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

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Paul Gray Esq
10 Downing Street
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20 December 1988

Dear Paul

NHS REVIEW

I attach a draft of the White Paper for discussion at Thursday's meeting of the Ministerial Group.

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

Yours

Andy

A J McKEON

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Copy No: 1

HC67

NHS Review

WHITE PAPER: FIRST DRAFT

1. Attached for the Ministerial Group's consideration on 22 December is a first draft of the White Paper, together with the current outline.

2. The draft includes revised versions of the three chapters circulated by the Secretary of State for Health under cover of HC62. The only chapter missing is that on health services in Scotland, Wales and Northern Ireland: the Health Departments concerned are circulating their contributions separately.

20 December 1988 — Dept. of Health

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WHITE PAPER: SUGGESTED OUTLINE

Chapter 1: <u>Foreword</u>

Chapter 2: <u>Delivering a better service</u>

Chapter 3: <u>GP practice budgets</u>

Chapter 4: <u>Self-governing hospitals</u>

Chapter 5: <u>Managing the hospital service</u>

Chapter 6: <u>The work of hospital consultants</u>

Chapter 7: <u>Funding hospital services</u>

Chapter 8: <u>Managing the family practitioner services</u>

Chapter 9: <u>Better decision making</u>

Chapter 10: <u>Working with the private sector</u>

Chapter 11: <u>Health services in Scotland, Wales and Northern Ireland</u>

Chapter 12: <u>Summary and timetable for change</u>

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Draft (20.12.88)

CHAPTER 1: FOREWORD

1.1 This White Paper explains how the Government plans to reform, strengthen and revitalize the National Health Service to make it fit for the 1990s and beyond.

1.2 Underlying everything we propose is a simple aim - a service that puts patients first. To achieve that, we must build on all that is best in the NHS, while standing by the principles on which it was founded. Our Health Service must continue to be available to all, regardless of income, free at the point of delivery, and financed out of general taxation. The society it serves today, however, is very different from that of the 1940s when it was created. Nowadays, we all quite rightly expect better service, higher quality, more choice. It is to those ends that this White Paper is directed.

1.3 To deliver the highest standards of care that we all want the NHS must be run more efficiently. In this respect, it is just like other businesses. Like them, it will benefit from stronger and more flexible management. The spur of competition will sharpen its performance. The quality of its service will be improved if it listens to what its customers want. Greater efficiency is the key to a better, more caring service for patients.

1.4 Change on the scale we propose is never easy. Nor will it happen overnight, for we must be certain that the new, modern NHS has strong and secure foundations. It will require huge effort and commitment from management and staff. I am confident that those who serve the NHS will make that commitment on behalf of those who use it.

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Draft (20.12.88)

CHAPTER 2: DELIVERING A BETTER SERVICE

Introduction

2.1 The NHS has an enviable record of success. Since it was established in 1948 it has played a major part in improving the nation's health. Immunisation and vaccination have virtually wiped out previously common diseases such as diphtheria and poliomyelitis. Perinatal mortality has fallen by three-quarters since 1948, and maternal mortality is down to 5% of its 1948 level. Medical advances have meant that people not only live longer but can enjoy a better quality of life. Transplant surgery, for example, is now commonplace, and it has become possible to carry out hip replacements for people in their seventies and eighties. The introduction of antibiotics has revolutionised the treatment of many diseases.

2.2 The NHS itself has grown out of all recognition. Its total gross expenditure in the UK has increased from £433 million in 1949 to nearly £24 billion in 1988/89, a fourfold increase in real terms. In England and Wales the number of hospital doctors and dentists has grown from 12,000 in 1949 to 40,000 in 1986, and the number of nurses and midwives from 147,000 to 403,000. NHS staff now care for nearly 4 million more in-patient cases than their counterparts in 1949.

2.3. Progress has been even faster in recent years. The service is treating 1½ million more in-patients, 4 million more out-patients and over half a million more day cases than it was a mere ten years ago. Improved productivity and a substantial increase in the money provided by Government have made this huge stride forward possible. The NHS now employs 15,000 more doctors and dentists and 70,000 more nurses than it did in 1978.

2.4 But although medical advance has been spectacular since 1948, the organisation that provides that care has not developed at the same rate. That is why the Government announced early in 1988 that it was undertaking a thorough review of the NHS. This announcement has in turn stimulated a wide-ranging debate. Many people share the Government's view that now is the time to bring the Health Service up to date.

The business of caring

2.5 Experience shows that direct, central government intervention and control is not the most effective way of delivering the services that customers want. By the same token, it is not the best way to deliver services for patients. It is essential that those whose job it is to meet the changing needs and wishes of those patients have the authority, flexibility and incentive to innovate and adapt.

2.6 Whilst remaining unique, the NHS must be run more like other businesses. The best businesses are geared to putting their customers first. They also know that their customers will get a proper service only if the unseen parts of the organisation are working well - if resources are properly managed; if talented people are found and given their head; if everyone working for the organisation is encouraged to give of their best, and rewarded for doing so.

2.7 Making the NHS more business-like will not make it less caring. It will mean that it can deliver better care and more care to more people than every before.

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Competition and choice

2.8 Doctors, nurses, managers and others who work in the NHS are committed to improving services for patients, and know how to do so. But they are often held back by the rigid way in which the service is presently organised and financed. The Government intends to free up the system by introducing more competition and more choice.

2.9 The most fundamental reforms proposed in this White Paper are directed to this end. In particular:

* large GP practices will be able to apply to have their own budgets for buying a range of services direct from hospitals. This will enable GPs and their patients to back their own choices with money, and the size of each practice's budget will depend on how many patients its GPs attract. GPs will be encouraged to compete for patients by offering better services. Hospitals will be encouraged to compete for the custom of GPs.

* hospitals will be given much more responsibility for running their own affairs. Major hospitals will be able to apply for self-governing status within the NHS. This means that they will be free, for example, to set the rates of pay of their own staff and, within annual financing limits, to borrow capital. They will be free to sell their services to other parts of the NHS, to the private sector and to patients. Because they will have an incentive to attract patients, they will want to make sure that the service they offer is what their patients are looking for.

* funding arrangements will be changed so that each health authority's duty will be to buy the best service it can

from its own hospitals, from other authorities' hospitals, from self-governing hospitals or from the private sector. Hospitals will be free to sell their services to different health authorities. In this way money will in future go more directly to where the work is done best. At present a hospital or service which becomes more efficient and could treat more patients may be prevented from doing so by its budgetary limits. At the same time, one which is failing to deliver is still paid its share of NHS resources. Any exercise of choice by patients and their GPs is thereby made less effective. The Government's proposals will change this.

2.10 These and related reforms are set out fully in chapters 3,4 and 7. They represent a shift of power and responsibility to people whose job it is, at local level, to advise patients, to provide services to them, or to fund services for them. By placing the patient centre-stage, they will improve the standard of service he or she receives.

Giving management the freedom to manage

2.11 In recent years the Government has given a high priority to strengthening the management of the NHS, most importantly through the introduction of general management following a report by Sir Roy Griffiths in 1983. The reforms outlined in paragraph 2.9 will build on this progress and take it further. It will become all the more important that objectives for improving services, and responsibilities for achieving those objectives, are clear; and that money is not spent ineffectively or inefficiently when it could be used to buy more or better services. Achieving objectives through the efficient use of resources is the job of management. Local managers in particular must be both freer and better equipped to do that job.

2.12 Chapters 5,6,8 and 9 propose a range of important changes to strengthen local management. They will build on the introduction of general management, and on the proposals for the better management of the family practitioner services (FPS) set out in "Promoting Better Health" (Cm 249). Among the most important aims behind these changes are:

* ensuring that hospital consultants - whose decisions effectively commit substantial sums of money - are involved in the management of hospitals; are directly responsible and accountable for their own use of resources; and are encouraged to use those resources more effectively.

* ensuring that GPs too take greater responsibility for their use of resources, and are in more effective competition with each other.

* introducing new arrangements for the effective monitoring of medical care by doctors themselves.

* providing the audit support which management needs, through a stronger and more independent source of financial and value-for-money audit.

* improving the information available to local managers, enabling them in turn to make their budgeting and monitoring more accurate, sensitive and timely.

* contracting out more functions which do not have to be undertaken by health authority staff and which could be provided cost effectively by the private sector.

* constraining the rate of growth in drug prescribing costs.

* turning District and Regional Health Authorities and Family Practitioner Committees into tighter, more effective management bodies.

* restructuring the national management of the service to provide for a corporate management team which is freer to manage the service within policy objectives and financial targets set for it by Government.

Customer care

2.13 All these reforms will in time improve the quality of the service that the NHS is able to offer those who use it. The quality of the Service's medical, nursing and other care is widely recognised as excellent, but there are other changes which will make a real difference to the day-to-day services which patients receive.

2.14 Many people are still having to wait too long for treatment, and still have little if any choice over the time and place at which treatment is given. The Government has already done much to tackle this problem. Over the past two years, for example, an additional £55 million has been spent on reducing waiting lists and waiting times, allowing over 200,000 patients to be treated. A half of all waiting list patients are now admitted from the list in five weeks or less. But the problem remains.

2.15 The service provided by a hospital is still too often impersonal, inflexible and unnecessarily stressful. Patients should be treated much more like valued customers. The practical improvements that may often be needed include:

* appointments systems which give people individual appointment times which they can rely on. Waits of two or three hours in out-patient clinics are unacceptable.

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* quiet and pleasant waiting and other public areas, with proper facilities for parents with children, for counselling worried patients or relatives, and so on.

* clear information leaflets about the facilities available and what patients need to know when they come into hospital.

* once someone is in the hospital, clear and sensitive explanations of what is happening: on practical matters, such as where to go and who to see; and on clinical matters, such as the nature of an illness and its proposed treatment.

* clearer, easier and more sensitive procedures for making suggestions and, if necessary, complaints.

* rapid notification of the results of diagnostic tests.

* a wider range of optional extras and amenities for patients who are prepared to pay for them - a choice of meals, single rooms, personal telephones, TVs and so on.

2.16 The Government has prepared detailed proposals for making the NHS more sensitive to the needs of patients, more efficient in the use of resources and better able to provide high quality care. The chapters which follow set out these proposals in full.

→ * making it easier to change your family practitioner

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CHAPTER 3: GP PRACTICE BUDGETS

Introduction

3.1 The service offered by the family GP is one of the greatest strengths of the NHS. On average, people visit their GP between four and five times a year. For most it is their first port of call if they are feeling unwell.

3.2 Of those who go into hospital some may go or be taken there direct, for example in an emergency. More usually, people who need hospital services - consultation with a specialist, diagnostic tests, or even immediate admission as an in-patient - are referred by their GP. Some 5 million new out-patients a year are seen by a hospital doctor on referral from a GP, and about a third will subsequently be admitted to hospital for in-patient treatment.

3.3 The GP is each patient's key adviser. He or she is best qualified to advise on whether or not someone needs to go to hospital, on which hospitals offer the best service, and on who are the best specialists to consult. The GP - acting on behalf of patients - is the gatekeeper to the NHS as a whole.

3.4 GPs, in this role of broker or go-between, hold the key to giving patients a greater say, and above all to improving the quality of the services they receive. Their special relationship with both patients and hospitals make GPs uniquely placed to improve patients' choice of good quality services. But there are three main obstacles to further progress:

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* there is at the moment no real incentive for NHS hospitals and their consultants to look on GPs as valued consumers whose patients' custom they have to win.

* the present system of funding hospitals effectively penalises success. It may take years for a hospital that provides a good service and attracts more patients to receive the extra resources it needs to cope with increased demand. As a result, waiting lists grow and waiting times lengthen in good, successful hospitals.

* there is no real incentive for GPs to offer their patients a choice where one is available.

