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LONDON SW1A 2AA

From the Private Secretary

25 November 1988

Dear Andy,

NATIONAL HEALTH SERVICE REVIEW

The Prime Minister held the fifteenth and sixteenth meetings of the group reviewing the National Health Service on 23 and 24 November. The group considered papers HC 57, 58, 51, 53, 56, 54 and 55.

I should be grateful if you and copy recipients would ensure that the record of the discussion is handled strictly in accordance with the CMO arrangements.

Those present at the first of these two meetings were the Chancellor of the Exchequer, the Secretary of State for Wales, the Secretary of State for Scotland, the Secretary of State for Health, the Chief Secretary to the Treasury, the Minister for Health, Sir Roy Griffiths, Sir Robin Butler, Mr. Wilson and Mr. Monger (Cabinet Office) and Mr. Whitehead (No.10 Policy Unit).

Those present at the second meeting were the Chancellor of the Exchequer, the Secretary of State for Northern Ireland, the Secretary of State for Scotland, the Secretary of State for Health, the Chief Secretary to the Treasury, Sir Robin Butler, Mr. Wilson and Mr. Monger and Mr. Whitehead.

Decisions so far

The first meeting began by considering the Cabinet Office note, 'Decisions So Far', HC 57.

The Prime Minister, summing up the discussion of this item, said that the group had agreed the note as a statement of decisions made and outstanding, subject to the following points:

a. The case for providing incentives to GPs tended largely to be ignored. It was nonetheless an important area. The Secretary of State for Health would consider what could be done.

b. The group had agreed that the timetable for the establishment of self-governing hospitals was important. Some progress might be made without

legislation through use of the existing power to set up Special Health Authorities. This was worth considering as a first step. But it would not by itself get very far since such Authorities lacked the power to charge for their services or to decide the pay of their staff.

c. A number of detailed points on the practical working of self-governing hospitals remained to be settled. One of these was how end-year flexibility would apply to them: there was a strong case for the view that a measure of such flexibility was essential to the running of the hospitals.

d. The group had considered whether to legislate in the forthcoming Housing and Local Government Bill for the Audit Commission to take over the external audit of the NHS. The group, while they wanted to press ahead with this change, would not want to import general discussion of the NHS review into the debates on the Bill. Whether this would happen would depend partly on whether the Long Title had to be drafted so as to refer to the NHS. The suggestion had been made in discussion that the Secretary of State could be given power, subject to affirmative resolution, to extend the Commission's powers. This might avoid any explicit reference to the NHS, and looked a promising possibility. The Secretary of State for Health should circulate a short note to the group on the whole question.

e. The group had also considered the case for Ministerial Chairmanship of the National Health Service Management Board. They believed that it was right for management, led by the Chief Executive, to operate the service within a framework of policy aims and objectives and of finance set by Government but without Ministerial interference in day-to-day management matters. The Chief Executive ought to be the person responsible for presenting and defending management decisions in public. The Group had therefore decided to return to the concept of a supervisory board under Ministerial Chairmanship to decide strategy, and a Management Committee which would be left the maximum freedom to manage the service, within the parameters set by Government.

Funding the Hospital Service

The group then considered the note 'Funding the Hospital Service', HC 58.

The Secretary of State for Health, introducing the paper, said that it had been agreed between himself and the Chief Secretary. It made detailed proposals for abolishing RAWP and moving over three years to a system of allocation to regions based on weighted capitation. The Chief Secretary and he had given particular attention to the distributional effects of the new system, especially the

effects on the Thames Regions which stood to lose from the continued operation of RAWP. As a solution to this problem, they recommended Option C, which involved setting funding at a higher level for those regions than for the others. This could be readily justified by pointing to the special health problems of London.

