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CC I. WHITEHEAD

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Earlier draft. Now overtaken. PRCC 20/1

J Anson, CB

Second Permanent Secretary

Public Expenditure

20 January 1989

John Mayne Esq
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Whitehall
LONDON SW1

Dear Mr Mayne

PRESENTATION OF THE NHS REVIEW

Thank you for your letter of 19 January.

X The immediate point of this response is to suggest that your Secretary of State should consult his colleagues on the Review Group on the popular version of the White Paper. The Chief Secretary's approval should, in any event, be sought.

I know how the printing timetable can take over at this stage in such a great enterprise, but we must hold it, however briefly, in check, for long enough to consult Ministers.

I am copying this to recipients of my letter of 13 January to Romola Christopherson, and to Richard Wilson.

Yours sincerely

M L Reader

pp **HAYDEN PHILLIPS**

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DRAFT PoP VERSION OF WHITE PAPER

The Health Service today

All in all, Britain's Health Service is the best system of its kind anywhere in the world. It has a highly skilled and dedicated staff, backed by huge and growing resources. There are 6,500 more doctors and dentists and 67,000 more nurses and midwives than in 1978. Spending has shot up over the same period from £8 billion to £24 billion (£XXX each week in 1979 compared with £XXX each week now. And the NHS now cares for 6 million more patients each year.

There is a lot to be proud of. Today, thanks to the Health Service, people in Britain, people are living longer and enjoying a better quality of life. But despite those successes, the performance of the NHS still varies greatly from place to place:

- people have to wait for operations much longer in some places than in others. A patient who has to wait several years in one District could have the same operation within a few weeks in another;

- drug costs in some places are nearly twice as high per head of population as in others.

- some GPs refer twenty times more patients to hospitals than others.

- the average cost of treating someone in hospital varies by as much as 50% between different health authorities.

Of course, the NHS is not a business run for profit, but it can certainly become more business-like. What the Government now wants to do is to take all that is best in the NHS, and raise the rest of it to that very high standard. An NHS that is run better will be an NHS that can care better.

The Way Ahead

Over the last year, the Government has been looking at ways of strengthening the Health Service. That review is now over, and its conclusions have just been announced. They all have a simple aim - a service that puts patients first. But while some of them will require major reforms in the way the NHS is run, the basic principles that have guided it over the last 40 years will continue to guide it into the next century. As now, the Health Service will continue to be available to everyone, free whenever they need it, and paid for mainly out of general taxation.

Some of these changes will need a change in the law, but they are all designed to enable those who work in the NHS to give you even better care. In future:

* as much power and responsibility as possible will be taken from central and regional administration and given to those working to provide care at a local level;

* resources will go more directly to those hospitals which offer the best service - popular hospitals which attract more patients will attract more money. Rewarding the best will increase the quality of patient care, and encourage all hospitals to improve their standards;

* major hospitals will be able to choose to run their own affairs. Known as "NHS Hospital Trusts", those self-governing hospitals will still be part of the NHS, but will have much more freedom to take their own decisions. In order to earn income, they will have to provide the kind of service that patients want. They will of course continue to provide emergency treatment to anyone who needs it;

* large GP practices will be able to buy a range of services direct from hospitals. They will be able to "shop around" to get the best possible care for their patients. This means that they will, for example, be able to send patients to hospitals where waiting times are shortest.

  all GPs will also be encouraged to offer a better service, because their pay will be increasingly affected by the number of patients they attract. Patients will also be totally free to choose their own GP and to change if they want to;

* there will be 100 new consultants over the next three years. This will help keep up the attack on waiting times and on the long hours worked by some junior doctors.

Putting Patients First

All these reforms will improve the quality of the service that the NHS provides. Some of them will however take time to work through. So there will be other initiatives to tackle the areas of greatest public concern more immediately:

i. the Waiting List Initiative will be continued. Over the last two years, a special £60 million fund has allowed an extra 220,000 people to be treated. Half of all waiting list patients are now admitted from the list within 5 weeks or less. Another £40 million will be spent on this initiative next year.

ii. To make sure that patients are treated more sensitively, each hospital will be expected to offer:

- individual and reliable appointment times;
- more attractive waiting areas, with proper facilities for parents with children;
- counselling for family and friends;
- clear and sensitive explanations of what is happening when someone is in hospital;
- rapid notification of the results of diagnostic tests.