3.5 As a result, there is too little choice and competition in the system. Just as in any other business, the quality of the service to the customer - in this case, the patient - suffers accordingly.

3.6 Building on the strong foundations of the family doctor service, the Government will introduce a new scheme which, by extending competition, will help ensure that patients receive the best available care. In future, the Government wants to see money flowing with the patient, so that the practices and hospitals which attract the most custom will receive the most money. GPs will compete for patients. Hospitals will compete to win the custom for which GPs are responsible. For the first time, both GPs and hospitals will have a real incentive to put patients first. The Government believes that this reform will deliver better care for patients, shorter waiting times, and better value for money for the NHS - which in turn will lead to more care for more people.

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3.7 The Government also believes that the scheme will be attractive to the many GPs who are keen to improve the services they offer. It will enable the practices which take part to influence directly the way in which money is used to provide services for their patients. It will give them scope to plough back savings into their practice. General practice will become a still more satisfying job.

How practice budgets will work

3.8 At the start of the new scheme, GP practices with lists of at least 11,000 patients (see paragraph 3.11) - will be able if they wish to apply to hold their own budgets for buying a defined range of hospital services. They will be free to buy from either NHS or private sector hospitals. The size of each practice's budget will depend primarily on the number of patients on the practice's list. There will be three categories of hospital services for which GPs within the scheme will be able to control their own budgets and buy services from the hospital or hospitals of their choice:

- * outpatient services, including associated diagnostic and treatment costs. With the exception of expensive out-patient treatment which has to be provided on a hospital site - radiotherapy, for example - continuing out-patient treatment will be included.

- * a defined group of in-patient and day case treatments, such as hip replacements and cataract removals, for which there may be some choice over the time and place of treatment. The inclusion of this category will make it easier for GPs to offer shorter waiting times to patients who are willing to travel. The Government will consult on the precise list of treatments to be covered.

* diagnostic tests, such as X-ray examinations and pathology tests, which are undertaken by hospitals at the direct request of GPs.

3.9 In addition, the Government intends the scheme to cover three important aspects of the services provided by GPs themselves:

* the 70% of practice (team) staff costs which is directly reimbursed to GP practices at present and which will be cash-limited under the Health and Medicines Act 1988. The inclusion of staff costs within the budget will, for example, encourage practices to consider whether to employ additional nursing or other staff and instead make less use of out-patient services.

* improvements to practice premises. The assistance available to GPs in improvement grants and under the cost rent scheme will also be cash-limited under the 1988 Act. Its inclusion within the scheme will add a small but useful element of budgetary flexibility.

* prescribing costs. Chapter 8 sets out the Government's proposals for setting indicative drug budgets for GPs generally. GPs within the practice budget scheme will be able to draw on the budgets allocated to RHAs for prescribing costs generally.

3.10 Participation in the scheme will be voluntary, and practices which have joined the scheme will be free to leave it again if they wish. All practice budgets will cover the specified range of hospital services, together with practice team staff and improvements to practice premises. Practices within the scheme will be able to choose whether or not to include prescribing costs in their budget. Although the different elements within the budget will be calculated or negotiated in

different ways - as set out in paragraphs 3.12-15 below - the result will be a single budget. The practice will be free to spend the money as it wishes within the scope of the scheme.

3.11 Practice budgets will need to be large enough to cope with fluctuations in demand for what will sometimes be expensive treatments. A hip operation, for example, may cost in excess of £2,000. The Government proposes that at the outset of the scheme participation should be limited to practices with lists of at least 11,000 patients, which is twice the national average. This should ensure that participating practices will have annual budgets in the region of £300,000 or more, excluding prescribing costs. On this basis over 1,000 practices will be eligible in the UK, which is nine per cent of all practices covering between them about a quarter of the population. The Government will consider relaxing the 11,000 patient minimum for practices which are prepared to include prescribing costs in their budgets. The Government will also consider relaxing the limitation generally if experience shows that budgets for 11,000 patients are more than large enough to allow for the necessary flexibility.

Negotiation of budgets

3.12 Chapter 8 sets out the Government's proposals for managing the family practitioner services, and suggests that in future RHAs should be responsible for allocating funds to FPCs as well as to DHAs. Practice budgets cannot be settled by a simple formula. That would be too inflexible. They will therefore need to be negotiated. The Government believes that the fairest and least cumbersome approach is for GP practices within the scheme to negotiate their budgets with the relevant RHA, which will in turn need to consult the practice's FPC. The FPC will continue to hold the GPs' contracts and be responsible for monitoring expenditure against the budget.

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Hospital services

3.13 The hospital services element in the budget will be settled by RHA alongside its responsibility for funding DHAs as proposed in chapter 7. This element will be taken out of the revenue allocation which the RHA itself receives from the Government for hospital and community health services. Each practice's share will be settled by reference to the number of patients on their list, weighted for the same population characteristics as are proposed in chapter 7 for allocations to Districts, and taking account of the practice's current referral rates. The RHA will then make corresponding adjustments to the relevant District allocations. The Government will be discussing with interested parties how best to ensure that the hospital service element of practice budgets is fairly assessed, and that adequate information is available to all concerned for this purpose.

Practice team staff and improvements to premises

3.14 A different approach will be needed to settling that element of the practice's budget which will be attributable to the costs of practice team staff and premises improvements. The Government expects that the budget for the practice's first year in the scheme will be based on the current costs of the practice team's staff, together with the practice's due share of the money available to the FPC for premises improvements. The practice could then receive its due share of any additional cash allocated to the FPC for these purposes. The Government will consider whether more detailed guidance is needed in the light of its discussions with interested parties.

Drugs

3.15 The prescribing costs element in a practice budget, where the practice has opted to include it, will need to be found from within the overall drug budget allocated to the RHA in accordance

with the proposals set out in chapter 8. The RHA will not be free to offer an amount in excess of the average level of spending which would be expected from the practice concerned, [assessed as described in chapter 8], but will be able to agree to any figure at or below that level. This element of each practice budget will need to be renegotiated periodically, and adjusted annually in the meantime in line with forecast increases in prescribing costs.

The management of practice budgets

Buying hospital services

3.16 Where costs are to some extent under the direct control of the practice itself, as with practice team staff and premises improvements, GPs should have relatively little difficulty in keeping within budget. But the costs incurred by hospitals in treating patients referred by the GPs are not within the GP's own control. It is essential that practices are able to limit their total expenditure, without denying services to their patients, where a hospital fails to control its costs. It is also important that practices manage their budgets in a way which enables them to negotiate the best deals they can.

3.17 To this end, practices within the scheme will need to make full use of the range of methods of buying hospital services described in chapter 7. To cover initial referrals for an out-patient appointment, for example, a practice will need to negotiate fixed-price contracts for an agreed range of services to all patients referred, so that any patient who needs the advice of a specialist can be sure of getting it. On the other hand, practices will also want to hold some money back, to keep open the possibility of buying services at marginal cost where hospitals have spare capacity to offer in the course of the year. GPs themselves will be responsible for deciding the best mix of budgeting and contractual arrangements for their practices, but

the Government will ensure that ideas and experience are widely disseminated.

Scope for flexibility

3.18 Practices within the scheme will be well placed to generate savings within their budgets. The Government intends that they should be free to spend up to 50% of any such savings as they wish, with the balance reverting to the RHA. This flexibility will allow them to plough money back into improving their practices and offering more and better services to their patients.

3.19 The Government recognises that practices may run into budgetary problems during the year, not necessarily through any fault of their own. It will be important to ensure that urgent treatment is still available to patients in such circumstances. The Government therefore intends to allow practices within the scheme to overspend by up to [5]% in any one year, but on the basis that this is contained within the RHA's overall cash limit and that any overspending is recouped in the following year. If a practice overspends in excess of [5]%, or persistently overspends at a lower level, the FPC will initiate a thorough audit, including a review by other doctors of any medical judgements which seem to be causing budgetary problems. An overspend in excess of [5]% for two years in succession will result in a practice losing the right to hold its own budgets.

Management costs

3.20 The Government proposes that each practice's budget should include a fee to cover the management and other costs of participating in the scheme.

Implementation

3.21 The Secretary of State will publish shortly a discussion document which develops in more detail the proposals set out in this chapter, as a basis for discussion with interested parties. The Government's aim is to encourage a substantial number of GP practices to apply to manage their own budgets with effect from April 1991, with more practices joining the scheme in subsequent years. In the meantime the Government will seek the necessary powers to enable GP practices to buy hospital services in the ways proposed. It will also encourage and invest in the development of the information systems which will be needed to support the calculation of budgets, the pricing and costing of hospital services to GPs, and the monitoring of prescribing costs.

3.22 The Government will look to RHAs and FPCs to give a positive lead in guiding and supporting GP practices which are interested in joining the scheme. The decision on any application will rest with the relevant RHA in each case, subject to a right of appeal to the Secretary of State. In reaching its decision the RHA will need to consider two main factors: first, the ability of the practice to manage its budget effectively, for example its practice management capacity, its technology and its access to hospital information; and, secondly, the GPs' commitment to, and policies for, the management of a collective budget which may affect their individual decisions.

3.23 The Government believes that the introduction of this practice budget scheme will bring substantial benefits to patients, building on the developments already in hand following its earlier White Paper on primary health care ("Promoting Better Health", Cm 249). In particular, people who live close enough to a practice within the scheme will be able to choose their GP partly in the light of the practice's policies and performance in buying hospital services. GPs will be encouraged to give more

information to their patients, and successful practices will attract more income through capitation fees. Hospitals and hospital consultants will be encouraged to compete with each other to attract the custom of GPs and the funds which will flow with the patients. The scheme will inject much of the choice, flexibility and competitiveness of private sector medicine into the security of a mainly tax-funded NHS.

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CHAPTER 4: SELF-GOVERNING HOSPITALS

Introduction

4.1 There are currently over 320 major acute hospitals in the UK - "major" defined as having more than 250 beds. This chapter sets out the Government's proposals for enabling as many of these hospitals as are willing and able to do so to run their own affairs.

have substantial resources.

4.2 Major acute hospitals are substantial businesses. Even the smallest of the management units which currently run these hospitals may have revenue budgets in excess of £10 million a year. The largest may have budgets in excess of £30 million.

4.3 It is already a central plank of Government policy to push down decision making to local, operational level. Some of the larger acute hospitals now have substantial responsibilities delegated to them for running their own affairs. The Government intends to take this process a significant stage further by providing for a new, self-governing status within the NHS.

4.4 The Government believes that greater independence for hospitals will encourage a stronger sense of local ownership and pride, building on the enormous fund of goodwill that exists in local communities. It will stimulate the commitment and harness the skills of those who are directly responsible for providing services. Supported by a funding system in which successful hospitals can flourish, it will encourage local initiative and greater competition. All this in turn will ensure a better deal

for the public, improving the choice and quality of the services offered and the efficiency with which those services are delivered.

Hospital Trusts

4.5 The powers and responsibilities of each self-governing hospital will need to be formally vested in a board of management. The Government will bring forward legislation enabling the Secretary of State to establish such boards, to be known as Hospital Trusts. The Government proposes that Hospital Trusts should be constituted as follows:

* each should have ten members, five executive and five non-executive, and in addition a non-executive chairman.

* the chairman should be appointed by the Secretary of State.

* of the non-executive members at least two should be drawn from the local community, for example from hospital Leagues of Friends and similar organisations. These two "community" members should be appointed by the Regional Health Authority (RHA). The remaining three non-executive members should be appointed by the Secretary of State on the advice of the chairman. All the non-executive members should be chosen for the contribution they can make to effective management of the hospital. None should be an employee of a health authority or hospital, of a trade union with members who work in the NHS, or of a major contractor or other hospital supplier. For teaching hospitals, the non-executive members will need to include a representative of the relevant medical school.

