

DEPARTMENT OF HEALTH

Richmond House, 79 Whitehall, London SWIA 2NS Telephone 01-210 3000 5560

> EL(89)MB/147 FPCL162/89

RHA Chairmen and RGMs DHA Chairmen and DGMs Unit General Managers General Managers of SHAs for London Post Graduate Teaching Hospitals FPC Chairmen and Administrators

16 August 1989

Dear Colleague,

"WORKING FOR PATIENTS": BRIEFING FOR MANAGERS

I enclose a copy of the first update to the Briefing Pack which was issued with Duncan Nichol's letter of 7 July (EL(89)MB/125, FPCL130/89). Other updates will follow as progress on the implementation of the White Paper proposals proceed.

2. The update contains a range of information and newly available material which will be of help to you in the important task of cascading information on the review to staff at all levels. Of particular note is further guidance on the content of applications for self-governing status, as promised in "Self-Governing Hospitals: An Initial Guide". Item (3.9) provides a detailed outline of the application document, plus the supporting financial statement, which applicants will need to prepare.

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August 1989



Diary of Events:

- AUGUST Issue circular on FPC Senior Managers Pay and Conditions of Service
 - Announce pilot sites for national quality demonstration projects in outpatient departments.
 - Issue draft circular on FPS medical audit for consultation
 - Issue guidance on SGH application process

SEPTEMBER- Issue operational guidance for contracts

- Issue working paper on non-medical education and training
- Seminar on NHS collaboration with Private Sector
- Announce pilot sites for demonstration projects on "Total Quality Management"
- Seminar on capital charges, hosted by South East Thames RHA



Working for Patients

11 JULY 1989

Mr. Janman: To ask the Secretary of State for Health whether decisions have been made on proposals made by health authorities under the pilot scheme for flexible pay supplements for nursing and midwifery staff in 1989-90; and if he will make a statement.

Mr. Kenneth Clarke: Yes. Regional health authorities are being notified today of the decisions which have been taken on their bids and of their additional financial allocations. Copies of the notifications will be placed in the Library.

District health authorities were invited to bid, through their region, against the sum—not exceeding £5 million—which the Government have made available in 1989-90 for a pilot scheme on flexible pay supplements for nursing and midwifery staff. I received a very positive response. Many authorities welcomed the opportunity to use this scheme to meet particular recruitment and retention difficulties for such staff. In total, I received 157 bids from 10 regions, covering 7,792 posts.

Decisions on the bids were taken by Ministers. following detailed analysis by a small panel of departmental and NHS officials. The main criteria used in assessing the bids were vacancy rates; turnover rates; degree of use of agency/bank staff and of overtime; the impact of these factors on service delivery; non-pay initiatives taken by authorities; and local labour market issues.

Altogether, 116 bids (covering 5,804 posts) were accepted as they stood; 19 bids (1,235 posts) were accepted but reduced in coverage to 963 posts; 9 bids (281 posts) accepted but extended in coverage to 397 posts; and 13 bids (472 posts) were rejected.

The supplements which cover all grades in the clinical structure and which range from £200 to £1,000, are payable from 1 July 1989.

Our evidence to the nurses' pay review body on the future of the scheme will take account of our experience of this first round of bids and of the close monitoring of the effects of the supplements that we are undertaking.

A summary of the bids approved, and their cost, is set out in the table.

Region	Number of posts covered	Total cost (including on-costs) £
Yorkshire	190	146,926
Trent	333	267,374
East Anglia	998	651,077
North West Thames	1,621	1,091,058
North East Thames	62	38,530
South East Thames	1.219	959.239
South West Tnames	2.067	1.077,027
Oxford	272	213,873
West Midlands	324	188,994
North Western	78	64,935
TOTAL	7,164	4,699,033



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EMBARGO: NOT FOR USE BEFORE 11.00 HOURS ON THURSDAY 10 AUGUST

89/352

10 August 1989

GOVERNMENT'S COMMENTS ON SOCIAL SERVICES COMMITTEE REPORT ON NHS REVIEW WHITE PAPER

Commenting on the Social Services Select Committee Report on the Government's NHS White Paper, "Working for Patients" Lord Trafford, Minister of State for Health said:

"I welcome the Committee's Report which we shall be studying in detail over the next few weeks. There is clearly much common ground between the Committee and the Government. I am particularly pleased that the Committee support many of our key proposals; for example, for delegating management responsibilities to the local level, ensuring the more efficient use of capital, providing better quality of care through medical audit, and improving information systems and the management of resources."

"The Committee have their concerns - which we will deal with in our response - and there are some points of outright disagreement. I think they are misplaced, perhaps based on a different perception of the proposals. I gather not the Members of the Committee agreed on these. differences are more over the pace, rather than the I do not share the Committee's of change. direction, fully confident concerns on this. I am implementation task we have set ourselves is achievable our discussions with a large number of people in the Health Service bear this out. What we are aiming for is steady, incremental progress and this will be informed by the practical lessons of experience. We are supporting a considerable number of development projects up and down the country to test out different aspects of our proposals on the ground and to ensure that workable systems are in place by April 1991 when our first reforms come on stream. the reform process will not-stop in 1991 - our reforms will continue to be evolved and refined well into the 1990s.

"What we do not favour is that our proposals for improving the Health Service should be some kind of academic experiment with endless fine-tuning conducted in a vacuum while the bulk of the NHS remains unreformed. This would be a recipe for inaction. We are determined that patients should benefit as soon as possible. That is why we have already made available £82 million to assist with implementation. As we have made clear, the necessary funding to introduce the new arrangements will not be at the cost of developing services for patients.

"The Committee suggest that there should be a two percent increase in funding each year. I think that figure has a spurious accuracy in forecasting likely demands for health services. Moreover, the Committee have neglected the fact that this year we have given the NHS an increase equivalent to some four per cent in real terms.

"We have already made substantial progress in implementing our reforms. For example, we have:

- * received over 170 expressions of interest in self-government and have issued detailed guidance on a number of key issues relating to the establishment and operation of self-governing hospitals. There will be wide ranging local consultation on every application but I do not think it would be sensible for health authorities to organise ballots of the local population. In no other field of service management are ballots customary.
- * issued a further working paper explaining how <u>Capital</u>
 <u>Charges</u> will work, agreed the basis of valuation for land and buildings and made arrangements for district valuers to carry out the necessary work by the end of this year. I am glad that these were applauded by the Committee;
- * announced details of how our commitment to high standards in <u>undergraduate</u> and <u>postgraduate Medical education and research</u> will be fulfilled. The Secretary of State will hold reserve powers to ensure, for instance, that undergraduate, postgraduate and continuing medical education and research are provided in self-governing hospitals. He will also ensure that postgraduate training posts are provided in self-governing hospitals in accordance with the national objectives set out in "Achieving a Balance";

- * we have agreed a funding mechanism for teaching and research to meet the extra service costs incurred by hospitals which support undergraduate medical education and research. In view of the special position of teaching practices in academic departments whose commitment is particularly heavy, Kenneth Clarke has recently announced an additional sum of up to £400,000 a year in England to meet their costs;
- * facilitated the introduction of <u>indicative prescribing</u>
 <u>budgets</u> by deciding that the PACT prescribing information
 system will be enhanced so as to provide all GPs, FPCs and
 Regions with monthly budgetary statements, thus taking away
 from GPs the burden of paperwork which might otherwise
 arise;
- * announced arrangements to enable the appointment of <u>FPC General Managers</u> to all 90 FPCs (64 out of 90 appointments have already been made).

The Committee did not have before them the Government's proposals on Community Care which we announced last month.

Lord Trafford added:

"We do not underestimate the task we have set ourselves. But with the help of many people within the Health Service we have been able to make substantial progress and, as implementation proceeds and our plans start to take shape, we will build further on the commitment and enthusiasm already apparent. We remain committed to a participative approach in our implementation programme and will continue to work with Health Service Managers, the professional bodies and the other main interest groups connected with the Health Service. The Government will, of course, be submitting a detailed response to the Select Committee.

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DEPARTMENT OF HEALTH



Richmond House, 79 Whitehall, London SWIA 2NS Telephone 01-210

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EL(89(MB)148

To all Regional General Managers

16 August 1989

Dear RGM

SELF-GOVERNING HOSPITALS: OUTLINE APPLICATION DOCUMENT

Subject to the necessary legislation, the Government's aim is to establish a substantial number of self-governing hospitals with effect from April 1991.

I attach an outline of the document that applicants for selfgoverning status will be asked to provide in due course. Some of the material they will need to prepare will be readily available: much will need to be gathered and developed over the coming months.

We do not yet have a firm deadline for the receipt of applications from units wishing to be self-governing from 1st April 1991. We are, however, clear that precise financial information of the kind called for in the supporting financial statement is unlikely to be sufficiently robust before the early summer of 1990. It may be therefore that we ask for the main application document and the supporting financial statement to be submitted separately. The former document will, in any case, provide a full basis for consultation with all interested parties.

I shall let you have a definite timetable as soon as possible. In the meantime I am sure that you and your Regional Coordinator for self-governing hospitals will be providing any necessary assistance to sponsors of potential NHS Hospital Trusts. Please do not hesitate to contact me or any other member of the Self-governing Hospitals Unit if we can be of help.

Yours sincerely

PETER GRIFFITHS
Head of Self-Governing
Hospitals Unit

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This letter will be cancelled and deleted from the communications index in August 1991 unless otherwise notified.