In addition, so that patients can feel more at home and exercise more choice, they will in future be able to pay for a number of optional extras such as a choice of meals, a single room, a telephone or a television.

Timetable for Change

Some of these reforms will bring major change for the NHS. They are too important to rush into. 1989 will be a year of preparation. By 1990, the new NHS will be taking shape, and the new method of funding hospitals will start. By 1991 the first NHS Hospital Trusts will be up and running. Some GPs will be buying hospital services for their patients. In the nineteen-nineties the new NHS will provide the country with an even more modern and effective service where patients have a bigger say than ever before.

SUMMARY OF NHS REVIEW WHITE PAPER - FOR NHS STAFF

INTRODUCTION

1. The Government has published a White Paper (Cm 555) setting out its plans to reform and strengthen the National Health Service.

2. Underlying every proposal in the White Paper is a simple aim - a service that puts patients first. The achievements of the NHS - in helping increasingly large numbers of people to enjoy a better quality of life and to live longer - will be the foundation from which an even better service can be built. All that is best in the NHS will be retained. The principles on which it was founded will remain unchanged - it will continue to be available to everyone, free at the point of delivery and financed largely out of general taxation.

A BETTER HEALTH SERVICE FOR PATIENTS

3. The NHS has an enviable record of success. For example, Health Service staff care for over 6 million more patients than in 1978. This increase in workload has called for a massive rise in spending - up from £8 billion in 1978/79 to £24 billion today, an increase of 36 per cent after allowing for general inflation.

4. Such growth in activity has itself placed additional pressures on the Health Service and its staff. At the same time, the demand for health services has risen, and is likely to continue to do so as the proportion of elderly people in the population grows, as new and better ways of treating people are discovered and as the expectations of the public in what can be done continue to increase.

5. So the NHS provides a great deal of excellent medical care. But because it's such a large and complex organisation, it tends to be slow to change so as to keep up with the changing needs of its patients. This can be frustrating and demoralising for its staff. The system needs to be opened up to allow greater patient choice and to give more scope for local responsibility and initiative.

6. The performance of individual hospitals needs to be sharpened-up so that all can reach the level of the best. There is clear evidence of wide variations at present. For instance, in 1986-87, the average cost of treating acute hospital in-patients varied by as much as 50 per cent, even _after_ allowing for the complexity and mix of cases.

7. To achieve its aims the Government intends to provide a framework in which the talent and enterprise of all those working in the NHS can flourish. It wants much more delegation of responsibility to those working in hospitals and the primary care services, increased choice for patients and greater rewards for those who successfully respond to local needs and preferences.

8. The present arrangements do not do nearly enough to encourage this. Hospitals which treat more patients, offer shorter waiting times or give better quality service often receive no additional funding. The White Paper proposals are designed to change this by ensuring that hospitals - and other providers of health care - are funded according to their success in attracting patients.

9. General practitioners have a key role in the Government's proposals because they choose the hospitals to which their patients are referred. The Government wants to help by giving them more information about a hospital's performance. It also proposes to give some of them the opportunity of holding a budget with which to obtain certain hospital services for their patients.

THE KEY PROPOSALS

10. The key changes proposed in the White Paper to secure these objectives are:-

* <u>More delegation of decision-making</u>

  All hospitals will be given much more responsibility for running their own affairs, enabling local commitment, energy and initiative to flourish.

* <u>Self-governing hospitals</u>

  Major acute hospitals will even be able to become independent <u>within</u> the NHS as NHS Hospital Trusts. These "self-governing hospitals" will be given more freedom to take the decisions which most affect them, such as negotiating pay with their own staff and (within limits) borrowing capital.

* <u>New funding arrangements</u>

  Much hospital care, including surgery for which waiting lists tend to build up, will be financed in a new way. At the moment, hospitals receive most funds in a fixed block. If they work harder than planned, they often get no more money [the next year to reflect this]. In future, all NHS hospitals - whether run by health authorities or self-governing - will be free to offer their services to different health authorities or to the private sector. In this way money will in future go more directly to where the work is done and where patients' needs and wishes are best met.