* the general manager, as chief executive, should be appointed by the non-executive members.

* the remaining four executive directors should include a medical director, the senior nurse manager and a finance director.

4.6 Hospital Trusts will assume all the powers and responsibilities previously exercised by the hospital's health authority. Specifically, they will be empowered by statute to employ staff; to enter into contracts both to provide services themselves and to buy in services and supplies from others; and to generate income within the scope set by the Health and Medicines Act 1988.

Funding and accountability

4.7 A self-governing hospital will need to generate income by selling its services. The main buyers will be health authorities. Other buyers will include GP practices with their own budgets, private patients or their insurance companies, and perhaps other self-governing hospitals. This form of funding will be an opportunity for growth and a stimulus to better performance.

4.8 It will be an opportunity for growth because the money will flow to where the patients are going. If a hospital attracts more patients it will get more income. A successful hospital will then be able to invest in providing still more and better services.

4.9 The funding arrangements will be a stimulus to better performance for two reasons. First, they will inject an element of competition. There will not always be an alternative provider of, say, local accident and emergency services. But for some services - and in some areas for many services - the hospital

will be at risk of losing business if it does not meet the needs of its customers. Secondly, the hospital's contracts will need to spell out clearly what is required of it, in terms of both price and quality, by those who entrust patients to its care.

4.10 Each Hospital Trust's line of accountability will be through these contracts. The consequences of a failure to meet the terms of a contract - potential loss of future business, for example, or renegotiation of the contract - will be for the buyer to settle. The arrangements set out in chapter [7] will ensure that patients who are in need of urgent treatment are not turned away from a hospital simply because their treatment is not, or may not be, covered by a contract with that hospital.

4.11 Each Health Department's Accounting Officer will have an overall stewardship responsibility for the use made by self-governing hospitals of public funds. But the Accounting Officer will not be accountable for each individual hospital. The Secretary of State will need specific powers for use in reserve to prevent any self-governing hospital with anything near to a local monopoly of service provision from exploiting its position, for example by charging high prices for its services.

Freedom and responsibility

4.12 The Government proposes to give Hospital Trusts a range of powers and freedoms which are not, and will not be, available to health authorities generally. The Government believes that greater freedom for self-governing hospitals will create more scope for competition, diversity and innovation within the NHS. Greater freedom for their leadership will stimulate greater enterprise and commitment, which will in turn improve services for patients. Self-governing hospitals will be a novel part of a system of hospital care alongside health authority-managed and private sector hospitals, and will increase the range of choice available to patients and their GPs.

Employment of staff

4.13 The Government intends that Hospital Trusts should be free to employ whatever staff they consider necessary, irrespective of any manpower controls which may apply to health authorities. The only exception should be junior doctors' posts, which will continue to need the approval of the relevant Royal College for training purposes. The Government sees it as particularly important that Trusts should employ their own consultants. Where consultants work also for other NHS hospitals or in the private sector, a Trust will need to employ them on a part time basis consistent with their commitment to the Trust's hospital.

4.14 The Government also intends that Hospital Trusts should be free to settle the pay and conditions of their staff, including doctors, nurses and others covered by national pay review bodies. They will not be able to alter unilaterally the existing contracts of employment of staff transferred from the relevant health authority to the self-governing hospital. But Hospital Trusts will be free, by agreement with their staff, either to continue to follow national pay agreements or to adopt partly or wholly different arrangements.

4.15 It will be important to ensure that this freedom does not simply generate higher pay costs which are passed on to the health authorities which buy the hospital's services. Health authority funding will continue to be cash-limited, and this will place authorities under a strong incentive to secure value for money through their contracts. Performance-related contracts of employment will similarly provide strong incentives for hospital managers to improve the quantity and quality of the services on offer. Competition with other hospitals, where it is effective, should also constrain costs.

Ownership of assets

4.16 The Government intends that Hospital Trusts should be constituted as public corporations. On this basis each hospital's assets will be vested in its Trust, as follows:

* the Trust will be free to use the hospital's assets to provide health care, in accordance with stated purposes laid down by the Secretary of State when self-governing status is granted.

* the Trust will be free to dispose of its assets, subject only to a reserve power for the Secretary of State to intervene if a disposal would be against the public interest.

* when it is established, the Trust will be given an interest-bearing debt equal to the value of its initial assets. The effect of this will be consistent with that of the new capital charging system proposed in chapter 5.

* the Trust will be free to retain surpluses and to build up reserves with which to improve services and finance investment. It will also be free to manage any temporary deficits, but will be required to break even taking one year with another.

* the Trust's operations will be subject to independent audit by the Audit Commission in accordance with the proposals in chapter 5. The National Audit Office will have right of access to papers relating to the accounts and audit of self-governing hospitals, and will be able to include self-governing hospitals in their value for money studies.

* the hospital's assets will revert to the ownership of the Secretary of State if for any reason the Trust is wound up.

Borrowing capital

4.17 As public corporations Hospital Trusts will also be free to borrow, either from the Government or from commercial sources, within an annual financing limit. The Government will seek limited, reserve powers for the Secretary of State to use if this freedom is being abused or if the Trust is getting into difficulties. The annual financing limit will be set each year by the Secretary of State following the Government's Public Expenditure Survey. Borrowing from the Government will be from the funds voted by Parliament for the NHS. Hospital Trusts will have to service their loans from their income, just as other NHS hospitals will be charged for their capital under the Government's proposals in chapter 5.

Achieving self-government

4.18 The Government will lay down a simple, flexible process for establishing a Hospital Trust. A hospital has no definable constituency equivalent to, for example, the parents of children attending a school. It will therefore be open to a variety of interests either to initiate the process or to respond to any initiative taken by the Secretary of State. These interests could include the DHA, the hospital management team, a group of staff, or people from the local community who are active in the hospital's support.

4.19 Similarly, the Government is not proposing a rigid definition of what a "hospital" should be for the purposes of self-government. For example, it will often be sensible for two

neighbouring hospitals to combine, or for a hospital to retain its existing obligations to run a range of community-based services.

4.20 The Government intends that hospitals should have to meet only a few essential conditions to achieve self-governing status. It has two main criteria in mind. First, management must have the skills and capacity to run the business, including strong and effective leadership, sufficient financial expertise and adequate information systems. Secondly, senior professional staff, especially consultants, must be involved in the management of the hospital, and there should be a comprehensive system of medical audit along the lines proposed in chapter 6. The Secretary of State will also need to satisfy himself that self-governing status is not being sought simply as an alternative to an unpalatable, but necessary, closure.

4.21 The Government will look to RHAs to play an active part in guiding and supporting hospitals which can be expected to meet these criteria and are interested in achieving self-government. In each case the Secretary of State will need to satisfy himself at an early stage that there is a good prospect of being able to approve the creation of a new Hospital Trust. With the advice of the RHA, he will also need to identify a "shadow" chairman who can act for the hospital in preparing the ground.

4.22 The RHA will be responsible for establishing the precise range of services and facilities for which the proposed Trusts will be responsible; for ensuring that the proposal to seek self-governing status is given adequate publicity locally; and for preparing and submitting a formal application to the Secretary of State. No-one will have the right to veto such an application.

What does this mean?

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Implementation

4.23 The Government believes that self-governing hospitals have a major role to play in improving services to patients. It will therefore encourage as many major acute hospitals as possible to seek self-governing status as Hospital Trusts. The Government's aim is to establish a substantial number of Trusts with effect from April 1991, in the wake of the necessary legislation. The experience gained will then inform the process of establishing more Trusts in later years.

4.24 In the meantime the Government and RHAs will take the initiative, ~~with the help of RHAs,~~ in identifying suitable candidates for self-government and encouraging them to seek and prepare for self-governing status. The Secretary of State will be publishing shortly a more detailed document which will form a basis for discussion with interested parties. The aim will be to ensure that the hospitals concerned make productive use of the next two years by building up their capacity to run their own affairs effectively and by securing the maximum devolution of management responsibility from their DHAs. Self-government will, then be - as it should be - a natural step forward from devolved management ~~within the present structure.~~ further.

4.25 The establishment of self-governing hospitals will mean a substantial change in the responsibilities of the DHAs which were previously responsible for their management. The Government does not believe that this implies a wholesale reorganisation of the NHS. But as more and more proposals come forward for establishing Hospital Trusts, RHAs will consider the viability of existing DHAs and, if appropriate, propose mergers of neighbouring Districts. The implications for the role of DHAs are set out more fully in chapters 7 and 9.

The logic is to merge with the F.P.C's.

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Draft (20.12.88)

CHAPTER 5: MANAGING THE HOSPITAL SERVICE

Introduction

5.1 With an annual budget now well in excess of £20 billion, the NHS is one of the UK's biggest businesses. It is also its largest employer with over a million staff.

5.2 The way in which this money is spent cannot sensibly be dictated in detail from Whitehall by Ministers or by civil servants. The Government's main task must be to set a national framework of objectives and priorities. Management must then be allowed to get on with the task of managing, while remaining accountable to the centre for its delivery of the Government's objectives.

5.3 Managers need to be properly equipped if they are to do their job effectively. This means having greater control over and better information about their use of resources. In particular, they must have more control over pay, and also over the use of capital which is their main investment tool. The Government's plans for self-governing hospitals will ensure that their managers are free to manage in this way. But the Government believes that the same principles should be applied in all hospitals. This chapter sets out its proposals for achieving this.

5.4 These are not new objectives. Since taking office, much of the Government's policy has been aimed at strengthening the management of the hospital service and improving its performance through the better use of resources. In any organisation that is as large and complex as the NHS, the full

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effects of better management take time to work through. But since a comprehensive system of general management has been introduced at all levels of the service, progress has been made towards:

* the establishment of a more effective planning and review process from Department to region and region to district and unit, through which national and local priorities can be identified more clearly;

* the introduction of a single focus for decision-making and, through the setting of objectives for individual managers backed at the most senior levels by performance related pay, the translation of national regional and local policies into specific management tasks;

* closer working relationships between managers and professional colleagues, particularly in the use of resources;

* the creation of a stronger foundation of better information, with a programme which will extend the information base into clerical as well as management areas;

* competitive tendering for support services;

* increasing the scope for health authorities to generate their own income.

5.5 The tauter approach to management has contributed to increased activity levels, taking advantage of falling lengths of stay and other clinical developments; and, since 1983, a marked fall in unit costs. It has further produced additional revenues of over £1 billion from cash releasing cost improvements and land sales since 1985.

5.6 Following the introduction of general management, the Government is committed to pushing down as much decision making as possible to the local level. Under its proposals some hospitals , with or without associated community health units, will be able to move towards full self-government. Chapter 4 sets out how this will work. But all hospitals and other management units will be expected to carry more direct responsibility for running their affairs. This will need to be within an agreed framework of objectives and resources, to ensure that a comprehensive service is provided within the financial limits laid down by the Government.

Leaner and fitter regions

5.7 The NHS Management Board could not directly exercise effective authority over the current 190 DHAs which have a total expenditure of over [£15] billion ([£20] billion with Family Practitioner services). RHAs will therefore continue to play a major role in the chain of accountability from the centre to the local level by ensuring that Government policies are properly carried out within their regions. To be effective they will need to concentrate their efforts on their essential tasks, which are:

* maintaining oversight of the performance of the health services and of the improvement of the health of the people within the region;

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* setting challenging performance targets/standards for Districts, comparing and monitoring the outcome;

* establishing a framework for service development on a regional or inter district basis to make best use of scarce or expensive resources;

* relating national funding provision to individual district requirements;

* establishing regional manpower requirements including a recruitment and training policy;

* ensuring that adequate facilities are available for clinical teaching and research;

* ensuring coordination of hospital services and primary care at the local level.

