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SECRET

Prime Minister

NHS REFORMS

I have been considering how most usefully to respond to the practical points raised during your recent NHS seminar. I think it would be helpful for you to be aware of the considerable quantity of guidance on detailed issues which is now available to the NHS, and of some of the work that is in hand to implement the Reforms.

Unavoidably, it makes for a rather bulky package of material. I have pulled this material together by means of the two papers which are also enclosed. The first, "The Implementation of Contractual Funding" describes my "phased" approach to implementation, and responds to a range of questions of the "What if" variety. It is cross-referred to the background material. It is also cross-referred to the second paper "Financial Management in District Health Authorities" (Paper A). This describes in detail how DHAs and Units will construct contracts and manage the financial consequences. It does so by means of an actual example drawn from a DHA which is more complex than average. I would particularly draw your attention to the evidence it provides that:

a. though a Unit may have many potential purchasers across many specialties, the number of contracts required is manageable; and

b. the proportion of uncommitted funds (or contingency reserve) that a DHA may need to hold is a very small proportion of its total resources.

I should also like to describe again why I attach importance to the introduction of a basic system of contracting from April 1991, and why contracts are inseparable from other aspects of the reforms such as NHS Trusts and GP Practice Funds.

Contracting is the hub of the Reforms which, over time, will secure our objectives of greater choice, quality, and efficiency. But there can be too much emphasis on the contract alone. In practical terms the move to resident-based funding for DHAs is also fundamental. It is not possible to introduce NHS Trusts and practice funds without introducing resident-based funding and contracts. NHS Trusts are a meaningless concept, and their freedoms illusory, if they can only obtain funds from their local DHA, and

this would be the consequence of retaining funds on a catchment basis. Resources for practice funds will be taken from DHA resources. They will be based on the number of patients in the practice and therefore have to be taken from DHA resources based on residents. Both reforms therefore depend on moving to resident-based funding, and NHS contracts are the only way, on this basis, that DHAs can secure services from NHS Trusts or outside their own District.

Of course, securing all our objectives is a longer-term aim. But, I believe that we need to put the structure in place in 1991. The April 1991 deadline is the only thing which has obliged the NHS to address existing management and information short-comings in the way that it is doing. Attempts to achieve improvement by direction or statements of intent from the centre have always failed in the past. I am already encouraged by the degree to which preparing for resident-based funding and contracts in 1991 has made DHAs and Units really face up to these issues, and secure real change for the better.

The objective for 1991 is to introduce the basis of the new system so that a real start is made to securing the benefit of the reforms. I am sure that we must avoid "paper reforms" or "shadow contracts" which will make no real difference and will disillusion all our enthusiasts in the NHS who are working for the success of the White Paper.

Inevitably, the move to resident-based funding of contracts will introduce an element of uncertainty which is inseparable from any radical change. The largest component in such uncertainty is the possibility of widespread shifts in referral patterns. The Management Executive's task is to ensure that this uncertainty remains predictable and manageable. I am confident that their approach will achieve this.

I believe that the key to successful reform is to maintain a reasonable pace. From 1 April, enormous opportunities will begin to open up for DHAs, GPFHs and NHS Trusts. The Management Executive's task is to ensure, through RHAs, that the NHS takes advantage of them at a speed that can be managed and does not cause disruption. The Management Executive is working with RHAs now to ensure that systems are in place so that, in particular, existing patient flows are maintained unless the RHA is satisfied that the effects of change have been thoroughly analysed and can be coped with. This will be the first phase. Future phases will build on this start as expertise grows.

I am copying this minute and attachment to John Major and Norman Lamont.

K C

26th June 1990
Department of Health