DRAFT OUTLINE APPLICATION DOCUMENT AND SUPPORTING FINANCIAL STATEMENT

- 1. "Self-governing Hospitals: An Initial Guide" explained that sponsors of a proposal for establishing an NHS Hospital Trust would be asked to set out their plans in an application document for the Secretary of State. It proposed that this application should focus on eight key areas and promised further guidance shortly. This paper now provides a detailed outline of the application document, and of the supporting financial statement.
- 2. The draft outline application document at Annex A sets out the issues that candidates for Trust status will need to cover to:
 - identify key tasks for management and staff in developing the proposed Trust;
 - provide a suitable basis for consultation with interested parties;
 - give the Secretary of State sufficient information to make a decision about whether or not to approve an application.
- 3. It is based on the need to satisfy the criteria for self-government set out in Section 5 of NHS Review Working Paper No.1 Self Governing Hospitals:
 - a. management must be able to demonstrate the skills and capacity to run the hospital, including strong and effective leadership, sufficient financial and personnel management expertise and adequate information systems;
 - senior professional staff, especially consultants, must
 be involved in the management of the hospital;
 - c. the Secretary of State will need to be assured that the proposal is consistent with maximising choice for patients and GPs; that the self-governing hospital would be financially viable; and that self-governing status is not being sought simply as an alternative to an unpalatable but necessary closure.

- 4. To assess whether or not these criteria have been satisfied, the outline application focuses on eight key areas:
 - a. the benefits to patients and the local community of the establishment of the particular hospital(s)/service(s) as a Trust;
 - b. proposals to develop services and assure quality;
 - progress in arranging contracts with commissioning agents for health services - primarily local DHAs;
 - d. leadership and management arrangements;
 - e. personnel matters;
 - f. information systems;
 - g. finance;
 - h. the estate.
- 5. An outline of the supporting financial statement is set out at Annex B. It will not form part of the application document itself nor be subject to consultation, but will enable the Secretary of State to make a more detailed assessment of the financial viability of the Trust and of the external financial limit (EFL) required for the Trust's first year of operation.
- 6. Guidance on how and when to submit applications for self-governing status in 1991 will be provided in due course.

OUTLINE APPLICATION FOR NHS HOSPITAL TRUST STATUS

1. INTRODUCTION TO THE PROPOSAL

This section should cover the following key issues:

- 1.1 The main benefits for patients and the local community, including how the establishment of a Trust would encourage patient choice.
- 1.2 A broad description of the services and facilities which the proposed self-governing Trust would manage.
- 1.3 The overall aims of the Trust and the rationale for its proposed composition. This should cover:
 - a. the management and organisational advantages of running the proposed hospital/group of hospitals or service/group of services as one unit;
 - b. how the Trust sees itself fitting into the pattern of services required by the local population, including, for example, local authority services;
 - c. the part it proposes to play in research, and in the education and training of medical, nursing and other staff, outlining any relationships with medical schools and/or other educational establishments and interested parties, including any changes proposed from the existing situation.
- 1.4 A summary of recent performance in key areas.

2. SERVICES

This section should set out the proposed Trust's service delivery plan. It should cover the following:

- 2.1 A description of all the main services provided, by specialty.
- 2.2 Proposed changes and developments in service provision, by specialty, and the rationale for such changes.
- 2.3 How the proposed services match the local DHA's decisions on local core services; and agreements reached on those core services the proposed Trust would provide.
- 2.4 Any interdependence between the services proposed within the Trust and other services currently provided locally. This should also set out any proposals for subcontracting services to or from the Trust.
- 2.5 Where relevant, the way services will meet teaching/research needs.
- 2.6 An assessment of any changes foreseen in the likely future demands for the Trust's services; and the implications of developments in the provision of services for the Trust's capital requirement. For example, is the unit aware of changing expectations from likely contracting health authorities which may require changes to the unit's existing:-
 - balance of provision of services;
 - ii. catchment areas for patients;
 - iii. quality of services
- 2.7 A description of the arrangements in place, or planned, to review systematically the quality of all clinical and nonclinical services provided, including support services (for example, medical audit systems).

2.8 Proposed arrangements for the regular testing of patient satisfaction with services provided and for handling patients' suggestions, enquiries and complaints.

3. CONTRACTS

This section should set out the proposed contracts for providing services for the local DHA(s) and other commissioning agents. It should cover commitments secured from commissioning agents for the services described in section 2 above. (See also Section 7 and the supporting financial statement for the financial projections arising from these proposed contracts).

4. LEADERSHIP AND MANAGEMENT

This section should set out the management arrangements for the Trust, including details of how the change from DHA managed to Trust Status would be handled. It should include:

- 4.1 The proposed management structure, and key team roles.
- 4.2 The involvement of clinicians in management and any proposals to change their role in the new structure. For example:
 - a. the extent to which clinicians are involved in the planning, monitoring and evaluation of the services they provide;
 - b. the extent to which clinicians are involved in budget setting;
 - c. the role of clinicians in developing the application for self-governing status.
- 4.3 Key tasks for managers in achieving the required level of organisational and management change.
- 4.4 The proposed working arrangements between the Trust and the medical school, and/or other relevant educational establishments/interested parties, as appropriate.

5. STAFFING ISSUES

This part of the application should indicate the proposed arrangements for handling key staffing matters. In particular the Secretary of State will need to be satisfied that the Trust will have the necessary capacity and skills to implement its intended policies and systems in relation to pay and conditions of service and associated matters.

The application should cover the following:

- 5.1 Medical and dental staffing policy, including
 - present numbers of staff by grade and changes planned;
 - position on juniors' hours and changes planned
- 5.2 A quantified description of the education and training provided within the unit and intended developments, by main staff groups.
- 5.3 Policies for management development.
- 5.4 Intended immediate and longer term policies in respect of pay and conditions of service and associated matters.
- 5.5 Current personnel management resources and changes planned, with a statement of the intended role of the personnel specialism and the extent to which line managers will be responsible for personnel issues.

6. INFORMATION SYSTEMS

This section should include a systems development plan. It should set out:

- 6.1 A brief description of current systems (for example, patient administration, clinical systems, resource management).
- 6.2 An assessment of the capability of current systems to cope with the new financial and management framework, taking into

account the requirements of quality assurance programmes and arrangements for contracts.

6.3 What the unit is proposing to do to address any systems deficiencies.

7. FINANCE

- 7.1 This section should set out the financial strategy of the unit, covering in particular:
- its proposed pricing policy
- attitudes to cost increases, including pay, where these run ahead of general inflation
- the effects of teaching and research funding
- policies towards income generations
- capital plans (see section 8).
- 7.2 Although detailed financial information of the kind to be included in the supporting financial statement and, in later years, in the business plan is not required as part of the application, this section should provide outline financial projections, setting out, in summarised form, how the income and expenditure account and balance sheet of the Trust would look if the strategies of 7.1 were successfully implemented.
- 7.3 This section should also set out the staffing and information systems implications of its financial strategy.

8. THE ESTATE

This Section should give details of the estate, covering three main areas:

- a. a description of the land and buildings to be used, if it is intended to use existing capital stock. If not, the assumptions made about planned capital developments;
- capital asset valuations;
- c. proposed land/assets sales, including the state of any surplus land, or land likely to become surplus.

NHS HOSPITAL TRUSTS

OUTLINE APPLICATION DOCUMENT: SUPPORTING FINANCIAL STATEMENT

The application should be supplemented by a supporting financial statement to provide a commentary on income level and trends, expenditure level and trends and the general financial situation. It should cover in detail the following areas:

- 1. Full information about recent financial performance.
- 2. Latest income and expenditure position for the present financial year, with an analysis of significant cost areas.
- 3. A financial projection for the next 3 years including:
 - a. income and expenditure accounts;
 - b. balance sheet forecasts;
 - c. statement of sources and application of funds;
 - d. assumptions on which financial projections are based (for example, volume of business assumed, pay, prices, interest rates).
- 4. Also included in the projection would be an analysis of capital investment and replacement strategies.
- 5. Sensitivity analysis based on the financial projection in order to show potential variability in the financial performance related to key assumptions.
- 6. Financial strategies for borrowing, investment of surpluses and day to day cash management.

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NHS REVIEW : COMMUNITY CARE

NOTE OF WORKSHOP ON COMMUNITY CARE AND SELF-GOVERNMENT: 24 JULY 1989

- 1. The Department of Health's Self-Governing Hospitals Unit arranged a workshop on 24 July 1989 to discuss the implications, for units considering applying for self-governing status, of the Secretary of State for Health's 12 July statement on community care.
- 2. Mr Gerald Wistow of the Nuffield Institute acted as facilitator for the workshop which was attended by 42 people from the NHS, a representative from the Kings Fund College and 12 people from the Departments of Health and Social Security. A list of participants is attached at annex A.
- 3. Karen Caines of the Department's Self-Governing Hospitals Unit welcomed participants to the workshop and explained its purpose. The day had been structured to allow as much time as possible for participants to discuss their ideas and concerns in order to identify key issues which should be considered by health authorities and NHS units locally and by the Department of Health during the preparation of the White Paper.
- 4. Since the Workshop had been considerably oversubscribed, it was agreed that a note of the key points should be issued for information in the next update of the Briefing Pack for NHS Managers.
- 5. Lynne Fosh of the Department of Health's Community Services Division summarised the main points of the Government's proposals for community care as outlined in the statement of the Secretary of State for Health of 12 July and Mr Freeman's statement on initiatives for mentally ill people of 13 July. The full texts of these statements together with Mr John Moore's statement on social security implications, are attached at annex B.
- 6. In particular Lynne Fosh emphasised:
 - that the changes were evolutionary rather than revolutionary. The role and responsibilities of health authorities were not changed dramatically. The nature of the change for local authorities, whilst carrying a significant management challenge, would build up gradually from the implementation date of April 1991
 - that at the same time, clarifying the responsibilities of statutory authorities, making them explicit, and drawing a clear distinction between responsibilities for social care and for health care created a sharper climate in which rational and truly collaborative planning could take place across authority and care boundaries
 - that the most significant change involved bringing together the care element of the current social security allowances for

residential and nursing home care, and the responsibilities and resources of Social Services Departments of local authorities. As well as managing this budget in the most cost-effective way, local authorities would be developing assessment procedures and case management arrangements which together would enable them to offer packages of care tailored to individual needs

- that health authority inputs into collaborative planning, assessment, care management and service delivery would be critical. The incentives towards developing shared objectives, shared skills and resources and collaborative working would be greatly enhanced
- that health authorities and local authorities might discover more similarities than differences in the management challenges they were both facing. For instance in the emphasis on separating the enabling/purchasing function from the providing function; in developing the necessary skills to draw up, negotiate and manage contracts for services; in working with independent providers in a "mixed economy of care"; in developing relevant management information systems; and in achieving a cultural shift within organisations
- that although the large strategic decisions had been announced, deliberations on the shape and content of the White Paper in the Autumn, and on issues that needed to be taken forward beyond that timescale, were still very much "work and thinking in progress". Any feedback from the workshop or elsewhere to help that process would be welcome.
- that managing the transition (which might be quite long) was as important, and arguably more complex, than achieving the longer-term vision.
- 7. In the subsequent question and answer session, the following were raised as possible issues to be addressed in the Government's Autumn White Paper on community care:
 - i) it was essential that local authorities be "seen to deliver". However the nature of the Secretary of State's relationship with local authorities was different from that with health authorities. The Secretary of State would be seeking powers to call for reports and plans from local authorities and the Social Services Inspectorate would have powers of inspection and monitoring. At the end of the day much would rest on exhortation and persuasion and the robustness of the new monitoring and accountability developments.
- ii) additional costs in the transition from NHS institutional care to community care. The Government's statement usefully addressed issues of freeing up the resources tied up in NHS facilities for the mentally ill, but these might not be enough both to develop replacement community facilities and to maintain the NHS institutions in the transitional period.