In future, RHAs will also have a key role to play in managing the wider programme of changes that are set out in the White Paper.

5.8 In addition, historically RHAs have provided a range of operational and management services to their districts. These range from distribution centres, ambulance and blood transfusion services which could not be provided economically in every district, through to legal, information and management services which districts have been able to draw upon as required. Following the introduction of general management and the re-organisation of regional headquarters, many RHAs have reviewed the provision of these services. As a result, some services have been streamlined, delegated to districts or contracted out to the private sector. There remains, however, a wide variation in the size of each region's operations and the Government believes that there is

still considerable scope for reductions in the number of staff directly employed by RHAs. Each RHA will therefore be asked to review the provision of its regionally managed services and submit plans, with expected cost savings, for Ministerial approval.

A stronger role for hospitals

5.9 District Health Authorities (DHAs) currently carry out a mixture of strategic and operational functions. On the one hand they implement Ministerial policies including securing an overall range of services, setting and monitoring standards, and maintaining financial control; on the other, they provide operational services such as information technology and the day to day management of the estate.

5.10 Through a new system of funding described in Chapter 7, the Government wants to distinguish more clearly between the different - and sometimes conflicting - roles of health authorities and hospitals as the "purchasers" and "providers" of services. In particular, specialist operational functions should lie as far as possible at the unit level with hospitals.

5.11 The Government does not intend to specify the precise details of devolution to hospitals since such a list would not make sense everywhere. Instead it will expect Regional Health Authorities (RHAs) to achieve a significant measure of devolution from the DHAs to units. Targets will be set to monitor change. The touchstone will be that operational functions should be devolved to unit level unless there is an overwhelming case for retention at district.

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5.12 The pace of change will need to take account of the scarcity of skills in key disciplines such as finance, information and personnel. But it will be necessary to ensure that proper priority is given to increasing unit capacity and that the inability of units to be self sufficient in specialist functions does not necessarily hold back the drive towards devolution. A clear distinction will need to be made between functions which should properly be retained at district level for functional or economic reasons and those which may temporarily need to be provided by districts as a service to units.

Better use of staff

5.13 In a staff intensive organisation like the NHS, one of the keys to successful management is the effective management of human resources. Chapter 6 includes proposals for ensuring that managers are able to deploy consultants in the most effective way. It is however the nurses who represent the largest single group of professional staff in the NHS and who are responsible for delivering direct patient care around the clock.

5.14 There have been many developments in recent years on the better use of nursing staff. These have included research into and experiment with different mixes of skills and grades; improved methodologies to assess the demand for nursing staff to deliver a given level of service; development of rostering systems to match available staff to workload more accurately; action to eliminate over-long shift overlaps; better nurse management information systems; and the use of 5-day wards.

5.15 The Government has concluded that there is room for more progress at local level. The Government has already endorsed the need to provide non-professional support staff to nurses with a better training. It will be necessary to re-examine all areas of work to identify the most cost-effective use of professional skills, which may, in a number of areas involve a reappraisal of traditional patterns and practices. Examples include the substitution of nurses for junior doctors in some casualty department duties and the use of clerical rather than nursing staff in receptionist work. There is scope also with other professions, some of which, such as physiotherapists, speech therapists and chiropodists, make little use of non-professional helpers.

Better information

5.16 The Government recognises that managers and professional staff need good information if they are to make the best use of the resources that are available to them. The Government has made considerable progress in developing better information systems in hospitals, but there remain some important limitations. In particular, there is at present only a limited capacity to link information about the diagnosis of patients and the cost of treatment. Neither is the information always as timely or reliable as it should be. The greater competition which the Government is proposing in the provision of services should stimulate managers to generate improved information more quickly. But the Government also recognises that national action will be needed if all hospitals are to have adequate information systems up and running within an agreed timetable.

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5.17 A key part of the Government's strategy will be to secure further improvements in cost information. The Government believes that the best way of delivering this is by extending and accelerating the existing Resource Management Initiative (RMI). The RMI is being piloted in selected health authorities and is intended to provide a complete picture of the resources used by hospital patients. It draws on basic data that are already available from existing operations systems such as the Patient Administration System (PAS), and from pathology and radiology departments. These data are not however at present generally integrated to provide a total picture of the cost of treating patients. The other key feature of the RMI is that doctors, nurses and other professional staff have been directly involved in its development. This should ensure that the new systems are actively used for the benefit of patients.

5.18 The Government therefore proposes to extend the RMI to a further 20 acute hospital units in 1989/90 with the aim of building up coverage to 260 acute units by the end of 1991/92. It is an ambitious timetable and some of the information generated may be less precise than that which has been released in the existing pilot projects. The Government believes however that, by using the experience gained from the current exercise, it will be possible to generate cost information that vastly improves what is currently available to managers and in which professional colleagues can have confidence. The Government will be discussing its proposals in detail with representatives of the professions who have been involved in the development of the new information systems.

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5.19 The Government remains committed to the production of regional information strategies by May 1989 running in parallel with the RMI. This wider information strategy will involve improving or introducing modern information systems to support both the clinical and administrative functions in hospitals. It will generate up-to-date information for managers and will enable more efficient use to be made of valuable staff resources. Few hospitals will start from the same point, and it will be essential to make the best use of the limited number of skilled information systems staff, both within the NHS and outside it. Three pilot sites will be launched in 1989/90, building up gradually to cover 260 sites by March 1993.

Pay flexibility

5.20 In addition to giving managers the tools with which to manage, the Government wants to give them greater control over the resources for which they are responsible. Pay accounts for over 70 per cent of all NHS expenditure. Getting pay wrong can therefore have serious effects on expenditure on the one hand, and on the availability of staff on the other.

5.21 The Government remains committed to a central framework for pay determination in the NHS. It does not believe that unrestricted local bidding and bargaining would be in the interests of the patient or the taxpayer. However the Government's objective is to move towards a system of broad pay ranges, centrally negotiated, with freedom of action for local managers in matching market forces and rewarding individual performance. With such freedom, individual hospitals will be better able to tailor their services to meet the health needs of the public they serve.

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5.22 There is at present no geographical variation of pay (other than London weighting) for doctors. The Nurses Pay Review Body, in its 1988 reports, recommended London supplements to be paid in addition to London weighting to nurses and the professions allied to medicine, and these were introduced from 1 April 1988. The Government has now asked the Review Body to look at the case for discretionary payments to nurses to help with particular local staff shortages and nurse management problems.

5.23 The established performance pay arrangements applying to general managers and other top managers have recently been extended to senior and middle managers lower down the scale. The extended arrangements, unlike the original ones, include an explicit market flexibility element for posts at these levels.

[5.24 Negotiations are already under way to introduce ~~market~~ flexibility into the administrative and clerical pay scales. This will be based upon a main pay spine, with management having latitude to supplement points on the national pay spine, to reflect market pressures.]

Capital

5.25 Managers should also be able to make the most flexible use of their physical resources. Capital in the NHS is treated for the most part as a "free good". Once an investment has been made, whether in land, buildings or equipment, no further revenue charges arise from the continuing use of these capital assets. In the private sector, for example, there would be interest and repayments to be met. This means that investment decisions tend to favour capital-intensive solutions, rather than forming a balanced, cost-effective package. It is difficult to make valid comparisons of efficiency between different parts of the NHS

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as no amount is taken of capital costs. It also means that it is impossible to compare the public and private sectors, in terms of overall cost-effectiveness, since the former takes no account of the cost of using assets, while the latter has to do so.

5.26 The Government therefore proposes to introduce a new system for accounting for capital in the NHS which will give managers more flexibility in the deployment of this key resource. In essence this will involve a system of charges for the use of capital assets, reflecting private sector practices of accounting for interest and depreciation. The Government's intention is to balance, overall, the increased revenue allocations to health authorities which would be needed to meet capital charges, with the income to the capital programme which such charges would represent.

5.27 Funds for capital investment will continue to be financed by the Exchequer, and allocated by RHAs from the overall capital programme. There will therefore continue to be strategic oversight of capital planning, within an overall cash limit. But a charging mechanism will ensure that managers have the appropriate financial measures available in taking decisions on capital deployment, and will reward those authorities which use their assets to best advantage.

5.28 The capital expenditure limits above which projects have to be referred up to the Department or the Treasury for approval will be increased. From now on schemes with a capital cost of over £15m (previously £10m) will be referred to Treasury for approval. Schemes costing over £10m (previously £5m) will be referred to the Department of Health. These increases will be a welcome step forward in speeding up investment approvals and giving health service managers greater freedom over key resource decisions.

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Private capital

5.29 As health authorities become more business-like in their approach to the provision of services, and to the use of the resources at their disposal, they are increasingly looking at the scope for involving private sector capital. Examples include joint ventures where the NHS provides land, and a developer puts up a building, or where a major capital-intensive service is contracted out to the private sector. The Government must maintain overall constraints on the use of resources, including capital from whatever source, within the public sector. And these resources should be used in the most cost-effective way. For these reasons Districts cannot have unfettered access to private capital.

5.30 But the Government recognises too that joint ventures with the private sector, and other income generation schemes, should be encouraged wherever possible. Competitive tendering needs to be developed further in the NHS, and treating the contractor's capital investment as if it were public expenditure can work against this aim. There should also be scope for more flexibility for an authority to work with a private developer to achieve a net saving. All these examples involve the use of, or access to, private capital, and the Government is determined that authorities should have the maximum freedom in this area, consistent with value for money and the proper use and control of public expenditure.

[Could put this section in private sector chapter]

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Audit

5.31 Currently, the statutory audit of health authorities' accounts is carried out by the Department of Health, using, to a limited extent, private firms of accountants under contract. Greater freedom over the use of resources brings with it greater responsibility for ensuring that resources are used in the most efficient and effective way. Through the annual review process, health authorities will continue to be accountable to Ministers for their use of resources. But, because of the huge sums of money involved, Ministers need an independent source of advice whose reports will be published and therefore available to Parliament and the public.

5.32 The Government has decided that the Audit Commission is best equipped to fulfil this role for the NHS, including self-governing hospitals, GP practice budgets and Family Practitioner Committee spending. It is currently responsible for the audit of local authorities in England and Wales and reports on this to the Secretary of State for the Environment. It has considerable experience and expertise in areas of work closely related to that of health authorities. In particular, it is accustomed to working in multi-disciplinary teams with professionals looking at the professional aspects of services. This would be an important part of its new role in the health service.

5.33 The Housing and Local Government Bill [currently before Parliament] includes a provision which will enable the Audit Commission to undertake audit work in the NHS under contract to the Secretary of State for Health. This will develop the experience of the Audit Commission, and enable its staff to start to work with the DH officials currently responsible for NHS audit. The Government proposes to bring forward further legislation formally establishing the Audit Commission as the NHS auditor, reporting to the Secretary of State for Health.

5.34 The role of the National Audit Office will remain unchanged. As an Officer of Parliament, the Comptroller and Auditor General will continue to report on the use of voted funds, and to certify the aggregated accounts of the NHS, drawing upon the individual health authorities audits of the Audit Commission.

Draft (20.12.88)

CHAPTER 6: THE WORK OF HOSPITAL CONSULTANTS

Introduction

6.1 The NHS employs over 45,000 hospital doctors, of whom 16,000 are Consultants. The reforms proposed by the Government in this White Paper will make it easier for Consultants and their colleagues to get on with the job of treating patients. The greater autonomy for hospitals proposed in chapters 4 and 5 will remove unnecessary controls. The new funding arrangements set out in chapters 3 and 7 will help Consultants to treat more patients. The expansion of the "resource management initiative" outlined in chapter 5 will give them budgetary and information systems more sensitively tuned to medical needs.

