PREM 19/1089

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NHS Expenditure and Efficiency

NATIONAL HEALTH

May 1979

Referred to	Date	Referred to	Date	Referred to	Date	Referred to	Date
14·3·83							
PART 1 ENDS							

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PART 1 ends:-

DHSS to MCS 14·3·83

PART 2 begins:-

S/S DHSS to S/S Env 7·4·83

Published Papers

The following published paper(s) enclosed on this file have been removed and destroyed. Copies may be found elsewhere in The National Archives.

Command 8479 - Government Response to the Fourth Report from the Social Services Committee, 1980-81 Session – Department of Health and Social Security, published by HMSO 1982 – ISBN 0 10 184790 4.

The Low Energy Hospital – Prepared by Department of Health and Social Security and Central Office of Information, 1981. Published by HMSO 1982 – ISBN 0 10 184790 4.

Summary of Health and Personal Social Services Accounts 1978-1979, together with the Report of the Comptroller and Auditor-General - Department of Health and Social Services Northern Ireland, published by HMSO 1980 – ISBN 0 10 175310 1.

Signed J. Gray Date 18/4/2013

PREM Records Team

SC

(2)

Prime Minister

To note. *

MLJ 24/3

(The Policy Unit are content with this publication.)

DEPARTMENT OF HEALTH & SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY

Telephone 01-407 5522

From the Secretary of State for Social Services

Michael Scholar Esq
Private Secretary
10 Downing Street

14 March 1983

Dear Michael

USE OF RESOURCES IN THE NHS IN ENGLAND

I enclose for information a copy of a review of the use of resources in the NHS in England over the last ten years or so which my Secretary of State plans to publish later this month.

The Chief Secretary and the other Health Ministers have raised no objection to its publication. My Secretary of State sees the document as having three main purposes:

- to review trends in NHS spending, output and efficiency;
- to show how the development and improvement of NHS services is linked to efficiency as well as spending;
- to emphasise the range and importance of the Government's measures to improve NHS efficiency.

He sees it as important to get these issues - and the Government's good NHS spending record - fully and clearly on the public record at this stage in Parliament. Both the PAC and the Select Committee on Social Services have called for such a review, and he expects them to react favourably to it.

The main historic analysis in Chapter 1 of NHS manpower and outputs follows very closely the material which we gave you on 8 September last year during my Secretary of State's discussion with the Prime Minister about the NHS management inquiry. It shows that when NHS manpower figures are adjusted to take account of the various transfer of staff and functions that occurred in 1974, and the introduction of shorter working weeks for some staff groups later in the decade, manpower productivity showed some decline in the first half of the 1970s, but has improved encouragingly in more recent years.

I am copying this letter to John Gieve (HM Treasury), Muir Russell (Scottish Office), John Lyon (Northern Ireland Office) and Adam Peat (Welsh Office).

Yours ever,

David

D J CLARK
Private Secretary

Department of Health and Social Security

HEALTH CARE AND ITS COSTS

The Development of the National Health Service in England

HMSO £ . net

Preface

For nearly two generations the National Health Service has provided health care for the very large majority of people in this country. This report gives an account of the ways in which the National Health Service in England has spent its money in recent years. It is mainly concerned with spending and with the amount of treatment and care provided. It does not pretend to be a description of the National Health Service in all its dimensions. Some important activities such as health prevention cannot come very clearly through figures like these. Nor can the human care for each individual patient and the concern for quality that must be central to any health service worthy of the name.

It is a giant organisation using huge sums of money and providing a huge range of services. Over the last decade substantial new resources have been made available to it. Nevertheless like health services overseas the National Health Service faces problems caused by growing demands. The growth in the numbers of elderly - and particularly the very elderly - and the development of new treatments will provide pressure for more health care. It is important therefore that the health service should use the resources available to it as efficiently as possible in order to get the best value out of the increased finances made available and to develop at the fastest practicable rate.

We should be clear just how much has been achieved in the last few years to get good value out of increased resources. Comparing the position in 1981 (the last year for which figures are available) with the position in 1978 we find that in 1981:

- there were over 500,000 more in-patients and day cases being treated in hospital than three years previously;

- over one and a half million extra out-patient and emergency cases were treated;

- staff-to-patient ratios in hospitals which care for mentally ill people and mentally handicapped people have continued to improve;

- some 375,000 more people were visited in their own homes by district nurses and health visitors;

- there are 1,250 more family doctors and their average list size has fallen by over 100 patients;

- 2 million more courses of dental treatment were provided on the NHS, 600,000 more sight tests, and 400,000 more pairs of glasses.

The service has had to be able to respond to dramatic changes by devoting resources to the new needs of patients. The pattern of change in acute hospitals has been that progressively more patients have been given more diagnosis and treatment in fewer beds. Changes in the methods of diagnosis and treatment and the higher proportion of elderly patients might have been expected to increase average case costs in the acute sector. Instead average case costs have tended to fall in recent years.

The Government's policy is to maintain its commitment to the National Health Service so that the patient can receive the best possible care. At the same time we believe we must improve the efficiency and effectiveness of the service even further if the NHS is to change and grow at the rate necessary to keep up with soaring demands. We have developed a regional review system to give leadership and a clearer sense of policy direction to the service. We have set up a management inquiry. We are introducing performance indicators, manpower planning and control, and policy scrutinies. We are introducing new approaches to supplies and purchasing methods and introducing information technology to theservice. The aim is to be even more successful in providing the best possible service for the patient out of the vast sums that the country is prepared to provide for health care. If we achieve greater success, the patient will be the beneficiary.

NORMAN FOWLER
Secretary of State for
Social Services

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HEALTH CARE AND ITS COSTS: THE DEVELOPMENT OF THE NATIONAL HEALTH SERVICE IN ENGLAND

Introduction

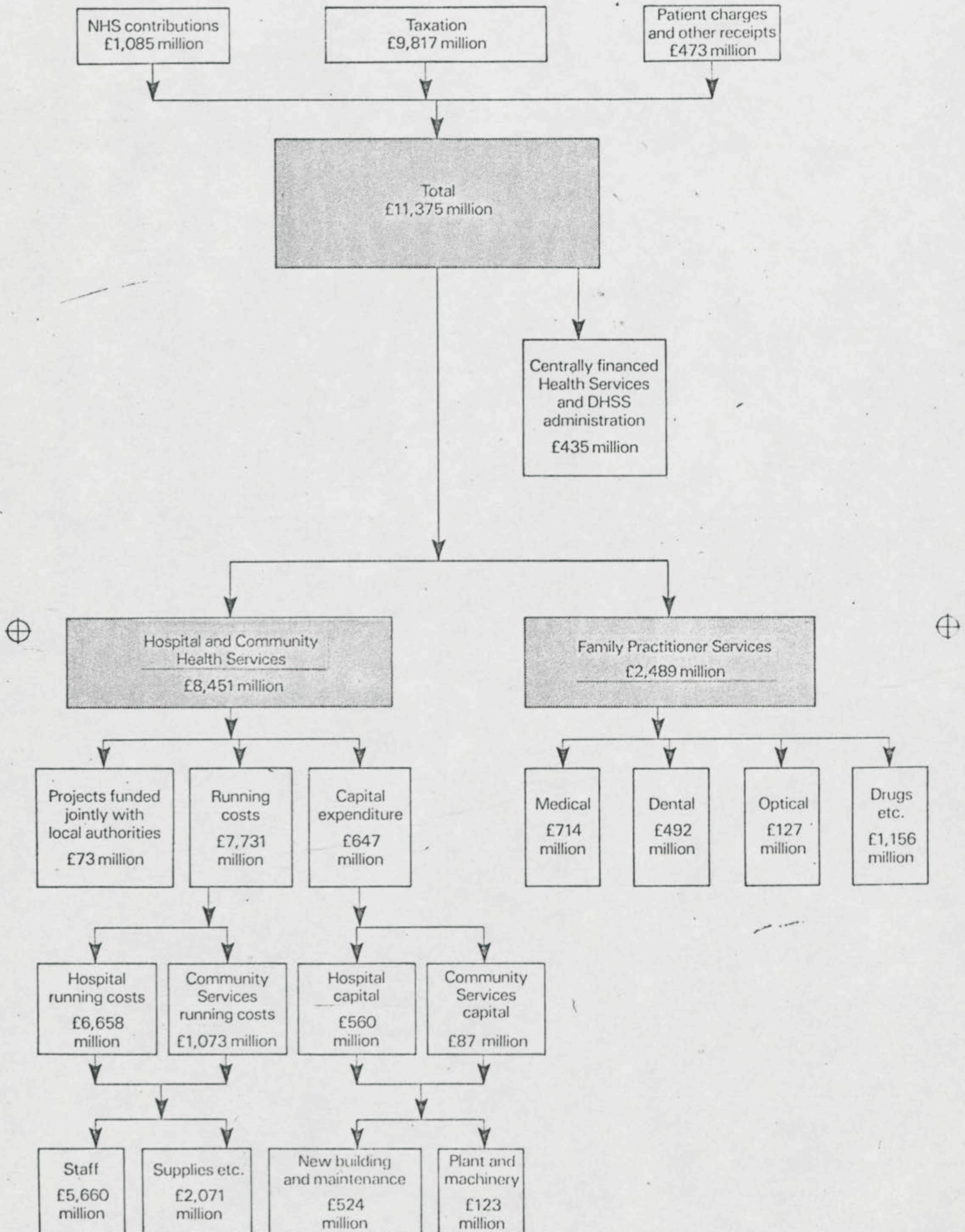
1. The National Health Service is the country's largest enterprise, using about one twentieth of our economic product and our workforce. This review explains how these resources are used in England.

2. Figure 1 shows how the NHS spent its budget of over £11 billion in 1981-82, and where that money came from. Modern health care requires a very wide range of different facilities and skills. The main focus of this review is on the hospital and community health services. They account for 70% of NHS spending, and provide surgical, medical, diagnostic and nursing facilities for all acute or serious illness needing specialist in-patient or out-patient treatment; specialist maternity and paediatric services; hospital care for long-term illness or handicap; care given to people in their homes by nurses and health visitors; and a variety of other important community and preventive services. In 1981, these services treated six and a half million in-patient and day cases, and dealt with nearly 49 million out-patient attendances. Some 7 million people were seen by health visitors and home nurses. NHS hospitals also provide the setting for much research, for the basic training of doctors, dentists, nurses and other health professionals, and for advanced specialist training.

3. Some material is also included on the family practitioner services, which through independent family doctors, general dental practitioners, opticians and pharmacists in contract with the NHS family practitioner committees provide primary medical, dental and ophthalmic care and the associated drugs and appliances. Many health services are closely linked with the local authority and voluntary sector personal social services, so the review includes some information on them as well.

4. Chapter 1 gives an overview of NHS money and manpower, and some indications of the efficiency with which they have been

Figure 1
National Health Service funding and expenditure in England, 1981-82



used over the last decade. Chapter 2 describes more fully how services have been developed and adapted to meet changing needs. Chapter 3 summarises the main challenges now facing the services, and describes how they are being tackled. The information on expenditure, manpower and activities in Chapters 1 and 2 is mainly from published sources. The sources, and additional comment on some issues, are given in Annex A.

Hospital and Community Health Services' Organisation and Accountability

5. The hospital and community health services are now organised and administered locally by 14 regional and 192 district health authorities. There are also nine special health authorities which administer postgraduate teaching hospitals. Health authorities decide within annual cash-limited budgets fixed in advance what patterns of services within national policies best suits their localities, and settle the mix of manpower and other resources that will deliver those services most efficiently and effectively. Within this framework doctors, nurses and other health professions provide care to individual patients according to their professional skills and ethics.

6. The role of the Department of Health and Social Security is to allocate the national budget between regional health authorities, who in turn distribute their shares to district health authorities; to control the resulting flows of money; to give guidance on national priorities in health care; and to review the performance of health authorities. The NHS is not a monolithic service, directed in detail from the centre, but the Government set overall national objectives. These are implemented through health authority plans, which also take account of local circumstances and aspirations. The Department discusses these plans with the regional health authorities; as a result, they may be changed, but central policies and priorities may also be modified. Plans are then translated into action at a local level. The Department monitors the way in which services develop and resources are used. The patterns of development in recent years are summarised in this review.

Figure 2

Expenditure on hospital and community health services 1971-72 to 1981-82

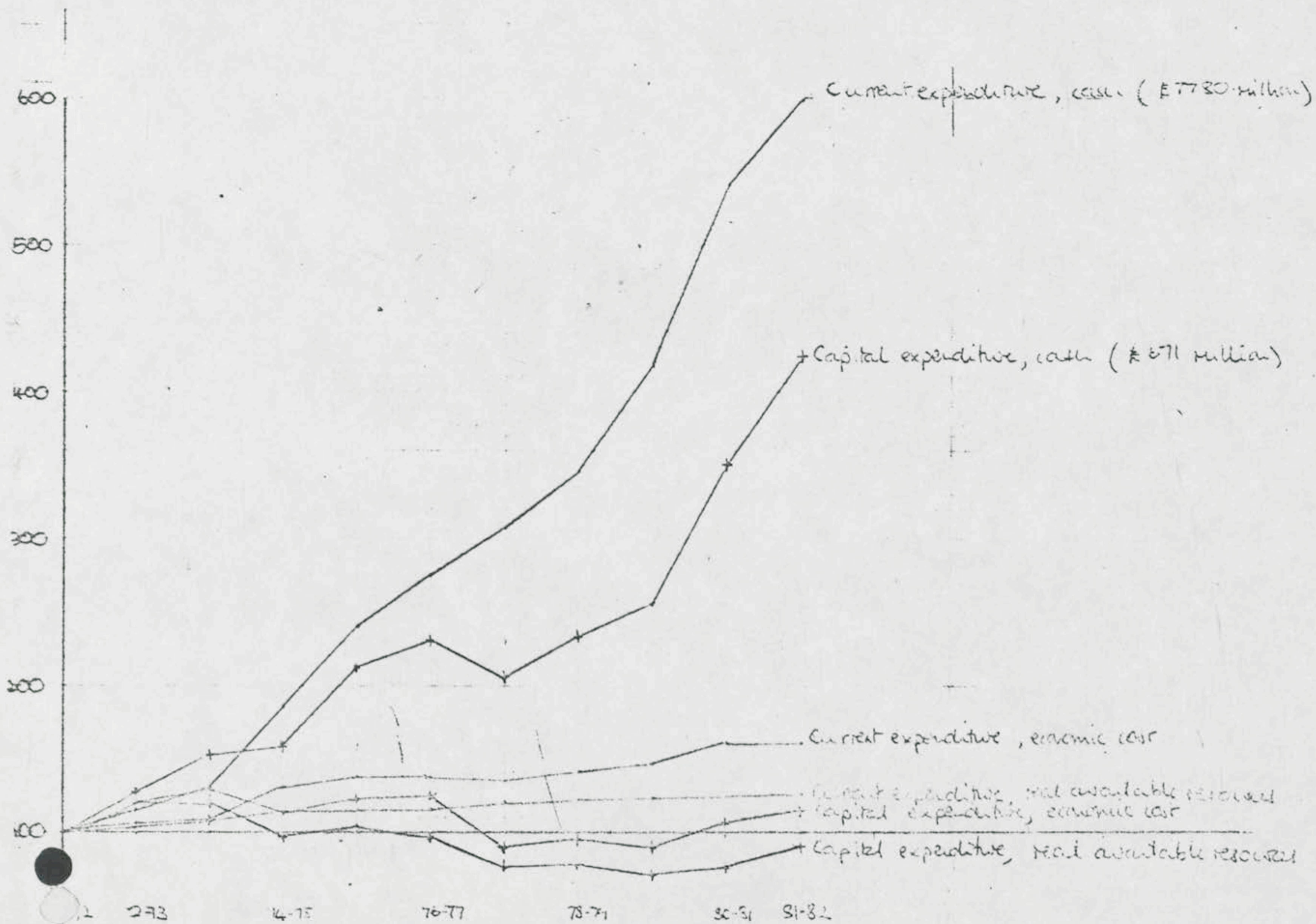
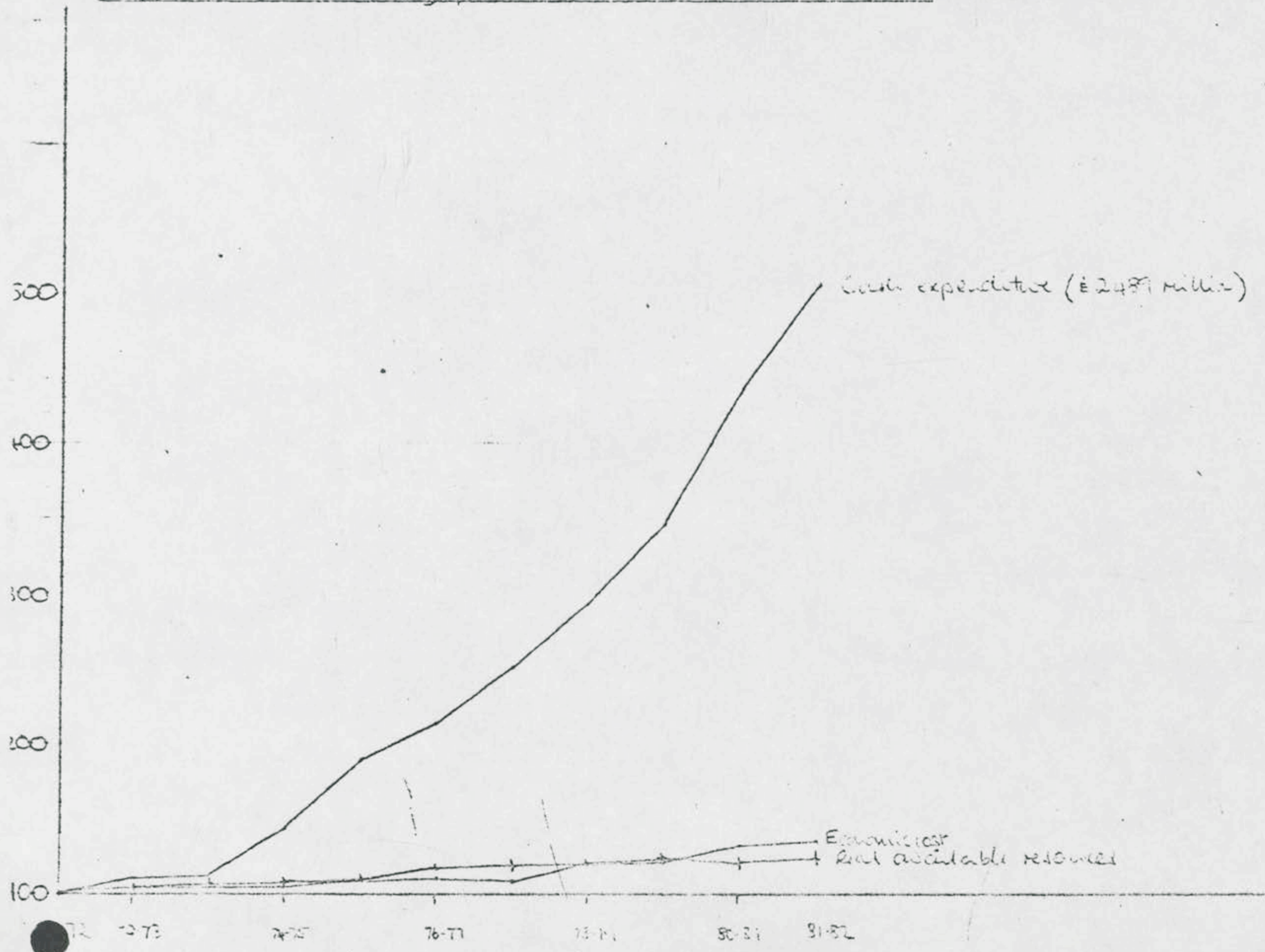


Figure 2a

Expenditure on the family practitioner services 1971-72 to 1981-82



CHAPTER I: THE USE OF RESOURCES: AN OVERVIEW

NHS EXPENDITURE AND ITS COST TO THE ECONOMY

1.1 Total NHS expenditure in the United Kingdom took 4% of the national gross domestic product in 1971-72. By 1981-82, this had risen to 5½%.

1.2 Spending on the NHS in England measured in <u>cash</u> without any adjustment for inflation was nearly six times as high in 1981-82 as in 1971-72. After allowance for increases in NHS pay and prices, the rise in the real <u>resources</u> available for services was 23%. However, NHS pay and price increases tended over the period to be greater than inflation in the national economy overall as measured by the Retail Price Index. As a result, the increase in the cost to the economy of financing NHS growth has been higher than the 23% NHS growth achieved. In fact, the increase in the <u>economic cost</u> of NHS growth over the decade was 50%.

1.3 Figure 2 shows the spending changes for each of two main NHS programmes - the hospital and community health services and the family practitioner services - in cash, economic cost and the real available resources with which this review is mainly concerned. It shows that the hospital and community health services grew quite fast up to 1975-76; growth since then has been steadier.

[Insert figure 2]

1.4 Over the same period, local authority expenditure on the personal social services also increased. By 1981-82, cash expenditure was seven times as high as in 1971-72. After allowance for pay and price changes the increase in real resources was 60%. As in the NHS, personal social services pay and prices have risen faster than costs in the economy generally. The increase in the economic cost of the 60% growth in the personal social services was 90%.

MAINTAINING AND IMPROVING THE CAPITAL STOCK

1.5 The NHS occupies about 50,000 acres of land and uses a wide diversity of buildings. The buildings include some 2,000 hospitals of various sizes, as well as health centres, clinics, laundries ambulance stations and residential accommodation for staff; their present replacement cost is about £21,000 million.

