incurred by any one patient. Indeed the variety of contracts enables prices to reflect average or marginal costs for individual or groups of conditions. But the need to recover costs means that the prices charged, and the underlying cost structure, should not be significantly out of step. Hospitals entering into effectively fixed price contracts will need information on costs and how these vary with casemix. Indeed this underpins all our current thinking on contractual approaches to funding. The more detailed the cost information the less likelihood of prices and costs being significantly out of step and the more able the hospital will be to quote for a comprehensive range of conditions and services. Initially one might expect hospitals to be cautious in their pricing decisions, reflecting in part the quality of the cost information available. Implementation of the Resource Management Initiative will help in this regard.

Incentives and Risk

3. Any contracts without volume limits would tend to provide GPs with an incentive to over-refer, thus placing strain on hospital

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provision. Contracts will be subject to periodic review and one would expect hospitals to reflect unanticipated increases in referrals in their renegotiated prices.

4. Hospitals entering into contracts which quote a variety of fixed prices for different treatments have an incentive not to take the more complicated and costly cases, especially where the price tariff is less well defined in terms of conditions or treatments. Over time GPs may choose not to refer cases to hospitals which exploit this. Alternatively, it might be a condition of the contract that all cases referred under the contract are handled either by the hospital or referred elsewhere with the hospital bearing the cost of the tertiary referral. The corollary of this is that unexpected complexity results in the under-recovery of costs by the hospital. Either way managers have a strong incentive to develop adequate cost information systems.

27(A-G)

Copy No. 1.

HC 39

NHS Review

SELF-GOVERNING HOSPITALS

Note by the Secretary of State for Health

1. Paper HC28 set out a path towards self-governing hospitals. Paper HC35 set out a new approach to funding the hospital service. This paper draws upon the main ideas from these two papers to outline a practical way forward to self-government.

Developing hospitals within the present system

2. Our main objectives may be summarised as follows:

- devolution of management responsibility to unit level;
- correspondingly stronger local management, and better tools available for them;
- switch from "formula" funding to a funding system which follows performance to agreed standards;
- more varied, flexible and competitive inter-relationships between DHAs, GPs, hospitals and the private sector.

3. All these objectives can be achieved within the present framework of the NHS and largely without legislation. So we shall be able to move quickly and without organisational restructuring. The key developments are:

i. The Resource Management Initiative which will give clinicians, as the main users of NHS resources, responsibility and accountability for the way resources are used, and information to help them in this.

ii. Greater flexibility over the manpower and capital resources used to provide services.

iii. A "contractual" style of management, making explicit the responsibilities of hospital and DHA and the quantity, quality and cost of services to be delivered.

iv. Contract-funding for cross-boundary flows where Districts would buy services within an internal market, mainly in elective treatments, according to the best available deal. This development would need legislation.

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4. We need to secure these developments for all hospitals, although it will take longer for some than for others. Once a hospital has reached stages (i) to (iii) it would be in a position to opt for self-governing status.

Self-governing hospitals

5. With self-governing status, the hospital would be empowered to hold its own contracts under 3(iii) and (iv), and would become the employer of its staff. This implies statutory change.

6. Given that self-governing hospitals will represent a final stage of development - and will call for considerable management skills in the use of contracts on the part of both Districts and the hospitals themselves - it would be unrealistic to expect self-governing status for many hospitals straightaway. But my aim will be for a small number of hospitals to seek self-governing status as soon as practicable after the legislation is passed so that we can learn any lessons from their progress and modify our approach as necessary.

7. The responsibility for guiding this development will be the NHS Management Board's, working through the slimmed down Regions. This will:

- give an impetus to the process;
- enable the lessons learned to be quickly passed on to all parts of the country;
- ensure fair competition within the NHS, and a proper spread of resources and services;
- help secure the interests of patients. There is no stable constituency of patients (as there is of parents in the schools context) so the consumers' interest will require special care which even the closer involvement of GPs will not wholly guarantee;
- ensure fair play. DHAs - and hospital managements - may have mixed motives for seeking change. It will be important that neither "side" seeks to take advantage of the other.

8. The main steps towards self governing status would be as follows:

- hospitals would be required to meet certain centrally determined criteria for quality of service and management, closely related to the advances they will need to have achieved along the lines summarised in paragraph 3;

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- the hospital management team would put forward proposals for running their services on their own;

- the Secretary of State, acting on the advice of Regions and after taking appropriate soundings, would decide whether or not to approve these proposals and, if so, would create of a management board for the hospital.

9. The main features of the status which hospitals would then adopt, and an outline of the funding and contractual arrangements which would apply, are set out in the annex. These are:

- each hospital would have a statutory management board comprising the management team and external "non-executive directors";

- hospitals would be accountable for the quantity and quality of their services through their contracts with Districts, GP practices and the private sector;

- hospitals would be accountable to Regions for their stewardship of publicly owned assets;

- hospitals would receive funding according to the contracts they won.

Conclusion

10. I invite colleagues to agree that:

(i) we should aim for the maximum sensible freedom and devolved responsibility for all hospitals, along the lines set out in paragraphs 2-4.

(ii) we should institute a centrally driven scheme for hospitals to opt into a statutory form of self-government, along the lines proposed in paragraph 5-9.