The funding of Regional and District Health Authorities will be simplified - it will not be based on a complex formula but on the size and circumstances of the local population. And instead of providing services directly to their population, DHAs will be expected to obtain the best possible services from whichever source.

* GP practice budgets

General Practitioners in large group practices will be able to join a voluntary scheme whereby they can hold funds to buy a range of operations and treatments for their patients, such as hip replacements, direct from hospitals. Hospitals will have a real incentive to attract those funds and so to improve the quality and quantity of the services they offer patients. And patients will be totally free to choose their GP and to change if they wish.

* Additional medical consultants

[ ] new consultant posts will be created over the next [ ] years, over and above the already agreed rate of expansion. This will help both to reduce waiting times further and to ease the problem of the long hours worked by some junior doctors.

SCOPE OF THE PROPOSALS

11. The White Paper proposals apply throughout the UK. The way they are implemented in each country will need to reflect each country's particular organisation of health care, as well as its distinctive needs and circumstances.

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SELF-GOVERNING HOSPITALS

The Government wants to create a number of "self-governing" hospitals within the NHS in order to:

* make the most of the energy, commitment and ability of hospital staff, by setting them free from many of the current constraints.

* encourage a stronger sense of local pride in major hospitals, many of which are substantial organisations spending £10-50 million a year.

* create an element of competition with other hospitals for NHS services, which should lead to more patient choice, greater efficiency and encourage other hospitals to do even better. As a result patients should receive better services.

Each self-governing hospital will be run by a Board of Management known as an NHS Hospital Trust. Boards will be small and operate like a commercial Board of Directors, with executive and non-executive members and a Chief Executive.

Self-governing hospitals will get their money from selling their services, mainly to health authorities. A hospital which is good at its job and attracts increasing numbers of patients will see its income rise.

A simple procedure will apply for establishing an NHS Hospital Trust. A variety of groups will be able to start the ball rolling, such as the hospital management team or the senior medical staff, with the Secretary of State for Health taking the final decision.

Self-governing hospitals will be free to negotiate pay and conditions with their staff. And they will have greater freedom (within limits) to raise capital for new investment.

The first self-governing hospitals should be established from April 1991, subject to the necessary legislation. A technical paper setting out the details will be published shortly.

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NEW FUNDING ARRANGEMENTS

At present, NHS funds are allocated from central Government to individual hospitals (via Regions and Districts) through a complicated and remote process. Regions get their money through the RAWP formula. RAWP has largely achieved its purpose of equalising the resources available to each Region. But it has disadvantages. It's highly complex and slow to compensate those Regions which take many patients from elsewhere. District funding too is slow to reflect these flows of patients across administrative boundaries. This means funding and workload may be out of step. As for hospitals, they are at present subject to the perverse effects of a system which can penalise success.

The Government wants to change all this. So it proposes to:

* change the method of funding Regions and Districts to a simpler one based on population numbers and weighted for the health and age of that population. The cost of treating patients from other Regions and Districts will be reflected in budgets much more quickly than now. The Thames Regions will get slightly higher funding per head - some three per cent - [to reflect their special problems]. The transition to the new system should be complete by April 1992 for Regions and April 1994 for Districts.

* place the funding of hospitals on a new footing. The objective is a system where the money goes more directly to where the work is done and done best.

At the hospital level there is a clear distinction to be drawn between services where guaranteed immediate access is necessary, such as Accident and Emergency, and those where the patient and his GP have some choice about when and where to be treated. Some immediate access (or "core") services will be funded through a management budget by which the DHA sets clear performance targets for its own hospitals. DHAs will also be able to buy such services from other Districts or from self-governing hospitals.

Where there is some choice over the time and place of treatment, services will be obtained through a contract, specifying the cost and amount of treatment. Hospitals will compete for these contracts, which DHAs can also place with self-governing, private or other DHAs' hospitals. [GPs will remain free to refer a patient to whichever hospital or consultant they think best].