- iii) the position of priority care groups, other than mentally ill people. The point was made that there seemed no reason why the new provisions for mentally ill people could not apply to other priority care groups. If not, mentally ill patients may be favoured at the expense of the mentally handicapped, physically handicapped and elderly.
- iv) the freedom of self-governing trusts (and directly-managed community units) to provide a continuum of health <u>and</u> social care, under contracts from HAs, LAs, GPs etc. It was generally agreed that the idea had merit; the important thing was to ensure clarity among the purchasers: that health provision was a matter for HAs and GPs and social care provision for the LA.
- v) this, in turn, drew attention to the social security provisions. Under current rules, residents of NHS facilities are not eligible for social security payments on the same basis as they would be in local authority, independent or voluntary facilities.
- vi) the assessment process for individual clients needing social care. It made sense for hospital patients to be assessed by the hospital on behalf of the LA, rather than subjecting patients to duplicate assessment processes. This would require common standards and a degree of trust between the hospital staff and the LA.
- vii) the relative priority to be given to the needs of people living in residential care over the needs of people living in the community. If nothing was said, local authorities, when assessing residential social care needs, might continue to give priority to people living in their own homes above those placed inappropriately in hospital. Health authorities and local authorities may have different views on this.
- viii) relief of bed-blocking. Bed-blocking patients might be in a self-governing hospital or a hospital managed by a different health authority from the patient's home health authority under the terms of a block contract. There might be little incentive on the home health authority to make additional payments to the hospital where the bed was blocked after a reasonable period. However 'block' contracts implied that unit costs would not be based on the costs of individuals. The bed-blocking effects would be averaged out.
- 8. After the question and answer session, participants separated into five syndicate groups for discussion. They addressed the following issues:
 - i) How did the Secretary of State's announcement on the implementation of Griffiths modify and/or clarify the responsibilities, powers, influence and resources of the NHS and local government, respectively?

- ii) What were the key areas of interface/interdependence between self-governing units and local authority social services departments?
- iii) What would units need to achieve for patients across those areas of interface?
- iv) What were the implications of (i) to (iii) above for:
 - a) information planning
 - b) contract specification, including assumptions about SSD provision
 - c) assessment procedures and service packaging for individual patients?
- v) What further steps, if any, needed to be taken nationally, regionally or locally to identify and address necessary linkages between self-governance and community care?
- 9. Mr Wistow suggested that, for the purposes of the plenary session, reports from the syndicate groups should be organised under the following headings:
 - i) What would potential SGH applicants need to know <u>quickly</u> to enable them to put in an application?
 - ii) What were the important areas of wider concern?
 - iii) What needed to be done by the Department and locally at unit or health authority level to take things forward?

A summary of the points made is attached at annex C.

- 10. Mr Wistow closed with a summary of the main points which had emerged from the workshop:
- Collaboration between health and local authority planners and providers of services at all levels, whether or not they were self-governing, would be very important. It remained to be seen how well collaboration would sit in the new contract culture. But health authorities would not be able to act unilaterally
- Collaboration between service providers at the interface between acute and community services was fundamental to proper assessment of client needs and service packaging
- Health and local authorities would need to reach a common view on how the use of resources should be balanced between discharging hospital patients into the community and keeping people in their own homes
- It was important that discussions between health and local authorities on responsibility for different facets of careprovision should begin as soon as possible

11. It was agreed that a network of people working on proposals for self-governing trusts to provide community care would be set up in the autumn. This would be coordinated by Caroline Langridge, currently UGM for West Lambeth Community Unit, who was joining the Self-governing Hospitals Unit in September 1989. In the interim, any enquiries should be made to Andrea Leonard (01-210-5659; Room 136) or Karen Caines (01-210-5639; Room G49, Richmond House).

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WORKSHOP ON COMMUNITY CARE AND SELF-GOVERNMENT LIST OF PARTICIPANTS

BRIDGE Mr C - UGM(MI), NE Essex

BROMLEY Mr Nicholas - Department of Health

BROWNING Mr Roger - UGM (MH), E Dorset HA

CAINES Ms Karen - Dept of Health, Self-governing Hospitals Unit

CHARMAN Mr Ray - Regional SGH Coordinator, Oxford RHA

CLARK Mr David - Department of Health

CLARK Ms Caroline - Unit Planning Officer Priority Care Services (NW Herts HA)

CLARKE Mr Peter - Project Manager MI/MH Services N Western RHA

CRAFTS Ms Rosemary - Policy Consultant to SETRHA

DOBINSON Mr Ian - Ass Regional Treasurer, Northern RHA

ELLIOT Ms Madeleine - Regional Nurse, Northern RHA

ELTRINGHAM Mr David - Ass Director of Planning, Northern RHA

FAULKNER Ms Sue - Regional SGH Coordinator, NWTRHA

FENTON Miss Norma - Department of Health

FISHER Mr Mark - Department of Social Security

FOSH Mrs Lynne - Department of Health

FRAZER Mr Ian - General Manager MH Unit, Wakefield HA

GILMOUR Ms Heather - General Manager Trainee, EARHA

GRAUD-SAUNDERS Mrs A M - Ass. Director of Planning, Oxfordshire DHA

GREEN Mr Gerry - DGM (elect), Bromley HA

GRIFFITHS Mr Chris - UGM Community, Halton

GRIFFITHS Mr David - UGM (MH), W Dorset HA

HEGINBOTHAM Mr Christopher - Kings Fund College

HEPPENSTALL Mr Chris - Ass Dir of Planning(P/S)SWTRHA

HOLMES Miss Pat - Divisional Planning Manager MI/MH (Trent RHA)

HORROCKS Dr Peter -Specialist in Community Medicine Yorkshire RHA

HOUGHTON Mr Peter - UGM MH/MI Cambridge HA

JENKINS Mr John - Department of Health

KANE Mr Eddie - General Manager Priority Services, Bradford HA

KERIN Mr Michael - Dept of Health, Self-governing Hospitals Unit

LANGRIDGE Ms Caroline - UGM, W.Lambeth Community Unit

LARCOMBE Mrs A - Unit Accountant, Priority Services W.Essex HA

LAW Ms Elizabeth - UGM, S Manchester HA

LEONARD Ms Andrea - Dept of Health, Self-governing Hospitals Unit

MacDONALD Ms Rhona - Senior Ass Treasurer SWRHA MAYERS Mr William - General Manager, Wakefield HA MURPHY Professor Elaine - DGM, Lewisham & N Southwark HA MURRAY Mr Mike - UGM MH Unit St George's Hospital (Mid-Staffs) NOCK Mr Mel - Regional SGH Coordinator, W Midlands RHA NOONS Mrs Pat - Department of Health PASHLEY Mr David - MI/MH Developments Manager, NWTRHA PYE Mr Michael - Finance Dept N Western RHA RICHARDSON Mr P - Deputy Director (Planning) NETRHA RICHARDSON Mrs E - UGM MI/MH Services, NW Surrey HA ROBERTS Mr Martin - DGM Wandsworth DHA ROWLAND Ms Hilary - MI/MH Coordinator, Mersey RHA SHERRIFFS Mrs Ann - Assistant Head of Primary Care, Mersey RHA SLOANE Mr Robert - Regional SGH Coordinator, Wessex RHA STEEPLES Miss Sheila - Prin. Manpower Officer, Personnel (Trent RHA) STIDSTON Ms Mary - Regional Manpower Planner, Oxford RHA STOOKES Mr George - Dept of Health, Self-governing Hospitals Unit THORNTON Mr Stephen - Regional SGH Coordinator, EARHA WEATHERBURN Mr Ross - Services Planning SWRHA WING Mrs Gillian - UGM MI Services S Lincolnshire HA WISTOW Mr Gerald - Senior Lecturer Nuffield Institute

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13 July 1989

ROGER FREEMAN ANNOUNCES INITIATIVES TO IMPROVE SERVICES FOR MENTALLY ILL PEOPLE

A number of initiatives to improve the provision of services for mentally ill people were announced* today by Roger Freeman, Parliamentary Secretary for Health.

The initiatives form part of the Government's overall response to the Griffiths Report on care in the community, which was the subject of a statement in the House of Commons yesterday by Kenneth Clarke, Secretary of State for Health.

Addressing a group of health professionals involved in the care and treatment of mentally ill people, Mr Freeman today reaffirmed the Government's longstanding policy of locally-based hospital and community services.

He said: "Working collaboratively with regional health authorities, we will ensure that hospitals are not closed before proper alternative provision is made.

"From 1991, we will require district health authorities to have care programmes for those discharged from hospital, upon which we will be issuing guidance, and we propose a new specific grant to local authorities, payable through health authorities, to help meet the social care needs of such patients.

"We are offering health authorities the possibility of, in effect, bringing forward the sale of hospital sites to fund new facilities such as hospital hostels.