In discussion the following were the main points made:

a. The new system also had major advantages of simplicity and transparency. The RAWP targets, which had caused endless trouble, would be abolished. Cross-boundary flows would be effected by simple payment in cash rather than by obscure and imperfect adjustments to the RAWP formula. The same principles would be applied to allocations to districts, although in their case the period of transition would have to be longer, perhaps five years.

b. The redistribution of resources away from the Thames regions had been one of the most controversial effects of the RAWP system. It resulted in part from the fact that, for historical reasons and perhaps because of proximity to hospitals, people in London made greater use of hospital services than those elsewhere. The new system went as far as was practical in correcting the RAWP bias against the Thames regions. The other options which had been examined were less favourable to those regions.

c. Even under the new system, there would, as the table attached to the paper showed, be some movement of resources away from the northern Thames regions. But these figures were highly artificial. They did not allow for the ability of London hospitals to attract patients from other parts of the country and receive payment for them under the new and improved arrangements for cross-boundary flows. Above all, they were based only on 1988-89 allocations, and did not allow for future increases in the total provision for the NHS. In practice these increases over the period of transition would mean that the resulting gains for the northern Thames regions would more than outweigh the losses they suffered from redistribution. The new arrangements for performance funding would also be relevant.

d. It was argued that the timetable in paragraph 24 of the paper was not sufficiently ambitious, especially as regards the development of self-governing hospitals. On the other hand, it was argued that this timetable was consistent with rapid progress to self-governing status of a large number of hospitals. It was expected that when the first candidates for this status were identified in April 1989 there might be as many as twenty.

The Prime Minister, summing up this part of the discussion, said that the group accepted Option C in the

paper on the basis that it was the best that could be done. The criteria for the allocation of money for performance funding would not be stated in advance. The group agreed with the timetable in paragraph 24 on the understanding that it was consistent with the rapid progress to self-governing status of a large number of hospitals.

Managing the Family Practitioner Services

The group then considered the note, HC 51, 'Managing the Family Practitioner Services', by the Secretary of State for Health.

In discussion the following were the main points made:

a. It was argued that the proposal for GP practice budgets as it now stood contained a major flaw. Payments would be made to GPs according to their number of patients, some of whom might have private hospital insurance and not require NHS hospital treatment. Payments could therefore be excessive, to an extent varying from practice to practice, and likely to depend on the areas in which the practices were based. There was also a risk that, where GPs were known to refer to private providers, their patients would no longer think it necessary to take out private insurance, thus increasing public expenditure. The cost to public funds could be £50million at first, and would probably rise as behaviour changed. It was argued on the other hand that the risk that allocations would be excessive was already in principle present in allocations to regions and districts, which also made no allowance for the number of private patients. Moreover, the new arrangement for GPs should give them an incentive to encourage their patients to take out private insurance, and that was highly desirable. For their part, patients were unlikely to give up private hospital insurance - which gave them control over the timing and location of treatment - for the possibility of GP referrals to private providers, which gave them neither. If there was a problem the best solution might be partially to adjust the size of budgets for opted out GPs to take any necessary account of this effect after a period of experience in operating the budgets.

b. The group discussed how best to get effective control over FPS expenditure. On the one hand, it was argued that the right way was through proper management of GPs' contracts. Considerable progress in this direction had already been achieved but it was necessary to move with care. The two biggest determinants of GPs' expenditure were prescribing habits and referral patterns. On neither was the information yet available to say what the right level of expenditure was. Once this information had been collected, the contract could be managed, if necessary with the help of penalties, to prevent excessive spending. Cash limits could not by themselves overcome

the problem of lack of sufficient information and control. Indeed they would be justifiably criticised by the profession for being based on inadequate information about the desirable level of spending.

c. On the other hand, it was argued that the right solution was to combine DHAs and FPCs and then cash limit the merged body. This would provide the maximum opportunity for viring between different types of expenditure and make it unnecessary to take a view on the right level for individual items. There were broadly similar arrangements already in operation in Scotland and Northern Ireland. Such a change would also eliminate the distortions now arising from the fact that hospital services were cash limited while the FPS were not.