6.2 Consultants must be as free as possible to do their job. But treating patients means spending money. The taxpayer has to find this money for the NHS, and expects management to use it efficiently and to good effect. The decisions taken by Consultants are critical to the way in which the money is used. It is therefore important to ensure that Consultants are properly accountable for the consequences of these decisions.

6.3 This chapter sets out the Government's proposals for striking a proper balance between two legitimate pressures: the professional responsibilities and rewards of the individual consultant; and the responsibility of managers (whether or not they are medically qualified) to ensure that the money available for hospitals buys the best possible service.

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Medical audit

6.4 A patient's primary concern is to be given an accurate diagnosis and then receive effective treatment. The quality of medical care available to NHS patients is obviously of central importance. Within the next two years, the Government would like to see all hospital doctors taking part in medical audit - a systematic, critical analysis of the quality of medical care, including the procedures used for diagnosis and treatment, the use of resources, and the resulting outcome for the patient.

6.5 Medical audit is essentially a professional matter, a means of ensuring that the quality of medical work meets acceptable standards through peer review of medical practice. It necessarily requires both specialised knowledge of current medical practice and access to medical records. It must also be developed and implemented with care. Medicine is an inexact science, often lacking generally accepted measures of the benefits to patients from different techniques and services. Medical audit must not discourage doctors from taking on difficult but essential clinical work.

6.6 The Government welcomes the initiatives which the medical profession is already taking, both nationally and locally, to foster the development of medical audit, and aims to work with the profession to build on what has been achieved. For example, the Secretary of State for Health has asked the statutory Standing Medical Advisory Committee to consider and report on how the quality of medical care can best be improved by means of medical audit, and on the development of indicators of clinical outcome. The Government will also encourage all the Royal Colleges to make participation in medical audit a condition of a hospital unit being allowed to train junior doctors.

6.7 Management too has a responsibility to ensure that medical audit becomes firmly established, especially at local level. The Government is publishing alongside this White Paper a document which sets out in more detail, as a basis for consultation with the profession, its proposals for securing effective framework for medical audit in all NHS hospitals by April 1991. The Government's approach is based firmly on the principle that the quality of medical work should be reviewed by a doctor's peers, whilst recognising also that management itself is responsible for ensuring that resources are used in the best interests of patients. It must also be available to management.

6.8 The Government's main proposals are as follows:

Also -- possibility of joint enquiries covering medical & management audit.

* every Consultant should participate in a form of medical audit agreed locally between management and the profession.

* the system should be medically led, with a local medical audit advisory committee chaired by a senior clinician.

* District management should be responsible for ensuring that an effective system of medical audit is in place, and also that the work of each medical team is reviewed at whatever regular, frequent intervals are agreed locally.

* peer review findings should be confidential, but the general results of medical audit should be available to management locally and the lessons learned published more widely.

* management should be able to initiate an independent professional audit, for example where there is cause

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Joint audit? to question the quality or cost-effectiveness of a service.

6.9 The Government also proposes that a hospital should have an effective system of medical audit before it can be granted self-governing status. By the same token, District Health Authorities (DHAs) will be asked to ensure that effective medical audit is in place before they sign a contract with a self-governing hospital or with a hospital in the private sector.

6.10 The Government recognises that medical audit is not cost-free. It needs a significant investment of time by doctors themselves, and adequate support to ensure that the necessary information is available. The Government is confident that this investment will prove worthwhile by further improving the quality of service to NHS patients.

Managing the Consultant's contract

6.11 Most hospital services are the responsibility of DHAs. But, with the exception of those working in Teaching Districts, Consultants' contracts of employment are held by Regional Health Authorities (RHAs). This has tended to cause confusion about the nature of a consultant's accountability to local management and the DHA. It has also tended to leave unclear what a District can and should expect of its Consultants.

6.12 The Government believes that it is unacceptable for local management to have little authority or influence over those who are in practice responsible for committing most of the hospital service's resources. This does not mean moving consultants' contracts from RHAs to DHAs, which would cause unnecessary disruption. The Government proposes instead to ensure that each DHA acts as its RHA's agent in agreeing with

consultants the scope and arrangement of their NHS duties in each hospital.

6.13 The key to this is that every consultant should have a fuller job description than is commonly the case at present, covering their responsibility and accountability both for the quality of their work and for their use of resources. These job descriptions, which will be subject to annual review, will be an essential tool for managing all consultants' contracts. They will need to be sufficiently detailed, for example as to the number of outpatient clinics which a Consultant is expected to hold, to enable District management to monitor whether Consultants are fulfilling their contractual obligations.

6.14 DHAs will be asked to agree a job description along these lines with each of their Consultants. They will need to do so in a way which preserves both the freedom of Consultants to take clinical decisions within the boundaries of accepted professional standards and their 24-hour responsibility for their patients. The Government will discuss with the medical profession nationally how best to implement this, including a suitable national framework for Consultants' job descriptions.

6.15 There is currently no provision for District management to take a full and formal part in the appointment of a Consultant. Consultant appointments are recommended by mainly professional Advisory Appointment Committees, whose primary consideration is the professional suitability of the candidate. The Government will seek to amend the Appointment of Consultants Regulations to enable District General Managers to take part directly in the appointments procedure. Professional suitability will and should remain a major criterion, but the general manager will be able to ensure that the chosen candidate is also willing and able to meet the managerial requirements of the post.

6.16 The Government intends to complement these changes by improving the present disciplinary procedures for Consultants. These procedures are at present cumbersome and inflexible. They have recently been reviewed by a Joint Working Party of the Health Departments and the profession, established by the Government in 1987. The Working Party has made a number of valuable recommendations. The Government will now open negotiations with the profession on the basis of the Working Party's report, which will be published.

6.17 The Government sets particular store by two of the changes which the Working Party suggests. The first is the introduction of new, local procedures for dealing with circumstances which warrant disciplinary action short of dismissal. The second concerns the unique right of a Consultant dismissed by his employer to appeal to the Secretary of State against his dismissal. This can be a time-consuming and costly process, the prospect of which may deter management from embarking on dismissal proceedings in the first place. The Government therefore welcomes the Working Party's proposal for a timetable which should normally lead to concluding an appeal within nine months of the dismissal.

Reform of distinction awards

6.18 Some 35% of Consultants are currently in receipt of a distinction award. This takes the form of a superannuable increase in salary at one of four levels. There are currently some 3,900 'C' awards (£6,260), 1700 'B' awards (£14,200), 700 'A' awards (£24,850) and nearly 200 'A'+ awards (£33,720). Distinction awards are intended to reward clinical excellence, and are payable until retirement. The normal pattern is for progression through the levels of awards. New and increased

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awards are given on the advice of an independent professional committee.

6.19 The distinction awards scheme was introduced in 1948, and has remained substantially unchanged since then. In their 1988 report (Cm 358), the Review Body on Doctors' and Dentists' Remuneration suggested that expenditure on the scheme should result as far as possible in a benefit to the NHS, as well as rewarding doctors for their individual efforts. The Government agrees. It believes that the nature and administration of the scheme should now be changed, with two main objectives in view: to reflect the wider responsibilities of Consultants for the effective use of resources, and not only the clinical merit of their work; and to ensure that the scheme offers Consultants stronger incentives to maintain and improve their contribution to local services.

6.20 Taking into account the specific suggestions made by the Review Body, the Government proposes to open discussions with the medical profession nationally with the following changes in mind:

* leaving unaffected the rights of existing award holders, to replace 'C' awards with performance-related pay of equal value for those consultants who demonstrate not only their clinical skills but also a commitment to the management and development of the service. The Government proposes that general managers and senior doctors should decide jointly which consultants should be rewarded in this way. There will be a small number of exceptions, to meet the circumstances of Consultants whose jobs include only a limited management content.

Medical school staff?

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* for the future, to restrict progression to the remaining three levels of award to those consultants who have earned performance related pay. The Government proposes that these higher awards should, as now, reward clinical excellence, but that there should be a stronger general management influence on the choice of award holders.

* to make new or increased awards, including performance-related pay, reviewable every five years.

* to make new or increased awards pensionable only if a consultant continues working in the NHS for at least three years. The Government believes that this will meet the criticism of the Review Body that awards given to those approaching retirement, with the additional pension benefits entailed, can hardly be said to be in the best interests of the Service.

Payable

Payable

None consultants?

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Draft (20.12.88)

CHAPTER 7: FUNDING HOSPITAL SERVICES

Introduction

7.1 Hospital services must be funded in a way that encourages more competition and more choice, two of the elements at the heart of the Government's proposals for a better health service. To do this a simpler way of allocating funds to health authorities is needed. So is a new method of funding those hospitals which continue to be run by health authorities.

7.2 At present a hospital or service which becomes more efficient and could treat more patients may be prevented from doing so by its budgetary limits. One which is failing to deliver may still be funded at the same level, despite its relative inefficiency. The Government is determined to change this. It believes that the key to doing so is to move towards a system in which health authorities are funded not for the services they provide but for the population they serve. The job of health authorities will then be to buy the best services they can for their - and their GPs' - patients, and hospitals will have to compete much more for their business.

7.3 This chapter sets out the Government's proposals for achieving these objectives.

Funding health authorities

The present system

7.4 Since 1977, money has been allocated to Regional Health Authorities (RHAs) on the basis of a formula which identifies

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target shares for each Region. The formula is known as RAWP (Resource Allocation Working Party). It is based on the size and expected growth of each Region's population, and also a range of other factors including the proportion of elderly people, the relative health of the population and the extent to which patients cross Regional boundaries for hospital treatment. Each year, when making financial allocations to Regions, the Government decides how far actual allocations should move towards the target shares. When the formula was introduced most Regions were significantly above or below their RAWP target. Now 11 of the 14 are within 3% of it. [The changes since 1979-80 are shown in figure 7.1.]