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GP PRACTICE BUDGETS

The GP service is one of the great strengths of the NHS. The GP is the patient's key adviser about the best hospitals and specialists. But it can take a long time for good and popular hospitals - which treat more patients - to receive more money. So GPs have little incentive to offer patients a choice of hospitals.

The Government wants GPs in large practices to hold their own budgets with which they can buy hospital services for their patients. These budgets will cover:

* out-patient services;

* a defined group of in-patient and day case treatments, such as hip replacements and cataract removals;

* diagnostic tests, such as X-rays and pathology tests.

And budgets will be bigger and more flexible (at least £600,000-700,000) by also including:

* the 70% of the cost of employing staff which the Government already reimburses;

* money for improving premises; and

* the costs of prescribing drugs.

At first only practices with lists of at least 11,000 patients (twice the national average) will be eligible to join this voluntary scheme. Over 1,000 UK practices could join, covering about 25% of the population. The details of each practice budget will need negotiation between the parties - it cannot be done through a formula. Half of any savings will be available to finance further improvements in the care delivered. And a fee will be provided to cover the management and other costs of participation. A technical paper will be published setting out the details of this scheme, which should start from April 1991.

TIENT CARE

12. Whilst the quality of clinical care in the NHS is widely recognised as amongst the best in the world, other improvements could make a real difference to the day-to-day services which patients receive.

13. Many people still have to wait too long for treatment and have little, if any, choice over the time or place of treatment. The Government has already done much to tackle this problem. Over the past two years, £60 million has been spent on a new initiative to reduce waiting lists and times, allowing over 220,000 additional patients to be treated. As a result, half of all waiting list patients are now admitted from the list within five weeks or less.

14. In 1989/90, another £40 million will be spent in this way. On top of that, the Government proposes to create, over the next [ ] years, [ ] new consultant posts in the areas where waiting times are longest. These posts will be in addition to those already agreed through the "Achieving a Balance" programme to improve the medical career structure.

15. People are often at their most vulnerable when they are feeling ill and perhaps need to go into hospital. So it is extremely important to create a more friendly and acceptable hospital environment for those patients. At present the service provided on admission to hospital is too often impersonal, inflexible and unnecessarily stressful. The Government intends to improve matters by ensuring that each hospital offers:

* appointment systems which give people individual and reliable appointment times.

* quiet and pleasant waiting and other public areas.

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

* once someone is in hospital, clear and sensitive explanations of what is happening.

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

* rapid notification of the results of diagnostic tests.

* a wider range of optional extras and amenities, such as single rooms, televisions and choice of meals, for those who want to pay for them.

AN EFFECTIVE HEALTH SERVICE

16. A quality Service - which provides not only clinical excellence but also makes patients feel valued - requires a quality management and organisation. To provide the best possible service from its resources, particularly as demands continue to grow, the NHS must always pursue the search for greater efficiency.

17. There will be no wholesale administrative reorganisation of the NHS. But local managers must have more freedom to manage. And those whose decisions affect the use of resources must be more accountable for that expenditure. For some time the Government has been concentrating on giving more responsibility for taking decisions to those actually working in hospitals. The White Paper aims to take this process much further by:

* ensuring that hospital consultants - whose decisions about treatment commit substantial sums of money - are more directly involved in hospital management; accept responsibility for their 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 compete more effectively with each other.

* building on the arrangements for the effective monitoring of the quality of medical care, which the medical profession have been introducing as "medical audit".

* continuing the drive towards better information systems for hospital managers, enabling them to improve their budgeting and monitoring.

* strengthening the capacity of hospitals to manage their own affairs by ensuring that - wherever possible - they are able to take the decisions that affect them most.

* ensuring that Regional and District Health Authorities focus on their strategic roles (and are staffed accordingly) and are turned into tighter, more effective management bodies. Community Health Councils will continue to act as a channel for consumer views.

* obtaining further improvements in the cost information available to managers, doctors and other professionals by extending the Resource Management Initiative - to up to 50 more acute hospitals in 1989/90, with the aim of covering all 260 major acute units by the end of 1991/92.

