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PRIME MINISTER

REVIEW OF THE NHS: OTHER OUTSTANDING ISSUES
[No papers, but HC43 (Outstanding Issues) and HC44 (Outline White Paper) may be referred to.]

1. You may wish to invite Mr Clarke to report orally on outstanding issues where the Group has commissioned work but not yet received detailed proposals. The main ones, outlined below, are:

   i. medical audit;
   ii. a package to improve the treatment of patients;
   iii. reconstituting District Health Authoritis (DHAs);
   iv. slimming down Regional Health Authorities (RHAs);
   v. the role of the NHS Management Board;
   vi. a greater role for the private sector (eg competitive tendering);
   vii. tackling restrictive practices in the professions;
   viii. remaining funding issues (in particular, top-slicing and cross-boundary funding);
   ix. charging for inessential treatment.

2. Some of these topics - such as the package of measures for patients - may involve public expenditure issues on departmental programmes (eg for Wales) which have not been settled yet. You will wish to make it clear that this is a matter between the Secretary of State concerned and the Chief Secretary, and you do not wish to prejudice that discussion.

3. Having run through these outstanding issues you may wish to conclude by considering the nature, style and scope of the White Paper. Depending on how the discussion has gone, it may be possible to agree that drafting should now begin.

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4. The Chancellor indicated at the last meeting that there was one issue which he might wish to reopen at this meeting. Our best guess is that this is likely to be the decision to give special fiscal incentives for company health insurance schemes, by raising the benefit-in-kind limit. He may receive some support from Mr Clarke on this. It is not clear that the Chancellor will raise the point, but if he does you may wish simply to say that a decision has already been taken and that, since this is a tax matter, if the Chancellor has misgivings, it might be best to discuss it separately between the two of you.

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Medical Audit

5. The importance of medical audit has been a consistent theme of the group's discussions. At the last meeting for instance it was seen as a means of monitoring the quality of treatment provided by self-governing hospitals, and as a safeguard against mal-practice by opted-out GPs cutting down on treatment for sick patients. In presenting the Review's conclusions it will be important to emphasise that securing the more efficient use of resources and developing greater responsibility to GPs and hospitals will not mean a poorer standard of treatment for patients. Positive proposals for medical audit will be one of the ways of reassuring the public on this point. You may therefore wish to make sure that the group are clear about what medical audit means in practice and who is going to do it. Particular aspects include:

i. arrangements at national level. In a paper in June (HC30) Mr Moore proposed establishing a new national body for medical audit. In his recent paper on outstanding issues (HC43) Mr Clarke talks about inviting the profession "to participate in a national initiative". You may wish to ask what this means in practical terms. Is there to be a new organisation for medical audit? If not, are the

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existing professional bodies likely to provide the drive which is needed? Do the information and the knowhow exist to enable audit arrangements to be strengthened?

ii. application to consultants. Mr Moore said in June that one of the major problems at present is that consultants can refuse to participate in medical audit. You may wish to explore how this is to be overcome. In HC43 Mr Clarke suggests that the Government should "use medical audit (together with outcome measures) as a tool in securing the accounatability of consultants for the quality of their work." How is this to be done?

iii. application to self-governing hospitals. In HC43 Mr Clarke refers to the inclusion of medical audit in the criteria for hospitals to become self-governing. You may wish to ask who or what body would conduct the medical audit.

iv. application to GPs. The same question arises in relation to GPs on such matters as the level of outpatient referrals and prescribing of drugs. Who would do it?

A Package to Improve the Treatment of Patients

6. The Group agreed on 8 July that the White Paper should include a package of changes that would improve the treatment of patients: for example in the appointments system for outpatients, the physical surroundings in which they are seen, the attitude of reception staff, visiting hours in hospitals and the management of waiting lists for hospital treatment. In HC43 Mr Clarke said simply that he was working on some ideas, summarised in very general terms in his outline White Paper. You may wish to ask what specificaly he has in mind, without being drawn into the public expenditure aspects, and over what period he intends to implement it.

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Reconstituting District Health Authorities

7. The Group agreed in July that there was a need to reconstitute DHAs so as to remove their political element. No proposals on this have yet been brought forward, although Mr Clarke has commented that he thinks it will be a politically contentious step, with Government backbenchers as well as with others. You may wish to ask him what proposals he intends to bring forward. There are a number of aspects including:

i. will it require legislation? Our understanding is that DHAs are statutory bodies, created under the National Health Service Act 1977 as amended, and that the local authorities have a right under that legislation to be represented on them. You may wish to confirm this;

ii. the number of members of DHAs. Our understanding is that the membership of DHAs is set by law (probably under a Statutory Instrument) at between 16 and 19 people. You may wish to ask whether a smaller body would be more effective, and whether the main aim should be to choose members for their financial and managerial skills;

iii. appointments to DHAs. The Secretary of State appoints the chairmen of DHAs; the Regional Health Authorities appoint the members of DHAs. Is this to continue, if RHAs are to be slimmed down?

Shirt I believe you sponsored. RRCG.

iv. meetings in public. Health Authorities are required by the Public Bodies (Access to Meetings) Act 1960 to make their meetings open to the public. In practice a number (for instance Wessex RHA) exclude the public from much of their business by holding only 5-6 public meetings a year and doing a lot of business in committees in between. You may wish to ask Mr Clarke whether he intends to discontinue the requirement that meetings should be held in public;

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v. slimming down DHAs. There are 190 DHAs. The administrative costs of their headquarters operations totalled £317 million in 1986-87 (the latest year for which we have been able to get a figure). You may wish to ask whether these headquarters operations could be slimmed down.

vi. Community Health Councils. In earlier discussion it was suggested that these Councils could usefully be kept as a way of channelling the energies of local politicians if the latter no longer had a place on DHAs. Is this agreed?