^{*} Mr Freeman is expected to start his speech at about 1730 hrs today.

"We propose this Autumn to lay before Parliament a Code of Practice for the compulsory assessment and treatment of patients suffering from mental disorder in hospital, and we will consider - though from a very questioning standpoint - the possibility of new legislation for compulsory treatment in the community.

"We are reviewing the work of the Health Advisory Service to ensure effective oversight of the quality of locally-based services, and we are reviewing our funding of voluntary bodies, to ensure that public funds are used in the most effective way to encourage the development and provision of services for patients and their relatives."

Mr Freeman said the Department was also looking at ways of increasing general practitioners' awareness of mental illness and how it could be treated; the extent and adequacy of emergency services for people with a mental illness, and what could be done to meet the needs of those members of the homeless population in London and elsewhere suffering from mental illness.

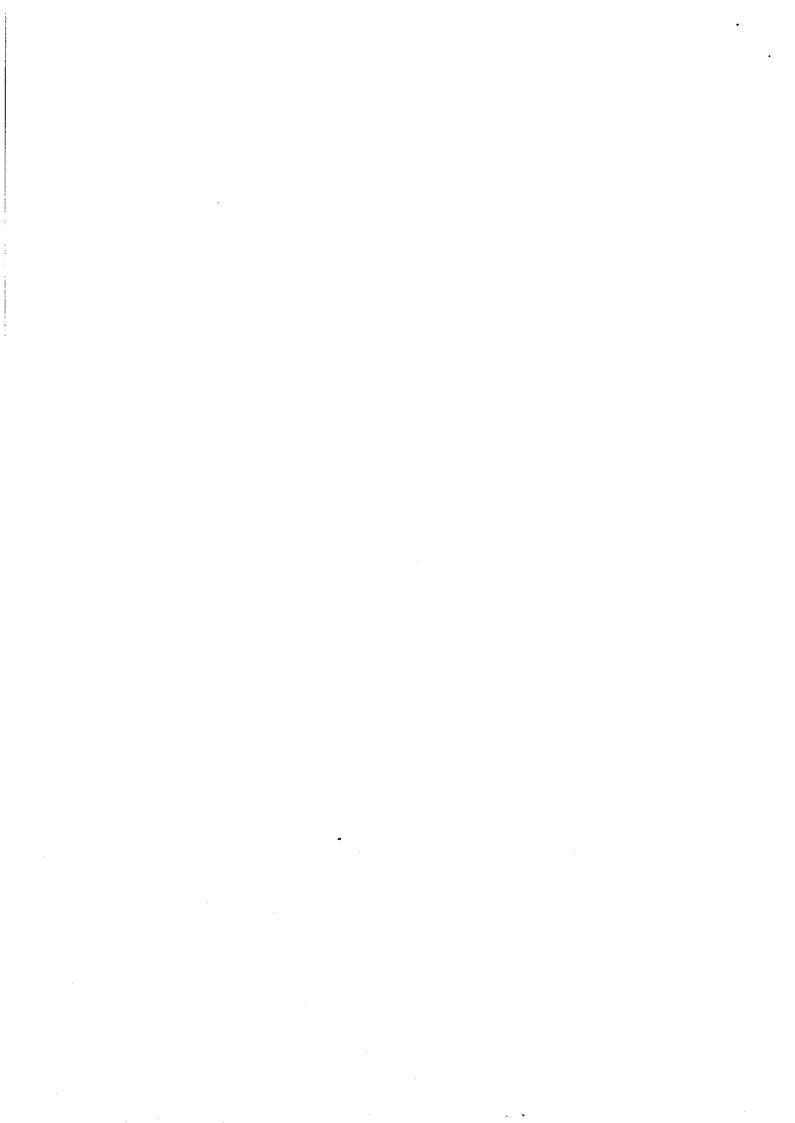
NOTES FOR EDITORS

- 1. The full text of Mr Freeman's speech is attached.
- 2. Last summer, the Department issued general guidance to health authorities on the closure of hospitals. The section relating to mental hospitals set out briefly the main components of a locally-based service, and set health authorities the objective of introducing individual care programmes by 1991. The guidance stated that the closure of mental hospitals was not the prime objective of Government policy.
- 3. Mr John Jenkins has, for the last five years, been the unit general manager for mental health and handicap services in Torbay and Exeter Health Authorities. His work has involved developing locally-based community services, and closing hospitals dealing with the mentally ill and the mentally handicapped. He has spent 25 years in the health service, and the last 13 of them in Devon.

4. Mr Andrew James Collier was, until retirement, a Deputy Secretary at the former Department of Health and Social Security. He is a former Head of that Department's Mental Health Division, and is also a Trustee of Stoke Mandeville Hospital, Buckinghamshire.

Since April he has been Chairman of a group of health professionals which is producing a Code of Practice, as required by the 1983 Mental Health Act. The group has been consulting on earlier drafts of the code, which covers areas of great legal, professional and ethical complexity.

[ENDS]



MENTAL ILLNESS INITIATIVES: TEXT OF A SPEECH GIVEN BY
MR ROGER FREEMAN, PARLIAMENTARY UNDER SECRETARY OF STATE FOR HEALTH
ON THURSDAY 13 JUNE AT RICHMOND HOUSE

I welcome the opportunity to outline Government policy towards the care in the community of the mentally ill and to indicate the initiatives we propose to take to improve these services in England. These will of course be included in the White Paper on Community Care to be published this Autumn which will set out the finer detail where necessary.

The Government's overall policy. Until the 1960s there was little alternative for those suffering from serious mental illnesses such as schizophrenia to prolonged in-patient care in one of the large and often remote mental hospitals. Scientific advances in the 1950s, particularly the discovery that the symptoms of schizophrenia could often be relieved by drugs, together with the development of community psychiatric services, opened up the possibility that many sufferers could be treated on a largely out-patient basis. The vision of a new pattern of services on this basis, reflecting an already occuring fall in the number of hospital beds, and anticipating a further fall, was outlined by the then Minister of Health, Mr Enoch Powell in 1961. It was turned into detailed policy under Sir Keith Joseph in the early 1970s, though the White Paper "Better Services for the Mentally Ill" - was actually published in 1975.

The policy as stated in that White Paper, the development of locally-based hospital and community services, including facilities providing long term asylum for those who need it, and as a consequence the closure of very large mental hospitals, has remained essentially unchanged since, supported by successive Governments. It is founded on scientific and therapeutic advances, and the knowledge that, with the right supporting services, many sufferers can live fuller lives in the community than in institutions.

In our view, this longstanding policy is a civilised and humanitarian one which has benefitted many patients who, otherwise, would have been destined to spend their lives in large isolated hospitals. It has also inspired many caring people to work in the psychiatric services. We know it can work. We have examples of services such as those in Buckingham and Hackney, which show what can be done through prevention, early intervention and well co-ordinated care at home working closely with family doctors. I am glad today to be able to reaffirm the Government's commitment to the policy, and our determination to ensure that it is properly implemented. There is no going back to the days when health service care for the mentally ill invariably meant long term institutional care.

Much current concern is about implementation, not the policy.

Although there are some who question the policy itself, most concerns are about implementation: the pervasive sense that all too often community care means no care: that insufficient resources have been put in place to provide effective alternatives to the old hospitals, where bed numbers have fallen substantially. I would make two points about this:

while we accept that there are deficiencies, it would be wrong to minimise the substantial shift of resources from hospital in-patient provision to community-based services provided by health and local authorities. Over the last ten (years for which information is available (1977 - 1987), the number of places for people with a mental illness in local authority, voluntary and private residential homes almost doubled (to 9,000) and there was a 50 per cent increase in day centre places (to 6,000). On the health service side there has been a 44 per cent growth in day hospital places (to 19,000) over the same period; the number of community psychiatric nurses has more than doubled since 1981, and it is estimated that the number of districts with a community mental health centre has doubled every two years throughout the 1980s;

we made quite explicit in last year's guidance to the NHS what has always been the intention: that hospitals should only close when proper alternative locally-based services were available. When the Secretary of State discussed this issue yesterday with the Chairmen of the regional health authorities he made it clear that he will not approve the closure of any mental hospital unless he is satisfied that proper alternative services are in place. This coupled with the requirement to introduce care programmes in 1991, means that no patient will be discharged from hospital without proper consideration of his or her need for continuing care and where needs are identified, plans to meet them.

Getting an even fuller picture of progress and problems. Over the last few months we have been working, and will continue to work, collaboratively with individual regional health authorities to identify the progress that has been made and the problems that have been encountered. Our purpose is not to recriminate over any inadequacies in the past, but to identify what we at the centre need to do to help health authorities implement policy effectively. It is through this work, and discussions with the Social Services Inspectorate and voluntary organisations, that we are building up a region-by-region picture of progress and problems, and I expect to have this around the turn of the year.

To enhance our capacity to undertake this work we have secured the services at the Department of one of the few general managers in the country with experience of developing locally-based services and closing a major hospital. Mr John Jenkins, who played a leading role in the development of services in Exeter and Torbay and the closure of Exminster Hospital will be working with us in an advisory capacity from next Monday, and will play a key role in our collaborative work with regional health authorities and the development of any further initiatives or guidance that seem necessary. I am glad that Mr Jenkins is able to be here today.

I would now like to outline a number of specific policy steps.

Guidance to health authorities on care programmes. Much concern has been expressed about the adequacy of continuing health service care for psychiatric patients discharged from hospital. through a health circular, a requirement was placed on district health authorities to initiate, by 31 March 1991, explicit individually tailored programmes for continuing health service care for all such patients. Later this month we will be formally consulting on guidance to authorities on developing these care programmes, which will emphasise the need for locally developed approaches, including local registers of vulnerable discharged patients and regular reviews of their needs. We expect to publish the definitive guidance in the Autumn. In addition, and we greatly welcome this, the Royal College of Psychiatrists has agreed to draw up minimum acceptable professional standards for assessing patients prior to discharge, and for follow up after discharge. A preliminary statement of good practice is expected from the College in late Summer, to be followed by a more substantive one developed in concert with the other professions concerned. These two initiatives will, together, provide much clearer guidance on good practice than currently exists.