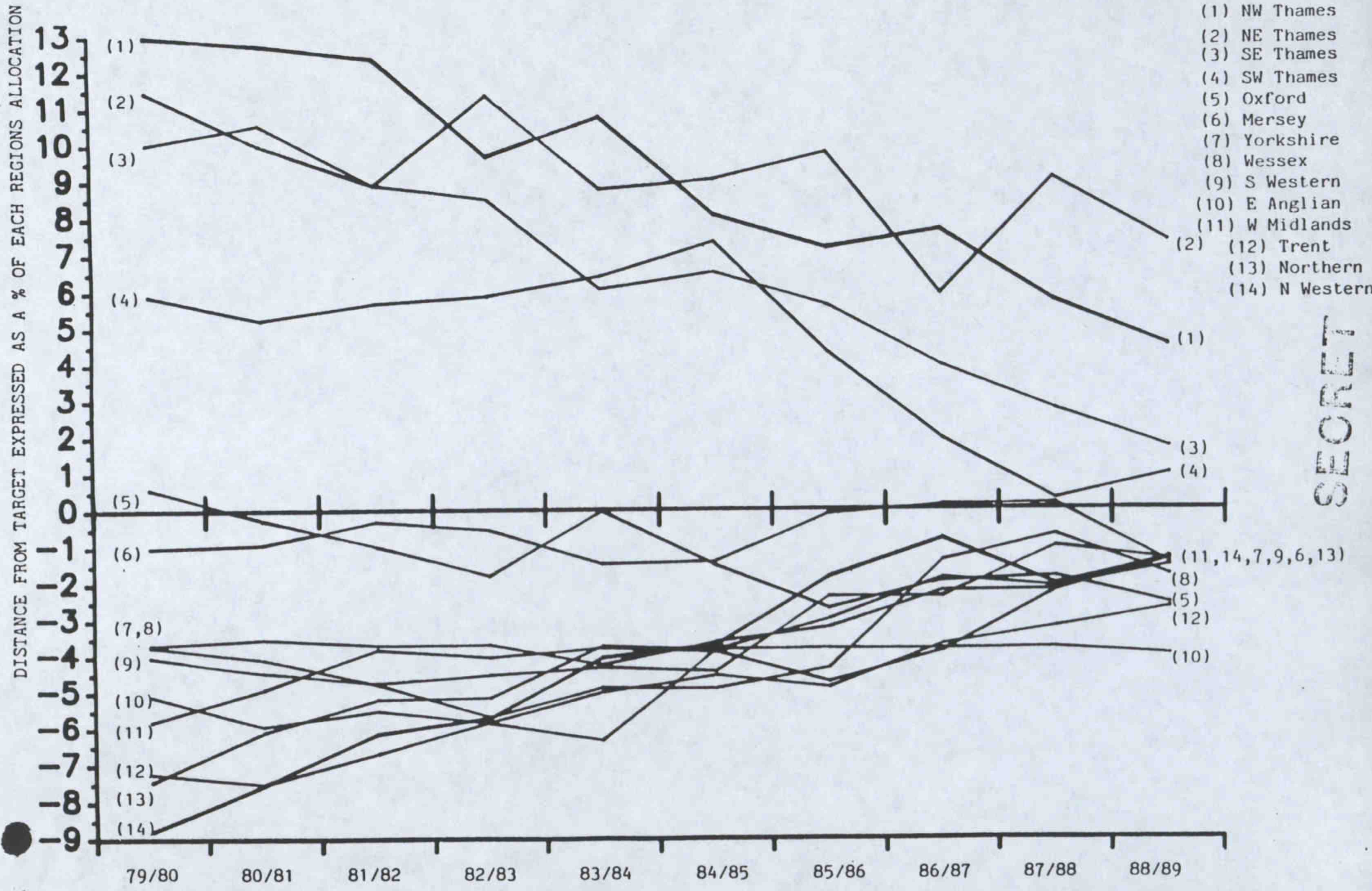
7.5 At District Health Authority (DHA) level, distances from RAWP target are greater. The extent to which RHAs rely on the RAWP formula when allocating funds to Districts tends to vary from Region to Region. In recent years growth money has usually been allocated on the basis of planned service developments - for example, to enable a new hospital to open - rather than by a simple application of the formula.

7.6 There is no direct relationship between the amount of money a District is allocated and the number of patients its hospitals are treating. This is partly because the movement of patients across Regional boundaries is reflected only retrospectively in the formula. Further, these adjustments affect only target, not actual, allocations, and may be based on forecasts which are not borne out in practice. Even significant changes in such "cross-boundary flows", therefore, may have little impact on the amount of money actually allocated.

A new approach

7.7 The Government proposes to simplify the arrangements for allocating funds to RHAs and DHAs. The underlying principles

FIGURE 7.1



to be applied are the same in both cases. The Government recognises the need for a transitional period, which will be longer at District than at Regional level.

Allocations to RHAs

7.8 Regions will be funded, on a weighted capitation basis, to buy services for their resident populations. The allocations will reflect, as now, the number of elderly people and the health of the population. The Thames Regions will receive a slightly higher level of funding - some two per cent higher per head of population than the rest - in recognition of the particular problems of providing services in the densely populated and high cost south east.

7.9 Funding Regions on the basis of their resident populations will leave them to pay each other directly for cross-boundary flows. Starting in April 1989, RHAs will be asked to begin work on agreeing the cost of these flows in preparation for funding on the basis of resident populations from April 1990. The present arrangements for funding cross-boundary flows will cease from that date. As a result, Regions will be paid much more quickly and in full for the work they do for other Regions.

7.10 It is the Government's aim to move over a two year period, starting in April 1990, to Regional allocations calculated on a weighted capitation basis. The transition to the new system will therefore be completed by April 1992. There will be no separate "targets": the move to weighted capitation removes the need to calculate target shares to which allocations should be moving.

7.11 These arrangements will replace the use of the RAWP formula.

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Allocations to DHAs

7.12 RHAs will continue to be responsible for allocating funds to DHAs. At present Districts are funded mainly according to where hospitals happen to be located. In future Districts, like Regions, will be left to pay each other directly for cross-boundary flows. A start to the process depends on improved information at the hospital and District level about population, the movement of patients and the costs of different treatments. The Government expects some DHAs to be in a position to pay each other directly for services provided from April 1991. Other authorities, drawing on the experience gained, will be expected to complete the process by April 1994.

7.13 Even after adjusting for the effects of cross-boundary flows on allocations, the differences between current levels of funding and those implied by a weighted capitation approach are much larger at District than at Regional level. Residents in Districts with relatively extensive hospital provision tend to use services more intensively than might be expected simply on the basis of the numbers of elderly people and the health of the population. While it is the Government's aim that Districts should in due course be funded on broadly the same basis as Regions, it recognises that an immediate switch would in some cases involve substantial changes in the money available to buy services for their resident population. Such changes must be carefully managed over a ~~period of time~~. The Government will discuss with RHAs the detailed implementation of these proposals.

Funding hospital services

7.14 The present system of funding Districts for their hospital provision leaves the relationship between workload and funding obscure and indirect. Hospitals are funded as

much because they are there as for the work they do or how effectively they do it. As a result, there are only limited incentives for them to satisfy the needs and preferences of patients or to take on additional work by improving productivity. They may even be penalised for their efficiency if they treat more patients than planned for and, as a result, have to close beds to stay within their budget.

7.15 As the new arrangements described so far in this chapter become established, each DHA's duty will be to buy the best service it can from its own hospitals, from other authorities' hospitals, from self-governing hospitals or from the private sector. Hospitals for their part will be free to sell their services to different health authorities. In this way money will in future go more directly to where the work is done best.

"Core" services

7.16 It will be essential to ensure that patients needing urgent treatment continue to receive it. Services to which patients need guaranteed immediate access where necessary can be divided into five broad categories:

- accident and emergency (A and E) departments.

- services for patients who need immediate admission to hospital from an A and E department, for example a significant proportion of general surgery.

- services for other patients who need immediate admission, such as most general medicine and a substantial proportion of hospital geriatric and psychiatric services.

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* out-patient and other support services which are needed in support of the first three categories, either on site or immediately available.

* public health, community based services and other hospital services which need to be provided on a local basis either as a matter of policy e.g. services for the elderly or the mentally ill, or practicability, e.g. district nursing and health visiting.

7.17 Where these core services are provided by a hospital which continues to be managed directly by its DHA, they will be funded through a management budget. The scope for competition may be limited but, through management budgets, a DHA can set clear targets for the quantity and quality of the hospital's services, and can then assess the hospital's performance against these targets. As better cost information becomes available, Districts will be able to refine and improve their planning and monitoring.

7.18 Where core services are bought in from a self-governing hospital, or from a directly managed hospital in a neighbouring District, it will need to be on the basis of an annually negotiated contract. Under this arrangement hospitals will provide an agreed range of services, for a fixed payment, to all patients referred or admitted. The fixed payment means that DHAs know how much they will spend, and the risk of increases in cost or volume is borne by the hospital. Contracts of this kind will need to be negotiated carefully because of the substantial volume of potential business involved and the need for hospitals to take account of variations in the costs of treating different conditions. Current costs and workload will provide a baseline from which to work.

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7.19 Hospitals will need to budget, on the basis of experience, for the treatment of patients who are not covered by an annual contract or by their own districts' management budgets. The costs of treatment will be reimbursed directly by each patient's own DHA. Core services must be provided without any question as to where the money is coming from.

Other services

7.20 Where patients and their GPs may be able to exercise some choice over when and where treatment is provided, it becomes possible for Districts to buy services in a more flexible way. This in turn widens the scope for switching money to where the best services - for example, the shortest waiting times - are on offer.

7.21 The precise range of services which could be funded in this way will tend to vary according to the accessibility of different hospitals. There are broadly three categories:

* those procedures or treatments which are currently provided in most Districts but for which patients may be prepared to travel if a better service is available elsewhere. These treatments are in the main surgical acute operations, such as hernias and hip replacements, which make up the bulk of waiting lists.

* services which are not currently provided in every District, such as ear, nose and throat (ENT), ophthalmology and oral surgery, and which some Districts will therefore need to buy in.

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* other services for which patients may wish to exercise choice as to location, for example some long-stay care for elderly people.

7.22 The Government envisages that most of these services will be bought in under a "cost and volume" contract. The number of cases to be treated would be specified within a range, with payments on the basis of work done above the minimum. This arrangement would cover most in-patient and day case treatment. The minimum payment assures the hospital of a contribution towards its fixed costs, whilst the maximum volume makes it easier for the hospital to offer shorter waiting times.

7.23 DHAs may also want to keep back a relatively limited budget for buying services on a case by case basis, at a price quoted by the hospital. This could not be a normal basis of funding, since it gives hospitals no guarantee of income and would leave Districts to bear the risk of unexpected costs within their cash-limited allocations. Used judiciously, however, it opens up the scope for buying services at marginal costs as hospitals try to use spare capacity.

7.24 The Government believes it essential that DHAs use this greater flexibility in funding hospitals to offer more choice to patients. This in turn means involving GPs far more in key decisions. When they place contracts, DHAs will need to take full account of the existing referral patterns of GPs in their Districts. They will also need to discuss with GPs the desirability of changing those patterns, whether on grounds of cost or quality of the services provided. GPs for their part will want to make sure that their views about the quality of care, and about shorter waiting times for out-patient appointments and in-patient treatments, are reflected in a DHA's contracts. GPs who take part in the practice budget

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scheme set out in chapter 3 will be taking these decisions for themselves.

7.25 At present an increasing number of hospitals are declining to accept referrals from GPs for patients who are not resident in the District. The Government's proposals will overcome this difficulty by enabling the patient's own DHA to pay directly for the services required. DHAs will need to allow for referrals by GPs to hospitals with whom no contracts have been placed, keeping in reserve some funding for this purpose based on previous referral patterns and discussion with the GPs themselves.

7.26 For these new arrangements to work well, GPs and their patients will need to be well informed about the choices on offer. The Government is putting further work in hand on two fronts to assist this. First, it will be seeking to improve the information available to GPs about their referral patterns. Information of this kind will be needed anyway for the practice budget scheme. Secondly, it will be exploring how best to develop and publish indicators of hospital performance which cover the quality as well as the efficiency of the services provided.

Funding specialist services

7.27 Districts cannot be self sufficient in all services. Specialist services can be divided into two broad categories:

* supra-regional services - these are designated and protected with central funding by the Secretary of State for Health. They include heart and liver transplants and neo-natal and infant cardiac surgery.

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* Regional and supra-district services - these are designated by RHAs and may include ophthalmology, ENT, neurosurgery, neo-natal care and radiotherapy.

7.28 The Government intends that most of these services should in future be bought by Districts from their basic allocations. The necessary contracts would cover both direct referrals from the A & E department or GPs and referrals to a specialist consultant from another consultant. The Government recognises, however, that it will be necessary to continue to provide some central funding for the development of supra-regional services. Central funds will cover the fixed costs of the units providing these services with the variable costs covered by contract funding from the buyers. RHAs may decide to adopt a similar approach to the funding of some regional and supra-District services. The Government will discuss with RHAs the detailed application to these services of the new funding arrangements it proposes.

Training and research

7.29 There are some significant overhead costs which hospitals will need to meet but which will not be incurred directly in the provision of services for its customers. The main examples are medical, nurse and other training; and research. The Government proposes that these costs should be met directly, either by central government or by RHAs, and will discuss with RHAs how best to secure this.