d. There was a very strong case for giving GP practices with their own budgets the further option of holding a budget for drugs.

e. The expansion of the Audit Commission's role should cover the FPS as well as hospitals. This would probably be achieved by the arrangements already agreed, but that would need to be checked.

f. It was a serious weakness of the present system that there was no control over the number of GPs, since each GP was able to call on public money. It had already been suggested that downward pressure would be exerted on GP numbers if their system of remuneration were changed to give a greater weighting to the element of capitation. As it stood, this proposal was subject to the difficulty that, under present arrangements, the Review Body would compensate automatically for any such change if that were necessary to achieve what they regarded as a reasonable level of net remuneration. Further work was needed on this.

The Prime Minister, summing up this part of the discussion, said that on control of FPS expenditure most members of the group agreed that the right solution was to merge the DHAs and FPCs and set reasonable budgets for the merged bodies. The White Paper would have to set out the case for making this the aim. But it could not be achieved at once. It had been pointed out in discussion that there was not at present enough information to reach a proper view on the level of expenditure on drugs and hospital referrals. There would therefore have to be a transition. The Secretary of State for Health should now prepare a note setting out his view of the timetable within which such information could be obtained and budgets could be based on it.

On the other matters discussed, the group had considered the argument that GP practice budgets as so far envisaged would lead to excessive allocations to those practices which had privately insured patients. They believed that the best solution to this difficulty would be

to adjust the size of the budgets for opted-out GPs to take account of this effect where this proved to be necessary after a period of experience in operating the budgets. An adjustment might take the form of allowing the GP to retain at least part of the excess allocation for some approved purpose such as investment in the practice. The Secretary of State for Health should circulate a note about this to the group.

The group had agreed that GP practices with their own budgets should have the further option of a budget for drugs.

The group had also agreed that the Audit Commission should provide the external audit of the FPS as well as the hospitals. The Secretary of State would check that this would be achieved by the arrangements now being developed following the previous discussions.

Finally, the group were agreed that some control over GP numbers was necesssary. The Secretary of State for Health should circulate a further note on the possible options. This should in particular consider the option of increasing the capitation element in total remuneration, and whether there was a way of ensuring that the Review Body's recommendations did not offset the effects of any such change.

A Better Service to Patients

The first meeting of the group then concluded. The second meeting began by considering the note by the Secretary of State for Health, 'A Better Service to Patients', HC 53.

The Prime Minister, summing up the discussion, said that the group had agreed as follows:

a. It was crucial to get the support of the public generally for the reforms to offset the possible criticism from professional vested interests. The public would judge the success of the review largely by the improvements it made in the treatment of patients. The importance the Government attached to such improvements should be a theme running right through the White Paper. There should be an appropriate reference in the foreword and a chapter setting out the list of specific improvements should come at the beginning of the White Paper.

b. For this purpose, what mattered most were specific practical improvements in the service received by patients rather than initiatives which would seem remote from the ordinary patient. A reduction in waiting lists for operations would seem of major importance to the public and more detail should be provided on how it would be achieved. Other desirable improvements which should be listed in the White Paper were: an appointments system that worked properly;

rapid notification of the results of tests; better information about availability of beds; shorter waiting times for appointments; an easier procedure for changing doctors; proper facilities for mothers and children in emergency departments; a better complaints procedure; and more information about optional extras and amenities.

c. The emphasis throughout should be on the responsibility of management to secure the necessary changes. Management would be supported by financial audit and medical audit. It must have effective control over professionals, including the power to hire and fire, and professionals should themselves accept more management responsibility.

d. One important task for management would be to ensure that best practice was applied more generally. The White Paper should give convincing examples of best practice in areas of practical importance to patients.

e. The White Paper should not propose the establishment of Quality Assurance Programmes or an Acute Sector Advisory Service. If management wished to set up multi disciplinary terms to advise it on any aspects of care it was of course free to do so, but the decision was its responsibility.

f. There should be no reference to health indicators. Standards of health depended on factors such as life style and diet more than on NHS treatment. Health indicators could however have a useful role for strictly internal purposes, to help the Department of Health to monitor the performance of the Health Authorities. It would also be wrong to give too much prominence to health education and promotion. The maintenance of a healthy way of living was a matter for individual decision, not Government interference.