1.6 Capital expenditure is necessary to provide new and improved facilities; but each year the NHS spends about a third of its capital resources to maintain existing buildings, many of which are very old. Capital spending grew in the early 1970s, but was sharply reduced in the middle of the decade. Since 1978-79 it has again increased considerably.

1.7 Capital expenditure has been used to improve services by:-

- providing new equipment to replace old, inefficient or otherwise outmoded stock and so, as resources permit, making available to patients the benefits of recent developments in medical technology;

- helping to reduce the gap between comparatively under-provided and better-off localities by providing new or better hospitals where they are most needed;

- providing new and more suitable facilities for people who need long stay care: large institutional premises are being replaced by smaller units (for example hostels for mentally handicapped people and experimental projects for nursing homes for elderly people) usually situated within the community served;

- renovating or replacing old buildings and making them less costly to run, for example by reducing energy costs.

1.8 Inevitably new capital investment leads to the closure of old hospitals because:

- new hospitals may replace old buildings which are no longer economical to maintain and run;

- as the population in different areas changes, services are relocated near patients in areas of population growth; generally this means a shift from inner cities towards areas like Oxfordshire, East Anglia and the Home Counties;

- as average length of stay in hospital falls (discussed in more detail in 1.12) more patients can be treated in fewer beds; concentration of services in fewer hospitals may sometimes need additional investment but can yield valuable savings in overheads;

- old long-stay hospitals are gradually being replaced by local residential units and non-residential care.

Although the number of cases treated has increased substantially over the decade (see Table 1 and paragraph 1.12 below), the number of hospital beds has been reduced by 68,000, while 70,000 new beds have been created in new or converted buildings. The total number of beds taken out of use through closure or replacement is therefore 138,000 - about a quarter of the bedstock at the beginning of the decade. This process of change causes understandable difficulty in the localities affected. But it represents a modernisation and reshaping of the hospital stock to meet changing patterns of need and service provision, and must continue if the NHS is to respond to the challenges that lie ahead.

Table 1

Trends in manpower, expenditure and activity between 1971 and 1981 in the Hospital and Community Health Services ≠

	Numbers			annual percentage change	
	1971	1976	1981	1971 to 1976	1976 to 1981
Manpower					
Medical and dental	28,200	34,100	39,000	3.9	2.7
Nursing and midwifery	319,600	364,500	391,800	2.7	1.5
Professional and technical	38,500	52,500	65,200	6.4	4.4
Ambulance	15,200	17,200	18,200	2.4	1.1
Ancillary	168,000	173,600	172,200	0.6	-0.2
Works and maintenance	21,800	25,000	27,200	2.7	1.7
Administrative and clerical	72,300	98,500	108,800	6.4	2.0
Total Manpower	663,700	765,300	822,400	2.9%	1.4%
Current Expenditure (£million) measured in real available resources	1971-1972	1976-1977	1981-1982	1971-1972 to 1976-77	1976-1977 to 1981-82
Staff	4650	5320	5660	2.7	1.2
Supplies etc	1590	1818	2071	2.7	2.6
Total current expenditure	6240	7138	7731	2.7%	1.6%
Activity (Thousands)	1971	1976	1981	1971 to 1976	1976 to 1981
Hospital services					
Inpatient and day cases	5171	5735	6474	0.7	2.5
Outpatient attendances (including accident and emergency)	46260	45473	48879	-0.3	1.5
Regular day attendance	2839	4671	5416	10.5	3.0
Community Health Services					
Health visiting - number of people visited	3978	3576	3760	-2.6	1.0
Home nursing - number of people treated	1841	2780	3367	10.8	3.9
Ambulance Services					
Total cases carried	22335	22364	20501	0.0	-1.7
Blood Transfusion Service (England and Wales)					
Bottles of blood issued	1358	1582	1837	3.1	3.0
Cost-weighted index of change in overall Hospital and Community Health Services' activity	100	105	117	1.0%	2.2%

≠ For details of the basis on which the manpower figures have been adjusted to obtain a comparable series, and explanatory notes on the activity figures and on the derivation of the cost-weighted index of activity change, see Annex A.

MANPOWER, RUNNING COSTS AND EFFICIENCY

Hospital and Community Health Services Overall

1.9 About 70 per cent of health authority current expenditure - spending on running costs - is on staff salaries and wages. Services to patients depend heavily on skilled people - doctors, nurses, and paramedical staff such as radiographers, physiotherapists and scientific staff in laboratories. Treatment and care are tailored to the needs of individual patients, so much NHS activity offers only limited scope for the kind of mechanisation on which manufacturing enterprises largely depend for improvements in productivity. In addition there are back up services - "hotel" services, administration, estate management - which are more comparable to activities in the commercial sector.

1.10 Table 1 shows broadly health authorities' increases in staff, spending in terms of real available resources, and activity rates (that is the numbers of cases treated and of other services provided to patients) between 1971 and 1981, and distinguishes between the first and the second halves of the decade. More detailed material on how these relate to particular services and groups of patients is in Chapter 2. The information needed for this kind of analysis is available in full only from 1971; but annex B contains some analysis of manpower, activity and productivity trends in the 1960s as well.

1.11 Taking the decade as a whole, the annual growth rates of manpower and spending moved closely in step. But when they are considered alongside hospital activity rates, marked differences are revealed between the periods before and after 1976 both in terms of absolute numbers and in terms of output and efficiency, as measured by the changes in average costs per case shown in Figure 3.

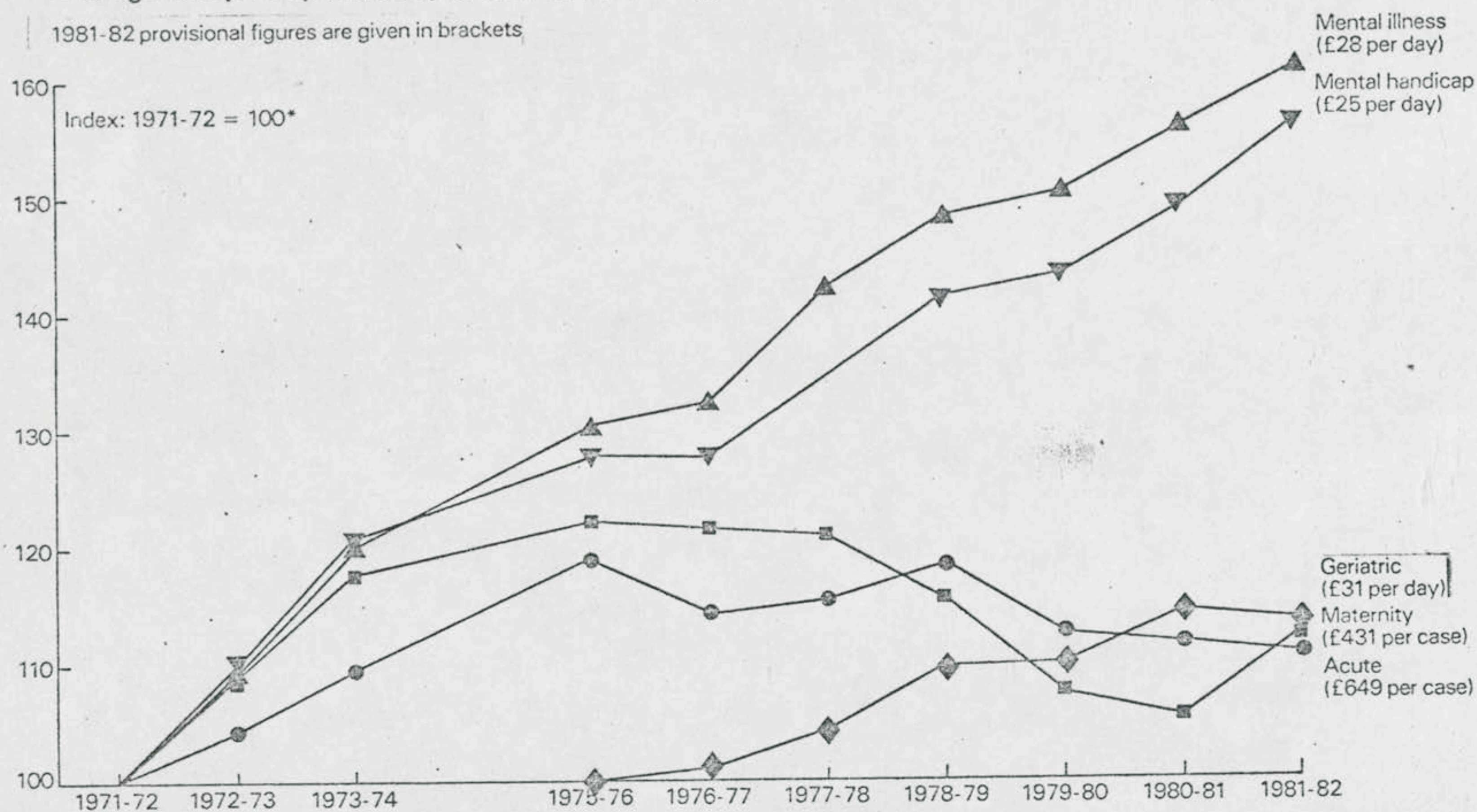
(Figure 3 opposite).

1.12 The earlier period is one of fast growth (2½% to 3% a year) in staff totals and expenditure, with the number of cases treated also rising, but - at about 1% a year - not so rapidly as resources. During the second period, growth in staff numbers and expenditure slowed down to about 1½% a year; but the number of cases rose by over 2% a year - faster than resources.

Figure 3

Trends in hospital in-patient costs 1971-72 to 1981-82

Average cost per in-patient day or case by hospital type



* No information on in-patient costs in geriatric hospitals is available before 1975-76. For geriatric hospitals, index: 1975-1976 = 100.
No information is available for 1974-75 for any hospital type.

Acute Hospital Services

1.13 Over half of hospital expenditure occurs in general acute hospitals which cater mainly for patients needing intensive surgical or medical care. The use of resources in such hospitals is therefore of great importance in the financial management of the hospital and community health services as a whole. During the first half of the 1970s, as is shown in Figure 3, average costs per case tended to rise in acute hospitals. Two factors contributed to this. New and more expensive techniques put up costs; and the number of elderly patients, whose treatment needs are more costly than those of other age groups, increased. Although these factors continued to apply throughout the second half of the decade - as they still do - from 1976 onwards the NHS managed to contain these pressures, and even to bring average acute hospital case costs down.

1.14 Average costs in acute cases depend on how much diagnosis, treatment and nursing care is given to a patient; on the cost of "hotel" services per day; and on how long a patient stays in hospital. The falling tendency in average acute case costs since 1976 has been partly due to reduced length of stay in hospital; this cuts down the number of beds needed to treat a given number of patients, and so reduces hotel costs and overheads. Diagnosis and treatment costs do not however necessarily fall. In fact, because the more accurate and effective methods of diagnosis and treatment that medical science now offers are usually more complex, these costs have tended to rise. Nor are the costs of nursing care greatly reduced by a shorter length of stay. A patient's need for nursing care is much greater in the early days of hospital stay when he or she will be more seriously ill - for example immediately after surgery; and it is the later "convalescent" period in hospital which has been reduced. In other ways too, nursing costs have increased because of more complex treatments and because the greater number of very elderly patients in acute hospitals are more dependent on staff.

1.15 The general picture in acute hospitals is therefore that progressively more patients have been given more diagnosis and treatment in fewer beds, with the obvious consequence that the ratio per bed of staff directly involved with patients doctors, nurses and professional and technical staff has risen. Changes in methods of diagnosis and treatment, and the higher proportion of elderly patients might have been expected to increase average costs per case - perhaps by some ½ per cent a year - in the acute sector. Instead costs per case have tended to fall, mainly because of a reduction in average length of stay in the acute specialties (from 10.0 days in 1976 to 8.6 days in 1981) and an increase in the average number of cases treated annually in each hospital bed (from 26.6 in 1976 to 31.1 in 1981).

Maternity Services

1.16 Many maternity services are provided in acute hospitals. But where they are provided in single-specialty hospitals, the trends have been comparable to those in acute hospitals generally. Average costs per case have tended to fall since 1976 because mothers have stayed in hospital for shorter periods and because maternity hospitals provision which had become surplus through the falling birthrate in the early 1970s was shed. Average length of stay fell throughout the decade, but most steeply in the second half - from 6.7 days in 1976 to 5.5 days in 1981 - when for the most part the birthrate was rising and facilities had to be used with more intensity. The provisional figures for 1981-82 show a rise in average case costs for the first time since the mid-1970s. This was probably caused in the main by the unpredicted fall in the birthrate during that year which led to fewer hospital births and hence to a slightly less intensive use of facilities.

Long term Hospital Care

1.17 Both hospital and community services are important in the care of mentally ill, mentally handicapped and geriatric patients. Where hospital in-patient care is necessary, it can vary considerably in length but may be prolonged. Costs per day are therefore a more appropriate measure of expenditure in hospitals which specialise in such care than costs per case. In these hospitals, average costs have tended to rise as shown in Figure 3. The extra costs reflect in particular an intentional increase, often from a very poor starting point, in the ratio of nursing staff to patients.

Successive Governments have encouraged this improvement to enhance the quality of care generally and to compensate for the higher average dependency of patients remaining in such hospitals now that, as explained in Chapter 2, care for the less severely ill or handicapped is increasingly provided in the community.

Questions about Manpower

1.18 The numbers of hospital medical, nursing and professional and technical staff are determined by the numbers of patients treated, the nature and complexity of the treatment they receive, the extent to which age or infirmity affects patients' needs for nursing care, and - particularly in long-stay hospitals - by the standards of nursing care provided. The evidence is that since 1976, taking the country overall, the increase in these staff has generally been justified by these factors.

1.19 For other staff groups the links with the amount of patient treatment are less direct. For example, ambulance staff have increased though the number of patients carried each year has fallen. The larger proportion of elderly patients carried, and the increasing number of emergency patients, may well have been an influence, but the position needs further scrutiny. Similarly, additional premises transferred to the NHS from local government in 1974 and the increasing volume and complexity of plant and equipment used in patient care may account for the rise in works and maintenance staff. Nevertheless there is to be a review of the works function in the NHS which should throw further light on the number of works staff necessary and the ways in which they are used.

1.20 The level of "hotel" services such as catering and cleaning is determined mainly by the number of occupied beds, although the pressure on some services such as portering and laundry will also be affected

by the number of in-patients who are admitted to and discharged from hospitals. More staff have also been needed for the day hospital services which have significantly expanded. Improvements in space standards and changes in the size and shape of hospitals may also have an effect on cleaning and portering services. In practice the number of ancillary staff providing these "hotel" services has fallen, but has not fallen as much as the number of occupied beds. More detailed analysis shows that, in acute hospitals, the cost of hotel services per occupied bed has fallen slightly in real terms by 1.5 per cent between 1975-76 and 1980-81. In the longer stay hospitals it has however risen. This may be a response to the continuing priority which Governments have given to improving standards and the quality of life in these hospitals. But, again, the position would benefit from further review, and the Government have recently announced a new initiative to promote competitive tendering for hotel services generally (see Chapter 3, paragraph 22).

1.21 Some administrative and clerical staff work on management functions such as finance and personnel; others work in direct support of patient services. In general, the need for administrative and clerical support of patient services is related to the number of cases rather than the number of bed-days - for instance medical records clerks are particularly concerned with patients on admission to hospital and on discharge.

1.22 Administrative and clerical staff numbers increased rapidly between 1971 and 1976, but have risen at a much slower rate since 1976. For those staff involved in management functions, the rapid increase during the earlier years is due partly to the more complex health authority structure introduced in the 1974 reorganisation and also the need to provide back-up to community services previously provided by local authority central departments, such as for finance, personnel, maintenance, supplies and computing. Following reorganisation there was further growth in health authorities' management, control and especially planning and

personnel activities. Some increase in staff providing support for patient services could be expected because of the growth in the number of cases, and was in line with the policy pursued throughout the decade of using more clerical support staff (medical secretaries, ward clerks and medical records clerks) where this could free doctors, nurses and other clinical staff to spend more time on patient care. Recent enquiries by the DHSS Department about the reasons for administrative and clerical staff increases in six health regions have confirmed that this last factor was an important one.

1.23 Nevertheless the increase in administrative staff at and following the 1974 reorganisation was excessive. To prevent this being repeated after the reorganisation of the NHS in April 1982, the Government are requiring authorities to reduce the proportion of their total budgets that is spent on management (see Chapter 3, paragraph 9).

General Trends in Productivity

1.24 The general conclusion to be drawn is that productivity fell during the early 1970s but has since improved. During the five years to 1981, the number of treatments given rose faster than expenditure and staff numbers, even though acute treatment was increasingly complex and standards of care were improved in the long stay sectors. This increase in productivity took place mainly in acute hospitals. Changes in both finance and organisation probably caused this reversal of the earlier trend. In financial terms, the money available for growth fell, and cash limits were introduced. At the same time the 1974 reorganisation gave authorities responsibility for providing services to a given population within a predetermined budget. As a result there was increased management and professional concern over costs and efficiency. One important method of

increasing productivity has been to reduce length of stay in hospital. Variations between authorities suggest that there is room for further improvement at least in some parts of the country. But more effort is needed to identify new ways of reducing costs, for instance by improving the way in which work is organised and staff are deployed, and by the use of cost-saving investment.

1.25 The Government have made important innovations in the machinery for monitoring and improving NHS efficiency. These are described in Chapter 3. Amongst the most important is the newly announced inquiry into NHS management. This inquiry will be able to look in much greater depth at individual areas of work, and will greatly strengthen the NHS's capacity to make the best use of its resources.

CHAPTER 2: THE DEVELOPMENT OF SERVICES

2.1 The main challenges facing the hospital and the community health services have been:

- to provide services for the increasing number of old and very old people;

- to reduce further perinatal mortality and morbidity (that is, the amount of disease and death occuring amongst new-born babies) and cater for the predicted increase in the number of births from 1978 ;

- to develop services generally to make greater use of new technology; for example haemodialysis for patients with chronic kidney failure, and surgical hip replacement in osteo-arthritis;

- to improve standards of care for mentally ill, mentally handicapped, and long-stay geriatric patients and wherever possible provide care for these patients in the community rather than in hospital;

- to strengthen primary care and preventive measures and improve liaison with the personal social services;

- and to bring about a more equitable distribution of resources across the country.

Progress towards these objectives is discussed below.

POPULATION CHANGES

2.2 Health care is usually most necessary around the time of birth, in early childhood and in old age. Average annual costs of providing care per head for the population as a whole, for births, and by age group are:-

Estimated average hospital and community health current expenditure per head of population in 1980-81, and by age group (England)

	Total Population	Births	0-4	5-15	16-64	65-74	75+
Expenditure per head	£160	£855	£155	£65	£85	£310	£765

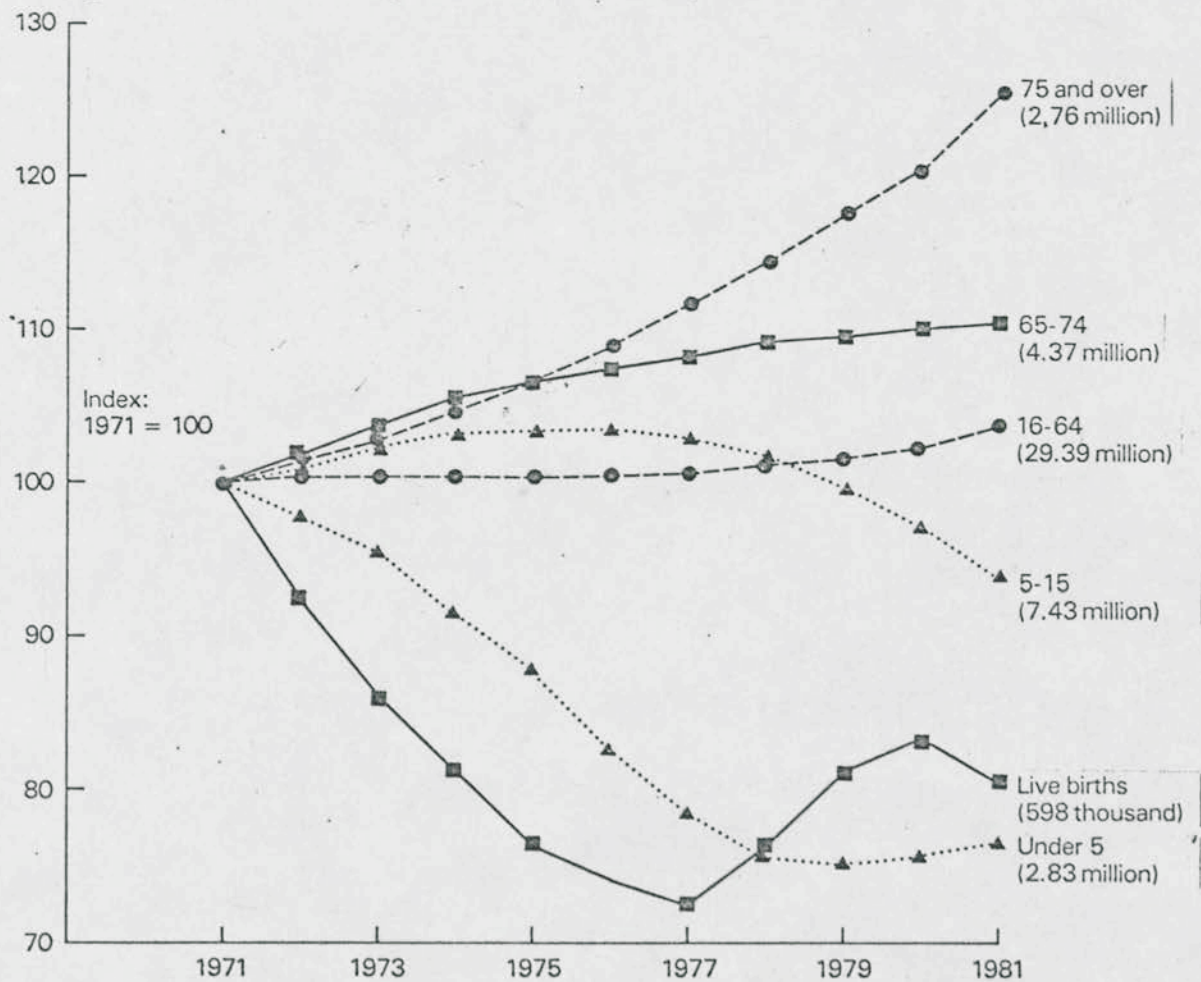
2.3 Population changes during the decade are shown in Figure 4. The number of births fell substantially in the six years to 1977, increased somewhat between then and 1980, and again showed a fall in 1981. Between 1976 and 1981, the number of children up to the age of 15 fell slightly, while the population of working age increased a little. But most significant was the rise of 16% over the decade in the number of old people, particularly those beyond their middle 70s who increased by 25%.