* introducing a system of accounting for capital which encourages managers to balance the need for new investment against the maintenance of older stock. Limits on the size of new projects needing central approval will be raised and joint ventures with the private sector encouraged.

* strengthening the audit of the hospital service - and so counterbalancing greater managerial freedom - by using the independent Audit Commission to undertake financial and value for money audits. Their reports will be published.

* ensuring that the rate of growth in drug prescribing costs is kept within reasonable limits.

* ensuring that services are carried out as cost-effectively as possible by contracting out some functions.

* re-examining the work of nurses and other professional staff so as to secure the most cost-effective use of professional skills.

* turning FPCs into smaller, more managerial bodies and making them accountable to Regional Health Authorities.

* strengthening the management of the NHS at the centre and leaving the central corporate team more free to run the Service within Ministers' financial and policy objectives.

18. The Government also wishes to see the development of a genuine mixed economy in health care. Those who choose to buy health care outside the Health Service add to the diversity of provision and choice. The Government does not wish to discourage those already using the private sector from continuing to do so. It therefore proposes to allow tax relief on the much higher insurance fees faced by those leaving employers' schemes and entering retirement.

MANAGING THE FAMILY PRACTITIONER SERVICES

19. Primary care provided by GPs and the work of hospitals are closely intertwined. The Government intends to build on the proposals in its White Paper on primary care services, "Promoting Better Health", by:

* encouraging GPs to take greater responsibility for their use of resources. One objective is to introduce a national framework for medical audit whereby GPs would systematically review their work, supported by a special committee in each FPC.

* pressing ahead with plans to let consumers have more information about GP services and to make it easier to change doctor.

* increasing competition between GPs by raising the proportion of their pay derived from the number of patients on their lists from 46% to at least 60% as soon as possible.

* reducing the rate of increase in spending on drugs through a new budgeting scheme whereby RHAs will give FPCs reasonable budgets for drug spending and GP practices will receive "indicative" budgets for their prescribing costs.

EFFECTS OF THE PROPOSALS

20. The White Paper proposals offer new opportunities - and pose new challenges - for everyone concerned with the running of the Service.

21. They will lead to a more modern, more efficient, even 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 an NHS in which it is more rewarding to work and - most important of all - which becomes even better at delivering the highest possible standards of care.

22. But although the proposals seek to make the NHS fundamentally different, they herald a change of pace and scale rather than of direction. They often build on achievements in some parts of the NHS today; they aim to spread their benefits more widely throughout the Service as a whole.

23. There is nothing new, for example, in delegating management responsibility to local level. What is different is the extent to which that process will in future be taken, and the particular twist it has been given through the concept of the self-governing hospital. Similarly, the drive to extend medical audit will build on well-established principles.

24. A single thread runs through all the proposals - a Service which puts the needs and wishes of patients first. The key to this is the introduction of much greater and more informed choice - particularly choice in the selection of a GP and choice on where to go for treatment. That choice will be made possible by the reforms set out in the White Paper. The outcome will be better care, reflecting much more closely what patients themselves want. In short, a better health service for patients.

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[illegible] TIMETABLE FOR CHANGE

Legislation will be introduced at the earliest opportunity to give effect to the proposals. The programme of reform will have three main phases:

PHASE 1

1989: planning and preparation

* During 1989, the Government will be consulting those most closely concerned about 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.

* Regional Health Authorities will help identify the first hospitals to become self-governing as NHS Hospital Trusts, and plan for their new status.

* The additional initiative to expand the numbers of consultants will begin.

* Regulations will be amended to make it easier for patients to change their GP.

PHASE 2

1990: development of proposals

* 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 NHS Hospital Trusts will start to develop their plans for the future.

* The new budgeting scheme for drugs prescribed by GPs will be introduced, with full implementation in phase 3.

PHASE 3

1991: the new NHS takes shape

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

* The new Regional Health Authorities will take over responsibility for Family Practitioner Committees and oversee the establishment of NHS Hospital Trusts.

* The new District Health Authorities will take over from their predecessors, buying services for their resident populations.

* The new Family Practitioner Committees, with stronger executive management, will take over from their predecessors.

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