Management of Capital

The group then considered the note by the Secretary of State for Health and the Chief Secretary to the Treasury, 'Management of Capital', HC 56.

The Prime Minister, summing up this part of the discussion, said that the group had agreed as follows.

a. A system of charges for the use of NHS capital assets was highly desirable.

b. Paragraph 4 of the paper suggested that disposals of more than 5 per cent of a self-governing hospital's total capital stock would require regional approval. This was much too restrictive and should be reconsidered by the Secretary of State for Health and the Chief Secretary.

c. Paragraph 5 of the paper proposed three stages in the

introduction of the system of real charges. The second stage involved the use of management accounts to enable the NHS to go through a process of familiarisation using notional figures. The group believed that notional accounts would carry little conviction and that it should be possible with use of proper accounting expertise to move quickly to the use of real charges. It should be made clear that the notional stage was only transitional and a clear timetable should be set for achieving the final stage. A period of two years seemed reasonable, so that the system could be in place by early 1991.

d. On access to private sector capital, it had been argued that this could take many forms and that more analysis was necessary to distinguish between them and establish sensible guidelines for each variant. The group agreed that more work was necessary, and that this should be undertaken by the Secretary of State and the Chief Secretary. But this further work should be firmly based on the general objective, to which the group attached importance, of giving self-governing hospitals the maximum possible freedom to run their own affairs and in particular to get access to private capital. The framework within which they operated should be enabling, not restrictive. Otherwise, they would not develop a proper business approach, and would fail to attract the best managers.

The Public and Private Sectors

The group then discussed the note by the Secretary of State for Health, 'The Public and Private Sectors', HC 54.

The Prime Minister, summing up this part of the discussion, said that the group broadly endorsed the proposals in the paper, subject to two points, which should be reflected in the White Paper. First, they thought it important that the NHS should provide more optional extras such as amenity beds, better food and television sets. Good progress had already been made in this direction, but more was desirable. Second, they believed that there was much more scope for competitive tendering. A recent CBI study had suggested that it was applied to only a comparatively small proportion of NHS purchasing. Areas to which it did not apply were said to be administration, portering, security, research, building and garden maintenance and estate management. There was also considerable scope for extending competitive tendering to clinical as well as non-clinical services. Good examples were pathology and blood tests; retired doctors might want to set up independent services in these areas. A major extension of competitive tendering ought to be achieved by the new pressures on management to be efficient that would follow from the reform proposals as a whole.

Professional and Employment Practices

The group then considered the note by the Secretary of

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State for Health, 'Professional and Employment Practices', HC 55.

Summing up this part of the discussion, the Prime Minister said that the group had rejected the idea of a new inquiry into professional boundaries. It ran the risk that the inquiry would respond to professional opinion and entrench some demarcations even more deeply. Progress could best be achieved by good management, supported by financial and medical audit, applying the lessons of best practice, including practice abroad. The White Paper should give examples of best practice in this respect. Flexi-nursing was an obvious possibility.

The group had briefly discussed the question of consultants' contracts. They broadly endorsed the proposals in the letter of 21 November from the Secretary of State for Health to the Chancellor of the Exchequer. They attached special importance to the participation of management in decisions about consultants' merit awards. This could be achieved by the proposal by the Secretary of State for Health in HC 43 that the 'C' awards should be replaced by performance-related pay, eligibility for which would be determined by general managers and senior doctors jointly. The group also attached importance to the proposal in the letter of 21 November that merit awards should be reviewable after five years and subject to completion of at least three years further service.

Timetable

Finally, the group discussed timetable and next steps.