As part of our 1990/91 research programme, we plan to commission research which will assist us to evaluate the effectiveness of the care programme initiative.

2. <u>Guidance on compulsory admission to hospital</u>. Another area of current concern is in relation to arrangements for compulsory admission to hospital, and the related issue of compulsory treatment in the community.

On hospital admissions, there seems to be wide agreement that the law is adequate, but concern that its interpretation by practitioners is sometimes not. We believe that these problems will be much reduced once the Code of Practice for admitting and treating patients compulsorily required under the 1983 Mental Health Act is available. In April we set up an expert group under the chairmanship of Mr James Collier, with Mr William Bingley, on secondment from MIND to whom we are indebted, as the full time executive secretary. Work is well advanced, and the Code will be laid before the House this Autumn.

We understand that in due course the Royal College of Psychiatrists will be giving us their views on the possible role of new legal powers to ensure compulsory treatment in the community. We will then explore this issue with all the interested parties involved. Without prejudicing the discussion, we would need to be very clear both of the benefits, and that they could not be achieved through voluntary means, before seriously considering asking Parliament to create provision for compulsory treatment in the community.

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3. Health service resources. Although the issues I have already referred to are important, we fully understand that underlying much of the current concern is the question of resources. Finance from mental hospital sites provides valuable capital for replacement facilities, but these facilities are needed before hospitals can be vacated. They in turn have to compete for resources with other priorities within capital programmes, and this may hold up the whole process. Existing arrangements offer one way of addressing this problem - with regions lending each other capital to match the timing of planned new developments. Another possible solution is for authorities to enter into agreements with developers to upgrade, purchase and build community facilities for the mentally ill, in return for which they would receive all or part of the vacated site. We plan to invite health authorities to identify sites where this approach would be suitable: the aim will be to bring about the degree of private sector involvement that maximises value for money.

We do understand the revenue burden of keeping open old hospitals which will close and new replacement facilities already open.

Clearly the quicker older facilities can be closed the lesser the burden of double running and running inefficient emptying facilities.

4. Local authority resources. Proper social care for the mentally ill in the community is vital. Yesterday the Government confirmed that local authorities would continue to be responsible for the social care of the mentally ill and announced that from 1991 we would be instituting a new, specific grant to local authorities to encourage them to make the necessary contribution to the services required. To encourage joint planning of services, and proper collaboration in relation to care programmes, we are making this grant payable through health authorities as the Secretary of State's agent, on the basis of agreed plans. Further details will be set out in the White Paper on Community Care, to be published this Autumn.

- 5. Ouality of services. We are very concerned that the new hospital and community facilities that are developing should provide a good quality service. In the wake of scandals about the conditions in some mental hospitals in the 1960s and early 1970s, the Health Advisory Service was established, to keep a watch on standards and encourage better services. I think that it is generally agreed that, over the years the HAS has been successful. We are now examining its work to identify how it might be done even more effectively, and in a way even more relevant to the NHS as it will develop following "Working for Patients".
- 6. The contribution of the voluntary sector. We believe that a lot can be done, through Departmental grants to voluntary organisations, to increase the information, services and mutual help available to the parents and friends of patients. Current grants to voluntary organisations in the mental health field, including mental handicap, are being reviewed with a view to ensuring that we use the nearly two and a half million pounds a year that we allocate in a way which best supports patients and their relatives and encourages new initiatives which are of clear and direct benefit.

Areas we need to explore more fully as a matter of urgency. I would like to refer to some of the issues that we are aware are causing concerns that we are beginning to address, and on which work will be undertaken in the course of the next year or so;

first, the need to improve the ability of general practitioners and others to prevent, detect and treat mental illness. The first of a series of Departmentally sponsored conferences on these themes was held in May; others are planned for the Autumn and next Spring. In the light of these discussions we will be considering what practical initiatives need to be taken;

- second, the need to provide appropriate services for those among the homeless population who suffer from mental illness. The incidence of mental illness among homeless and destitute men and women in London and other cities has been linked by some to the fall in the number of hospital beds. Research funded by the Department shows that, most commonly, homeless mentally ill people have had care organised outside hospital but have lost touch with the service. We expect to reduce the future numbers losing touch through the measures to which I have already referred. But we need to address the existing problem, and will be doing so in the light of a recent study by the Policy Studies Institute, again funded by the Department, on schemes for delivering primary health care to single homeless people;
- third, the need for adequate arrangements in each health district for emergency care of people suffering from mental illness. In some places this is handled through the normal accident and emergency service; in others by specialist mental health emergency arrangements. We will be discovering the extent of arrangements and seeking to evaluate alternatives.

Summary

Finally, let me summarise what we are announcing at this stage.

- We reaffirm our commitment to the longstanding policy of locally based hospital and community services, including asylum;
- working collaboratively with the regional health authorities, we will ensure that hospitals are not closed before proper alternative provision is made;

- from 1991, we will require district health authorities to have care programmes for those discharged from hospital, upon which we will be issuing guidance, and we propose a new specific grant to local authorities, payable through health authorities, to help meet the social care needs of such patients;
- we are offering health authorities the possibility of, in effect, bringing forward the sale of hospital sites, to fund new facilities such as hospital hostels;
- we propose this Autumn to lay before the House a Code of Practice for the compulsory assessment and treatment of patients suffering from mental disorder in hospital, and will consider, though from a very questioning standpoint, the possibility of new legislation for compulsory treatment in the community;
- we are reviewing the work of the Health Advisory Service, to ensure effective oversight of the quality of locally-based services;
- we are reviewing our funding of voluntary bodies, to ensure that public funds are used in the most effective way to encourage the development and provision of services for patients and their relatives;
- we are looking at ways of increasing general practitioners' awareness of mental illness and how it can be treated; the extent and adequacy of emergency services for people with a mental illness, and what can be done to meet the needs of those members of the homeless population in London and elsewhere suffering from mental illness.



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12 July 1989

KENNETH CLARKE'S STATEMENT TO PARLIAMENT ON THE FUTURE ARRANGEMENTS FOR COMMUNITY CARE

The Government's response to Sir Roy Griffiths' report 'Community Care: Agenda for Action' was given in a statement to the House of Commons today by Kenneth Clarke, Secretary of State for Health. The full text of the statement is attached.

In outlining the aims of the new arrangements, Mr Clarke said:

"We want to enable people to lead as full and as independent a life in the community as possible where they wish to do so. To achieve this we need to ensure that care is provided on the basis of a sensitive judgement of the needs and preferences of each individual and their relatives and friends who are caring for them."

" In future, there will be a single source of public funds which will enable local authorities to make sure that care is tailored to individual needs in a sensible, flexible way. Local authorities will have clear responsibilities to ensure that the right services are delivered and will be held to account for doing so."

Sir Roy Griffiths said today: "The changes will oblige care agencies to focus on the needs of individuals and those members of their families and others who look after them. They will enable services to be planned and delivered so as to match those needs effectively, and will remove the obstacles that have prevented local authorities from discharging their care responsibilities effectively. Local authorities now have an exciting opportunity to contribute more fully to the satisfactory implementation of community care policy. I hope the decisions will be welcomed by the representatives of voluntary bodies, informal carers, and others who I consulted in the preparation of my report."

NOTES FOR EDITORS

- 1. 'Community Care: Agenda for Action' by Sir Roy Griffiths was published on 16 March 1988. Copies are available through HMSO price £3.90, (ISBN 0 11 321130 9).
- 2. The Government will publish a White Paper on community care in the Autumn which will spell out the proposals in further detail.

[END]

COMMUNITY CARE: STATEMENT

- 1. With permission, Mr Speaker, I wish to make a statement on the Government's proposals for the future organisation and funding of community care.
- 2. Community care is a policy to which successive Governments have been committed for almost thirty years.
- 3. The key aim of this policy is to enable people to live as full and independent a life as is possible for them in the community for so long as they wish to do so. For many people, this means providing the services and support they need to continue to live in reasonable comfort in their own homes for as long as possible. For others, who may have experienced long stays in hospital and have more intensive care needs, it means helping them to re-establish their lives away from large institutional settings. I am sure that the vast majority of people wish to live in or near their own homes until or unless age or disability make that impossible. It is Government's purpose to help them and the people who care for them to achieve that aim. Success depends crucially on the availability of adequate services in the community.
- 4. The background to the developments I am about to announce is one of tremendous growth in both resources and manpower for community care. To give the House some examples of the progress that has been made between 1979/80 and 1986/87 expenditure by the NES on the community health services has risen by 40% in real terms and local government spending on the personal social services has grown by almost 27%. The number of day centre and day hospital places for mentally handicapped people rose by 10,000. The number of home helps grew by 20% and the number of day centre places for elderly people by 18%. The number of residential places for mentally ill people rose by over a half, and places in day centres and day hospitals by a third. Between 1981-86 the number of community psychiatric nurses doubled. This growth in resources has

been taking place alongside a dramatic change in the delivery of care and the movement of people out of hospitals and into community settings. Between 1980 and 1986 the number of children in mental handicap hospitals fell from 2,500 to less than 400 and the number of mentally handicapped adults in hospital fell by around 14,000 while the number in Local Authority, voluntary and private community based homes rose by 11,000. In addition we have, through the benefit system, put huge additional resources into supporting people in private residential care and nursing homes. The amounts spent on supporting these people have increased from £10m in 1979 to £878m in 1988.

