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Prime Minister

NATIONAL HEALTH SERVICE REVIEW

1. The timetable for the completion of the NHS Review will leave little opportunity for discussion of particular Northern Ireland issues. I therefore felt that it would be useful to highlight now those local issues which I should like to see addressed in the relevant chapter in the White Paper or in a supplementary local paper. In doing so, I am taking account of the points made by Peter Walker in his memorandum of 21 November.

IMPROVED SERVICE TO THE CONSUMER

2. The main recommendations of the Review will, of course, apply equally to Northern Ireland as to other parts of the United Kingdom. My intention is to build on existing initiatives designed to improve management performance and services to patients. In particular I want to delegate responsibility further to hospital level, and to provide the medical profession with the information and tools for them to become more involved in management not only in hospital but also in the community.

3. I am sure we should preserve and strengthen the present integrated service in Northern Ireland which, uniquely in the United Kingdom, brings together not only hospital and community health services (including the family practitioner services) but also the personal social services, within a unified management structure. While the full potential of this structure has still to be realised, I am confident that it provides substantial benefits to the consumer in terms of continuity of care and is a significant advantage in driving forward our strategy of a shift in the balance of care towards the community services.

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4. My principal objective is, as elsewhere in the United Kingdom, to obtain discernable improvement in the services to patients and clients. I want to see reductions in waiting times for outpatient appointments, diagnostic tests and inpatient care, together with better screening services. I also intend to encourage the publication by Health and Social Services Boards of guides to the services available in individual hospitals and GP practices, including an indication of the quality of the care to be expected, in terms of waiting times, etc.

MORE EFFECTIVE MANAGEMENT

5. The completion of the NHS Review coincides with the completion by the four Health and Social Services Boards in Northern Ireland of a detailed management audit. As expected, the audit has identified various weaknesses which I wish to correct speedily. In particular, I wish to build on the introduction of general management by pushing further decision-making to the local level. General Managers have been in place for some years at board level, but Units are currently managed by Unit of Management Groups. This arrangement reflects the belief at that time that it would be counter productive to impose general management on services at the local level, where no general management culture existed and that its imposition would risk alienating those professions whose co-operation and support was required to implement effective management change, not least the medical profession.

6. I now believe that the emerging management culture at local level would support the appointment of Unit General Managers in major acute hospitals, where the process of driving down and controlling costs is particularly important. Similarly, within the psychiatric field there is a growing realisation that the process of change from institutional care to care in the community requires a more effective management focus in a Director of Psychiatric

Services. I am encouraged in the belief that a change in the management culture is taking place through the increasing willingness of hospital consultants to assume management responsibility and to take the lead in developments in the information field, including resource management projects which are underway in two of our hospitals.

7. I do not, however, propose at this stage to introduce Unit General Managers in community care where the existing management arrangements, which include social services staff, are operating reasonably well. What is decided on the future organisation of community care nationally will affect how we proceed in Northern Ireland.

MANAGEMENT OF CONSULTANT CONTRACTS

8. I should like to emphasise the importance which I attach to better arrangements for the monitoring and control of consultants' contracts. I welcome the thrust of the relevant papers, but would be anxious to underline the need for a strong management involvement in the process, including the revised Distinction Awards System. The role of medical audit is of course an essential ingredient in ensuring high quality and cost-effective care.

SELF-GOVERNING HOSPITALS

9. The introduction of Unit General Managers in major acute hospitals will also enable us to progress towards self-governing status for a small number of hospitals. As in Wales, most of Northern Ireland's major acute hospitals are widely dispersed and hence the scope for competition in elective surgery is limited. Only two or three hospitals would fit the criteria outlined by the Department of Health; these hospitals are located in Belfast and

provide most of the Province's regional medical services, together with acute services for the local population.

10. The management of these major teaching hospitals requires significant improvement and I would wish to ensure that their arrangements for financial control are substantially improved before I would contemplate self-governing status. Initiatives are in train to improve their management, including the implementation of improved information systems for both management and clinical purposes, which will take time. But more needs to be done.

11. I therefore intend to create a new divisional structure within the Board responsible for the major Belfast teaching hospitals, led by a Divisional General Manager. The latter's first task will be to bring forward proposals for the rationalisation of their services and their complementary working, as a first step in their possible development to self-governing status. Another step will be the implementation of effective financial and clinical information systems enabling the other Boards to "buy" the regional and other services they require for their resident populations. As elsewhere in the United Kingdom, effective safeguards would be required to prevent these hospitals abusing their position as monopoly supplier, including the Department acting as an arbitrator. This risk is particularly significant in a market isolated from the rest of the United Kingdom. Nonetheless Boards could still shop around for services, including in the Republic of Ireland, with whom I wish to develop a market in health care.