September 1988

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Annex

FINANCIAL AND CONSTITUTIONAL FRAMEWORK

1. A fully self governing hospital would be run by an independent board of management. It would be free to develop and offer packages of services that the board considered most effective, and to buy in or sub-contract out any part of its operation.

2. This annex describes the funding, constitution, accountability and management of the self governing hospital which is fully free of DHA management control.

Revenue funding

3. Self governing hospitals, as autonomous legal entities, would provide services under contract and receive funds accordingly. The main types of contract and corresponding funding arrangements are as follows:

"Core" services - essential local services which cannot effectively be provided elsewhere. In some areas there may be competition for the provision of these services. In general, DHAs will lay down tight performance specifications in terms of overall volume, availability and quality, which hospitals will be required to meet. It might be necessary to provide certain statutory obligations on self governing hospitals, or else arrangements for settling disputes over the scale and cost of core services in non-competitive situations. Payments to hospitals would flow steadily through the year, regardless of the actual patient throughput.

"Contract services" - primarily elective services which can be obtained further afield if need be, and at a chosen time. Hospitals would contract with DHAs and GPs participating in the GP practice budget arrangements (and with the private sector) for a set level of provision at an agreed unit price, with a number of different buyers. They would be competing against other hospitals to win such contracts. Payment would flow according to the patients treated.

Training - hospitals would be separately funded under contracts with RHAs for the provision of training overheads for nurses and doctors.

Constitution

4. Self governing hospitals would be constituted as distinct legal entities, enabling them to make contracts, own assets, employ staff, etc. Various models are available: special health authority, trust, or limited company (by shares or guarantee). The most appropriate model is probably a new form of statutory body, established under new legislation. This body would be the board of management of the hospital.

5. The management board should be designed to provide firm but accountable management on a businesslike basis. They should not follow the present DHA model of representative or political appointments.

6. There are four key roles to be filled:

Chairman

Chief Executive (General Manager, in current NHS terms)

Executive Directors (senior clinical staff)

Non-executive Directors (eg outside businessmen)

7. These roles can be combined in various ways, and not all roles need to be filled by formal members of the board of management. For example, the Chief Executive could be a servant of the board, as is the current health authority practice, and not a member. Or the chairman and Chief Executive roles could be combined.

8. A key requirement is that the board should not become a self-perpetuating oligarchy. Appointments to management boards could therefore be made by, or on behalf of, the Secretary of State. It would be possible, however, to allow boards some powers of co-option, perhaps subject to ratification.

9. Further work needs to be done to identify the preferred model for boards of management and, indeed, whether a single model needs to be prescribed. Other factors such as payment for non-executive directors, and the likely availability of sufficient candidates, will also need consideration.

Accountability

10. Self governing hospitals, or rather their boards of management, would be accountable to DHAs and to GPs (or FPCs) through the terms of their contracts for services. This would in practice be the most significant day-to-day discipline on the hospital management team. Boards would also be accountable for their stewardship of assets; this is discussed further below. Further work will be necessary to devise arrangements for handling, for example, failure to deliver services according to contract, or legal action against a hospital by a patient.

11. The Secretary of State will remain ultimately accountable to Parliament for the services provided by self-governing hospitals. Districts will be accountable, through Regions, for the amount and quality of services procured through their contracts with self-governing (and private) hospitals, as well as for the services provided by any directly managed units which remain.

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12. Boards of management could be encouraged, if not required, to make their own arrangements for involving the local community in the affairs of the hospital.

Management of capital assets

13. The main aims for the management of capital are:

- to delegate responsibility;
- to ensure that managers receive appropriate economic signals in their use of resources;
- to ensure that public assets are used most effectively in support of the health service as a whole.

14. It would be possible to vest ownership of all assets in the management boards. This would achieve the fullest delegation of responsibility, but it would limit the scope for gradually changing the distribution of assets to reflect wider service needs. Furthermore, since a self governing hospital could in principle cease trading (at least with the NHS) the assets it uses should not be alienated from public ownership.

15. Vesting ownership of all major assets in the Secretary of State would secure flexibility in their longer term distribution, while still enabling substantial delegation of responsibility for their day-to-day management, including their acquisition and disposal. This could be coupled with a system of charges for the use of capital which would reflect the cost of using assets, and provide corresponding incentives to use them cost-effectively.

Manpower

16. Self-governing hospitals also need to have maximum delegated responsibility for the management of their other key resource, manpower. In particular, management boards must be free to hire and fire staff. In principle this should embrace all staff, but we shall need to give further thought to the position of consultants.

17. Self governing hospitals could also have greater freedom to determine pay levels and working practices in ways which meet the needs of the hospital in meeting its contractual obligations and market opportunities. This freedom of management to control staffing and staff costs should not be constrained by rigid central determination of national pay and conditions as at present. However a free-for-all in the public sector would be likely to inflate staff costs unnecessarily. A national pay bargaining system would need to be established under the auspices of the Department of Health, but with considerable latitude for regional or local variation.

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18. Long-term manpower planning, and medical and other professional training, could not be left to individual hospital boards. National and regional oversight of future needs for skilled manpower, and of the corresponding professional training needed to meet them, would continue to be necessary as at present, and individual hospitals and other units would continue to provide training. Funding specifically for training would be channelled through the RHAs, and would, in effect, be subject to contracts similar to those for service provision.