7.30 More particularly, the Government remains firmly committed to maintaining the quality of medical education and research. It recognises the complexity and special needs of these areas. Health authorities involved in medical education incur additional costs which will continue to be reflected in the new funding arrangements through an enhanced SIFT (Service

Increment For Teaching). The Government has established an inter-departmental Steering Group on Medical Education to examine the special problems of this area. It will develop its work, and make recommendations in the light of the proposals in this White Paper. It will be a principal task of RHAs to see that appropriate facilities are maintained for teaching and research.

Waiting times

7.31 The Government believes that the new funding arrangements described in this chapter will bring down waiting times for hospital treatment, both through the greater flexibility they offer in moving money to where the work is done and through making maximum waiting times an important feature of contracts and management budgets. DHAs, and GPs within the practice budget scheme, will tend to buy where waiting times are shortest, and hospitals will have a stronger incentive to become more efficient. In the meantime, the Government intends to build on the current waiting list initiative. The central waiting list fund will be targeted at Districts who can show that they can use the extra money effectively. They will be enabled to treat, on a contract basis, patients from that District or elsewhere in the Region who have already waited excessively.

7.32 As a further, immediate measure the Government proposes to introduce a scheme under which a number of additional, permanent Consultant posts can be created over the next two years. These posts will be over and above the 2.2 per cent annual expansion in Consultant numbers to which Regions are already committed. The details of the scheme will be worked out with representatives of the profession and NHS management. In essence it will concentrate on increasing the number of Consultants in those acute specialties which currently have the longest waiting times for treatment. Establishing a new

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Consultant post also involves indirect costs, such as nursing and other staff and the provision of equipment. The Government recognises this and will ensure that effective use can be made of the new posts.

Draft (20.12.88)

CHAPTER 8: MANAGING THE FAMILY PRACTITIONER SERVICES

Introduction

8.1 This chapter makes a number of proposals for building on the policies set out in the Government's White Paper on primary health care, "Promoting Better Health" (Cm 249). It does so in four areas: medical audit; competition; prescribing costs; and management. In each case the Government's proposals complement those in the rest of this White Paper by aiming to improve services for patients, both directly and through achieving better value for money.

Medical audit

8.2 Chapter 6 outlines the Government's proposals for ensuring that effective medical audit is established throughout the hospital service over the next two years. Medical audit is no less important in primary care. The quality of the medical care offered by a GP is just as fundamental to patients. Are referrals to hospital always well judged? Are drugs used effectively and efficiently? Does the coverage of clinics, and do clinic times, suit patients? Are relationships between doctors, community nurses and health visitors working satisfactorily? Is night and weekend cover good enough?

8.3 As with the hospital service, the Government intends to work with the medical profession nationally to establish a system of medical audit in general practice. The aim will be to build on the foundations being laid by the profession

itself, such as the Royal College of General Practitioners' "Quality Initiative". The organisation of medical audit will be less straightforward than in hospitals. Care is delivered in more places; periods of treatment are less well defined; medical records are usually less detailed. But the Government is confident that these are difficulties which can be overcome.

8.4 The Government believes that the following key features will be generally applicable to medical audit in general practice:

* medical audit locally should be based primarily, but not exclusively, on self-audit by GPs and GP practices.

* local practice and procedures should be led, supported and encouraged by a medical audit advisory committee established by each Family Practitioner Committee (FPC).

* each FPC should establish a system for identifying possible indicators of poor quality care, such as emergency admissions to hospital resulting from poor health surveillance or a failure to refer for specialist advice.

* each FPC, in consultation with its GPs, should set up a small unit of doctors and other staff to support and monitor the medical audit procedures of its practices.

* the local advisory committee should guide the work of the medical audit unit and, where necessary, help to arrange an external peer review of a GP or GP practice.

* The F.P.C. should have access to the general results (not particular cases) of medical audit of G.P.

8.5 The Government recognises that it may take longer than in hospitals to establish a satisfactory approach to medical audit in general practice. The Government will consult the profession and FPC interests on the detail of the approach it has in mind. The Government believes that, once a satisfactory system has been developed, all GPs should be required by their contracts to take part.

Competition

8.6 In "Promoting Better Health", the Government described a range of measures it intended to introduce to "put the patient first". A greater degree of competition was needed to improve services to the public. A better informed public, and a remuneration system geared to consumer demand, were seen as key mechanisms. This White Paper provides an opportunity for the Government to clarify some key objectives.

Capitation fees

8.7 At present, capitation fees form on average 46% of a GP's income. "Promoting Better Health" stated the Government's intention to raise this proportion. The Government remains of the view that GPs will have a stronger incentive to satisfy their patients if a greater proportion of their income is attributable to the number of patients on their lists. The Government intends, therefore, to raise average remuneration accounted for by captitation fees from 46% to 60%, as soon as possible. This will still allow scope for targeted incentive payments, for example for childhood immunisation or cervical cancer screening.

8.8 It will be important to ensure that good, young doctors who wish to enter general practice will find an adequate number of practice vacancies to apply for. The Government proposes to take two further steps to achieve this. First, it

will seek in due course to reduce from 70 to 65 the retirement age for GPs which has been introduced through the Health and Medicines Act 1988. Secondly, it will ensure that, when filling single-handed practice vacancies, FPCs give priority to younger doctors who are keen to work as members of primary health care teams.

Patients ~~as consumers~~ ch

8.9 The Government also remains of the view that patients must be able to exercise a real choice between GPs. "Promoting Better Health" outlined two particularly important changes to this end. The first is to make patients better informed. [Sentence referring to MMC consideration of doctors' advertising.] The second key change is to enable patients to register with a new doctor without having to go through the present procedure, which requires them first to approach either their existing doctor and FPC. The Government believes that patients should be quite free to choose and change their doctor without hindrance, and will bring forward the necessary amending Regulations as soon as possible.

Prescribing costs

8.10 The drugs bill is the largest single element - 36% - of expenditure on the family practitioner services (FPS), accounting for £1.9 billion in 1987-88. It has grown on average by four per cent a year in real terms over the past 5 years. The Government has taken a number of steps in recent years to contain the rate of growth in drug costs by encouraging more economical prescribing. The introduction of the selected list scheme in 1985 is just one example.

8.11 If unnecessary spending on drugs can be saved, money is released for other aspects of patient care in the NHS. The Government believes that there is more scope for reducing the

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rate of growth in prescribing costs without harming patient care. For example, drug spending in different FPCs varies in England from £26 to £40 per head of population. To some extent these variations will reflect differences in population structure and morbidity. But they also reflect varying attitudes to the cost of drugs by doctors who have no direct or personal interest in the cost of the drugs which they charge up to the NHS and the taxpayer when they prescribe them. In the Government's view the time has come to establish a more rigorous approach to securing better value for money. It is extremely unlikely that the drugs bill will fall as important and expensive new drugs are produced steadily by successful research. More must and can be done to prevent the bill rising so quickly

8.12 Accordingly, the Government proposes to establish as soon as practicable - if possible from April 1991 - a new budgeting scheme to encourage economical and cost effective prescribing. Under this scheme FPCs will be given reasonable budgets for their drug spending, based on sensible assumptions about patient needs and prescribing patterns in their area. FPCs will in turn allocate indicative budgets to individual GP practices, and monitor spending in the light of those budgets. The aim will be to put downward pressure on the rate of growth in drug spending in the highest spending practices.

8.13 The Government will consult interested parties on the detailed development and implementation of this scheme, which will include the following main features:

[to be drafted in the light of final decisions on HC63]

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8.14 Before the scheme can work fairly and effectively, adequate information on drug prescribing and costs will be needed. An improved prescribing information system - known as "PACT" - was introduced in August 1988. This provides good quality feedback to doctors about their prescribing, three months after the quarter to which the information relates. FPCs will also have access to this information. The Government recognises that some improvement in the timeliness of this information will be needed. Subject to that, it believes that "PACT" information will form an adequate basis for monitoring expenditure against budgets.

Managing the FPS

8.15 The Government believes that there is a clear need to strengthen further the management of the FPS. "Promoting Better Health" set out a substantial body of changes which have still to be implemented by FPS management. This White Paper includes others. The rest of this chapter sets out the Government's proposals for stronger executive management, for streamlined non-executive leadership, and for firm monitoring and accountability.

Executive management

8.16 The Government proposes to create new chief executive posts in all FPCs, to be filled by open competition. The salaries for these new posts will be set significantly above those of the present FPC administrators, to be attractive to good quality managers from both inside and outside the NHS. FPCs will also need to strengthen their management and administrative skills at every level of the organisation. The main task of the new chief executives will be to supply the drive needed to manage change, working closely with the contractor professions themselves.

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Composition of FPCs

8.17 FPCs currently consist of 15 members from the contractor professions and 15 lay members. The Chairman may be from either group. All the members are appointed by the Secretary of State. The 15 professional members are drawn from nominations made by the professions' local representatives. Four of the lay members are drawn from District Health Authority nominees, and a further four from local authority nominees.

8.18 The Government believes that it is no longer sensible for the management of contracts with practitioners to be the responsibility of bodies on which the professions themselves are so strongly represented. Nor does it believe that a committee with 30 members can lead the management of the FPS as effectively as the changes now envisaged will require. The Government will therefore seek powers to replace FPCs with new bodies, to be known as Family Practitioner Authorities, with the following composition:

No FPA means Family Planning Assoc.

* a maximum of 12 members in total.

* a chairman appointed by the Secretary of State.

* three professional members - a doctor, a dentist and a pharmacist - appointed by the Regional Health Authority (RHA).

* a majority of lay members, appointed by the RHA and chosen for their experience and personal qualities.

* the chief executive, appointed by the chairman and lay members.

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8.19 The Government intends that the new Authorities should be freer than FPCs are now to determine their own sub-committee structure, and should be able to co-opt members to the committees as necessary. There is scope for slimming down radically the extensive sub-committee structure which currently applies.

Accountability of FPCs

8.20 Since April 1985, the 90 English FPCs have reported directly to the Department of Health. A good deal has been achieved by way of setting objectives for the Committees. But in the longer term the Government does not believe that it makes practical sense for central government to be so directly involved in local management, or for the Department to be responsible for monitoring the performance of 90 different bodies. This White Paper includes a number of proposals which, for good practical reasons, will give RHAs direct responsibility for FPS matters. The drug budget scheme described earlier in this chapter is one example, and GP practice budgets is another.

8.21 The Government will therefore seek powers to make the new Family Practitioner Authorities accountable to RHAs, and to enable RHAs to monitor and, if necessary, direct the work of these Authorities as they do that of DHAs. This change will have the further, important advantage of bringing responsibility for primary health care and hospital services together at a strategic level. It will then be easier to plan and monitor effectively comprehensive policy initiatives spanning both services, for example in the field of health promotion and disease prevention.

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Draft (20.12.88)

CHAPTER 9: BETTER DECISION-MAKING

Introduction

9.1 Today's health service is a complex, multi-billion pound enterprise. Demand is continually changing and increasing while resources are inevitably limited. The Government recognises the demands that this places on health authority Chairmen and members and is very appreciative of their efforts.

9.2 Chairmen and members will continue to have a vital role in the running of the health service. Indeed, they will need to spearhead the changes that the Government is proposing in the White Paper. To enable them to discharge this role effectively, the Government has decided that authorities should be streamlined. It also recognises the need for the centre to provide authorities with a clear framework of objectives and priorities within which to operate. This chapter sets out its proposals in both areas.

Composition of health authorities

9.3 Regional and District Health Authorities currently comprise a Chairman and between 16 and 19 members. The Chairmen and members of RHAs are appointed by the Secretary of State. The Chairmen of DHAs are also appointed by the Secretary of State, and most of the members are appointed by the relevant RHA. The RHA is required to consult various interests, and must appoint a representative of the appropriate university. Between 4 and 6 of the members of DHAs are directly appointed by relevant local authorities.

9.4 The Government does not consider that an authority of this size and composition is conducive to effective decision-making . If authorities are to discharge their new responsibilities in a business-like way, they need to be smaller and to provide a single focus for corporate decision-making.