Slimming down Regional Health Authorities

8. In earlier discussion the Group saw a strong case for slimming down the operations of the regional health authorities and indicated that they might in time become regional offices of the Department of Health. Mr Clarke has indicated in discussion that he has reservations on the latter point but has referred in a recent paper to "slimming down the regional function overall" (paragraph 4 of HC41). You may wish to ask him what proposals he has in mind.

i. Slimming down. The headquarters costs of all RHAs taken together totalled £110 million in 1986-87. The number of administrative and clerical staff totalled £7,800. You may wish to ask what degree of slimming down is possible, over what period. The answer presumably turns on what the functions of those authorities are mean to be. Mr Clarke has referred to them as 'agents of change' in implementing the proposed reforms. What role does he have in mind? Do they have a long-term future as separate statutory bodies? What do they contribute to the running of the NHS, and is it worth £110 million per annum?

ii. Membership. As with DHAs, there is a possibility of reducing the number of members. You may wish to explore.

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iii. Meeting in public. As with DHAs, the regional authorities are required to meet in public by the 1960 Act.

The Role of the NHS Management Board

9. The Group in July concluded tdhat there would need to be some revision of the role of the NHS Management Board and asked for a paper on it. Mr Clarke has since taken over chairmanship of the Board. You may wish to ask what proposals he has in mind. There are two main aspects.

i. the NHS Management Board. Who sits on it? What decisions does it take (eg in the last three months)? Does it in fact manage the NHS? How does it relate to the Regional Health Authorities? Do Family Practitioner Committees report to it (I believe not)? What changes are needed in it?

ii. the Health Services Supervisory Board. This is a separate Board, also chaired by the Secretary of State. You may wish to ask whether it is needed. How does it relate to the NHS Management Board? Who sits on it? What decisions does it take (eg in the last 3 months)?

A Greater Role for the Private Sector

10. Another major theme of the Group's work has been the need to encourage the role of the private sector and blur the distinction between public and private. You may wish to ask how this is going to be translated into practical action in the Review. Particular aspects include:

i. competitive tendering. The Group in July asked for more work to be done on extending contracting out to clinical work including services such as pathology and radiology. You may wish to ask about progress;

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ii. joint ventures. Discussions between the Treasury and the Department of Health on the treatment of capital continue. You may wish to ask for a paper for the next meeting of the Group;

iii. spare capacity. The Group endorsed the idea of asking all NHS hospitals to review the scope for selling spare capacity to the private sector. How will this be carried forward?

iv. pay beds. The Group endorsed the idea of encouraging more pay beds in hospitals, particularly the introduction of new private wings (eg in accommodation which becomes surplus following rationalisation). How will this be carried forward?

Restrictive Practices in the Professions

11. The Group has already discussed the handling of consultants' contracts at some length (Mr Clarke's latest paper proposes that self-governing hospitals should be able directly to employ their own consultants). You may wish to ask:

i. what plans are there for the employment of consultants on short-term contracts to help deal with waiting lists, as discussed earlier in the Review?

ii. are there any other restrictive practices in other professions in the NHS, to free up the supply of key personnel, which need to be tackled?

Remaining Funding Issues

12. There are two issues on funding, arising out of earlier discussion, on which you may wish to check progress:

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i. top-slicing. The Chief Secretary made proposals for setting aside a proportion of the increase in expenditure on the NHS each year to reward hospitals, districts or regions for their greater efficiency and to reduce waiting lists. You may wish to ask where this has got to, and when it will be implemented;

ii. cross-boundary flows. The group has agreed the need to develop a system which allows money to follow the patient. One problem is the length of time it takes for a hospital to be paid for treating a patient from another district. You may wish to ask how this is to be tackled. Will it require legislation?

Charging for Inessential Treatment

13. Finally, a paper was commissioned in July on the case for ending the provision of inessential treatment free on the NHS, (such as chiropody for the under-60s [£5 million per annum in 1985-86]). Mr Clarke in HC43 proposes that this should not be pursued. Are you content?

WHITE PAPER

14. Mr Clarke invited the Group's views on the style and content of the White Paper in HC44. He offered a choice between a detailed, analytical document and a much shorter paper setting out "the main themes and conclusions", supported by consultative documents. His own preference on balance was the second option. You may wish to discuss what guidance should be given on this. At this stage there are perhaps two main points:

i. length. It may look odd if after such a full and lengthy Review the Government produces only a short White Paper, with a number of detailed consultation documents. Is there a position in between the two options which Mr Clarke proposes? The Government might produce a full analytical White Paper, together with a shorter 'popular' version setting out the key conclusions;

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ii. content. There needs to be clear guidance on the main thrust of the White Paper. For instance, the draft outline which Mr Clarke circulated included a separate chapter on Wider Health Issues which the Group has never touched on. You will wish to consider whether the White Paper should concentrate on the delivery of services in the NHS or provide a wider survey on the nation's health.

15. Depending on how the discussion goes, you will wish to conclude by considering whether further discussion is needed on the policy issues; or whether drafting of the White Paper should now begin.

RTJW.

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Cabinet Office
14 October 1988

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