- 5. Nonetheless, I am sure that we all agree that progress has not been as even nor as rapid as we should like. The rapid growth of residential and nursing home care has been unplanned and largely based on the availability of social security benefits. The Government recognised the need to see whether the arrangements for delivering community care could be improved when we asked Sir Roy Griffiths in December 1986 to report on ways by which the better use of public funds for community care might be achieved.
- 6. We are indebted to Sir Roy for his report "Community Care:
 Agenda for Action", which we published in March last year. The
 report has succeeded in stimulating valuable public debate. Over
 280 organisations, professional bodies and members of the public,
 have sent us their views on it, many in support of the
 recommendations, but some favouring other options. We have taken
 full account of the wide range of views expressed, and considered a
 wide variety of options. Our conclusions are as follows.
- 7. We accept the distinction Sir Roy Griffiths makes between health and social care. Our proposals do not alter the functions or responsibilities of health services. The community health services will continue to play an essential part in meeting the medical and nursing needs of people outside hospital.
- 8. We are proposing to make important changes in the way in which

non-health care is provided and, where necessary, funded at public expense. The great bulk of community care will continue to be provided by family, friends and neighbours. The majority of carers take on these resonsibilities willingly and I admire the dedicated and self-sacrificing way in which so many members of the public take on serious obligations to help care for elderly or disabled relatives and friends. Our proposals are aimed at strengthening support for those many unselfish people who care for people in need.

- At present, people who are unable to support themselves and 9. need help with social care can look to two separate sources of statutory help: to social security offices for payments towards the cost of places in residential care and nursing homes; and to local authorities, for home care, day care and residential care services. We accept that the present arrangements are flawed because they cannot ensure that priority is given towards supporting people at home where that is possible and desirable. Social security payments for residential and nursing home care are subject to no assessment of individual needs for care. The public agencies have a financial incentive which no-one ever intended to give to them to rely as much as possible on the availability of social security for residential care. We do not believe that these present arrangements secure the best possible outcomes for people in need, or indeed the best possible use of taxpayers' money.
- 10. We therefore accept Sir Roy's recommendation that those two sources of public funding should be brought together and allocated on the basis of a proper judgement of an individuals' needs. By creating this unified source of funding for the full range of social care services, we can ensure that the objective of sustaining people in their own homes wherever possible be given the necessary priority.
- 11. We propose to introduce a new funding structure for those seeking help from public funds for the cost of care. In future

there should be a single budget to cover the costs of care whether in a person's own home or in residential or nursing home. This will enable sensible decisions to be taken about the type of care that best meets an individual's needs and provides best use of public money. At the same time we will remove the perverse incentives in the present benefit system by making all claimants eligible to income support and housing benefit on a similar basis, whether they are living in their own homes or in independent residential or nursing homes.

- We have considered carefully which care authority should hold 12. this new budget and take on the responsibility for the assessment of need and provision of care. Local authorities are already responsible for the full range of social care services and have a great deal of expertise in this area. We have concluded that the best way forward will be to build on local authorities' existing responsibilities. We accept Sir Roy Griffiths' proposal that local authorities should assume responsibility for the care element of public support for people in private and voluntary residential care and nursing homes, and for making the best use of those funds in relation to an assessment of people's needs and priorities. Collaboration between medical, nursing and social services agencies will be essential in assessing individual needs, and in designing suitable arrangements for care. We shall look to local authorities to ensure that suitable multi-disciplinary assessment procedures are in place and to health authorities to make their contribution to these procedures.
- 13. We attach great importance to securing a smooth transition to this new structure, avoiding uncertainty for people currently living in homes and for their relatives. We therefore propose that the new arrangements for social security benefit entitlement will apply only to people not already in residential or nursing home care after the date on which the new arrangements come into force.

Residents of homes who are in receipt of income support when the

new system is introduced will therefore retain their entitlement to help through the existing system. People who are self-financing residents of registered homes when the new system is introduced will also be able to apply for Income Support under the existing arrangements if their funds become exhausted subsequently. My Rt Hon Friend the Secretary of State for Social security is today announcing further details of these new arrangements.

- 14. We accept that further efforts will be needed to improve coordination between heath and social services in the arrangement and delivery of services to individuals. We believe that the clarification of roles in our proposals will make it easier to achieve this.
- 15. The local authorities' responsibilities, in collaboration with others including doctors and other caring professions, will be to assess individuals' needs, design suitable care arrangements, and secure their delivery. It is not necessary for local authorities to provide all this service directly themselves and they should make maximum possible use of the voluntary, not-for-profit and commercial sectors so as to widen individuals' room for choice, increase the flexibility of services and stimulate innovation.
- 16. The Government has long urged local authority social services departments to act in an "enabling", and not just a "providing" capacity. Some authorities are already moving in that direction. To minimise disruption and to ensure that local authorities have every incentive to make use of the independent sector and offer people choice, we propose that they should continue to meet the full cost of accommodating people in local authorities' own homes, subject to their existing powers to make charges according to residents' ability to pay. My Rt Bon Friend is not therefore proposing to change the benefit rules for residents of these homes.
- 17. We believe that these new financial arrangements will give local authorities the necessary incentives to develop better services for people at home, and make greater use of independent

providers. It will be important that local authorities should have clear plans for the development of community care services, worked out in collaboration with health authorities and the independent sector. I shall expect all authorities to have such plans, and shall ensure that they are open to inspection by my Social Services Inspectorate. I also propose to take powers to call for reports on local authorities' community care services.

- 18. Local authorities will need adequate resources for their new responsibilities. That means that we shall transfer to the local authorities the resources which the Government would otherwise have provided to finance care through social security payments to people in residential and nursing homes. The aggregate amount of transferred resources will allow for the projected growth in the numbers of people needing support. Resources will be needed by the local authorities to carry out their new tasks of assessing individuals' needs, arranging appropriate care services for people at home, and buying private residential and nursing home care.
- 19. We are confident that the proposed funding changes, by putting more emphasis on supporting people in their own homes, will provide both more appropriate services closer to individuals' wishes and needs, and better value for money from public spending than under the existing arrangements. We shall be discussing the detailed financial implications with local authority representatives. The necessary decisions on the resources to be transferred will be taken in the Public Expenditure Survey next year.
- 20. I have summarised our conclusions on the main proposals in Sir Roy Griffiths' report. They represent a major challenge for local authorities and social services departments. There are a number of associated issues on which the House will expect me to make the Government's position clear.
- 21. First, we have been especially concerned to ensure that care for severely mentally ill people is properly managed. Here as in

other areas, we have concluded that the right course is to ensure that existing responsibilities are discharged effectively. On the health side, I will ensure that discharges of seriously mentally ill people from hospital will take place only when adequate medical and social care is available for them outside hospital. More details of the initiatives we are taking here will be announced shortly. On the social care side, we have decided to create a new specific grant directed at encouraging local authorities to make their necessary contribution to services, in line with health authority plans and objectives. To achieve that, we have decided that the grant should be payable by health authorities, acting as my agent, on the basis of plans and targets put to them by the relevant local authorities. The details of this proposal will be worked out in discussion with health and local authority representatives.

- 22. Second, both Sir Roy Griffiths and Lady Wagner made recommendations about the registration and inspection of residential care and nursing homes. Local Authorities will be asked to establish inspection and registration units, at arms length from the management of their own services, which should be responsible for checking on standards in their own homes, and to involve independent outsiders in these arrangements. We have concluded that, for the present, existing statutory functions should remain unaltered.
- 23. Third, we would expect general practitioners to ensure that social services departments are aware of their patients' needs for social care as recommended by Roy Griffiths in his report.
- 24. I have outlined our conclusions on the main issues. My Rt Hon Friends the Secretaries of State for Scotland, Wales are today

announcing separately our conclusions of particular relevance to them. My Rt Hon Friend the Secretary of State for Northern Ireland will be doing the same early next week. We propose to spell out our proposals in more detail in a White Paper which we aim publish in the autumn. It will be necessary to ensure that the necessary legislative framework is in place before implementation, which we propose should be in 1991.

- 25. Our proposals bring the policy of community care up-to-date and will improve the way in which it is put into practice on the ground. Community care is no longer primarily about providing an alternative to long-stay hospital care. The vast majority of people needing care have never been, nor expect to be in such institutions. The policy aim now is to strike the right balance between home and day care on the one hand, and residential and nursing home care on the other, while reserving hospital care for those whose needs truly cannot be met elsewhere. The changes we propose will for the first time ensure that all public monies are devoted to the primary objective of supporting people at home wherever possible. They provide a solid basis for the future, and are founded upon the principles of preserving individual independence, freedom of choice and providing services in a sensitive and personal way.
- 26. I believe they deserve wholehearted support, and commend them to the House.

Nursing Homes

Mr. Barry Field: To ask the Secretary of State for Social Security whether he has any plans to change the basis on which social security benefits are paid to residents of residential care and nursing homes: and if he will make a statement.

Mr. Moore: My right hon, and learned Friend the Secretary of State for Health has today announced that the Government are to make local authorities responsible for meeting the costs of care for residents in residential care and nursing homes who are unable to finance it from their own resources. This is to be implemented in April 1991. From that date I will therefore be making changes to the way the benefit system provides support.

At present income support can be available to help with the fees charged by residential care and nursing homes, subject to specified limits which I review annually. I propose that from April 1991 residents of homes will be given access to help from the normal income support system and from housing benefit on a similar basis to the help they would receive in their own home. The special income support system for those in homes will be ended and local authorities will be responsible for providing any further help required towards the cost of residential care in the cases where they decide that that form of care would be best.

The present system will remain in place until April 1991 for all those who need it. Claimants who are receiving income support in a home at the date of change will continue to receive the full level of heip available via income support under current rules for a: long as they need it and the system-will continue after-April 1991 for these cases. The limits will continue to be subject to annual review. The Government have also decided that other residents of registered residential care and nursing homes in April 1991 will also be eligible for help through the continuation of the existing income support system, should they need to turn to the state for support.

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The Government have decided that community care grants should continue to be available from the social fund after April 1991, broadly as they are now. We will keep this under review.

We are not proposing to make any changes to the benefit rules for residents of local authority homes.

Full details of the new system will be published in the White Paper later this year, which will also include the Government's proposals for the calculation of housing benefit in residential care and nursing homes.