Figure 4

[Insert attached graph]

Figure 4
Population by age 1971-1981: mid-year estimates for England

Figures for 1981 are shown in brackets



2.4 By 1981, these population changes led to extra need for hospital and community health services equal to about 4% of spending in 1976-77. If the NHS nationally had failed to deliver extra services of at least that amount - an annual average of 0.7% over the country as a whole - standards would have dropped.

SERVICES FOR ELDERLY PEOPLE

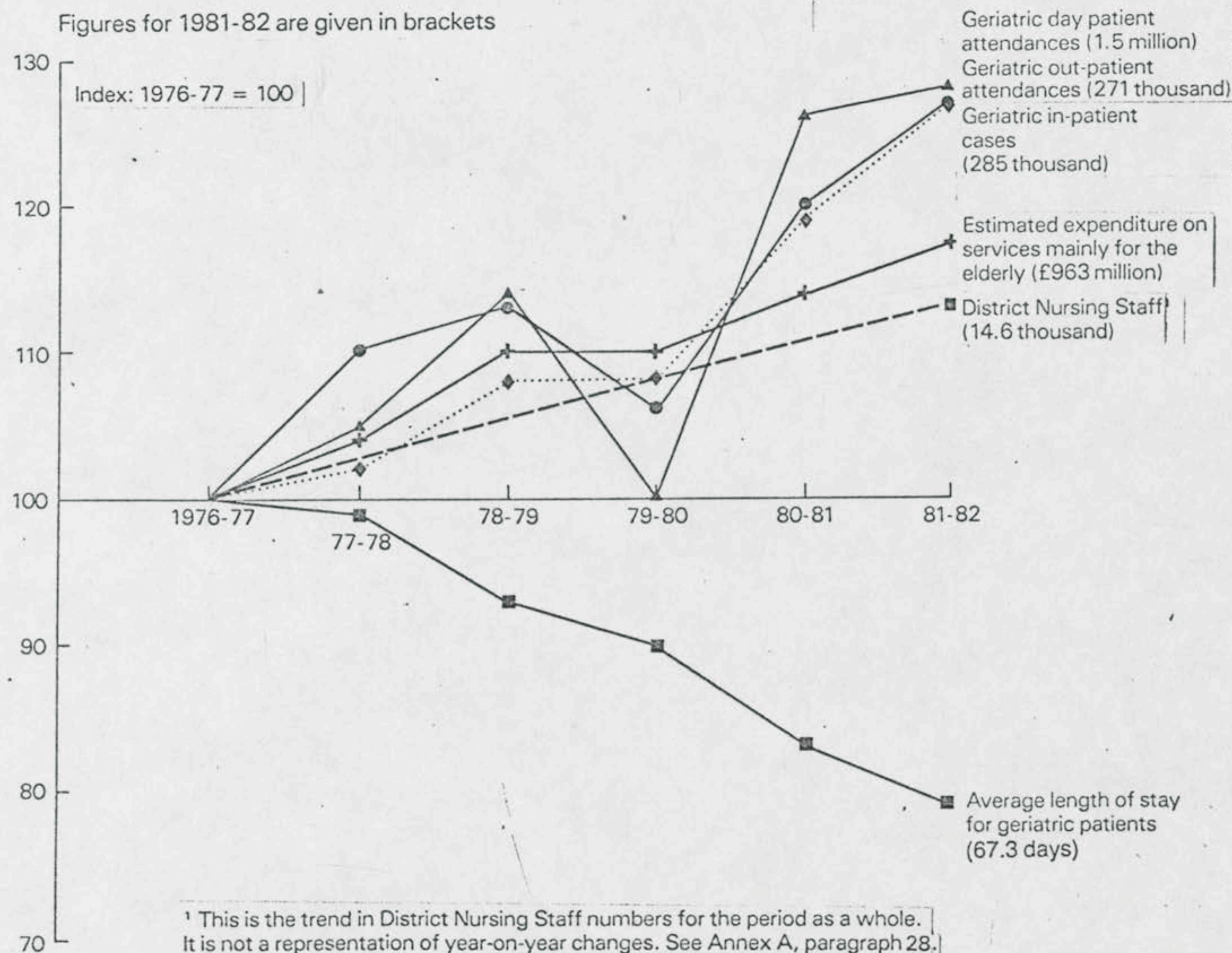
2.5 The rising proportion of old and very old people in the population has naturally increased pressure on the geriatric hospital and the district nursing services. The increases in these services and in spending on them is shown in Figure 5. The additional pressures the rising elderly population place on the general acute services are described later in the chapter.

Figure 5 HOSPITAL AND COMMUNITY HEALTH SERVICES FOR ELDERLY PEOPLE

Figure 5

Hospital and Community Health services for elderly people 1976-77 to 1981-82

Figures for 1981-82 are given in brackets



[1] This is the trend in District Nursing Staff numbers for the period as a whole. It is not a representation of year-on-year changes. See Annex A, paragraph 28.

2.6 People are more likely to be ill as they grow older; and the treatment they then need has often to be more comprehensive and may well last for a longer time than treatment for younger patients. Consequently the costs of caring for elderly people are higher than for most of the rest of the population - on average, the hospital and community services spend nearly 9 times as much per head on people over the age of 75 as on people of working age. Expenditure on services mainly for elderly people has increased at a faster rate for most of the period since 1976 than services for other client groups - at about 3.2% a year.

2.7 The average age of people needing geriatric care has risen. This could have led to a rise in average geriatric hospital treatment costs. But it was partly offset by a fall in the average length of stay of geriatric in-patients by 21% between 1976 and 1981 - a trend which reflects in part some progress towards implementing Government policy to care for more elderly people in the community wherever possible. To help achieve this, the district nursing service has been expanded and more elderly people attend hospitals as day patients.

2.8 To meet the need for more hospital services specifically for elderly people, the numbers of staff have increased as follows:

	1976	1981	annual percentage increase
Geriatric medicine - consultants and junior doctors	1,100	1,400	5.4
Hospital nursing staff working particularly with the elderly	36,600	40,650	2.1

The ratio of nursing staff to in-patient geriatric beds increased by 13% but some of these staff work in the day hospital services.

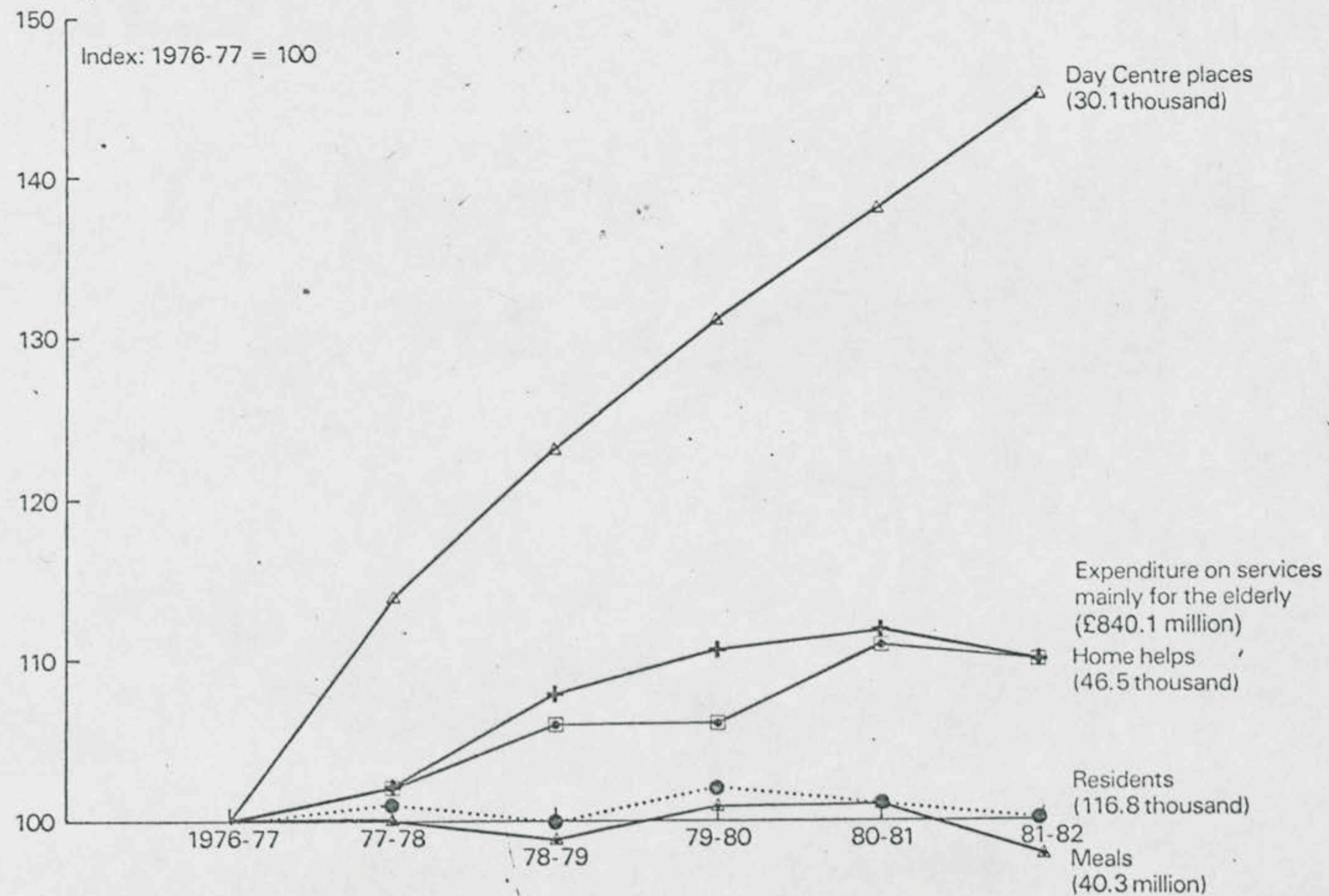
2.9 The emphasis on developing community care for elderly people has led to an increase over the period in expenditure on services provided by local authorities as well as those provided by the NHS. The changes since 1976-77 are shown in Figure 6.

Figure 6 LOCAL AUTHORITY SERVICES FOR THE ELDERLY

Figure 6

Local Authority services for elderly people 1976-77 to 1981-82

Figures for 1981-82 are shown in brackets



MATERNITY SERVICES

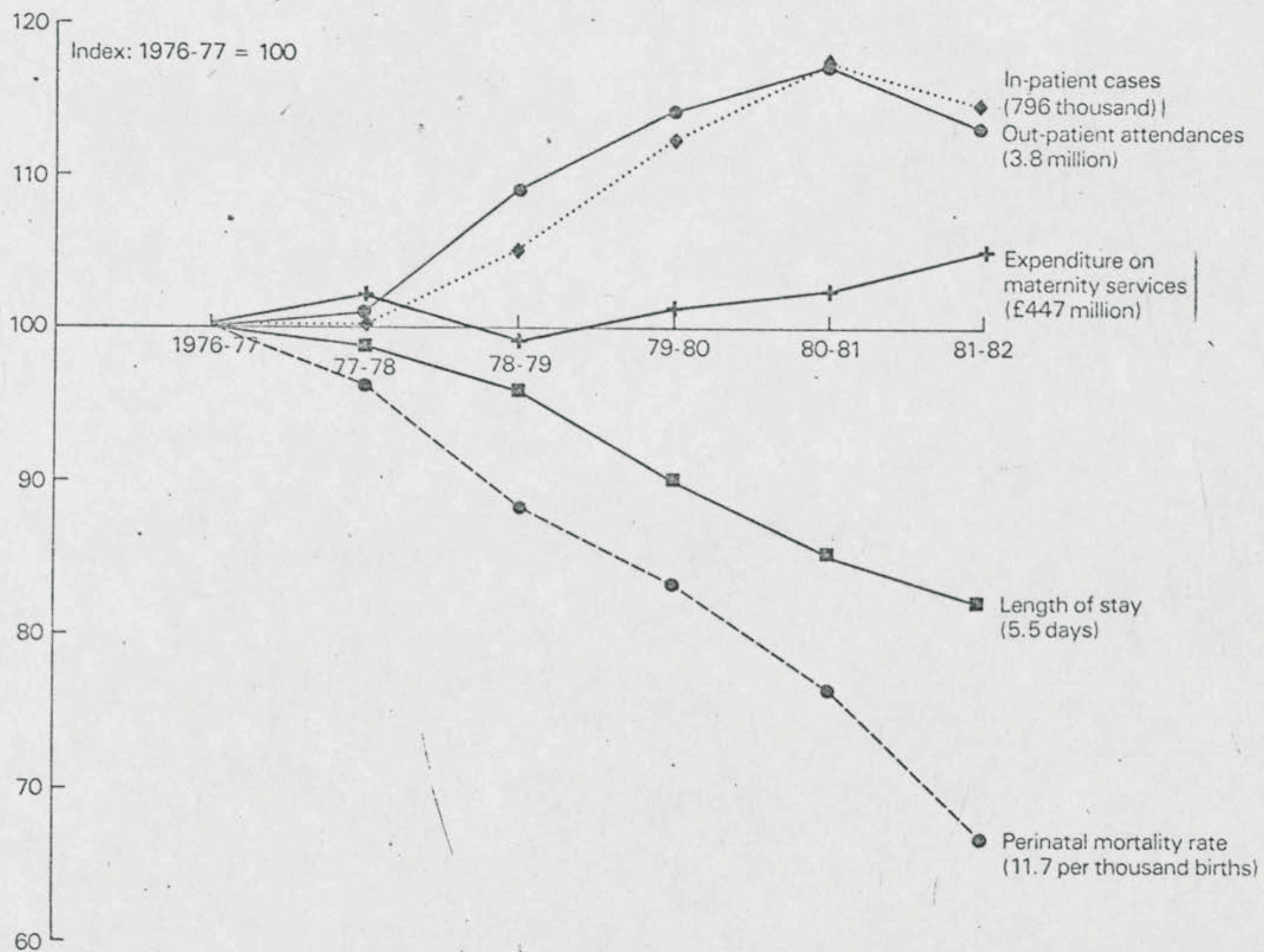
2.10 The maternity services have needed to provide for the sharp upturn in the birthrate between 1978 and 1980. There has also been much public concern about rates of perinatal mortality and morbidity here compared with some other countries.

2.11 Between 1976 and 1981 the perinatal mortality rate has continued to fall - from 17.6 per thousand births in 1976 to 11.7 in 1981. There has been a growing trend for maternity cases to be treated in general rather than single-specialty hospitals, in line with policy to rationalise all acute hospital service provision, and to ensure that maternity patients have access to the fuller range of facilities and staff skills available in a general hospital. Trends in average case costs are explained in paragraphs 14 and 15 of Chapter 1.

Figure 7 MATERNITY SERVICES

Figure 7
Maternity services 1976-77 to 1981-82

Figures for 1981-82 are given in brackets



2.12 The growth in hospital-based medical and nursing manpower working in the maternity services has been as follows:

	1976	1981	annual percentage increase
Doctors: Consultants and juniors specialising in obstetrics and gynaecology	2,200	2,350	1.6
Nursing staff in hospital maternity units and midwifery staff in hospitals	26,800	28,350	1.1

ACUTE HOSPITAL SERVICES

2.13 There has been sustained pressure for more treatment to be provided in the acute hospital sector. This is due mainly to the increase in the numbers of elderly people who use the acute services more than others. Patients aged 65 or more represent a quarter of cases in the acute specialties, but account for over two-fifths of the occupied beds because they stay in hospital longer than younger people.

2.14 In addition, if the NHS is to remain a modern and effective health care system, it must make accepted modern methods of investigation and treatment more widely available.

2.15 In some instances improved treatment methods can lead to net savings, because they reduce the need for prolonged hospital treatment; but more often medical progress calls for increased expenditure. Innovations often extend demand by bringing more patients within the range of active treatment. Many new treatments require more highly trained staff to handle the increasingly complex techniques, instruments and drug regimes involved, and this means that, in turn, manpower costs per case will often rise. New techniques and treatments may also mean the purchase and maintenance of expensive equipment. Additional costs will also arise because new treatments need careful monitoring; and some may entail a financial commitment lasting throughout a patient's life.

2.16 Examples of some specific advances in available treatments which have affected demand on the acute services include:

- hip joint replacement by surgery (arthoplasty). For patients with arthritis of the hip, this operation can relieve pain dramatically and improve mobility and the ability to undertake normal work. It costs about £2,000 per case; the number of operations performed each year increased nearly three-fold between 1969 and 1979 to reach about 31,000.

- haemodialysis and kidney transplantation. These are life saving treatments for patients with chronic renal failure. The total number of patients on dialysis or with a functioning transplant in the United Kingdom rose from 1,270 in 1971 to some 7,900 in 1981. Average hospital dialysis costs about £13,000 a year, and home dialysis around £9,000. A successful transplant costs about £5,000 at the time it is performed, and a further £1,500 annually for the rest of the patient's life. Of those patients on dialysis about 1,000 are now being treated by the recently introduced technique of continuous ambulatory peritoneal dialysis at a cost each year of up to £9,000 per patient.

- coronary artery by-pass grafting. This operation relieves the pain of intractable angina and prolongs the life of patients with some kinds of coronary heart disease. About 5,000 such operations were performed in the United Kingdom in 1980, at an average cost of £2,500 each, compared with some 250 operations in 1971.

- neonatal intensive care. Major technical developments in neonatal care over the past 15 years mean that many babies who would previously have died can now be kept alive often to grow up as normaly healthy children.
The techniques involved are very expensive, mainly in staff. The number of neonatal intensive care cots has expanded considerably.

- treatment of haemophilia. The use of blood clotting factors (factors 8 and 9) has been developed to treat haemophilia patients, enabling them to live relatively normal lives, survive minor injuries and undergo surgery. The use of these factors has risen from 10 million units in 1970 to 65 million units in 1980; demand is expected to reach 100 million units by 1985. The cost of each unit is about 10p.

- bone marrow transplants. These cost about £12,000 per case and are life saving for some patients with certain forms of blood disease.

2.17 The rapid development in recent years of diagnostic techniques has significantly increased hospital activity,

New techniques do not necessarily replace existing procedures but supplement them. They are frequently labour-intensive and require staff to learn new skills. The equipment needed is usually expensive. Examples of diagnostic developments are:

- brain and general purpose computer tomography (CT) scanners. Introduced in the 1970s, these scanners have made a significant impact on the diagnosis of lesions of the brain, and in defining the extent of cancer in the body. Over 90 brain and general purpose CT scanners are now available in England and Wales. They represent a capacity to examine up to 220,000 patients a year.
- diagnostic ultrasound. This is valuable in the detection of fetal abnormalities, in the diagnosis of congenital heart disease in children and the investigation of abdominal disease.

- equipment for continual monitoring of the electro cardiograms of ambulatory patients. This enables disturbances of heart rhythm to be detected and treated more effectively.

- fibre-optic endoscopy for internal examination of the gut. The technique was introduced in the late 1960s and over 100,000 examinations are now carried out each year.

- gynaecological cytology. This was introduced in the 1960s for the early detection of cancer of the cervix. Over three million tests are now done each year.

- cytogenetic tests have become available to diagnose congenital disorders during pregnancy. As these become more widely used in support of genetic counselling, a progressive reduction in the number of babies born with handicapping disorders can be expected.

- immunological techniques and clinical chemistry to measure blood hormone levels are now within the capacity of district hospitals. They are used to investigate thyroid disease and infertility; in the early detection of malignant disorders, and in the matching of donors and recipients for transplants.

2.18 Improvements in anaesthesia have made available new techniques for treating intractable pain and the management of post-operative and emergency patients. Intensive therapy units have been established in most major acute hospitals and many districts have pain clinics. More advanced and safer anaesthetic procedures, together with more refined surgical techniques have enabled surgical treatment to be given to patients who would previously have been considered too frail for major surgery. Between 1971 and 1979 the number of operations performed on older age groups rose as follows:

Operations on People 65 and over and percentage increase between 1971 and 1979 in England and Wales

	1971	1979	percentage increase
Operations on people aged 65-74			
Total number of operations	218,170	279,240	28%
Operations per 100,000 elderly population (aged 65-74)	5,040	6,080	21%
Operations on people aged 75 and over			
Total number of operations	124,860	186,650	49%
Operations per 100,000 elderly population (aged 75 and over)	5,306	6,819	29%

2.19 In its forward costings the Department of Health has assumed that additional expenditure on the hospital and community health services nationally of ½% a year is necessary as a contribution to the costs of this constant process of medical innovation.