The Prime Minister, summing up the discussion, said that another meeting of the group had been arranged for 16 December. This would consider:

a. The further work commissioned at the meetings on 23 and 24 November.

b. The paper on pay being prepared by the Secretary of State for Health and the Chief Secretary jointly. On this subject, the group believed that the NHS must move away from national pay bargaining, and that there was a very strong case for leaving self-governing hospitals free to decide the pay of their own staff, and to hire and fire them.

c. A first draft of at least part of the White Paper, including especially the chapter on self-governing hospitals. Work on drafting should start straightaway.

A further meeting would be arranged in the week of 19 December to consider a full draft of the White Paper.

It was essential that the White Paper should be published before the first anniversary of the announcement of the review. There would be further meetings as necessary in the week beginning on 2 January to consider drafts of the

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White Paper, and it would go to E(A) and Cabinet in the week of 9 January. The White Paper must be crisp and readable and a special effort must be made to ensure that it had an attractive presentation with good illustrations.

The group had noted that decisions would be needed at some point about the future of community care. Further work was needed on this, but it was probably right to take the necessary decisions on health first, and set them out in the White Paper, before settling the question of community care.

I am sending copies of this letter to the Private Secretaries of the other Ministers at the meetings, and to the others present.

Yours,
Paul

(PAUL GRAY)

Andy McKeon, Esq.,
Department of Health.

G.R. 134-9
Type fair - today if poss. - please. P.

Mr Gray

G W MONGER
25.11.88

SW2A0C

Draft letter for Mr Gray to send to
Principal Private Secretary, Department of Health

National Health Service Review

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In discussion the following were the main points made:

a. The new system also had major advantages of simplicity and transparency. The RAWP targets, which had caused endless trouble, would be abolished. Cross-boundary flows would be effected by simple payment in cash rather than by obscure and imperfect adjustments to the RAWP formula. The same principles would be applied to allocations to districts, although in their case the period of transition would have to be longer, perhaps five years.

b. The redistribution of resources away from the Thames regions had been one of the most controversial effects of the RAWP system. It resulted in part from the fact that, for historical reasons and perhaps because of proximity to hospitals, people in London made greater use of hospital services than those elsewhere. The new system went as far as was practical in correcting the RAWP bias against the Thames regions. The other options which had been examined were less favourable to those regions.

c. Even under the new system, there would, as the table attached to the paper showed, be some movement of resources away from the northern Thames regions. But these figures were highly artificial. They did not allow for the ability of London hospitals to attract patients from other parts of the country and receive payment for them under the new and improved arrangements for cross-boundary flows. Above all, they were based only on 1988-89 allocations, and did not allow for future increases in the total provision for the NHS. In practice these increases over the period of transition would mean that the resulting gains for the northern Thames regions would more than outweigh the losses they suffered from redistribution. The new arrangements for performance funding would also be relevant.

d. It was argued that the timetable in paragraph 24 of the paper was not sufficiently ambitious, especially as regards the development of self-governing hospitals. On the other hand, it was argued that this timetable was consistent with rapid progress to self-governing status of a large number of hospitals. It was expected that when the first candidates for this status were identified in April 1989 there might be as many as twenty.

The Prime Minister, summing up this part of the discussion, said that the group accepted Option C in the paper on the basis that it was the best that could be done. The criteria for the allocation of money for performance funding would not be stated in advance. The group agreed with the timetable in paragraph 24 on the understanding

that it was consistent with the rapid progress to self-governing status of a large number of hospitals.

Managing the Family Practitioner Services

The group then considered the note, HC 51, 'Managing the Family Practitioner Services', by the Secretary of State for Health.