WORKSHOP ON COMMUNITY CARE AND SELF-GOVERNMENT SUMMARY OF POINTS RAISED IN PLENARY SESSION

- a) Clarification and/or understanding of the issues outlined below would be essential for potential SGH applicants to draw up realistic service-development plans.
- (i) Definition of service -
 - need for the distinction between purchasers and providers to be clearly understood in order to define who potential customers would be, where contracts would come from, and how many contracts there might be
 - need to know timescale purchasers would be working to for identifying and planning contracts to meet service needs
 - should service development plans reflect the current pattern of service provision or future aspirations of the customer? Need to consider the extent to which this is affected by the current local political scene what changes are likely?

ii) Resources -

- need for clarification of what resources would be available for community care eg would resources be earmarked for particular client groups
- would SGHs be able to provide services for people in receipt of social security benefits. It would be best for clients if SGHs could provide a continuum of care by contracting with both DHAs and LAs for health and social care.
- iii) Collaboration and coordination of service planning, integration of service delivery
 - How would collaboration between health and local authorities work in the future at both authority and service-delivery level? How would this fit into a contractual relationship? What would the role of the service provider be?

b) Main areas of general concern

General concerns fell into two main categories - service planning and funding.

i) Planning

- Problems for realistic service-development planning for SGHs which might have to deal with several LAs and the relevant County Council, possibly more than one DHA and also

FPCs when SGH catchment area was unlikely to be coterminous with any of these. How would Joint Planning be conducted?

- Would there be a formal mechanism for arbitration between HA and LA on responsibility for clients? Would the service provider have any say in this?
- Apparent lack of clear incentives for LAs to expand services eg Part III accommodation would not help the problem of bed-blocking in acute hospitals.
- Would GP practice budget holders have a role in negotiating community care contracts?
- Need to avoid development of a large number of very small SGH Trusts providing services on a competitive basis this would not be good for proper development of services to meet client needs
- Who would provide the training needed for social workers to develop skills as case managers purchasing a mix of services for individual clients?
 - Would providers tend to manipulate service planners by defining the range of services available? Was there a need for an objective advocate to act on behalf of the client?

ii) Funding

- How would funding of services be distributed to be "appropriate" to needs if based on historical levels of social security support which may, for example, reflect availability of homes rather than client needs.
- Would funds be available other than for tried and tested packages of services? Could there be some form of fund to aid innovation?
- How would joint finance be administered?
- Would the new community care grant for mentally ill people be available to those ex-patients, already discharged from a long-stay hospital to find better aftercare etc.

c) Need for action now

There was a clear responsibility on those at both national and local level to clarify their intentions and move positively towards a strategy for action.

i) Action by the Department

- Need to reinforce the main messages of the Secretary of State's 12 July statement and to give clear guidance on what was meant by "health" and "social" care provision
- Need for clear guidance on the vision of care the Government would like to see eg. how would integrated care

be managed; what would be the role of "key workers"; will it be possible for one unit to provide a "seamless rope" of care undertaking contracts to provide both health and social care. Service planners and providers will need to be able to identify requirements for change

- Need for a statement on how capital provision for the needs of <u>all</u> priority care clients would be managed
- Need for clarification of who would carry out assessment of clients' needs

ii) Action locally

- DHAs should define core services as soon as possible
- DHAs and LAs should agree on a definition of health and social care provision which they intended to work to as soon as possible. This would be essential if SGH applicants were to begin to work on service-development plans.
- Need for clear view from planners, in health and local authorities, of the type of community care development they wanted to see and where funding would come from.
- Need for local planners to recognise the fundamental importance of the interface between acute and community services.
- Need for major effort on the part of local service planners to avoid stagnation or planning blight between now and 1991.



- 1. General management is being introduced into FPCs to reflect the wider managerial role they will have to play to meet consumer and service needs following the reforms introduced in the two White Paper: "Promoting Better Health" and "Working for Patients".
- 2. The pay and conditions of service for GMs in FPCs follow those for GMs in health authorities. The key elements are:.
 - flat-rate salaries:
 - short-term rolling contracts of employment; and
 - performance-related pay.

Further details, including recruitment and appointment procedures, are to be found in circular: HC(FP)(89)9 issued in May.

3. By 8 August, 64 FPCs had appointed General Managers who will be taking up post between now and December.

SENIOR MANAGERS IN FPCs: HC(FP)(89)12

- 1. One of the first tasks of a General Manager, when in post, will be to examine the management structure within the FPC to ensure that they are equipped to deal with the many challenging tasks ahead. The issue of this circular in August means that for the first time senior management arrangements will be available to managers in FPCs. This represents the next stage in the strengthening of the executive management of Committees.
- 2. The key elements of the scheme are to be the same as those for Senior Managers in health authorities:
 - flat-rate salaries;
 - contracts which either link continuation of the contract to satisfactory performance under IPR procedures or is based on short-term rolling contracts;
 - performance-related pay.



Kenneth Clarke, the Secretary of State for Health announced on 24 July that family doctors will, from April 1991, receive monthly statements to enable them to monitor their indicative prescribing budgets.

Working Paper 4 of the NHS Review services ("Indicative Prescribing Budgets for General Medical Practitioners") indicated that the ideal way of providing information at all levels to operate the indicative prescribing budget scheme was an enhancement of the existing Prescribing Analysis and Cost system known as PACT.

Feasibility studies have confirmed that PACT can be speeded up, and made more frequent and comprehensive. The Prescribing Pricing Authority and the Department are developing PACT to provide all GPs with monthly budgetary statements from April 1991. These budgetary statements will normally be provided no more than four weeks after the month in which the relevant prescriptions were dispensed. Existing PACT reports will continue to be provided.

Discussions are being held with interested parties about the detailed content and format of these reports and other associated improvements to PACT. In addition, PACT data aggregated at FPC level shall be made available to all FPCs and RHAs in August 1989 to enable them to prepare for indicative prescribing budgets.

August 1989



Kenneth Clarke, the Secretary of State for Health, announced on 20 July that he would press ahead with plans to implement the new contract agreed with GP leaders on 4 May and that he saw no sensible basis for re-opening negotiations. This announcement followed the rejection in a ballot of GPs of the new contract.

It is planned to lay regulations before Parliament in the Autumn with a view to bringing the new contract into effect on 1 April 1990. The GPs' negotiating body, the General Medical Services Committee, are being consulted on the detailed regulations.

The new contract is designed to improve the family doctor service by rewarding good performance and tackling the variations in the service patients get. A recent study of GP practices by economists at York University showed wide differences in the range and quality of services provided across the country under the old contract.

The main features of the new contract from 1st April 1990 will be:

- more money paid through capitation fees as a result of abolishing supplementary basic practice allowance, supplementary capitation fees and group practice allowance and reducing seniority payments;
- new capitation payments for newly registered patients;
- higher capitation payments for patients aged 75 and over;
- new two-tier payments for reaching targets for childhood immunisation and cervical cytology to replace item of service payments;
- new payments for GPs who provide child health surveillance services;
- a new postgraduate education allowance available to

all GPs for <u>continuing</u> medical education to replace the vocational and postgraduate training allowances;

- reduced overall payments through basic practice allowance but
- weighted to help small list practices;
- a new basic practice allowance supplement for GPs practising in areas of deprivation;
- a allowance for GPs who teach medical students;
- new payments for GPs who provide minor surgery services;
- a new sessional fee for running health promotion clinics;
- a higher level night visit fee where the patient is visited by a doctor from the patient's own practice or from a small non-commercial local rota.

The Secretary of State wrote to all GPs on 3 August (attached) to explain how the changes to their contract will affect them.

August 1989



DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Richmond House, 79 Whitehall, London SWIA 2NS Telephone 01-210 3000

From the Secretary of State for SCHINGEXX Health

TO ALL GPs

3 August 1989

Da Dae.

GENERAL PRACTICE: THE NEW CONTRACT

On 23 February I sent you a document entitled "A New Contract" setting out the Government's then position on the reform of the family doctors' remuneration system. That document set out the state of play from the Government's point of view after the first hundred hours of detailed discussions spread over twelve months with your representatives, the General Medical Services Committee. I am writing now to bring you up to date on the steps that the Government is now taking.

The proposals set out in "A New Contract", were later modified in a number of important respects as a result of more lengthy discussions with the General Medical Services Committee negotiators, on 4 May. The modified package was commended to the profession by the Chairman of the GMSC and his negotiating team. I regret the subsequent decision of a majority of GPs not to support their leaders, especially as I had made a number of important concessions in order to secure a fair deal.

Since I wrote to you in February I have conceded:

- the retention of seniority payments but at a reduced level with the opportunity to increase them to present levels through the new post graduate education allowance;
- the introduction of a second and lower threshold for target payments for childhood immunisation and screening for cancer of the cervix;
- the retention of the present rural practice payments scheme until the Central Advisory Committee on Rural Practice Payments has considered how to revise it;
- the continuation of entitlement to BPA based on partnership average list size instead of personal lists as originally proposed and lowering the new threshold for full BPA from 1,500 to 1,200.

I have decided not to withdraw any of those concessions that I made on 4 May although the basis of my agreement with the GMSC negotiators was quite clear that I would be free to consider doing so if the profession did not accept the agreement I had reached with the negotiators.

The main features of the new payment systems to doctors from 1st April 1990 will therefore be:

- more money paid through capitation fees as a result of abolishing supplementary basic practice allowance, supplementary capitation fees and group practice allowance and reducing seniority payments;
- new capitation payments for newly registered patients;
- higher capitation payments for patients aged 75 and over;
- new two-tier payments for reaching targets for childhood immunisation and cervical cytology to replace item of service payments;
- new payments for gps who provide child health surveillance services;
- a new postgraduate education allowance available to all gps for <u>continuing</u> medical education to replace the vocational and postgraduate training allowances;
- reduced overall payments through basic practice allowance but weighted to help small list practices;
- a new basic practice allowance supplement for gps practising in areas of deprivation;
- a new allowance for gps who teach medical students;
- new payments for gps who provide minor surgery services;
- a new sessional fee for running health promotion clinics;
- a higher level night visit fee where the patient is visited by a doctor from the patient's own practice or from a small non-commercial local rota.