12. The final stage in the route to self-governing status would be the definition of a strategic framework which would ensure the continued delivery of a range of basic services to the local community and their continued linkages with community services. The framework would also secure the place of their teaching and research responsibilities.

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GP PRACTICE BUDGETS

13. There are only 10 GP practices in Northern Ireland with more than 11,000 patients and the majority of them are just above this "cut-off" figure. Like Peter Walker in Wales, I doubt the capacity of GPs in Northern Ireland to assume responsibility for practice budgets. A substantial training programme in the requisite management skills would be required, together with a substantial investment programme in information systems and personnel. For a relatively small number of GPs it is doubtful if the necessary investment could be justified, although it might be possible to take advantage of parallel developments in Great Britain. I also share Peter Walker's concern over the investment of underspends, arrangements for monitoring the quality of care and the problem of determining budgets.

14. While I am keen to explore the potential for opting-out, I am anxious that the initiative should not detract from our current efforts in Northern Ireland to improve our primary care services by a range of initiatives, including the greater involvement of GPs in the delivery of community health and social services, and improvements in prescribing habits and referral patterns.

MEMBERSHIP OF HEALTH AND SOCIAL SERVICES BOARDS

15. I face special difficulties in Northern Ireland on the proposal to remove local political representatives from the membership of health authorities. There are few opportunities for elected representatives in Northern Ireland to contribute to the discussion of local issues. Their removal from Health and Social Services Boards will be widely interpreted as a further erosion of local democracy. Moreover, with local authorities in Great Britain continuing to administer personal social services, it will be argued that I am breaking parity with Great Britain.

16. On the other hand the contribution of District Councillors has generally been ineffective. In general, they have opposed government policy and promoted sectional interests. I am therefore disposed to apply the national policy in Northern Ireland and weather the resulting political storm.

17. To balance the removal of District Council representation from the Boards, I would wish to strengthen existing consumer committees - the equivalent of Community Health Councils in Great Britain. These District Committees currently shadow particular Units of Management and include in their membership representatives of the District Councils as well as voluntary and other interests. Their limited remit and highly localised focus has not given them an effective consumer voice. I therefore intend to replace the existing network of 16 District Committees by four area based Committees which would shadow each of the four Boards, with significant local authority representation.

AUDIT

18. On the audit of health authorities, I agree with Peter Walker that the government should set minimum standards in order to lessen the risk that audit will drive up costs. I support the new role for the Audit Commission, but its activities do not currently extend to Northern Ireland. Instead, I propose to continue progressively to privatise the external audit function in Northern Ireland against audit standards set nationally.

FINANCIAL SYSTEMS

19. I intend to replace the present PARR formula (a derivative of RAWP) for the allocation of revenue resources to Health and Social Services Boards by a simpler capitation-based formula, as in Great

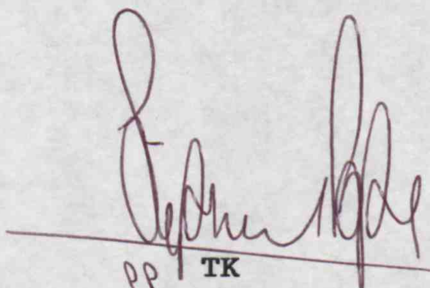
Britain. The adoption of the new approach will require, as in the rest of the United Kingdom, better and more timely financial information on the cost of treating patients in other Board areas.

20. I understand that a paper on pay will be available for the next meeting of the Review Group. Despite the outcome of this year's Survey, I believe that pay remains a major uncertainity for health authorities throughout the United Kingdom. The position would be eased if the date for non-Review Body settlements could be brought forward, as happened recently with Review Body settlements. The Northern Ireland position is exacerbated by the timing of pay awards for social services staff who are employed on the same terms and conditions as their counterparts in local authorities in Great Britain. If pay settlements were made in advance and over an extended period, health authorities would know where they stood and have a more stable base on which to plan.

CONCLUSION

21. Whether I publish a more detailed supplementary paper for Northern Ireland will obviously depend on the space.

I am copying this minute to Nigel Lawson, Kenneth Clarke, Peter Walker, Malcolm Rifkind, John Major and David Mellor; to Sir Roy Griffiths, Professor Griffiths and Mr Whitehead in the No 10 Policy Unit, and to Mr Wilson in the Cabinet Office.



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(Approved by the Secretary of State
and signed in his absence)