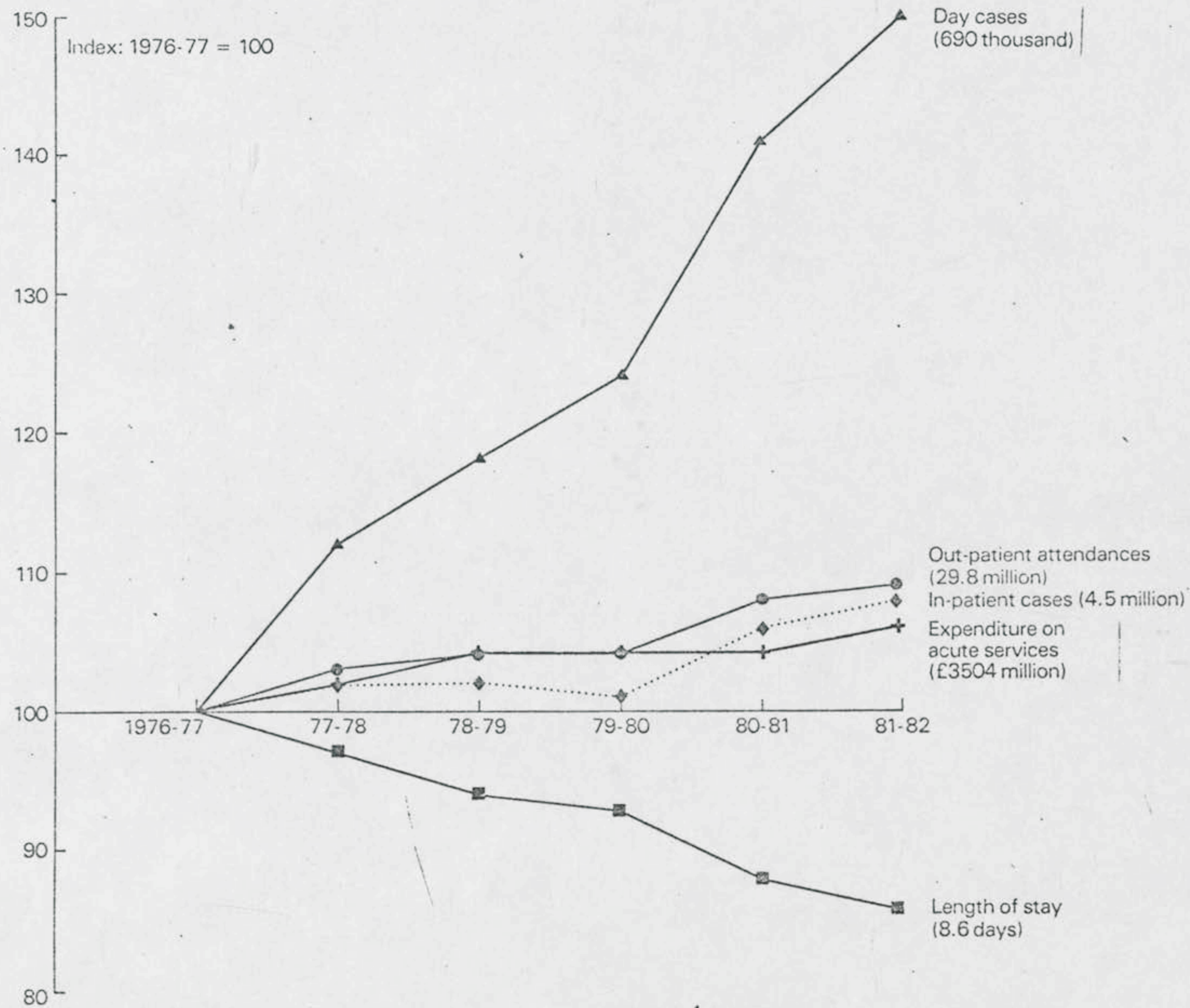
2.20 The response to the increasing number of elderly patients and the introduction of new forms of diagnosis and treatment has been a rise in hospital activity in the acute sector. As shown in Table 1 (page 5A) and explained in paragraphs 11 and 14 of Chapter 1 acute in-patient and day cases grew between 1976 and 1981 at an annual rate of 2.3% while out-patient attendances rose by 1.8% a year. During this period expenditure grew less fast and average case costs tended to fall which suggests a gain in efficiency.

Figure 8 ACUTE HOSPITAL SERVICES

Figure 8

Acute hospital services 1976-77 to 1981-82

Figures for 1981-82 are given in brackets



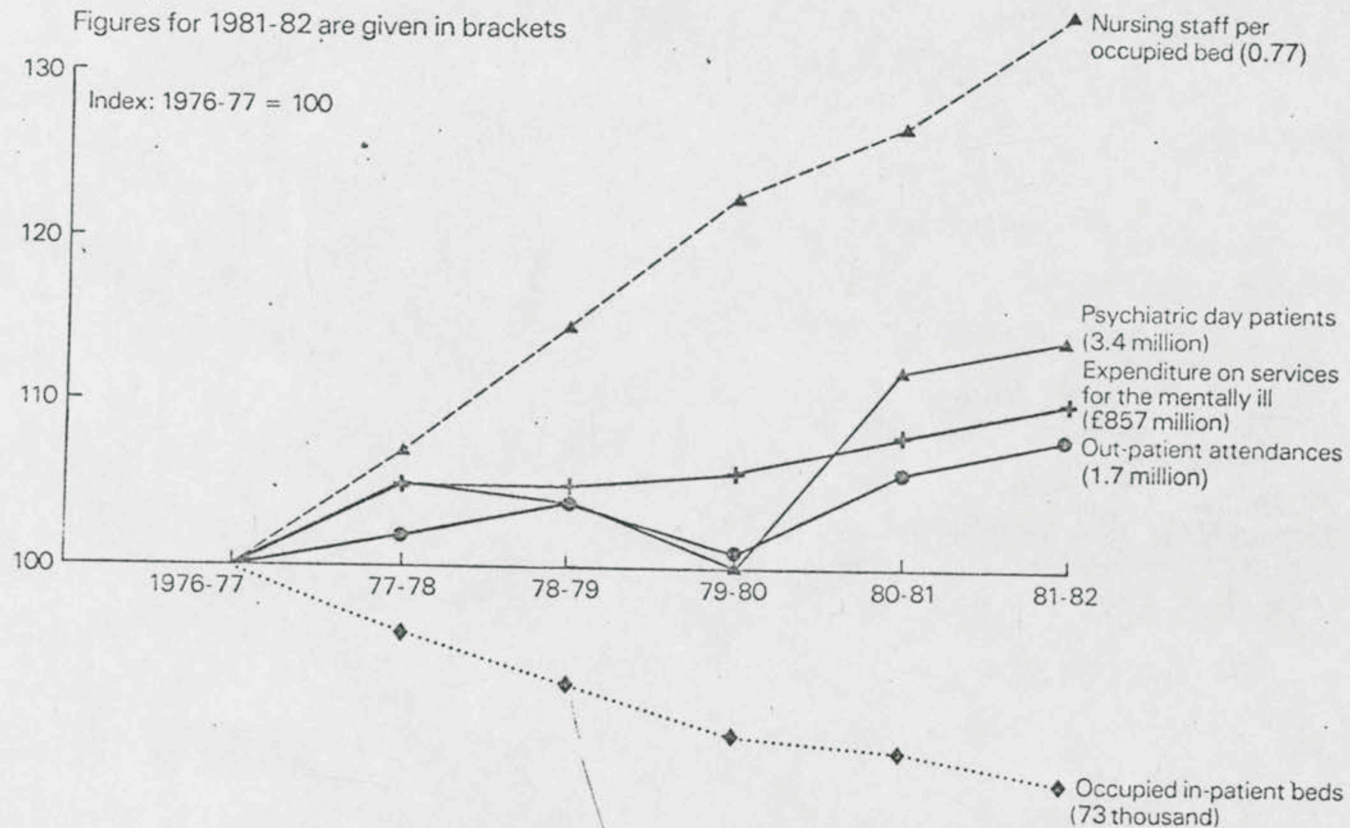
2.21 The expansion of acute services has required increases in medical manpower. Over the period, the number of doctors (consultant and juniors) has increased as follows:

	1976	1981	annual percentage increase
Medical specialties	6,950	8,000	2.9
Surgical specialties	8,550	9,800	2.9
Pathology	1,850	2,150	3.1
Radiology	1,000	1,200	3.9
Anaesthetics	3,050	3,600	3.0
Total	21,500	24,850	2.9%

Nursing staff working in the acute services have also increased, though less than in the geriatric, mental illness, mental handicap and primary health care services. But precise figures cannot be given because these nurses are not separately identified in the manpower statistics.

Figure 9

Hospital services for mentally ill people 1976-77 to 1981-82



SERVICES FOR SPECIAL GROUPS

2.22 A major priority is to improve services for mentally ill and mentally handicapped people, disabled people and long-stay patients - often elderly people. During the last 25 years or so there has been a growing recognition that community care would be far better for many such patients than prolonged periods in hospital. There has also been concern about standards in some of the long-stay hospitals specialising in their care. There have therefore been pressures for change of two kinds - improvement of standards in hospital care mainly through better staff/patient ratios, and the development of community services (such as day facilities and community psychiatric nursing in the NHS, and domiciliary and other social services provided by local authorities). Encouraging progress has been made, in both the health and personal social services, towards meeting these goals, but there is still a long way to go.

SERVICES FOR MENTALLY ILL PEOPLE

2.23 The main model for the present pattern of care for mentally ill people is the 1975 White Paper "Better Services for the Mentally Ill, which envisaged that a satisfactory network of services would take a period of 25 years or so to build up.

2.24 The increasing number of elderly people has had and will have a growing impact on the demand for psychiatric services. For example, it has been estimated that prevalence of dementia in those aged 65 to 74 is 3%, but rises to 13% in those aged 75 and over and to 22% in those over 80. Since the numbers of people aged 75 and over increased by about 25% in the decade to 1981 and is forecast to rise by 13% over the next ten years, there will be significant pressure to expand as well as improve present services

Figure 9

HOSPITAL SERVICES FOR MENTALLY ILL PATIENTS

[Take in graph]

2.25 Figure 9 shows that expenditure on in-patient services has increased slightly despite falling numbers, in line with policies to improve hospital standards. For those who need to remain in hospital, in-patient care is now more often available within the patient's own health district: the number of psychiatric Departments in general hospitals increased from 137 in 1976 to 157 in 1980, while the ratio of nursing staff to patients has improved by about 22% between 1976 and 1981. At the same time, more people who would earlier have been admitted as in-patients now remain in the community. They have the support of the psychiatric nursing service, and day hospitals; and of the local authority day centres and other community-based services shown in Figure 10.

2.26 Better health care for the mentally ill is also reflected by the growth of medical and nursing staff working in the mental illness services:

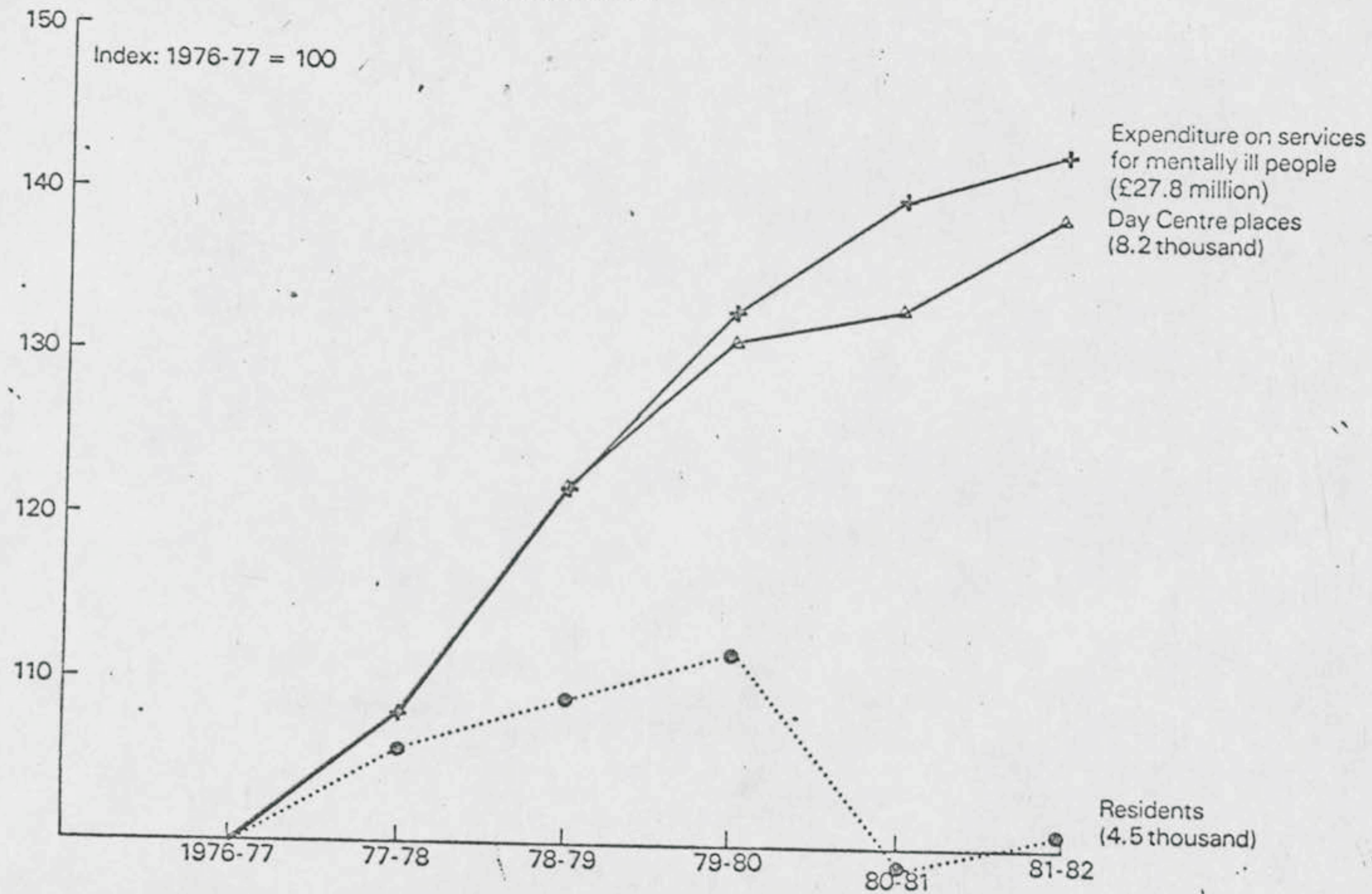
	1976	1981	annual percentage increase
Doctors: Consultants and Juniors	2,700	3,250	3.7
Nursing staff	48,500	56,500	3.1

Some of these staff provide services for patients in the community, as well as for patients in mental illness hospitals.

Figure 10

LOCAL AUTHORITY SERVICES FOR MENTALLY ILL PEOPLE

Figure 10
Local Authority services for mentally ill people
Figures for 1981-82 are given in brackets



SERVICES FOR MENTALLY HANDICAPPED PEOPLE

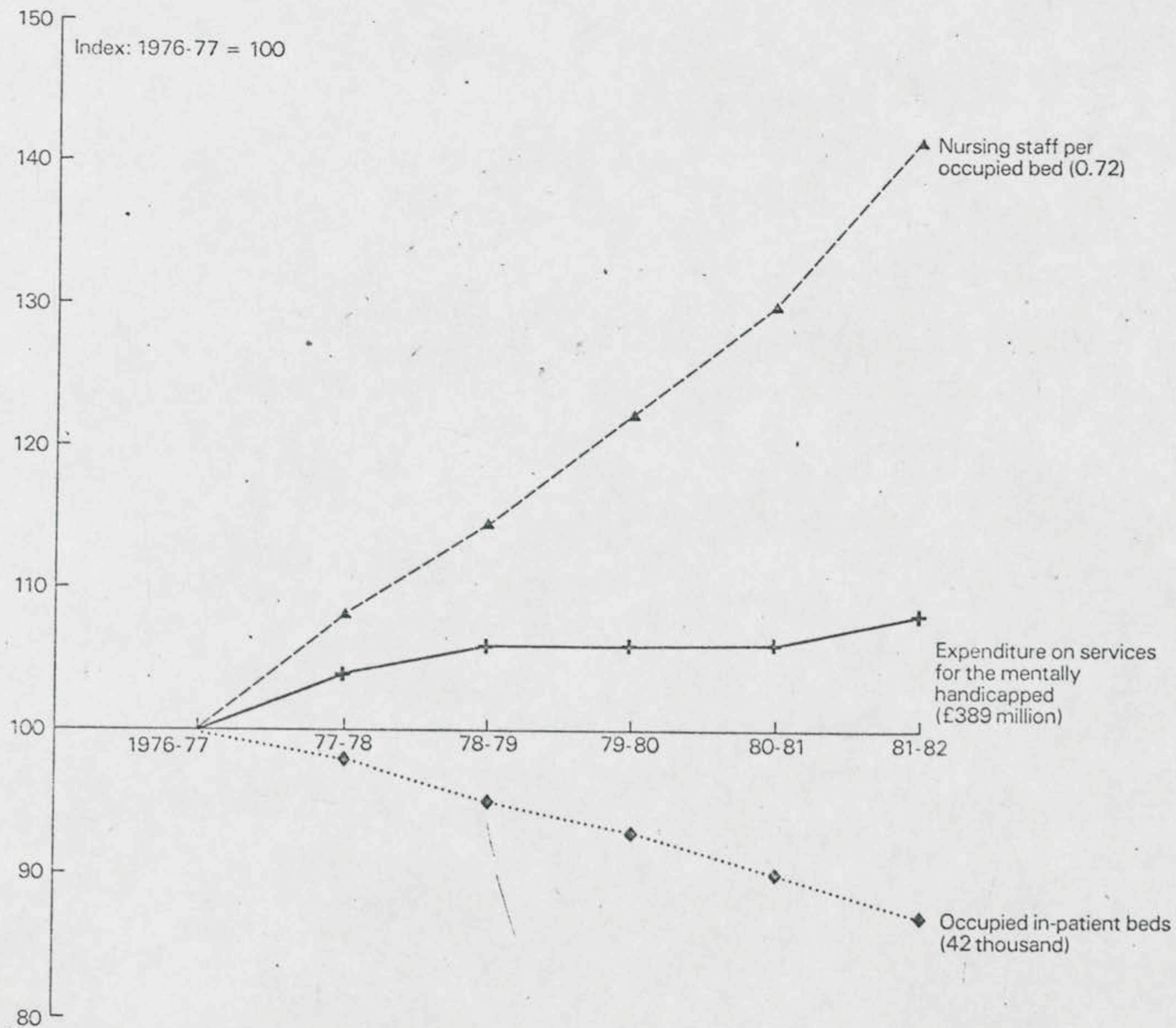
2.27 The objectives for the pattern of care for mentally handicapped people were set out in the 1971 Government White Paper "Better Services for the Mentally Handicapped". Although the shift in the balance of care between hospital and social services provision has been slower than was originally hoped, Figures 11 and 12 show that steady progress is being made in hospital and local authority services.

Figure 11

HOSPITAL AND COMMUNITY HEALTH SERVICES FOR MENTALLY HANDICAPPED PEOPLE

Figure 11
Hospital services for mentally handicapped people 1976-77 to 1981-82

Figures for 1981-82 are given in brackets



2.28 Between the beginning of 1976 and the end of 1981, the numbers of mental handicap in-patients fell by over 6½ thousand; the decrease was particularly dramatic so far as children were concerned. Since 1976, the number of mentally handicapped children in hospital has fallen from well over 4,000 to below 2,000 now, as a result of discharges, fewer admissions, and children growing up. Expenditure on hospitals has risen despite these falling numbers, to secure some essential and overdue improvements. The ratio of nursing staff to residents has risen by ~~about~~ 46% between 1976 and 1981. Similarly, there has been an improvement in the ratio of physiotherapists, psychologists and other professional staff to patients.

2.29 The growth in medical and nursing staff numbers working in the mental handicap services is shown below:

	1976	1981	annual percentage increase
Doctors: Consultants and Juniors	200	250	4.7%
Nursing staff	24,800	30,400	4.2

Some of these staff provide services for day patients and patients in the community, as well as for people resident in mental handicap hospitals.

2.30 Expenditure on local authority services for mentally handicapped people has risen markedly over the period, reflecting progress in building up community-based services for mentally handicapped people and their families.