The precise figures to be placed on each and every component part of this contract can only be settled finally after the Government have received the Doctors and Dentists Review Body's report next year. I believe therefore that I have responded to most of the serious points put to me by the profession after I sent my last document to all GPs. I am still receiving some letters from GPs who are concerned that the increase in capitation from 48% to 60% of the contract will mean a return to the "bad old days before the GPs' Charter in the 1960s", longer lists and less time for patients. I am convinced that that will not happen. There are a lot of important differences between then and now. Two in particular stand out.

In the early 1960s there was concern amongst GPs that recruitment to the profession was declining while the population was rising. The situation is totally different now. The population is virtually static and the number of doctors in general practice is increasing at the rate of over 500 a year. General practice is clearly a popular option and average list size seems likely to decline still further.

The other main difference between the early 1960s and now concerns the way practice expenses are reimbursed, particularly expenditure on staff and premises. Before the changes to the GPs' contract in 1966 all the cost of staff and premises had to be paid out of fees In other words a GP who recruited staff and and allowances. provided good surgery premises was worse off financially than one To deal with that situation we now have a system of who did not. direct reimbursement for practice team staff and for premises That system is to be retained and improved. development. Government intends to invest more in expansion of practice teams and in improvements to premises. In future FPCs will target additional funds where they are most needed. For example, there will be more help with the recruitment of extra staff to provide a wider range of services.

Everything in the field of primary health care has been moving in the right direction: more doctors, more practice team staff and better premises. But general practice needs a new patient-oriented impetus.

My aim is to improve the family doctor services with this new and fairer contract which will reward those who work hardest and provide the good quality services which we all want. It will not reduce the average net income of doctors at all but it will mean that some gain and some lose. Of course many practices will find that their incomes increase based on the workload and performance they already achieve.

The GMSC is still being consulted on the detailed amendments to Regulations and the Statement of Fees and Allowances which will be required to implement the new contract. Once the consultation process has ended, I will place Regulations in their final form before Parliament with a view to implementation on 1 April 1990.

It is clearly of the utmost importance that GPs should be kept fully informed of the changes to their contract so that they can prepare for the new arrangements. I am enclosing with this letter a revised version of the document sent to you under cover of my letter of 23 February. This document - "The 1990 Contract" - includes all the changes agreed on 4 May. As soon as the detailed changes to the Statement of Fees and Allowances and terms of service have been settled, copies of those documents will be sent to you.

I hope you find "The 1990 Contract" helpful in providing you with a comprehensive picture of the changes to be made to your remuneration system and terms of service.



KENNETH CLARKE

CAPITAL CHARGES

CAPITAL CHARGES UPDATE 89/2

This update, which is the second of what is intended to be a regular series, has 4 purposes:

- 1. to introduce the newly formed Capital Charges Unit
- to advise on the formation of the Capital Charges
 Steering Group
- 3. to provide some further guidance on the preparation of asset registers
- 4. to confirm the interest rate to be used Capital Charges Unit

The Capital Charges Unit has been formed to help the NHS implement capital charging as explained in Working Paper 5. The unit will be a small resource centre to support regions and districts and to record progress within the service. It is apparent that progress made so far varies widely and it is hoped the unit will provide a means of transferring knowledge. The unit is intended as being of assistance to managers in the health service; please feel free to seek guidance from the office. The unit is headed by Mr R J Peters who can be contacted at room 434, Friars House, 157-168 Blackfriars Road, London SEI 8EU (01 972 2000 ext 23406 or 23407).





Capital Charges Steering Group

Working Paper 5 referred to the formation of a Capital Charges Steering Group to ensure that the details of the scheme were developed in association with the health service. This group has now been formed and has wide representation from the NHS, and the Department. It is intended that the group will form a number of technical sub-groups working on specific aspects. This will bring the involvement of still more NHS staff which is seen as vital in ensuring that the final product is a workable scheme.

The full membership of the Group currently is:

Ms S V Masters - NHSME Director of Finance

(Chairman)

Mr D Allison - RGM North Western RHA

Mr G Ayres - Asst RGM, North Western RHA

Mr D Clark - Director of Finance, Northern RHA

Mr E Jackson - Regional Supplies Manager,

Oxford RHA

Mr R MacLaren - Scottish Office

Mr M Parsonage - Economic Advisors Dept, DH

Mr R Peters - Head of Capital Charges Unit, DH

Nr N Thomas - Welsh Office

Mr R Underwood - Director of Finance, SE Staffs HA

Mr D Wellard - HM Treasury

Mr T Whiteley - Estate & Property Management

Directorate, DH

Asset Registers

Queries received already have demonstrated that there is a requirement for some further guidance on the preparation of asset registers. The Department does not wish to be over-prescriptive in respect of asset registers as much will depend on the existing data base within each authority and on management responsibilities for assets. However, an Annex is attached to this update which restates the requirement and offers some further guidance.

Managers will by now be aware that the Department has announced that £11.5 million extra resources are being made available to assist with the cost of constructing asset registers and it is hoped that this will enable the required timetable for preparation to be met.

In respect of computing (it is assumed that authorities will create computerised asset registers), EL(89)MB/60 drew attention to systems used in 3 pilot sites and there are other systems commercially available. The selection of systems is a matter for local determination but the Capital Charges Unit will in due course have data on those systems most frequently used by authorities.

Interest Rate

Working Paper 5 stated that the Government would specify the rate of interest to be levied for capital charges. The

Government has announced that this rate will be 6%. (See appendix 8 to Financial Matters May 1989).

Any queries in relation to this Update should be directed to Mr R J Peters.



PREPARATION OF ASSET REGISTERS

Working Paper No 5 requires Authorities to establish comprehensive asset registers by 31 March 1990 and EL(89)MB60 gave Authorities some details of pilot sites which had prepared such registers.

Asset registers will be of immense benefit to Authorities in the management of their resources and Authorities are commended to complete and maintain detailed registers. Further guidance is outlined below on the preparation of registers. This guidance refers principally to the minimum requirements of asset registers necessary to provide the basis for calculating capital charges. Registers for this purpose must be available for April 1990. Data over and above these minimum requirements is extremely useful and seperate guidance will be issued to Authorities in this context.

Definition of an asset

The annex to EL(89)MB62 gave details of the revised definition of capital expenditure. Any asset acquired from expenditure meeting this definition and which has an expected useful life of more than 1 year should therefore be recorded as an asset for the purpose of capital charges. An asset which would reasonably require repair and/or maintenance would usually fall into this category. Groups of assets, of which individual items may have a cost of less than £1,000,

which are inter-dependent or would normally be provided and replaced as a group should be treated as capital assets for this purpose. This description still of course has to comply with the requirement of durability. For the purpose of further illustration, the stock of furniture in a ward would be regarded as one asset as would a suite of office furniture but all of the books in a medical library would not be. It may be advisable to record ward furniture as 'beds' and 'other'.

Minimum data set for asset register (for capital charges)

In order to allow for the introduction of capital charges, the following data will be required as a mimimum in asset registers. Additional data will of course be required in order to secure benefits from improved asset management.

Asset identification & - serial no., category (1)

description

Asset location - management responsibility

Date of acquisition -

Method of acquisition - purchase, donation, loan etc

Initial capital -

expenditure (2)

Expected replacement -

cost (3)

Expected date of replacement (or end

of life)

(1) The category of assets will be important as it is intended to promulgate asset lives for various categories.

Final categories (or groups) of assets are subject to further discussion but the following is a possible classification:

Freehold land

Leasehold property

Vehicles

Office equipment (e.g.

typewriter)

Light and power system

Medical gases

Internal decorations

(including floor coverings

and soft furnishings)

IT equipment

Freehold buildings

Furniture

Beds

Small portable

appliances (e.g.

kettles, irons)

Heating system

Communications

Medical equipment

Some of these categories (e.g. medical equipment) will probably require sub-divisions.

- (2) On first construction of asset registers, if the initial capital expenditure is unknown, this can be omitted provided that the (approximate) date of acquisition and the replacement cost are known.
- (3) Replacement cost should include the cost of any material and labour associated with the replacement. It should not include the residual cost of the asset being replaced, any demolition or removal costs, any costs of disruption during replacement or any associated fees. The replacement cost should be expressed at a current price base.

Work is now underway to ensure that the quantitative information which is required within the NHS and the DH for implementing the NHS Review and for which some national uniformity is necessary, is identified in a nationally co-ordinated fashion and that a timely implementation schedule is agreed through appropriate consultation.

The following joint NHS/DH Working Groups have been identified and are in the process of being convened.

- Inpatients and day Cases
- 2 Outpatients and A & E
- 3 Waiting Times and Lists for In and Out-patients
- 4 Availability and Use of Facilities
- 5 Community Health Services
- 6 Finance
- 7 Manpower
- 8 DH Cross sector central requirements
- 9 Estate
- 10 District Information and associated IT project
- 11 National comparative data & Health Service Indicators
- 12 'Identification' codes
- 13 Co-ordination of information issues at the FPS/HCHS boundary

The Working Groups are being asked to produce by 31 October 1989 a report that contains in a final form those recommendations to be implemented by 1 April 1991 and, at least in outline form, those recommendations to be implemented at a later date. A consultation document will be issued at the end of December 1989.



	Reference	<u>Title</u>	Date of Issue
	HC(FP)(89)9	FPC General Managers: Appointments, Pay and Conditions of Service.	1 June 1989
	EL(89)MB/118	Additional funds for White Paper Implementation: Personnel and Training	22 June 1989
(EL(89)MB/124	Self-Governing Hospital: An Inital Guide	7 July 1989
	EL(89)P/119	Capital Charges Update No 2	14 July 1989
	EL(89)MB/130	Pricing of Contracts	19 July 1989
	EL(89)MB/135	Flexible Pay Supplement for Nurses and Midwives Pilot Scheme	27 July 1989
	EL(89)P/118	Income Generation Initiative: Guidance on Taxation	31 July 1989
	EL(89)MB/137	Secretary of State to Medical Profession: Letter to NHS Chairman Managers and Medical Officers	31 July 1989

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AMENDMENTS TO JULY BRIEFING PACK