9.5 At district level, the arrangements for appointing members also reinforces a lack of clarity in the role of health authorities. At present they are neither truly representational nor management bodies. This confusion is underlined by the appointment of some members direct by local authorities. The Government believes that members should be appointed on the basis of the skills and experience they can bring to the authority and not according to the constituency which they represent.

9.6 The Government therefore proposes that, with effect from [April 1991]:

* RHAs and DHAs will be reduced from their present 16-19 members to 5 non-executive and 5 executive members plus a non-executive chairman;

* the executive members, who will be co-opted by the non-executive members, will include the General Manager and other senior staff such as the Finance Director, a leading clinician and nurse manager;

* the Secretary of State for Health will continue to be responsible for appointing the Chairmen and [non-executive] members of RHAs and the Chairmen of DHAs;

* RHAs will continue to be responsible for appointing the [non-executive] members of DHAs;

Guidelines?
as to who to appoint

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* non-executive members will be appointed on the basis of the skills and experience they can bring to the authority;

* local authorities will no longer have an automatic right to appoint members to DHAs [but will [can] be consulted by RHAs as part of the normal appointments procedure.];

why?

* teaching districts will continue to include a representative of the Medical School;

* [RHAs will include a representative of the FPC Chairmen.]

Community Health Councils

9.7 The interests of the local community will continue to be represented by Community Health Councils (CHCs) which act as a channel for consumer views to health authorities and FPCs.

Central management of the NHS

9.8 Under the proposals set out in this White Paper, the NHS will continue to be largely funded by the Government from tax revenues. Ministers must be fully accountable to Parliament and to the public for the spending of these huge sums of money. and for the services which they finance. The Government therefore believes that a central Management Board for the NHS must be retained within the Department of Health and be under Ministerial direction and control.

Not in detail.

9.9 The Government proposes however to streamline management arrangements with the Department by giving the Board a clear role in major strategic issues. In particular:

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* responsibility for the family practitioner services will be brought under the Board. The better integration of primary care and hospital services is an important objective;

* the Management Board will be chaired by the Chief Executive and will deal with ~~day-to-day~~ operational matters under the guidance of [a Policy Board] chaired by the Secretary of State;

* the [Policy Board] will be strengthened by the appointment of non-executive members from the NHS and from the private sector of business;

* the [Policy Board] will replace the former Health Service Supervisory Board.

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Draft (20.12.88)

CHAPTER 10: WORKING WITH THE PRIVATE SECTOR

Competitive tendering for wider no. of services CBI report

10.1. The Government's aim is that there should be a genuine mixed economy in health care to the benefit of all those needing health care, whether in the National Health Service or in the independent health sector. Both the National Health Service and the independent health sector should be able to learn from each other to help each other and to buy and sell services to each other. The greater choice and spur of competition provided by such a mixed economy should make a substantial contribution to achieving the objectives of the Government's proposals for reform.

Scope of independent health sector

10.2. Since 1948 the National Health Service has been complemented by an independent health sector made up of a broad spectrum of private, voluntary and charitable bodies. The independent sector has re-inforced the National Health Service not only in areas such as elective surgery where public provision is universal, but also in areas where NHS coverage is limited. These range from hospices, nursing and convalescent homes to fitness training, screening and chiropody. Its contribution to health care in the UK is now significant:

- 5.25 million people or 9 per cent of the population of the UK are covered by private insurance;

- its acute hospitals in England have 7 per cent of acute beds and treat over 400,000 in patients and day cases a year;

- it carries out 17 per cent of all elective surgery, including 28 per cent of all hip replacements and 19 per cent of all coronary artery by-pass grafts;

- it provides over 90 per cent of all hospice beds and convalescent home places;

- there are over 52,000 beds in nursing homes.

10.3. The advantages brought by the independent sector are that it:

- increases the range of options available to general practitioners and patients and offers the consumer choice;

- contributes, and could contribute more, to the cost effective treatment of NHS patients. It increases the options available to NHS management as well as to individual patients;

- responds flexibly and rapidly to consumer needs, thanks to its diversity.

These advantages can be developed to the benefit of all patients. Just as the private sector has no monopoly of efficency or quality of hotel services, so public provision has no monopoly of caring or the quality of clinical treatment.

Meeting the NHS's needs

10.4. There is already a growing partnership between the NHS and the independent health sector, which provides some 3,000 residential places for mentally ill people and some 7,500 places for mentally handicapped people. In 1986, contractual arrangements between the NHS and independent sector led to over

26,000 patient treatments at a cost of some £45 million. Many of these are long term contracts. As part of the Government's drive to improve hospital waiting lists, many health authorities have entered short term contracts with private hospitals specifically to treat waiting list cases.

10.5. The Government believes that there is considerable scope for building on these initiatives. Under the proposals set out in Chapter [7] general practitioners and their patients will be able to choose treatment in the private sector for certain conditions if this offers better quality or better value for money than buying NHS services. Similarly, health authorities will continue to be able to buy in services from the private sector if these are not available locally and if they offer a better deal than is available from other NHS hospitals.

Joint Ventures

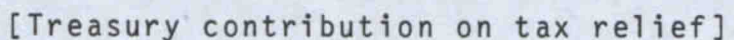
10.6. Current examples of co-operation between the two sectors include the purchase of expensive equipment or minor captial developments, joint ventures to build day surgery units and the construction of a private hospital on NHS land adjacent to a new NHS hospital. These schemes allow the shared use of expensive facilities and their costs to the benefit of each partner. For instance the private sector has increased its ability to perform day surgery, an area in which it has so far lagged behind the NHS. The NHS has achieved additional treatment of patients and the opportunity to market its own facilities. The Government expects all health authorites to consider the opportunites for co-operative ventures as part of their regular reviews of hospital performance.

Competitive tendering

10.7 The Government launched a competitive tendering initiative in 1983. By the end of the June 1988, 97% of domestic and laundry services, and 76% of catering services had been put out to tender, generating savings of almost £108 million annually - some 17% of previous costs. Though 85% of contracts have been awarded in-house, it is clear that the spur of external comptetition has produced substantial savings. Together with other NHS acitivities for which competitive tendering has been the established practice (eg estate services and some property maintenance), the total value of NHS services now subject to regular tendering is well in excess of £1 billion annually.

10.8 The Government believes that there is scope for much wider use of competitive tendering, beyond the non-clinical support services which has formed the bulk of tendering so far. This can extend as far as the wholesale "buying in" of treatments for patients from private sector hospitals and clinics, as has proved effective in the Waiting List Initiative. But competitive tendering should not be a "top down" exercise. The Government's objectives of pushing down decision making to the operational level and introducing more competition into the provision of services will greatly increase the opportunities for managers to buy in services from the private sector where this will improve the services to patients.

[Treasury contribution on tax relief]



CHAPTER 11

SUMMARY AND TIMETABLE FOR CHANGE

Introduction

11.1 Taken together, the proposals in this White Paper represent the most far-reaching reform of the NHS in its forty-year history. They offer new opportunities - and pose new challenges - for GPs, for consultants, for hospital staff, for hospital managers, for regional and district health authorities, and for FPCs. They will mean change at the centre, and change on the ground.

11.2 They will lead to a more modern, more efficient, more caring NHS, better able than ever before to make the most of its formidable resources and the reserves of talent and commitment at its disposal. Their aim is to ensure that the NHS provides a more rewarding environment in which to work, and - most important of all - that it becomes even better at delivering the highest possible standards of care and treatment.

11.3 Although the reforms outlined in this White Paper are designed to make the NHS fundamentally different, in many respects they herald a change of pace and scale rather than a change of direction. Frequently they build on what is already being achieved in some parts of the NHS today; their aim is to spread the benefits of those achievements more widely throughout the service as a whole.

11.4 There is nothing new, for example, in the idea of devolving management responsibility down to local level. What is different is the extent and degree to which that process will in future be taken, and the particular twist it has been given with the development of the concept of self-governing hospitals. Similarly, the drive to extend Medical Audit will be building on well-established principles.

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11.5 What is new, however, is the way in which the Government's policy will work to free up the NHS and give more choice to patients, more choice to GPs, more choice to DHAs as buyers of services. By introducing competition and by rewarding those who offer the best service the Government plans to overcome the "take-it or leave-it" attitude still found too often in the NHS. As a result of those reforms, those who work in the NHS will have to think even more carefully about the needs and wishes of patients.

Summary of proposals

11.6 A single thread runs through all the proposals in this White Paper - the drive for a properly managed health system that will deliver the best quality care - but it will affect different groups connected with the NHS in different ways. The main changes for each major group can be summarised as follows:

i. GPs

- large GP practices will in future be able to opt to hold their own budgets (ch.3);
- money following the patient will mean that GPs referral patterns will have a greater impact on hospital services (ch.x);
- a new system of medical audit will be introduced (ch.x);
- publication of information on the clinical records of hospitals and units will give GPs a better informed choice (ch.x);

ii. Consultants

- will have more responsibility for the management and delivery of hospital services (ch.x);

- there will be medical audit in all DHAs and SGHs within 2 years (ch.x);

- will be affected by new criteria for distinction awards (ch.x);

- will have a greater say in the way their hospitals are run as a result of devolution of managerial responsibility and the establishment of new self-governing hospitals (ch.x);

- will be affected by the introduction of GP budgets and money following the patient (ch.x).

iii. Managers

- will be affected by the abolition of RAWP and the introduction of funding to HAs on a weighted capitation basis (ch.x);

- will be affected by the devolution of managerial responsibility to hospitals and the introduction of self-governing status (ch.x);

- will be affected by the increased involvement of consultants in the management of hospitals (ch.x);

- more competitive tendering (ch.x);

- external audit by the Audit Commission;

- a smaller NHSMB with more non-executive directors from outside the Health Service. The Executive Committee will be chaired by the Chief Executive, and the HSSB will be abolished (ch.x);

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- DHAs will become primarily buyers of services (ch.x).

iv. Structural change

- smaller HA membership with executive and non-executive membership (ch.x);

- delegation of RHA's executive role to DHAs (ch.x);

- smaller FPC membership and reduced professional membership (ch.x).

v. Patients

All the proposals listed above will in time work towards better delivery of care and thus a better service to patients. But in particular, those who use the NHS will benefit from the greater choice brought by:

- GP budgets with money following the patient (ch.3);

- the publication of information about the clinical records of hospitals and units (ch.x);

- appointments system etc (ch.2);

- ability to pay for "extras" (ch.2);

- more pay beds and private wings (ch.x);

11.7 A Timetable for Change

The programme of reform will have three main phases.

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PHASE 1

1989: planning and preparation

11.8 During 1989, the Government will be consulting those most closely concerned and discussing with them the best way of turning the proposals in this White Paper into action.

The Resource Management Initiative will be extended to more major acute hospitals.

Regional Health Authorities will review their functions, and those of their Districts, and start planning how to devolve operational responsibility down to unit level.

Regions will help identify the first hospitals to become self-governing, and plan for those new status.

PHASE 2

1990: legislation and development

11.9 During the 1989-90 session of Parliament the Government will introduce a Bill to give effect to the major changes proposed in this White Paper; Operational responsibility will be devolved to local level.

The introduction of new management structures and financial and information systems in hospitals will gather momentum.

'Shadow' Boards for the first group of self-governing hospitals or Hospital Trusts will start to develop their plans for the future.

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PHASE 3

1991: the new NHS takes shape

11.10 In April 1991, the first Hospital Trusts will be established.

The new, streamlined Health Authorities will take over from their predecessors, buying services within an internal market in the NHS, and working with the new Hospital Trusts.

The first GP practice budget-holders will exercise their new powers.

11.11 Peroration

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