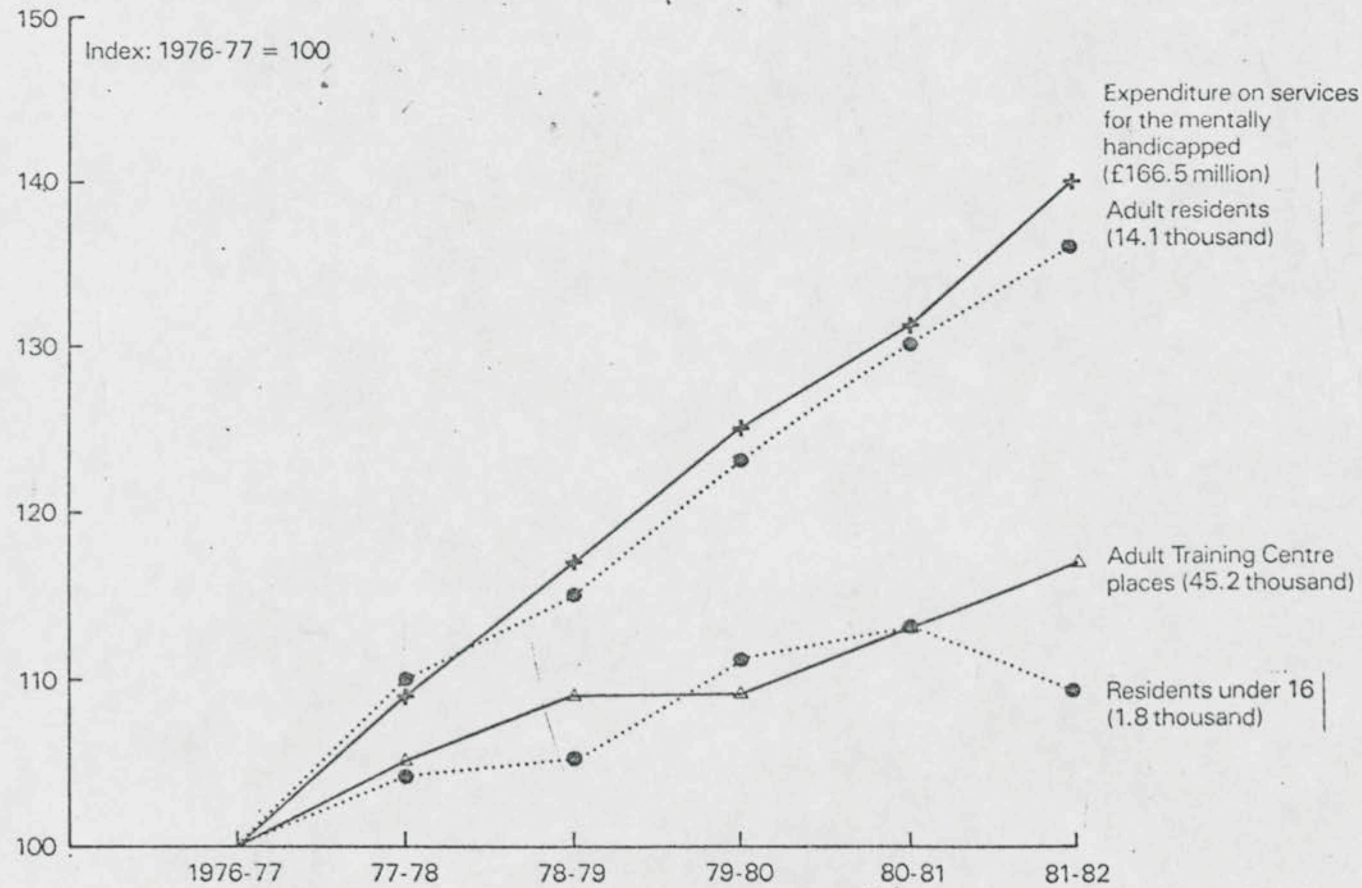
Figure 12

LOCAL AUTHORITY SERVICES FOR MENTALLY HANDICAPPED PEOPLE

Figure 12

Local Authority services for mentally handicapped people 1976-77 to 1981-82

Figures for 1981-82 are given in brackets



SERVICES FOR DISABLED PEOPLE

2.31 Continued progress in maternity and paediatric care should help to reduce the incidence of congenital abnormality. Where disability cannot be prevented, the services aim to reduce its effects and to enable people to lead purposeful lives, if possible in the community.

2.32 People who do become disabled have access to a wide range of hospital, community and primary care for treatment and rehabilitation. In addition, the NHS provides seven specially designed and staffed units for treatment and rehabilitation of people with severe spinal injuries. These cost some £7 million to run in 1981-82. Since 1971, 77 Younger Disabled Units(costing £20m in 1981-82) have been established. These provide a mixture of long-term and short-term care and relief residential care for disabled people under retirement age and enable patients to maintain as independent a life as possible. Before the 1970s many severely disabled people in younger age groups were placed in geriatric wards.

2.33 There has been increased expenditure and emphasis on local authority services specifically for disabled people, such as improved domiciliary services including day centres. Schemes pioneered by local authorities have included the use of foster families for physically disabled adults, night-sitting services, specialist home help services and short term care in residential homes to assist families looking after disabled relatives. Many of these schemes are funded in part by health authority joint finance.

2.34 In addition, the Department of Health provides artificial limbs, wheelchairs, hearing aids, and other appliances to people with permanent disability. The Department also supports voluntary organisations in the disability field, many of whom are developing a variety of schemes to help disabled people live more independent lives, whether in residential care or in the community; for example, increased provision of respite care and care attendant schemes to relieve pressure on caring

relatives. The Family Fund, which helps to meet special financial needs of families with severely handicapped children, disbursed £4.6m in 1982. Expenditure on all the Department's central services helping disabled people totalled £75m in 1981-82.

PRIMARY AND COMMUNITY CARE

2.35 Primary care is . provided partly by independent contractors - family doctors, general dental practitioners, opticians and pharmacists - through the family practitioner services; and partly through health authorities' community health services. The community health services include health visitors, district nurses, midwives and psychiatric nurses; school health services; chiropodists; and immunisation and cervial cytology services. The expansion of community nursing services to help the growing number of old people, and to improve community psychiatric services, has already been referred to. The trend described in Chapter 1 towards the earlier discharge of patients after acute hospital treatment and of mothers after the birth of their babies has also increased the role of the community nursing services.

2.36 Expenditure on the community health services overall rose from £584 million in 1976-77 to £665 million in 1981-82 - an average yearly increase in real terms of 2.6%. Over the same period the comparable real increase in spending on hospital services was 1.7%.

Family Practitioner Services

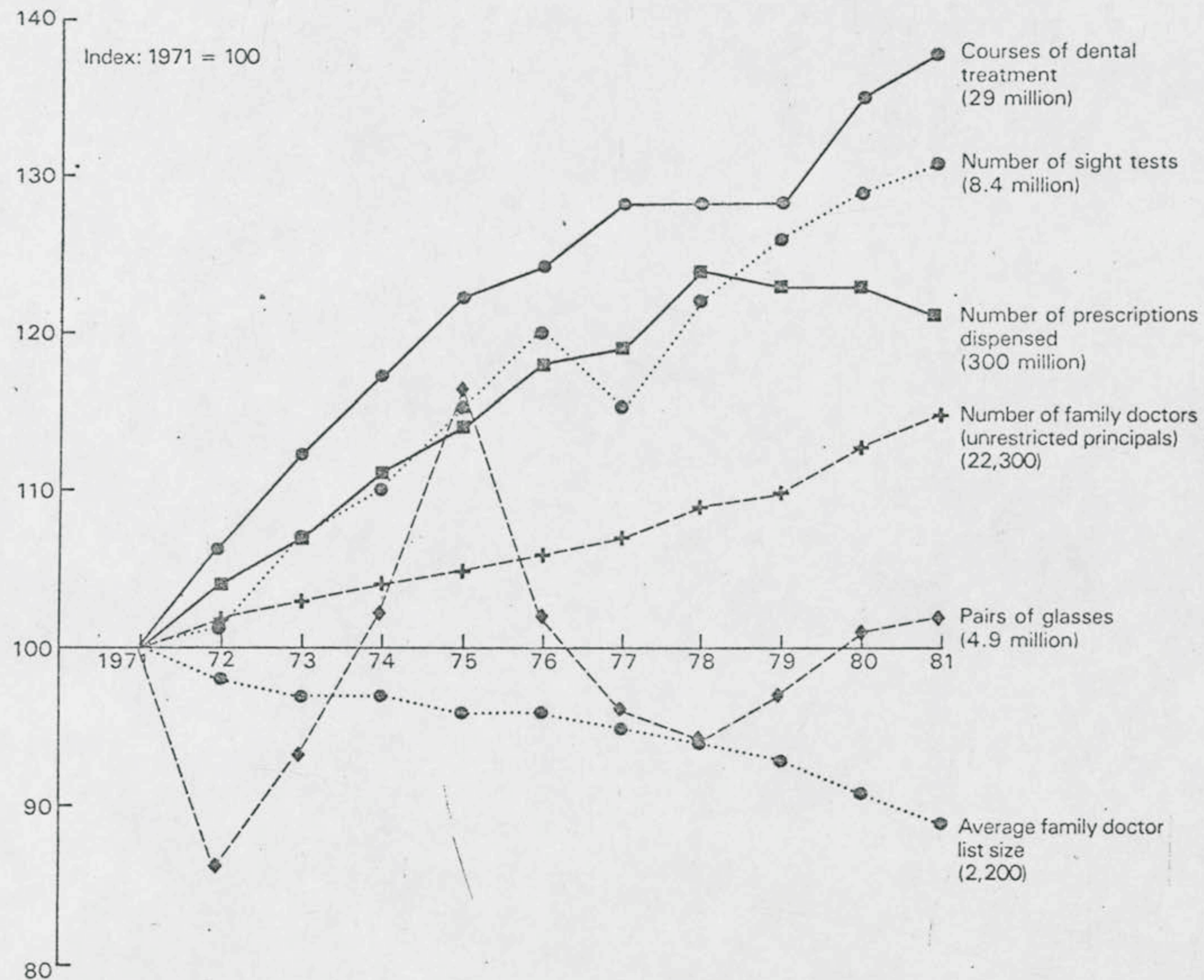
2.37 Figure 13 shows some key trends in Family Practitioner Services provision from 1971.

Figure 13 FAMILY PRACTITIONER SERVICES 1971-1981

2.38 Between 1971 and 1981 the number of family doctors in England increased by 15% from 19,374 to 22,304 and their distribution has improved. Over this period there was little growth overall in the population and, as a result, the average list size fell by 10½%. The number of patients for which a family doctor is responsible influences the amount of time he can give to each, so this reduction of about 1% a year represents a potential improvement in general practice care. However, this may be offset by the increasing demands placed on family doctors by the growing proportion of elderly people on their lists.

Figure 13
Family Practitioner Services 1971-1981

Figures for 1981 are given in brackets



2.39 Over the same period the proportion of family doctors in group practice rose from 58% to 75%, and over 80% of district nurses, midwives and health visitors are now attached to general practices. There were over 1,000 health centres in 1981, compared with 270 in 1971, and the proportion of family doctors working in health centres rose from 8% to 25% in 1981.

2.40 The amount of treatment provided under the General Dental Services has increased at the rate of some 3% per year, in spite of some short-term fluctuations. Within this overall increase, there has been a greater emphasis on the conservation of teeth, often involving complex restorative treatment (for example crowns, inlays and bridges) and advanced periodental treatment.

2.41 The number of prescriptions for drugs rose for most of the decade, but fell away slightly between 1977 and 1981. The number of sight-tests provided through the general ophthalmic service rose fairly steadily, though - probably as a result of changes in charges to patients - there were large fluctuations in the demand for NHS lenses.

Links with Personal Social Services

2.42 To encourage joint planning between health and local authorities and to stimulate developments in community care, some health authority funds have been specially designated since 1976-77 for use on projects planned and funded jointly with local authorities. From a modest beginning of £8 million (cash) in 1976-77, the money made available in this way for 'joint finance' projects has risen each year to nearly £85 million in 1982-83.

New policies for Community Care

2.43 The Government last year announced important initiatives to accelerate the transfer of patients and resources from hospital to the community. These initiatives were taken following full consultation with the NHS, local authorities, voluntary organisations, and others involved, on proposals published in "Care in the Community" (1981).

2.44 The new arrangements have now been introduced. They enable district health authorities to make continuing annual payments to local authorities and voluntary organisations for people moving into community care. They also extend existing joint funding arrangements for projects designed to help people move out of hospital.

2.45 It is also intended that district health authorities should be able to make payments to support local authorities and other bodies such as housing associations in providing education for handicapped people, and housing. This needs a change in legislation. Suitable powers are being sought in the Health and Social Services and Social Security Adjudications Bill at present before Parliament.

2.46 In addition the Government have made available some £20 million from 1983-84 for the central support of special initiatives designed to improve services for elderly people suffering from psychiatric disorder and for mentally handicapped people; to develop intermediate treatment for young offenders or potential offenders; to develop day care for the under-fives; and to improve primary health care in the inner cities. In 1983-84 there will also be a further substantial increase to £96 million in joint finance.

IMPROVEMENTS IN GEOGRAPHICAL DISTRIBUTION OF HOSPITAL AND COMMUNITY HEALTH RESOURCES

2.47 For historical reasons and because of population shifts, there are major imbalances in the level of health resources available in different Regions in the country. The south-east corner - the four Thames Regions - is well-provided relative to other parts of the country.

2.48 In the first twenty years of the NHS, resources were allocated primarily on the basis of existing provision, with additions when new hospital buildings were commissioned. This meant, in effect, that regions which had the most hospital provision received the most resources, while those with less developed services received less. In 1970, population - weighted to reflect the age-sex structure of each region - was introduced as a criterion in the distribution of resources. In 1977-78, following a major review by the Resource Allocation Working Party (RAWP) designed to improve equity in the distribution of resources, new and fuller criteria based on relative need as assessed through local population make-up and mortality patterns, were introduced. The results so far are summarised in Figure 14. This shows the changes in each region's distance from its target share of resources for current expenditure. The main achievement has been to reduce the degree of variation in the level of individual regions' resources. In 1977-78, the individual regional health authorities ranged from 15% above to 11% below their target shares of expenditure. By 1982-83, the range had been narrowed so that the best-off regions is now 12% above and the least well-provided region 6. below their targets.

2.49 There are also imbalances in the distribution of resources within regions. Regional health authorities are responsible for remedying these on the same principles as are used for re-distribution between regions.

2.50 Redistribution of capital resources is similarly being achieved by directing available resources to the relatively under-provided regions

Regions' distances[1] from Resource Allocation targets 1977-78 to 1982-83

16
14
12
10
8
6
4
2
TARGET
-2
-4
-6
-8
-10
-12

N.W. THAMES
N.E. THAMES
S.E. THAMES
S.W. THAMES
MERSEY
OXFORD
YORKSHIRE
W. MIDLANDS
S. WESTERN
WESSEX
NORTHERN
N. WESTERN
E. ANGLIA
TRENT

1977-78 78-79 79-80 80-81 81-82 82-83

[1] Distance from current expenditure targets expressed as percentages of regions' allocations.

CHAPTER 3 - ACHIEVEMENTS, PROBLEMS AND NEW DEVELOPMENTS

ACHIEVEMENTS

3.1 In many respects, the NHS has significantly improved services to patients over the last decade, and - particularly in recent years - has shown some encouraging trends in productivity:-

- the acute hospital services have both kept pace with the increasing demands of an ageing population and made modern medical techniques more widely available;

- perinatal mortality has fallen faster than in any previous period;

- hospital services for elderly, mentally ill and mentally handicapped people have been improved, and community services for these groups expanded;

- hospital and community services have been more closely integrated since they were brought together in 1974, and better links have been created between health and personal social services;

- primary care has also improved and expanded: there are more general practitioners with fewer patients on their lists; and more district nurses and health visitors many of whom are now attached to general medical practices;

- resources are more evenly distributed geographically;

- since 1975-76 the average costs of providing acute and maternity care have tended to fall, and by international standards this care costs less here than elsewhere;

- strict cash limits have been successfully introduced for health authority services.

PROBLEMS

3.2 Despite this there remain serious problems, for example:

- services for elderly, mentally ill and mentally handicapped people are sometimes inadequate or unsuitable;

- provision of such acute treatments as surgical hip replacement and haemodialysis in chronic kidney failure still falls short of need; and waiting lists and times are too long in some specialties and some localities, even after allowance is made for the effects of the industrial action in 1982;

- considerable variation in the costs of treatment in different geographical areas, particularly in the acute services, suggests scope for further improvements in efficiency;

- geographical imbalances in standards remain; in primary health care provision, the standard of general medical services in some inner city areas causes particular concern

- more effort needs to be put into persuading people to adopt healthier life styles.

3.3 More resources will be needed to remedy these and other deficiencies, and to provide for the continuing growth in the number of elderly people. But the money available to the NHS depends on the performance of, and the weight of other demands on, the national economy. The NHS should therefore look first to improvements in the use of existing resources to provide better services.

3.4 The systems for the planning and management of health authority resources, for budgetary control and audit of both capital and current expenditure, and for the identification and costing of future developments are basically sound. Some weaknesses have, however, become apparent in recent years:

- the chain of command has been excessively long, leading to duplication of effort and diffusion of responsibility;

- health service planning has not put enough emphasis on identifying immediate problems and

- manpower planning has lagged behind service development and financial planning, and it is not clear that all the growth in staff not directly concerned with patient care has been justified;

- there has been difficulty in meeting the running costs of some new hospitals planned in the early 1970s when the growth in current spending was higher than it has been since 1975;

- information for planning, and for assessment and improvement of performance has been inadequate, particularly because of difficulty in linking activity, financial and manpower information and because some information has become available too late.

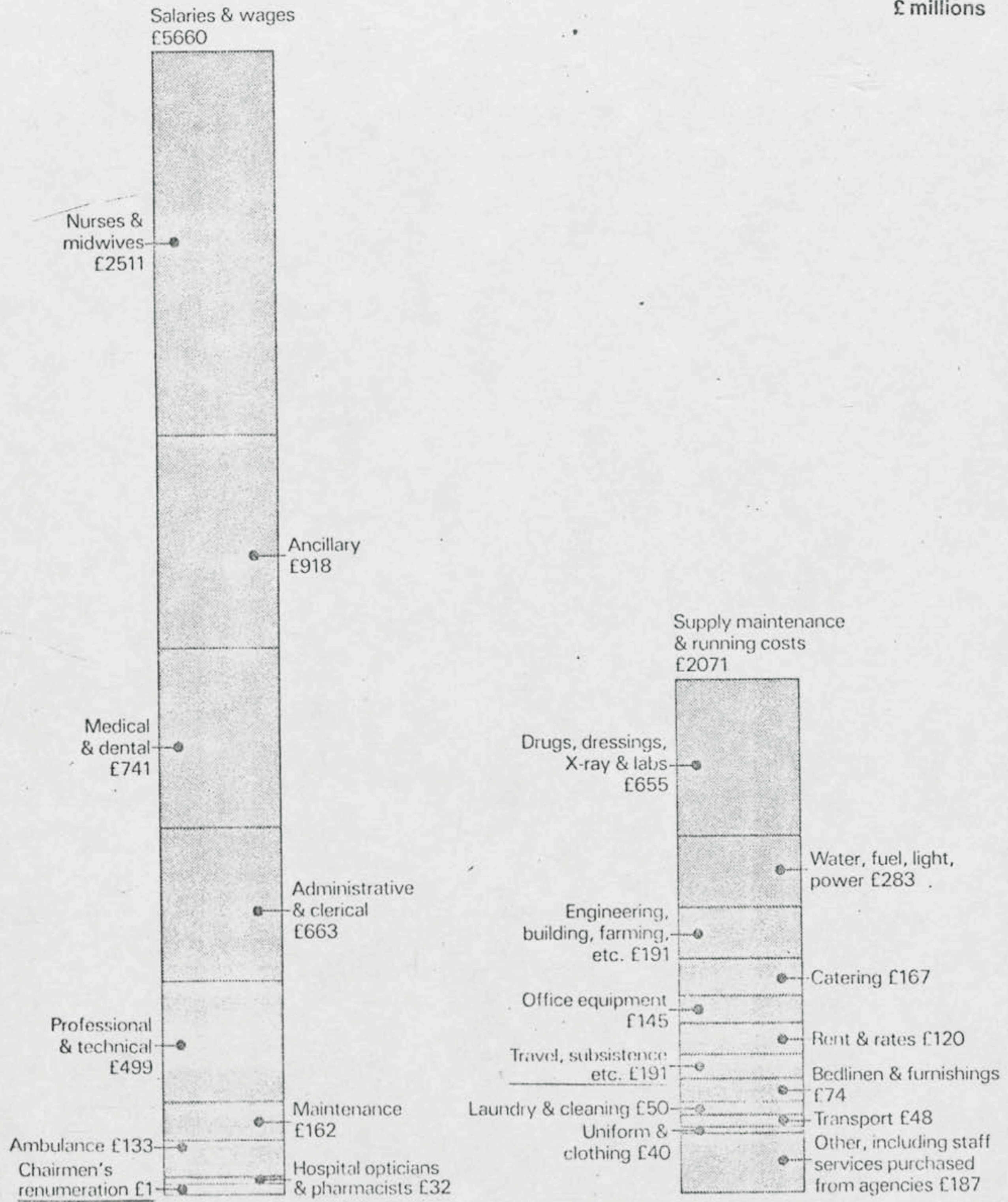
More generally, there has been a lack of sustained and systematic pressure to increase efficiency. There has been a good deal of work on efficiency but it has been ad hoc, and improvements in productivity have tended to depend on reductions in length of stay in hospital. It is now necessary to search rigorously for new ways of improving efficiency, looking nationally at all areas of work, and comparing the performance of individual health authorities.

NEW DEVELOPMENTS

3.5 The Government have recently taken or set in hand a number of initiatives to tackle these weaknesses. They include changes to the structure of the NHS; a new machinery for reviewing health authority performance, new arrangements to plan, control and monitor manpower, improvements in audit and information for both central and local monitoring, a new scrutiny procedure for administrative and managerial functions; measures to improve efficiency in specific areas such as purchasing goods and

Figure 15

Health Authority expenditure on staff, goods, and services in 1981-82



services. Health authorities spend some £2 billion a year on a wide range of goods and services, as Figure 15 shows broadly and Annex C in more detail. But the large bulk of their expenditure is on manpower. The measures for improving efficiency and monitoring performance that are described here will in due course influence all types of health authority expenditure, but the changes in structure, the new measures for performance and planning review, and the innovations concerned specifically with manpower can be expected to make a particular impact on manpower control and efficiency.