In discussion the following were the main points made:

a. It was argued that the proposal for GP practice budgets as it now stood contained a major flaw. Payments would be made to GPs according to their number of patients, some of whom might have private hospital insurance and not require NHS treatment. Payments could therefore be excessive, to an extent varying from practice to practice, and likely to depend on the areas in which the practices were based. There was also a risk that, where GPs were known to refer to private providers, their patients would no longer think it necessary to take out private insurance, thus increasing public expenditure. The cost to public funds could be £50m at first, and would probably rise as behaviour changed. It was argued on the other hand that the risk that allocations would be excessive was already in principle present in allocations to regions and districts, which also made no allowance for the number of private patients. Moreover, the new arrangement for GPs should give them an incentive to encourage their patients to take out private insurance, and that was highly desirable. For their part, patients were unlikely to give up private hospital insurance which gave them control over the timing and location of treatment for the possibility of GP referrals to private providers, which gave them neither. If there were a problem the best solution might be partially to adjust the size of budgets for opted out GPs to take any necessary account of this effect after a period of experience in operating the budgets.

b. The group discussed how best to get effective control over FPS expenditure. On the one hand, it was argued that the right way was through proper management of GPs' contracts. Considerable progress in this direction had already been achieved but it was necessary to move with care. The two biggest determinants of GPs' expenditure were prescribing habits and referral patterns. On neither was the information yet available to say what the right level of expenditure was. Once this information had been collected, the contract could be managed, if necessary with the help of penalties, to prevent excessive spending. Cash limits could not by themselves overcome the problem of lack of sufficient information and control. Indeed they would be justifiably criticised by the profession for being based on inadequate information about the desirable level of spending.

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d. There was a very strong case for giving GP practices with their own budgets the further option of holding a budget for drugs.

e. The expansion of the Audit Commission's role should cover the FPS as well as hospitals. This would probably be achieved by the arrangements already agreed, but that would need to be checked.

f. It was a serious weakness of the present system that there was no control over the number of GPs, since each GP was able to call on public money. It had already been suggested that downward pressure would be exerted on GP numbers if their system of remuneration were changed to give a greater weighting to the element of capitation. As it stood, this proposal was subject to the difficulty that, under present arrangements, the Review Body would compensate automatically for any such change if that were necessary to achieve what they regarded as a reasonable level of net remuneration. Further work was needed on this.

The Prime Minister, summing up this part of the discussion, said that on control of FPS expenditure most members of the group agreed that the right solution was to merge the DHAs and FPCs and set reasonable budgets for the merged bodies. The White Paper would have to set out the case for making this the aim. But it could not be achieved at once. It had been pointed out in discussion that there was not at present enough information to reach a proper view on the level of expenditure on drugs and hospital referrals. There would therefore have to be a transition. The Secretary of State for Health should now prepare a note setting out his view of the timetable within which such information could be obtained and budgets could be based on it.

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The group had also agreed that the Audit Commission should provide the external audit of the FPS as well as the hospitals. The Secretary of State would check that this would be achieved by the arrangements now being developed following the previous discussions.

Finally, the group were agreed that some control over GP numbers was necessary. The Secretary of State for Health should circulate a further note on the possible options. This should in particular consider the option of increasing the capitation element in total remuneration, and whether there was a way of ensuring that the Review Body's recommendations did not offset the effects of any such change.

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should be provided on how it would be achieved. Other desirable improvements which should be listed in the White Paper were: an appointments system that worked properly; rapid notification of the results of tests; better information about availability of beds; shorter waiting times for appointments; an easier procedure for changing doctors; proper facilities for mothers and children in emergency departments; a better complaints procedure; and more information about optional extras and amenities.

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a. A system of charges for the use of NHS capital assets was highly desirable.

b. Paragraph 4 of the paper suggested that disposals of more than 5% of a self-governing hospital's total capital stock would require regional approval. This was much too restrictive, and should be reconsidered by the Secretary of State for Health and the Chief Secretary.

c. Paragraph 5 of the paper proposed three stages in the introduction of a system of real charges. The second stage involved the use of management accounts to enable the NHS to go through a process of familiarisation using notional figures. The group believed that notional accounts would carry little conviction and that it should be possible with use of proper accounting expertise to move quickly to the use of real charges. It should be made clear that the notional stage was only transitional and a clear timetable should be set for achieving the final stage. A period of two years seemed reasonable, so that the system could be in place by early 1991.

d. On access to private sector capital, it had been argued that this could take many forms and that more analysis was necessary to distinguish between them and establish sensible guidelines for each variant. The group agreed that more work was necessary, and that this should be undertaken by the Secretary of State and the Chief Secretary. But this further work should be firmly based on the general objective, to which the group attached importance, of giving self-governing hospitals the maximum possible freedom to run their own affairs and in particular to get access to private capital. The framework within which they operated should be enabling, not restrictive.

Otherwise, they would not develop a proper business approach, and would fail to attract the best managers.

The public and private sectors

The group then discussed the note by the Secretary of State for Health. 'The public and private sectors' HC 54.

The Prime Minister, summing up this part of the discussion, said that the group broadly endorsed the proposals in the paper, subject to two points, which should be reflected in the White Paper. First, they thought it important that the NHS should provide more optional extras such as amenity beds, better food and television sets. Good progress had already been made in this direction, but more was desirable. Secondly, they believed that there was much more scope for competitive tendering. A recent CBI study had suggested that it was applied to only a comparatively small proportion of NHS purchasing. Areas to which it did not apply were said to be administration, portering, security, research, building and garden maintenance and estate management. There was also considerable scope for extending competitive tendering to clinical as well as non-clinical services. Good examples were pathology and blood tests; retired doctors might want to set up independent services in these areas. A major extension of competitive tendering ought to be achieved by the new pressures on management to be efficient that would follow from the reform proposals as a whole.

Professional and employment practices

The group then considered the note by the Secretary of State for Health, 'Professional and Employment Practices', HC 55.

Summing up this part of the discussion, the Prime Minister said that the group had rejected the idea of a new enquiry into professional boundaries. It ran the risk that the enquiry would respond to professional opinion and entrench some demarcations even more deeply. Progress could best be achieved by good management, supported by financial and medical audit, applying the lessons of best practice, including practice abroad. The White Paper should give examples of best practice in this respect. Flexi-nursing was an obvious possibility.

The group had briefly discussed the question of consultants' contracts. They broadly endorsed the proposals in the letter of 21 November from the Secretary of State for Health to the Chancellor of the Exchequer. They attached special importance to the participation of management in decisions about consultants' merit awards. This could be achieved by the proposal by the Secretary of State for Health in HC 43 that the 'C' awards should be replaced by performance related pay, eligibility for which would be determined by general managers and senior doctors jointly. The group also attached importance to the proposal in the letter of 21 November that merit awards should be reviewable after five years and subject to completion of at least three years further service.

Timetable

Finally, the group discussed timetable and next steps.

The Prime Minister, summing up the discussion, said that another meeting of the group had been arranged for 16 December. This would consider:

a. The further work commissioned at the meetings on 23 and 24 November.

b. The paper on pay being prepared by the Secretary of State for Health and the Chief Secretary jointly. On this subject, the group believed that the NHS must move away from notional pay bargaining, and that there was a very strong case for leaving self-governing hospitals free to decide the pay of their own staff, and to hire and fire them.

c. A first draft of at least part of the White Paper, including especially the chapter on self-governing hospitals. Work on drafting should start straight away.

A further meeting would be arranged in the week of 19 December to consider a full draft of the White Paper.

It was essential that the White Paper should be published before the first anniversary of the announcement of the review. There would be further meetings as necessary in the week beginning on 2 January to consider drafts of the White Paper, and it would go to E(A) and Cabinet in the week of 9 January. The White Paper must be crisp and readable and a special effort must be made to ensure that it had an attractive presentation with good illustrations.

The group had noted that decisions would be needed at some point about the future of community care. Further work was needed on this, but it was probably right to take ~~solve~~ the necessary decisions on health first, and set them out in the White Paper, before settling the question of community care.

I am sending copies of this letter to the Private Secretaries of the other Ministers at the meetings, and to the others present.