[Insert Figure 15 here]

Health Authority Structure

3.6 In April 1982 the Government established a simpler and tighter health authority structure, which itself should provide a greater degree of control. Under the 14 regional health authorities

- the 90 Area health authorities comprising 199 Districts are replaced with a single structure of 192 District health authorities. The number of chief officer teams has fallen from 251 to 193, reducing duplication and referral "up the line". Authority members are now better placed to plan for the needs of their localities and to answer for the local working of the NHS;
- the "chain of command" is shortened by removing the sector management level within the district and increasing management responsibility at unit - that is hospital or community service - level. Management skills are now focussed where they are needed;

- the arrangements for obtaining advice on management issues from health professionals are simplified.

In effect, one major layer of management has been removed and the rest has been simplified. These changes are expected to yield savings in management costs of some £30 million a year from 1984-85. These savings will be available to improve services to patients Legislation has also been introduced to remove the present administrative dependence of family practitioner committees on district health authorities and make them directly accountable to the Secretary of State for all their functions.

Regional Reviews and the Planning System

3.7 The maximum delegation of responsibility to local health authorities must be accompanied by systematic monitoring to ensure that district health authorities are properly accountable through regional health authorities to the Secretary of State and to Parliament. The planning system remains essential for monitoring the performance of health authorities in meeting the Government's broad policy objectives and strategies, but it has now been simplified. The Government have also introduced annual reviews to hold health authorities to account for their management of resources; these will include monitoring of strategic planning as well as progress in achieveing agreed objectives. Starting last year, DHSS Ministers hold these reviews with the chairman and chief officers of each region. Parallel reviews of districts are being held by regions. In each review the aims are:-

- to ensure that the authority is using the resources allocated to it in accordance with the Government's policies, to agree with the chairman on the progress and development to be achieved in the ensuing year, and to review progress against previously agreed plans and objectives;

- to assess the performance of regions and their districts in using resources, including manpower. Through these reviews Ministers will hold regions to account; and regions will in turn hold their constituent districts to account.

Performance Indicators

3.8 A set of indicators of performance for use in regional and district reviews was developed and tested jointly by the Department and the Northern Regional Health Authority during the first half of 1982. The indicators enable comparisons to be made between health authorities in four major areas: clinical activity, manpower, finance, and estate management. They have been used on an experimental

basis in the last seven of the 1982 regional reviews. The various indicators are looked at together in these reviews to gain an overall impression of activity and resource use within the region, because the aspects of activity they cover are inter-dependent. Questions about apparently atypical patterns of activity and resources use are then raised, as the starting point for further investigation. Regions are expected to follow these up with their districts and report back. The first such accounts of follow up will be made during the 1983 reviews. The indicators have already been revised to reflect experience of their use in 1982; those for use in 1983 are summarised in Annex E. Later in the year, the values for all the indicators for every health district in the country will be published. This will enable any authority to compare its indicator values with those of any other district or districts it chooses.

3.9 Performance indicators require further development in order to achieve their maximum potential. This will mean both working out indicators for types of activity not yet covered, and the assessment of existing indicators in the light of further experience. A joint NHS/DHSS group is to oversee this development. Performance indicators are also being developed for family practitioner committees, as an aid to local management and to help the Department compare their administrative performance.

Manpower Planning and Control

3.10 Efficiency in the use of manpower is of key significance if further improvements in the service are to be achieved. The Department is therefore taking steps specifically aimed at strengthening manpower planning and control.

3.11 Manpower indicators are included in the performance indicators already described. In addition, health authorities were last autumn required to review their staffing plans in line with current expenditure allocations for the remainder of the present financial year and to notify the DHSS of their manpower estimates for March 1983. These have been discussed and agreed between the DHSS and regions. In future, manpower levels and plans will be reviewed regularly to ensure that they remain in line with plans for improving efficiency and developing services within available finance.

District annual programmes for 1983-84 are to include manpower targets for each main staff group. Regions must satisfy themselves that these targets properly reflect resource assumptions and service and efficiency plans and bring them together to form regional targets. These will be agreed with the Department and monitored through regional reviews and new quarterly returns on staffing levels which were introduced last year.

3.12 Because of the key importance of manpower efficiency, the complex and widely differing circumstances in which NHS staff are used, and the concern expressed in Parliament and elsewhere about manpower levels in the NHS, the Government have recently announced the creation of a special inquiry into NHS management.

3.13 The inquiry is headed by Mr Roy Griffiths, deputy chairman and managing director of Sainsburys. It will be able to investigate NHS resource use as fully as its members think necessary, and will advise the Secretary of State for Social Services on what further management action if any is needed either centrally or by health authorities.

Information

3.14 A Steering Group chaired by Mrs Korner (formerly Vice-Chairman of South Western RHA) is reviewing the NHS's collection and use of information. The main aim is to get better and earlier information for local management, including where possible data which links activity and outputs with statistics on financial and manpower resources, so that the resource cost of activities is known better. There will be a common core of information so that different health districts can be compared more easily and information can be more effectively aggregated at regional and national level.

Audit of NHS Performance

3.15 Changes are taking place in the internal and external audit of the NHS. A Working Party under the chairmanship of Mr Patrick Salmon has recently concluded a review of the standard of internal and external audit in the NHS. Additionally the accounts of eight district health authorities will be audited by private firms for an experimental period of three to five years, starting with the accounts for the year ending 31 March 1983. This experiment, to discover the cost-effectiveness of using private firms to audit the NHS, will be extended to a further 6 health authorities for the year ending 31 March 1984. About 10% of the total external audit capacity is devoted to looking at "value for money". Discussions are also taking place with the Exchequer and Audit Department to see if there is scope for greater co-operation in mounting special reviews in areas thought likely to result in savings. Matters of significance arising out of external audit may be pursued through the new regional review system, as well as through the normal reporting procedures. In December 1982 the DHSS called on all Health Authorities to review their security arrangements in relation to supplies, stores and articles in use, and to report on progress towards new strategies by December 1983. The DHSS has also commissioned a firm of accountants to review existing procedure in this area.

Rayner scrutinies

3.16 Since 1979, many of the activities of central Government Departments have been the subject of special scrutinies carried out under the auspices of Lord Rayner. These scrutinies begin by considering whether a given activity needs to be done at all; and then look in detail at efficiency of performance. These studies have been very successful in central government and a similar approach is being introduced in the NHS. Scrutinies are being done regionally by senior NHS officials reporting to the regional chairman, who will in turn report to the Secretary of State for Social Services. The 11 studies in the initial programme are listed in Annex D. The topics include for example aspects of new hospital planning, staff recruitment, the ambulance service, collection of revenue, catering and storage of supplies.

Management Advisory Service

3.17 A trial is being conducted in the Oxford and South Western Regions to assess the benefits of establishing a Management Advisory Service to provide

regional and district health authorities with an independent assessment of their services. Ministers will consider establishing similar arrangements on a wider basis in the light of an independent evaluation of the trial.

Promoting more cost-effective practice in the NHS

3.18 The DHSS's health services research programme, which is complementary to the mainly biomedical research programme of the Medical Research Council, includes two developments of particular potential importance.

3.19 Although there are a large number of clinical trials in this country, research into the economic consequences of other aspects of clinical practice has been hampered by the comparative crudeness of available costing data. To help remedy this, the Department has recently promoted the development of a method of specialty costing. This has been tested successfully in seven Districts. In addition an attempt is being made to develop a practicable method of patient, or disease, costing through a Financial Information Project based in the West Midlands.

3.20 Efficiency may be better promoted if clinicians themselves are given more incentive to economise in the use of the various resources at their disposal. The Department is therefore sponsoring research to see whether clinical budgeting for consultants and their clinical teams would improve "value for money" and so enhance clinical practice.

Drugs

3.21 Drug costs represent about 10% of NHS spending. To encourage more cost-effective use of drugs, family doctors are provided with information on the comparative costs of different drugs. Those who themselves wish to audit their prescribing are given a regular analysis of their prescribing patterns and their costs. This service is to be improved by the computerisation of prescribing data. These measures are supported in the recently published report of an Informal Working Group on Effective Prescribing and, with other recommendations, are the subject of consultation with interested organisations. The main central influence on the purchase cost of drugs is the Pharmaceutical Price

Regulation Scheme. The Government have announced that the working of this scheme is to be reviewed.

Hotel Services, Supplies, Capital and Land

3.22 The initiatives described above are general in their application. They are potentially relevant to all aspects of health authority performance and expenditure. There have also been initiatives to improve efficiency and cost-effectiveness in the acquisition or use of specific services and assets.

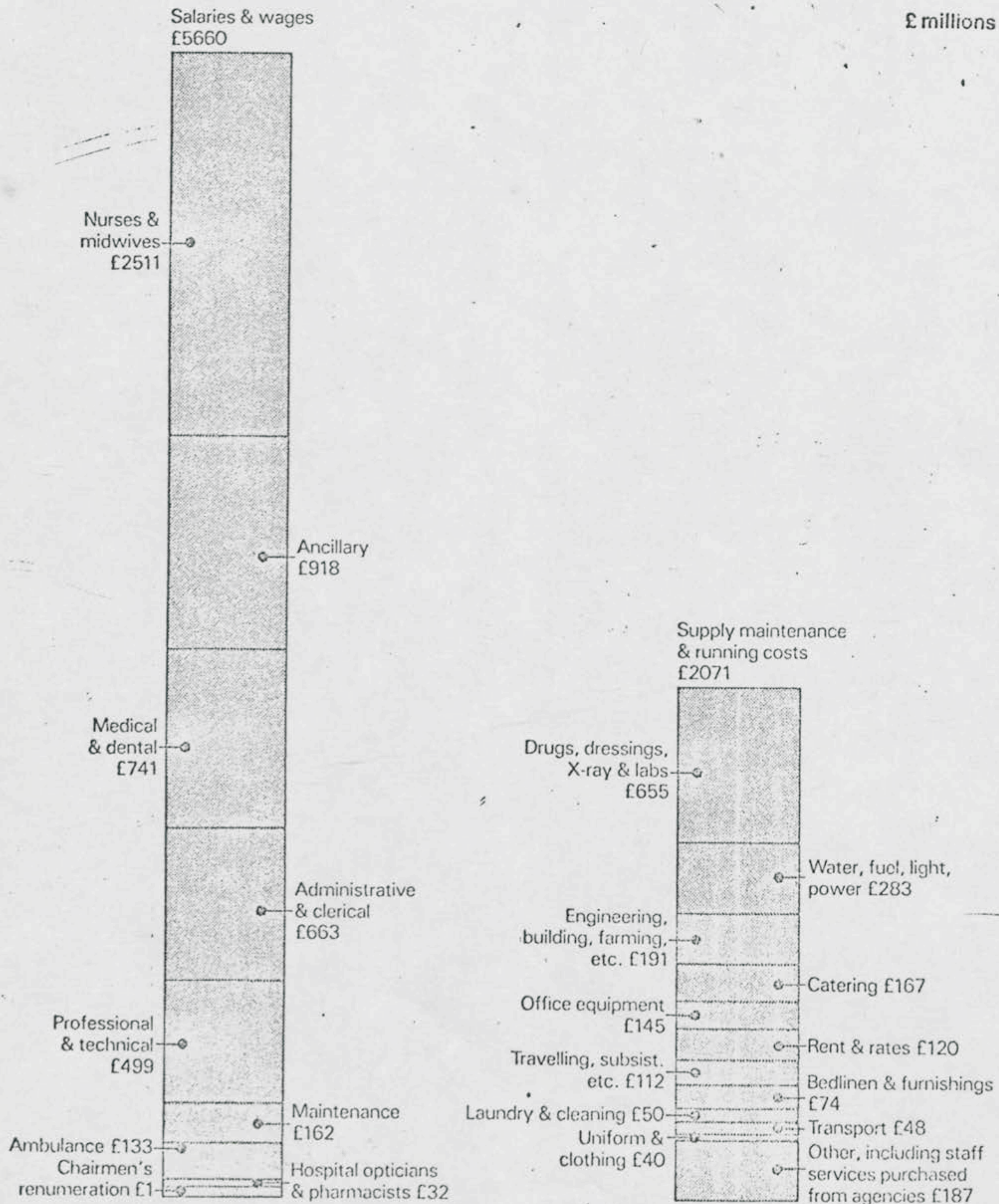
3.23 Figure 15 shows that health authorities spend over £1000 million a year on "hotel" functions such as domestic, laundry and catering services. In 1981-82, only £17 million of this was contracted out; the rest was provided by direct labour (though authorities do contract out some £160 million of spending on services overall). Through an initiative announced to Parliament in February 1983, the Government are promoting competitive tendering for the supply of domestic, laundry and catering services between health authorities' in-house direct labour services and private external contractors. Consultation is in progress on the detail The new arrangements should ensure that the discipline of market tendering and pricing is brought fully to bear on this major area of NHS spending. Savings will be kept by the health authorities who make them, and will contribute to the development of patient services. To ensure that private contractors can tender on a fair and equal basis, the Chancellor of the Exchequer has announced his intention to seek powers to remove the anomaly under which health authorities pay Value Added Tax on most contracted-out services.

3.24 Given authorities' large expenditure on general supplies, efficient purchasing is vitally important. The Government have therefore set up a Health Services Supply Council to help health authorities improve their purchasing arrangements. The Council

has already put proposals to regional health authorities on how the NHS supplies services should be organised in future; advised health authorities to introduce computer-based information systems to improve their procurement decisions, and on the application to the NHS of the Government's policy for using public purchasing to improve the competitiveness of UK suppliers; and supported the introduction of a quality assurance scheme designed to help the NHS to purchase goods manufactured to an acceptable standard. Each of these initiatives is subject to continuing surveillance by the Council. The Council is now focussing more on specific areas where improved value for money can be achieved. These include the identification of new purchasing arrangements which will result in savings; the development of a means of monitoring the effectiveness of the Council's policies; a review of training for supplies staff and a review of storage and distribution arrangements.

3.25 Cost effective capital investment is one of the avenues to future efficiency. The DHSS already issues advice on building standards and design to increase efficiency and reduce capital and running costs, for example through energy conservation.

Figure 15
Health Authority Expenditure on staff, goods, and services in 1981-82



In 1982, the DHSS advised health authorities on investment and option appraisal techniques to improve the quality of decisions on the use of capital.

3.26 Last year, the DHSS encouraged health authorities to make better use of their estate by selling surplus land and property. The extra resources available to health authorities from such sales have grown: in 1981-82, 1199 acres of land were sold bringing in about £19 million, compared with 386 acres in 1976. This initiative was followed by an enquiry, by a team including two members with relevant private sector experience. The team was asked to recommend ways of making the best possible use of the NHS estate and of identifying and disposing of surplus land and property. Its report was published in January 1983, and is being energetically followed up.

FUTURE PROSPECTS

3.27 The Government are committed to an efficient National Health Service; and appreciate the pressures to cater for the growing numbers of very old people, to improve standards and to make modern medical techniques more widely available. However, service expansion cannot be provided just by shifting more resources, especially manpower, into health care. There are limits to what the economy can afford, and growth must, as in any other enterprise, depend partly on increasing productivity.

3.28 The analysis in Chapters 1 and 2 shows that in recent years the NHS has in some important respects an encouraging record of improving efficiency and redeploying resources to meet national priorities and local needs. There is no doubt that the service responded to the discipline of cash limits by releasing more resources through lower average acute case costs and by meeting new needs through redeployment as well as growth.
The Government are accelerating progress by a series of initiatives which tighten further the disciplines of planning and accountability and give much higher priority to improving efficiency. Regional authorities have agreed that they will seek to improve efficiency by at least ½% a year. At the same time districts and managers at a local level have been given

more responsibility and central policies have been made more flexible. The Government hope that the NHS will respond by speeding up the improvements in efficiency to provide further development of services to patients within the inevitably limited resources that the economy can afford for health care.

NOTES ON EXPENDITURE, COST, MANPOWER AND ACTIVITY DATA

A: GENERAL

1. All figures relate to England only unless otherwise stated.

2. Unless otherwise stated, all figures for health and personal social services expenditure, manpower, and activity derive from regular returns made by health and local social services authorities to central government. Aggregates of these returns are published annually. The latest publications are:

Health and Personal Social Services Statistics 1982; HMSO.

Health Services Costing Returns Year Ended 31 March 1981; DHSS and Welsh Office.

Hospital In-Patient Enquiry; Main Tables for 1978 (HMSO)
Summary Tables for 1979 (HMSO)

In-Patient Statistics from the Mental Health Enquiry for England, 1978; HMSO.

3. The first two publications mentioned are the main sources, and contain figures up to the financial year 1980-81, or the calendar year 1980 as appropriate. Figures for the financial year 1981-82 and the calendar year 1981 used in this review will be published in the appropriate series in due course. The unit costs for 1981-82 shown in Figure 3 (Chapter 1), and the 1981-82 expenditure figures for the different patient groups and personal social services activity figures given in Chapter 2, are all provisional and liable to alteration once the returns on which they are based have been fully verified and analysed.

4. Figures are in most cases rounded; but all percentage changes and annual rates of growth are calculated on unrounded figures.

5. The programme budget method used to bring together activity and expenditure figures was described in "Priorities for Health and Personal Social Services in England" (HMSO, 1976). A

fuller account is in "Programme Budgeting in the DHSS" by Mrs G T Banks in Chapter 8 of "Planning for Welfare; Social Policy and the Expenditure Process" (ed. Booth) (Blackwell and Robertson 1979).

6. The DHSS has provided the House of Commons Select Committee on Social Services with retrospective programme budget analyses each year since 1980. This material, including notes of caution on the limits of its accuracy, has been published by the Committee in Minutes of Evidence associated with its reports on Public Expenditure on the Social Services in the Parliamentary sessions for 1979-80, 1980-81 and 1981-82.

EXPENDITURE AND COST FIGURES

7. All expenditure and cost figures relate to the financial year ending on 31 March, and are gross (that is they include revenue from charges to patients.) They are presented on a common 1981-82 price base unless otherwise stated, and therefore illustrate trends in real resources.

8. The 1981-82 price base for expenditure and cost figures has been obtained by adjusting for known overall movements in the price of staff and non-staff resources used in the NHS and the personal social services respectively.

9. In Table 1 of Chapter 1, in Figure 15 of Chapter 3, and in Annex C, expenditure on agency staff is included in expenditure on

goods and services purchased by health authorities rather than in expenditure on staff.

MANPOWER

Sources

10. The manpower figures are based on health and local authority census returns at 30 September each year, and on returns from other agencies as appropriate.

Definitions and Coverage

11. NHS manpower numbers are shown as whole-time equivalents based on contractual hours, with part-time staff being counted on the basis of the relationship between their hours and the full-time contractual hours.

12. Except where noted otherwise, the manpower groups are defined as follows:-

a. Medical and dental staff: excludes hospital practitioners, part-time medical officers (clinical assistants), general medical practitioners participating in Hospital Staff Funds, and occasional sessional staff in the Community Health Services; but includes locums.

b. Nursing and midwifery staff: includes agency nurses and midwives, and health visitor students; but excludes student nurses (community).

c. Professional and technical staff: excludes Works staff.

d. Administrative and clerical staff: includes staff of the Dental Estimates Board, and the Prescription Pricing Authority.

e. Ambulance Officers and Control Assistants are included with Ambulance Staff and not with Administrative and Clerical Staff.

Adjustments of Manpower Figures to obtain a comparable series

13. The manpower figures for 1971 and 1976 have been adjusted to allow for changes in NHS functions in 1974 and reductions in the contractual hours of some staff groups during the period 1971-1981 as follows.

14. The actual numbers of whole-time equivalent staff employed in the hospital and community health services are given in Table A below, unadjusted and as previously published.

Table A - Unadjusted Figures

	1971	1976	1981
Medical and dental	24,600	34,100	39,000
Nursing and midwifery	256,900	341,700	391,800
Professional and technical	38,500	52,500	65,200
Works and maintenance	21,800	25,000	27,200
Administrative and clerical	62,500	98,500	108,800
Ambulance	-	17,200	18,200
Ancillary	164,900	173,600	172,200
TOTAL	569,200	742,500	822,400

15. Following the NHS re-organisation in 1974, staff providing community health services who were previously employed in Local Authority Health Departments were transferred to Area Health Authorities, while some other staff were transferred from health to local authorities. Table B shows the estimated numbers of staff that the NHS would have needed to employ had these changes been in effect in 1971.

Table B - Figures for 1971 adjusted to show estimated numbers needed had health authorities' functions then been as they were after 1974

	1971	1976	1981
Medical and dental	28,200	34,100	39,000
Nursing and midwifery	285,400	341,700	391,800
Professional and technical	38,500	52,500	65,200
Works and maintenance	21,800	25,000	27,200
Administrative and clerical	70,400	98,500	108,800
Ambulance	15,200	17,200	18,200
Ancillary	168,000	173,600	172,200
TOTAL	627,500	742,500	822,400

16. Over the period 1971-1981 a number of significant changes were made in the basic working week of most staff groups. The basic hours of nurses and midwives fell from 42 to 37½, and of administrative and clerical staff from 38 to 37. Table C below shows (together with the adjustments at Table B above) the numbers of staff in these two groups that would have been needed in 1971 and 1976 had their contractual hours been as in 1981 (ie the whole-time equivalents in terms of the 1981 standard working hours of the actual man-hours in the earlier years). There were also reductions in the contractual hours of other groups (notably Ancillary and Professional and Technical staff). The position for these groups was however more complex and it has not been possible to calculate any reliable adjustments for them. The adjustments made therefore tend to understate the overall reduction in manpower resources caused by shorter contractual hours; and the figures still therefore tend to overstate the services' actual increase in manpower resources.

Table C - Further Adjustment of 1971 figures and adjustment of 1976 figures to show estimated numbers of staff needed in those years had contractual hours been reduced to the levels of 1981

	1971	1976	1981
Medical and dental	28,200	34,100	39,000
Nursing and midwifery	319,600	364,500	391,800
Professional and technical	38,500	52,500	65,200
Works and maintenance	21,800	25,000	27,200
Administrative and clerical	72,300	98,500	108,800
Ambulance	15,200	17,200	18,200
Ancillary	168,000	173,600	172,200
TOTAL	663,700	765,300	822,400

17. The adjusted figures for 1971 in Tables B and C include staff then working in the health departments of local authorities, whose work was transferred to the NHS in 1974. They do not, however, include those staff engaged in Treasurers', Works Personnel, Supplies and Computer Departments who provided the back-up to the Community Health Services because they were not transferred although the relevant funds were. As a consequence, the NHS had to appoint more staff to cover these central support functions when they were transferred in 1974. No adjustment has been made on this account, because the number of such extra staff cannot reliably be estimated; they are therefore included in the 6.4% increase in health authority administrative and clerical staff shown as occurring between 1971 and 1976.

18. The figures in Table C above are those used in Table 1 of Chapter 1; and comparable adjustments have been made to all the hospital and community health service manpower figures for 1976 given in Chapter 2. These adjustments are estimated; but, subject to the provisos in paragraphs 17 and 18 above, they indicate the broad changes that occurred in the real levels of health authorities' manpower resources between 1971 and 1981.

ACTIVITY FIGURES

19. Figures for hospital activity (ie numbers of cases treated and other patient services) are based on the annual hospital SH3 returns made to the Department and relate to calendar years. The number of in-patient cases is derived by counting all in-patient discharges and deaths. Figures for day cases are not available prior to 1972; estimates for the number of day cases in 1971 have therefore been made in Table 1 and for 1961 in Annex B. These estimates reflect an assumption that trends on day cases were the same as for in-patients. The number of out-patient attendances is composed of total out-patient and accident and emergency attendances by new and old patients; similarly the number of day attendances comprises total attendances by both new and regular day patients.

20. Activity figures for the Family Practitioner Services are based on information collected regularly from Family Practitioner Committees, the Dental Estimates Board and Prescription Pricing Authority and relate to calendar years. The number of general medical practitioners and their average list sizes are based on census data as at 1 October each year.

21. Personal social services activity statistics are derived from local social services authorities' annual returns to the Department. They are mostly census-based and relate to 31 March of each year.

B. SPECIFIC VARIANTS AND EXPLANATIONS

CHAPTER 1

22. The cost-weighted index of overall hospital and community health services activity in Table 1 on page ("Trends in manpower, expenditure and activity between 1971 and 1981 in the Hospital and Community Health Services") has been derived by weighting the rates of change in the various activities for 1971, 1976 and 1981 by their estimated shares of total hospital and community health service expenditure in 1980-81. No allowance has been made for any changes in the mix of cases within each

category of activity, but the result shows broadly the overall increases in output in these services between 1971 and 1981 (1971 = 100). The comparable index in Annex B has been similarly derived.

23. Due to a change of definition in 1972, activity figures for health visiting (number of persons visited) and district nursing (number of persons treated) are not available for 1971 on a basis comparable with later years. 1972 figures have therefore been used in Table 1, and the increase shown here for the first half of the decade is based on the period 1972-76. In this respect, the Table understates the increase in these activities over the ten years from 1971.

24. In Figure 3 ("Trends in Hospital In-Patient Costs"), the material relates to types of hospital. Maternity, mental illness, mental handicap and geriatric hospitals provide care mainly for patients within these specialties. However, acute hospitals also provide a significant amount of maternity and geriatric care as well as some psychiatric care in addition to the acute care which is received by the majority of their cases. The figures in Figure 3 for average case costs in acute hospitals include all cases in hospitals classified as acute, mainly acute or partly acute. However, the figures for average length of stay in the acute sector given in paragraph 1.14 are for acute cases only; they exclude maternity, psychiatric, and geriatric cases. They also exclude long-stay younger disabled cases.

25. The percentage changes in average case costs from 1971-72 to 1981-82 represented in Figure 3 are as follows:

CHANGES IN AVERAGE UNIT COSTS (Percentage change over previous year)

	Acute, Mainly Acute and Partly Acute hospitals (Cost per In-patient case)	Maternity hospitals (Cost per In-patient case)	Mental Illness hospitals (Cost per In-patient day)	Mental Handicap hospitals (Cost per In-patient day)	Geriatric hospitals* (Cost per In-patient day)
1971/72	-	-	-	-	-
1972/73	4.3	9.0	9.1	10.0	-
1973/74	5.0	8.1	10.2	9.6	-
1975/76+	4.2	1.8	4.2	2.9	-
1976/77	-3.9	-0.5	1.5	-0.1	1.0
1977/78	0.9	-0.5	7.2	5.4	3.0
1978/79	2.7	-4.6	4.3	5.2	5.4
1979/80	-5.1	-7.0	1.4	1.3	0.1
1980/81	-0.7	-2.0	3.6	4.0	4.0
1981/82	-0.9	6.8	3.3	4.8	-0.7

* No information on in-patient costs in Geriatric hospitals is available before 1975-76

+ No information is available for 1974-75 and the 1973/74 to 1975/76 growth rate is given

CHAPTER 2

26, Manpower

Figures exclude locum medical/dental staff and agency nursing staff, as accurate data are not readily available which categorise these staff by area of work or specialty; this is in contrast to Table 1 where such staff are included.

27. Figure 5

The year on year movements for District Nursing staff are not available on a consistent basis for the whole period because of intervening changes in the method of collecting district nursing staff statistics. A DHSS estimate of the trend is therefore shown.

28. Figures 6 and 10

Day Centre places in Local Authority mixed centres have been allocated pro rata between the elderly, younger physically handicapped and mentally ill.

29. Paragraph 2.8

Hospital nursing staff working particularly with the elderly are defined here as those receiving the geriatric lead: this covers qualified nursing staff and nursing auxiliaries working in geriatric wards and units but excludes all student and pupil nurses working in geriatric wards and units.

30. Paragraph 2.12

The figures for nursing staff in hospital maternity units and midwifery staff in hospitals shown here understate the total number of staff working in hospital maternity services as some district midwives in hospital deliveries.

31. Figure 8 and Paragraphs 2.13 to 2.21

This material on hospital acute services covers all hospital services except maternity, mental illness, mental handicap, geriatrics and facilities for the younger disabled.

32. Figures 9 and 11

When calculating the ratio of nursing staff to in-patient beds, it is not possible to disaggregate from the nursing figures those psychiatric nurses who are providing care in the community for all or part of the time. The figures therefore slightly overstate the number of psychiatric nurses providing in-patient care.

33. Figure 10

In 1981 the basis for counting residents was changed to exclude those who do not receive financial support from local authorities. The 1981 figure is therefore not fully comparable with earlier years.

34. Paragraphs 2.26 and 2.29

The figures for nurses working with mentally ill and mentally handicapped patients are based on authorities' returns of nurses working in mental illness or mental handicap hospitals and units.

ANNEX B

NOTES ON MANPOWER, ACTIVITY AND PRODUCTIVITY 1961-1971

Introductory

1. These notes record trends in health service manpower and activity over the period 1961-1971, and, by relating these two trends, give an indication of trends in productivity. The manpower figures are not directly comparable with those given in Figure 2 of the main text (the figures used here exclude locum medical and dental staff, agency nursing and midwifery staff, nursing cadet and staff at the Dental Estimates Board and the Prescription Pricing Authority), because similarly detailed figures are not available before 1971. But the trends shown by the 2 sets of data do enable some rough conclusions to be drawn over the period 1961-1981.

Manpower

2. The estimated numbers of whole time equivalent staff employed in the NHS in the period 1961-1971 are shown in Table I below. To provide a realistic assessment of manpower trends, adjustments have been made ov the period to reflect changes in the structure of the NHS and in the basic working week of nurses and midwives and of administrative and clerical staff, along the lines set out in paragraphs 14-17 of Annex A.

Table I

	1961	1971	annual percentage increase 1961-1971
Medical and dental	19,000	27,000	3.4
Nursing and midwifery	239,000	309,000	2.6
Professional and technical	25,000	39,000	4.6
Administrative and clerical	47,000	69,000	3.9
Ancillary	142,000	168,000	1.7
Others	31,000	37,000	1.9
Total	503,000	648,000	2.6

Activity

3. Details of the main hospital and community health services provided over the period 1961 to 1971 are given below:-

Table II

	Thousands		
	1961	1971	annual % rate of change 1961-1971
Hospital Services			
In-patient cases	4035	5171	2.5
Out-patient and accident and emergency attendances	40133	46260	1.4
Regular day patient attendances	445	2839	20.4
Community Health Services			
Health visiting - number of people attended	na	na	na
Home nursing - number of people nursed	na	na	na
Ambulance Services			
Total cases carried	16403	22335	3.1
Blood Transfusion Service (England and Wales)			
Bottles of blood issued	948	1358	3.7
Cost-weighted Index of change in overall Hospital and Community Health Services activity*	79	100	2.5

* This index is derived by the same method as the comparable index in Table 1 in Chapter 1 - see paragraph 23 of Annex A.

Productivity

4. Over the period 1961-1971, on the basis of the figures used in this Annex, activity grew by 2.5% per annum or 28% over the 10 years, while total staff numbers grew by 2.6% per annum or 29% over the 10 years.

HEALTH AUTHORITY EXPENDITURE ON STAFF, GOODS AND SERVICES IN 1981-82[1]

[as illustrated in Figure 15]

A. EXPENDITURE ON STAFF SALARIES AND WAGES (£ million)

1. Nurses and Midwives

Team nurses, specialists and divisional nursing officers, and others of nursing officer grade or above	133.2
All other trained nursing staff	1,529.2
Nursing assistants and auxiliaries	480.8
Unregistered/unenrolled staff in training	365.1
Nursing cadets and pre-nursing students	2.6
	2,510.9

2. Ancillary Staff £918.4

[1] Figures extracted from the 1981-82 National Summary of Health Authority Accounts (England)

	£m
3. Medical and Dental Staff	
a. Medical	
Consultants	305.6
Hospital doctors other than consultants	344.6
Health authority medical officers, and doctors (including trainees) working in Community medicine	52.3
	702.5
b. Dental	
Consultants	7.4
Hospital dentists other than consultants	8.5
Health authority dental officers, and dentists (including trainees) working in community dentistry	20.4
Other dental practitioners	2.0
	38.3
	740.8
4. Administrative and Clerical Staff	
Administrative and clerical staff	624.2
Ambulance staff on Administrative and Clerical salary scales	34.6
NHS staff on Local Authority salary scales	3.9
	662.7

£m

5. Professional and Technical Staff

	£m
Professions supplementary to medicine	214.5
Medical Laboratory scientific officers	109.3
Dental, pharmaceutical and all other technicians	89.7
Works staff	47.3
Scientists	33.6
Chaplains	5.0
	499.4

6. Maintenance Staff

	£m
Engineering trade grades	94.0
Building trade operatives	58.5
Planning estimators	9.1
	161.6

7. Ambulance Staff

	£m
Officers and control assistants (excluding those included with Administrative and Clerical)	9.8
Others	123.6
	133.4

8. Hospital pharmacists and opticians

Pharmacists	30.8
Opticians	1.1
	31.9

9. Chairmen's remuneration 0.8

TOTAL	£5,659.9m

[Note: payments to agency and other non-NHS staff included in Section B of this Annex (ie with expenditure on suppplies, maintenance, running costs etc)].

B. EXPENDITURE ON SUPPLIES, MAINTENANCE, RUNNING COSTS ETC 1981-82

ITEM OF EXPENDITURE	£m
1. Drugs etc	
Drugs, medical gases and dressings	266.8
Medical and surgical equipment	225.5
Laboratory equipment, servicing and non-NHS work	61.0
Patients' appliances and therapy equipment	55.9
X-ray equipment, materials and servicing	45.4
Fluoridation payments to water authorities	0.5
	655.1
2. Water, Fuel, Light, Power	
Oil	108.2
Electricity	73.4
Gas	58.9
Coal	21.0
Water	20.5
Other	0.6
	282.6
3. NHS Building stock and land	
Engineering maintenance and equipment	99.3
Building maintenance and equipment	85.3
Gardening and Farming	6.3
	190.9
4. Catering	
Provisions	165.9
Contract catering	0.7
	166.6
5. Office Equipment etc	
Telephones	56.7
Printing and Stationery	39.5
Office equipment	25.8
Postage	15.4
Advertising	8.1
	145.5

6. Rent and Rates

Rates	101.5
Rent	18.9
	120.4

7. Travelling and Subsistence etc

Travelling and subsistence	100.2
Removal expenses	11.7
	111.9

8. Bed linen and furnishings

Bedding and linen	42.4
Furniture	21.7
Crockery etc	9.5
	73.6

9. Laundry and cleaning

Cleaning	35.5
Laundry	14.3
	49.8

10. Transport

Fuel	19.1
Hire (including Hospital Car Service)	13.7
Maintenance and equipment	13.4
Vehicles purchased	0.4
Other	1.3
	47.9

11. Uniform and clothing

Staff uniform and clothing	24.7
Patients' clothing	15.6
	40.3

12. Agency and other non-NHS staff

Nursing	43.3
Administrative and clerical	7.3
Professional and technical	5.4
Medical and dental	3.8
Ancillary	2.3
Others	2.5
	64.6

13. Other

Contractual arrangements for patient care	31.8
Patients' allowances	8.3
Student bursaries	8.0
Payments for shared premises with local authorities (under National Assistance Act 1948)	4.9
All other expenses	68.9
	121.9
TOTAL	£2071.1

ANNEX D

RAYNER SCRUTINIES IN THE NHS

STUDY	SPONSORING REGION
Completed study	
1. Collection of payments due to health authorities under the provisions of the Road Traffic Act.	South West Thames
Studies currently identified to start in 1983	
2. The administrative arrangements for preparing the briefs for major hospital building schemes.	Northern
3. Arrangements for advertising for staff.	East Anglia
4. Documentation and procedures in the ambulance service.	West Midlands
5. Collection of income due to health authorities.	North Western
6. Policies and management for health authorities' residential property.	Oxford North West Thames
7. The storage of supplies.	North East Thames
8. Catering costs.	South East Thames
9. The cost and effectiveness of meetings of health authority officers.	Wessex
10. Procedures for acquisition, distribution and recovery of aids.	Oxford
11. Health Authorities' use of transport other than ambulance services.	Mersey

ANNEX E

HEALTH AUTHORITY PERFORMANCE INDICATORS BY DISTRICT FOR USE IN 1983

ACUTE HOSPITAL SERVICES

Activity Indicators (for General Medical, General Surgery, Trauma and Orthopaedic and Gynaecology Specialties)

1. Urgent, immediate or emergency in-patient admissions in relation to the population served.

2. All in-patient admissions in relation to the population served.

3. Average length of stay.

4. Average number of patients per bed per year.

5. Turnover Interval: average length of time a bed lies empty between admissions.

6. Day Cases as a percentage of deaths and discharges and day cases.

7. New outpatients [illegible] in relation to the population served.

8. Ratio of returning out-patients to new outpatients.

9. Admission Waiting Lists in relation to the population served.

10. Estimated days taken to clear waiting lists at present level of activity.

Financial Indicators (by hospital category)

11. Cost per day and per case by hospital and district. (Actual and "expected").

12. Actual and percentage component costs by hospital.

13. In-patient catering costs per in-patient day by hospital.

14. Domestic and cleaning cost per cubic metre by district.

Manpower (by district)

15. Percentage breakdown of registered, enrolled, learners, auxiliary nursing and midwifery staff for all acute, and mainly or partly acute hospitals.

16. Ratios of acute sector nursing staff to (i) number of day cases and in-patient cases and (ii) number of day cases and in-patient days.

17. Ratio of nursing auxiliaries/assistants to domestic staff in acute and mainly or partly acute hospitals.

ACCIDENT AND EMERGENCY SERVICES

Activity Indicators

18. New Accident and Emergency patient referral rate in relation to population served.

19. Ratio of returning Accident and Emergency patients to new patients.

Financial Indicators

20. Cost per new Accident and Emergency case by ospital and by istrict.

MATERNITY SERVICES

Activity Indicators (by District)

1. Percentage admissions resulting in a still or live birth.

2. All in-patient admissions in relation to the population served.

3. Average length of stay.

4. Average number of patients per bed per year.

5. Turnover Interval: ie average length of time a bed lies empty.

6. New out-patients in relation to the population served.

7. Ratio of returning out-patients to new out-patients.

Financial Indicators (for single specialty maternity hospitals)

8. Cost per day and per case by hospital and district.

9. Component costs by hospital (actual and percentage).

10. In-patient catering costs per in-patient day by hospital.

11. Domestic and cleaning costs per cubic metre by district.

Manpower Indicator (by district)

12. Ratio of midwifery and nursing staff in hospital maternity departments and community midwifery staff to numbers of all births in District (except for births in private hospitals).

SERVICES FOR THE ELDERLY

Finahcial Indicators

1. Cost per in-patient day by district and by hospital.

2. Component costs by hospital (actual and percentage).

3. In-patient catering costs per in-patient day by hospital.

4. Domestic and cleaning costs per cubic metre by district.

Manpower Indicators

5. Percentage breakdown of registered, enrolled, learners and auxiliary nursing staff in geriatric, long stay and mainly long stay hospitals by district.

6. Ratio of WTE geriatric nursing staff to occupied bed days in geriatric long stay and mainly long stay hospitals by hospital and by district.

7. Ratio of nursing auxiliaries/assistants to domestic staff in long stay and mainly long stay hospitals by district.

NOTE These indicators relate only to single specialty geriatric hospitals.

SERVICES FOR THE MENTALLY ILL

Financial Indicators

1. Cost per in-patient day by district and by hospital.

2. Component costs by hospital (actual and percentage).

3. In-patient catering costs per in-patient day by hospital.

4. Domestic and cleaning costs per cubic metre by district.

Manpower Indicators

5. Percentage breakdown of registered, enrolled, learners and auxiliary nursing staff for mental illness hospitals by district.

6. Ratio of whole time equivalent of mental illness nursing staff to occupied bed days in mental illness hospitals by hospital and by district.

7. Ratio of nursing auxiliaries/assistants to domestic staff in mental illness hospitals by district.

NOTE These indicators relate only to single specialty hospitals for the mentally ill.

SERVICES FOR THE MENTALLY HANDICAPPED

Financial Indicators

1. Cost per in-patient day by district and by hospital.

2. Component costs by hospital (actual and percentage).

3. In-patient catering costs per in-patient day by hospital.

4. Domestic and cleaning cost per cubic metre by district.

Manpower Indicators

5. Percentage breakdwon of registered enrolled, learners and auxiliary nursing staff for mental handicap hospitals.

6. Ratio of whole-time equivalent mental handicap nursing staff to occupied bed days in mental handicap hospitals by hospital and by district.

7. Ratio of nursing auxiliaries/assistants to domestic staff in mental handicap hospitals by district.

NOTE These indicators relate only to single specialty mental handicap hospitals.

AMBULANCE SERVICES

Financial

1. Cost in relation to population served.

2. Average cost in relation to patients carried.

3. Cost of management and supervision as a percentage of total cost.

Manpower

4. Overtime costs as a percentage of total staff wages and salary costs per ambulance staff.

LAUNDRY SERVICES

1. Laundry Cost per 100 articles by laundry.

ESTATE MANAGEMENT INDICATORS

1. Ratio of managed population to land owned or occupied.

2. Ratio of building area to beds and of expected building area to beds.

3. Maintenance and operation expenditure per annum and as 5 year moving average per 100 cubic metre per annum.

4. Ratio of energy usage of giga joules to 100 cubic metres and energy expenditure (£s) to giga joules.

5. Disposable land as percentage of all land.

6. Cost per 100 cubic metre to bring the condition of the hospital estate up to a serviceable standard (condition B).

WHOLE DISCIPLINE MANPOWER INDICATORS (by district)

1. Comprehensive staff cost (including overtime) per whole-time equivalent by major staff groups (administrative and clerical, nursing and midwifery, professional and technical, works, maintenance, medical and dental, ambulance, ancillary).

2. Percentage breakdown of staff (including agency staff) by major staff group by whole time equivalent.

3. Overtime costs as percentage of total staff wages and salary costs for each of the following staff groups:

i. nurses

ii. ancillary staff

4. Contribution of part-time staff to total whole-time equivalents for

i. qualified nurses

ii. unqualified nurses excluding learners

iii. ancillary staff.

OTHER MANPOWER INDICATORS (by district)

5. Ratio of Medical Laboratory Scientific Officers to number of unweighted laboratory requests.

6. Ratio of diagnostic radiographers to radiological units.

DEPARTMENT OF HEALTH & SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY

Telephone 01-407 5522

From the Secretary of State for Social Services

Mr Ingham

This arrived late last night - DHSS told us earlier that their SofS was contributing an article - I can't see the Guardian carrying it as an article though.

2

Peter Preston Esq
Editor
The Guardian
119 Farringdon Road
LONDON
EC1R 3ER

10 February 1983

Prime Minister

I doubt if the Guardian will print this, but it has some good material in it.

11/2

Were you aware of this? I have no objection!

11/2

Your leader of 3 February was correct in stating that the Government does not "admit to cutting" the National Health Service; it makes no such admission since such cuts have not taken place and are not planned.

Other aspects of the article could be misleading. I enclose an article which sets out the facts about the Government's commitment to the service. I hope you will feel able to publish it.

NORMAN FOWLER

File

D89

Mr Butler

Will this commission the material the PM wants?

10 DOWNING STREET

From the Private Secretary

2 September 1982

Mr. Scholar
Re: x/ — not by itself. I suggest you do ~~But there was a~~ y/. But you may like first to look at Z, which I passed to you or CF yesterday.
FERB 7.9.

Or shd I ask DHSS for GB figs on the basis at flag A?
MCS 7/9

NHS STATISTICS

Thank you for your letter of 27 August, and for all the work that must have gone into preparing the statistics that were attached to it. The Prime Minister was very grateful for this note.

I attach the final version of the note that I put to the Prime Minister for her trip to Scotland. I should be grateful if you could let me know if it contains any glaring errors. It would also be useful if you could possibly provide the run of figures showing the growth in real terms of gross expenditure on the NHS in Great Britain between 1979/80 and 1982/83, to complement the first line of the brief, which gives the figures in cash terms. Mark Dexter very helpfully sent me the corresponding figures for England, but it would be useful if the Great Britain figures could be provided.

I am copying this letter and its enclosure to Jill Rutter (HM Treasury).

W. F. S. RICKETT

Mrs. Carole Souter,
Department of Health and Social Security.

WR

PRIME MINISTER

c.c. Mr. Butler

Attached are:-

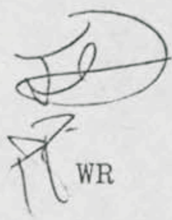
(a) Some statistics on the NHS, which I hope cover the points you made this morning;

(b) A speaking note for Ministers prepared by Mr. Fowler's Office;

(c) The brief you used for Questions in July;

(d) The extracts from the Report of the Royal Commission on the NHS pointed out by Sir Alec Merrison;

(e) The Vauxhall advertisement in the Daily Mail which you asked for.



WR

31 August, 1982.

NHS Statistics

1. Central and Local Government Expenditure on NHS, Personal Social Services, and Education (GB Totals) (CSO)

65% inc over 79/80

	78/9	1979/80	1980/81	1981/82	1982/83	83/84
NHS:	7.7	9.3 B	12.01B	13.4 B	14.5 B (6) (increase in cash terms over 1979/80 of 55%: the RPI has increased by about 40% in the same period)	15.3
Personal Social Services:	1.5	1.93B	2.30B	n/a 2.6	n/a 2.8	3.0 *
* Education:	8.8	10.01B	12.33B	n/a 13.4	n/a 14.29	14.16
Social Security Benefits:	16.4	19.4 B	23.46B	n/a 28.5	n/a 32.5	34.8

1983 Cmnd 8789 Table 4.1

Compare Total Yield from Income Tax 1981/82 £28.5B
In 1982/83, 1p on the Income Tax yields £950M

* excludes any part of unallocated mag. of LA current expend. on Eng. + takes no account of reduction in NIS from 1.4.83

2. Per Capita Expenditure

Assuming a GB population of 54.3M (1981):

	78/79	1979/80	1980/81	1981/2	1982/83	1983/4
NHS:	140	about £170 for every man, woman and child	£220	245	£265	£280 5
Personal Social Services:	28	£ 35	£ 42		n/a 48 52	55
Education:	162	£185 4	£225 6	245	n/a 261	259
Social Security Benefits:	300	£360	£430	520	n/a 600	640

/ 3.

3. Nurses Pay Bill

	1979/80	1981/82	% increase
Great Britain:	£1.45B	£2.646B	82%
RPI:	173.2 (Av Q1 79 to Q180)	224.6 (Q181 to Q182)	30%
Scotland:	£262M	£385M	47%

e.g. GB: about £25 per head in 1979/80, £50 in 1981/82
Scotland: about £50 per head in 1979/80, £75 in 1981/82

Scottish figures assume a Scottish population of 5.1M.

4. Cost of offer

Great Britain:	original offer:	£282.5M	(£40M)
(Scottish figures in brackets)	final offer:	£418M	(£51M)
	to meet 12% claim:	£740M	(£89M)

- These cover all grades under negotiation (not doctors, who have settled).
- The addition to the nurses' paybill of the 7.5% offer would be about £200M.(GB)

5. Number of Nurses

England: Up by the equivalent of 34000 between 1979 and 1981

Scotland: Up by the equivalent of 5000 between 1979 and 1981

6. Total Staff

England: Up by equivalent of 47000 between 1979 and 1981

Scotland: Up by the equivalent of 6000 between 1979 and 1981

Total UK: Up by the equivalent of 57000 between 1979 and 1981

/ 7.

7. Doctors

	1979	1981
England:	37100	39000: up 5.1% or 1900
Scotland:	Up by about 155 GPs and 38 Hospital and Community Service Doctors or by 193 in total	

8. Breakdown of the Offer

Nurses and Midwives	7.5%
Ambulancemen, pharmacists, etc.	6.5%
Other groups	6.0%

Of the nurses, the "hard to come by" groups such as tutor nurses will get as much as 10.4%. The "administrative" nurses may get less than 7.5%.

9. Illustrative Earnings Figures (These apply throughout the UK)

9.1 Grades comparable with Female Non-Manual Workers, for whom average earnings in Scotland is £92.50 (April 1981)

(a) Student Nurse 1st Year:

Current Average Earnings : £69.72
After final offer, if accepted: £74.95
an extra £5.23 or 7.5%

(b) Staff Nurse on Maximum:

Current Average Earnings : £99.85
After final offer, : £107.35
an extra £7.50 or 7.5%

(c) Ward Sister on Maximum:

Current Average Earnings : £157.74
After final offer : £169.58
an extra £11.84 or 7.5%

/ 9.2

9.2 Grades comparable with Male Manuals, Average Scottish Earnings £124.80 (April 1981)

(a) Qualified Ambulanceman:

Current Average Earnings	: £142.62	an extra £9.23 or 6.5%
After final offer	: £151.85	

(b) Male Porter:

Current Average Earnings	: £100.49	an extra £6.03 or 6.0%
After final offer	: £106.52	

9.3 Grades Comparable with Female Manuals, Average Scottish Earnings of £73.30 (April 1981)

(a) Female Porter:

Current Average Earnings	: £ 82.78	an extra £4.97 or 6.0%
After final offer	: £ 87.75	

NHS PAY - SPEAKING NOTE FOR MINISTERS

The Government's decision on this year's pay award to workers in the National Health Service is final. Industrial action will not alter that. Nor would a vote against the offer in the Royal College of Nursing ballot. There is no money for a higher offer.

The offer is fair. It ranges on average from 6 per cent for ancillary, administrative and clerical and technical staff, through 6.5 per cent for ambulancemen and hospital pharmacists, to 7.5 per cent for nurses, midwives and professions supplementary to medicine. It compares with settlements for civil servants (5.9 per cent) and teachers (6 per cent) - both reached after arbitration; with the armed forces (6.1 per cent) and university teachers and senior administrative staff (5 per cent); and with the police, whose net increase after increased pensions contributions is 5.6 per cent. More than 8 million workers in the economy as a whole have settled for increases averaging 7 per cent.

It will cost the taxpayer £417.8m. to fund the Government's final offer to staff in Great Britain. The unions' demand for 12 per cent would cost £740m. The additional £320m. would run 12 average district general hospitals for a year or cover the earnings of 50,000 staff nurses.

It is true that there are NHS workers receiving low pay. But that is not unique to the health service; the profile of pay within the service is not substantially different from that within the economy as a whole, where almost three million people - one fifth of all full-time adult employees - earned less than £80 a week last year. The NHS employs people of widely varying skills and levels of responsibility who consequently receive varying rates of pay. There is no indication that NHS staff are paid less than workers elsewhere who are doing comparable jobs; and the NHS is not experiencing difficulty in recruiting and retaining the staff it needs.

Full-time female NHS ancillary staff earn on average about £84 per week; the average earnings of all female manual workers in the economy are about £72 per week. Full-time male ancillary workers earn on average £104 per week, compared with £118 per week for manual workers in the economy as a whole for a group with a higher proportion of skilled jobs than in the NHS.

There is one way in which NHS staff <u>are</u> in a different position from other workers, and that is in terms of job security. The Government's commitment to the NHS has led to its increasing its funding to the record figure of £14.5 billion in Great Britain this year - a growth in real terms of 5 per cent since 1978-79. This has meant an increase in jobs of 57,000 over two years, at a time when manpower cuts have been the general rule in the public service. The Government has moved from the original 4 per cent pay factor in making the increase from its earlier offer to its final one. In the case of the Civil Service, for example, although there has been an average pay increase of 5.9 per cent, the increase in the wages bill is being held at 4 per cent, the difference being made up in lost jobs. The position in the NHS is completely different.

The Government would like to move forward to discussions about improved pay determination arrangements for the future, so as to reduce the danger of there being more disputes like the present one. Talks are already under way on these with nurses and midwives - an indication of the Government's, and public's, recognition of the special skills and responsibilities of this group, which is why they and other comparable groups like physiotherapists have received a higher pay offer.

But Ministers have also said that they are ready to begin talks with unions at any time on future pay arrangements for <u>all</u> NHS staff - an invitation which has so far been ignored by the unions. The way forward now should be for those talks to begin, and for the unions to return to the Whitley Councils to negotiate the distribution of this year's pay award. It is time to end the pointless and dangerous industrial action which must damage not only the patients but also the service itself, and thus the future of its employees.

<u>20 August 1982</u>

N.H.S.

National Health Service

The new offer which has been made by the Secretary of State for Social Services is right in the middle of the range of recent pay settlements in the public sector: 6.1% for the armed forces, 5.9% for the civil service, 6% for the teachers, and 4% for Ministers and MPs. It is a reasonable offer. The unions' continuing demands for 12% are unreasonable. I very much hope that they will think again, and that we will see an end to the damaging industrial action of recent weeks. Strike action harms patients, endangers jobs, and will not have the effect of persuading the Government to increase the present offer. We have now made our maximum offer.

Supplementaries

The new offer is

1. Low in relation to the TSRB awards? The Clegg Commission gave the National Health Service its equivalent of the TSRB awards. They caught up in 1980. The TSRB groups are still only 8% above the 1980 recommended levels. Nurses are now nearly 14% above their 1980 (Clegg) level.

2. How can the Government claim that the nurses are a special case at 7½% when the police got 13.2% and the fire service 9.7% and the water manuals 8.8%?

Answer: We have been pursuing for some time now our desire to establish long term arrangements for determining nurses pay designed to avoid the kind of problem we have experienced this year.

3. Low Pay: Everyone is against low pay - provided that higher pay is linked with higher productivity and so does not lead straightforwardly to higher unemployment. Low pay is a wider problem than the NHS.

4. Divide and Rule? It is our view that the nurses are a special case and that is why we have framed our offer as we have, and we are seeking long term arrangements for nurses pay. We necessarily deal with the professional bodies separately from trade unions, because it is the wish of the professional bodies not to be affiliated to the unions. That is surely their right.

Some nurses

Nurses Pay: Fact Sheet

New offer: Nurses and midwives 7½%
Ambulancemen, pharmacists etc. 6½%
Other groups 6%

Some nurses will get as much as 10.4%.

- Hospital and community health service expenditure rose from £4.4b in 1978-79 to £8.2b in 1982/83 - i.e. by 5.8% in real terms.

- Nurses' paybill in March 1979 £1.45b. In March 1982 = £2.646b.

- Numbers up 34,000 (England) between 1979 and 1981 - to 479,000 (all figures in whole-time equivalents). Total NHS staff increase 47,000.

- We funded a reduction in nurses' working week from 40 to 37½ hours (equivalent to 6½% on basic pay).

- In 1960 there were 565,000 staff: in 1979 1,200,000.

- Some 55% of full-time nurses earned less than £100 per week in March 1982 (many of these student and pupil nurses; 17% of all nurses are students or pupils).

- Pay increases for nurses and midwives have more than kept pace with inflation since May 1979 (up 59% - cp civil servants 57%).

- Cost of original offer to all NHS staff ~~£233m.~~ 282.5 m
~~We have now offered a further~~ Cost of new offer (not Doctors) ~~£392.8m.~~ 418 m
To meet the 12% claim would cost ~~£700m.~~ 740 m in total

Useful NHS Quotes

"Any industrial action in the Health Service is likely to pose some risks to patients. Only the innocent will suffer if the Health Service workers allow their anger to run out cf control. There can be no point in taking it out on the injured, the sick, the old and others who depend on the Health Service."

Mr. Ennals, February 1979.

"I deplore the way in which some situations have been used for party political purposes." And: "Is it not deplorable that party political capital should be made out of the positive difficulty that arises?".

The First was Mr. Ennals in February 1979

The second Mr. Laurie Pavitt, during the same period.

"I must make it clear that the Government will not abandon its responsibilities and let wages rip. The only result would be mounting inflation, balance of payments problems, cuts in public services, high taxes and rates,more on the dole. Those who suffer most from this will be the low paid, and those on fixed incomes such as pensioners."

Mr. Ennals, 1979

Royal Commission on NHS Report

21.4 Nonetheless, many of those who gave evidence to us considered that expenditure on the NHS was nothing like enough. The BMA told us that:

"for some years now the money allocated by the Government for the service has been quite inadequate to meet the demands made upon it by the public"

and the TUC argued that:

"In the longer term an increased proportion of the national income must be devoted to the health service."

21.5 Our evidence proposed amongst other things that more money should be spent on improving the hospital stock and services for children, the mentally ill and handicapped, and the elderly. There is no doubt that more could be spent, and spent well, on all of these. There were few suggestions for economies. The effect of lack of resources on morale in the NHS, and the low pay of some NHS workers were also mentioned. We had no difficulty in believing the proposition put to us by one medical witness that "we can easily spend the whole of the gross national product."

21.6 It was also argued that the NHS should get more money because other countries spend more on their health services than we do. Figure 21.1 shows the proportion of gross domestic product devoted to health services by a number of developed countries. Although such international comparisons are not wholly reliable there seems little doubt that the UK is towards the bottom of the league.[1]

21.7 These arguments do not take us far in establishing what the right level of expenditure on the NHS should be, if indeed there is meaning in the concept of "the right level". We noted in Chapter 3 that international comparisons do not suggest that greater expenditure automatically leads to better health in those countries considered, and it is at least arguable that the improvement in the health of the nation would be greater if extra resources were, for example, devoted to better housing.

21.8 There are also the questions of whether the NHS is making the best possible use of existing resources and the extent to which additional funds would be used to benefit patients directly or to increase the salaries and wages of NHS workers. We consider that NHS gives good value for money, but there is still considerable room for improvement. Regional Administrators in England told us:

"The National Health Service has become accustomed throughout the 25 years preceding reorganisation to the prospect of continual growth in the financial resources available to it. Though agreeable, the result has been to allow slack management, with no incentive to examine obsolete patterns of spending, or to develop a coherent plan for the future."

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[1]See also Table 3.6.

Cmnd 7615

...his view was supported by other evidence that we received, by the research studies we commissioned and by much unofficial and official published material. The government's priorities document, "The Way Forward",[1] for example, contains an interesting appendix listing ways in which resources could be more efficiently used. It is essential that a service which spends three quarters of its budget on manpower should make efficient use of its labour force.

21.9 Figure 21.1 indicates that many of those countries which devoted a greater share of their resources to health services in 1974 were richer than the UK. They could better afford to spend more on health care both absolutely and relative to their gross domestic product. The relatively slower rate of growth of the UK economy since 1974 compared with many developed countries will tend to widen the gap in health spending.

21.10 We naturally accept that the resources the nation devotes directly to health care must stand in competition with other claimants on the public and private purse, particularly when those claimants may well contribute themselves to the good health of the nation. Nor have we any evidence to suggest that the NHS has fared badly in this competition. But this does not mean that we are satisfied with the nation's present level of expenditure – no thoughtful person could be – and indeed our recommendations would, if adopted, add significantly to NHS expenditure. The national income is growing, if relatively slowly, and it is right that as it does, more resources should be devoted to the care of the nation's health.

21.11 But we should sound two notes of caution. The first is that spending more on the NHS will not make us proportionately healthier or live proportionately longer, though it may improve the comfort and quality of life of patients or the pay and conditions of staff. The other is that whatever the expenditure on health care, demand is likely to rise to meet and exceed it. To believe that one can satisfy the demand for health care is illusory, and that is something that all of us, patients and providers alike, must accept in our thinking about the NHS.

Methods of Financing the NHS

21.12 The NHS is funded almost entirely by the Exchequer. In 1978/9, 88% of NHS finance was raised through general taxation, 9.5% from NHS national insurance contributions, 2% from prescriptions and other charges, and the balance from other sources such as sale of land and port health charges. The proportion of finance from general taxation has risen since the early 1960s, while the importance of both the NHS insurance contribution and revenue from charges has declined. At no stage has less than 94% of NHS expenditure been raised from general taxation and NHS insurance contributions.

21.13 We received several proposals for changing the arrangements for financing the NHS. Their purpose was either to supplement the Exchequer contributions, or to replace it with a system which might encourage more

[1]Department of Health and Social Security, *The Way Forward: Priorities in the Health and Social Services*, London, HMSO, 1977, Appendix III, pages 35-42.

NHS STATISTICS - SCOTLAND

1. Total NHS Staff (WTE)

	1961	1971	1976	1979	1981
	51149	67186	111372	115782	122106
Actual Manpower Increase over 1961 :-		16037	60223	64633	70957
% " " " "		31%	117%	126%	138%

2. Total NHS Nursing Staff (WTE)

	1961	1971	1976	1979	1981
	26960	37983	53405	56037	61010
% of all NHS Staff	52.71%	56.53%	47.95%	48.40%	49.96%

3. Total Other NHS Staff (WTE)

	1961	1971	1976	1979	1981
Admin and Clerical	2426	3688	12690	12950	13456
Ancillary	17598	21875	26878	27282	27339
Ambulance Staff	646	1100	1534	1758	1818
Maintenance	3519	2540	2525	2703	2836
Works	(incl in Maint above)		682	779	851
Total	24189	29203	44309	45472	46300

4. (a) Av. No Available Beds

1961	1971	1976	1979	1981
63811	63073	62843	61053	60706

(b) Av. No Occupied Beds

1961	1971	1976	1979	1981
53259	52439	50191	48731	48419

5. Patient Activity (In Patient Discharges)

1961	1971	1976	1979	1981
574266	727601	709056	735446	774246

6. [illegible]tal Staff Per Bed ?

1961	1971	1976	1979	1981
1.25	0.94	0.56	0.53	0.50

7. Total NHS Staff/Patient Discharges

1961	1971	1976	1979	1981
0.09	0.09	0.16	0.16	0.16

8. Hospital Waiting List

	1961	1971	1976	1979	1981
	x N.A.	48066	53381	70970	67180
Actual Numerical Increase over 1971:-			5315	22904	19114
% Increase over 1971:-			11.05%	47.65%	39.77%

9. Total Cost of NHS (Scotland)

Year	Appropriation A/c Net	NHS Conts	Dept Admin	PSA Capital	Total Cost (Outturn)	Real Terms Growth 1971-72 = 100
1971-72	235.3	20.7	-	-	256.0	-
1976-77	609.6	54.0	3.3	0.4	667.3	126.2
1979-80	940.5	79.0	3.4	1.2	1024.1	133.4
1981-82 (provisional)	1373.0	113.3	6.9	2.0	1495.2	139.0

10. Cost of nurses' pay 1979-80 £262m
    Cost of nurses' pay 1981-82 (est) £385m

11. Cost of Administrative and Clerical only pay 1979-80 £54M
    Cost of Administrative and Clerical only pay 1981-82 (est) £80M.

N.B. i. Costs for all aspects of the pay bill prior to 1977 not held.
ii. Constant price figures for individual pay groups are not available as our records are not compiled in this fashion.

Scottish Office
27 August 1982

Social Services

PA

vice of the chief insurance officer on eligibility of community service volunteers for invalid care allowance; and if he will make a statement.

Mr. Rossi: I understand that in certain such cases referred to him, the chief insurance officer has drawn attention to the published Commissioner's decisions R(P)3/52, R(P)1/65 and R(P)4/68 and has suggested that these point to the conclusion that the volunteers concerned were gainfully employed and receiving payment in excess of £6 a week, which is the current earnings limit for invalid care allowance. It is, of course, open to any claimant who is dissatisfied with the insurance officer's decision to appeal to the local tribunal.

Management Information and Accounting System

Mr. Eggar asked the Secretary of State for Social Services which Minister in his Department is responsible for management information and accounting within his Department.

Mr. Fowler: I am.

Cigarette Advertising

Sir Peter Mills asked the Secretary of State for Social Services if he will introduce legislation to ban all cigarette advertising on home video cassettes.

Mr. Kenneth Clarke: I refer my hon. Friend to my hon. Friend's reply to the hon. Member for Wolverhampton, North-East (Mrs. Short) on 15 July—[Vol. 27, c. *457*.]

Nurses

Mr. Pavitt asked the Secretary of State for Social Services if he will take steps to ensure that qualified nurses working within the family practitioner service will be employed by the district health authority in common with other nurses.

Mr. Kenneth Clarke: I shall let the hon. Member have a reply as soon as possible.

Fluoridation

Mr. Arthur Lewis asked the Secretary of State for Social Services whether, in the light of the answer to the hon. Member for Newham, North-West on 1 July, *Official Report*, c. *385*, giving the total sums allocated to the Fluoridation Society for the period 1974 to 1983 as £65,000 and the answer on 27 July, *Official Report*, c. *485*, giving the figure of £71,000 for the same period, he will take steps to improve the general accounting efficiency of his Department.

Mr. Kenneth Clarke: I shall let the hon. Member have a reply as soon as possible.

New Cross Dental School

Mrs. Dunwoody asked the Secretary of State for Social Services (1) whether he will inform the committee of management at New Cross Dental School that it has authorisation to offer the staff section XXXIX of the General Whitley Council Conditions of Service;

(2) whether, in view of the fact that clinical tutors and dental therapists must by law work in the National Health Service, he will authorise the committee of management at New Cross Dental School to waive the part of section XXV of the General Whitley Council Conditions of Service, which specify that redundancy pay is not allowed if an employee is re-employed by the National Health Service.

Mr. Kenneth Clarke: I shall let the hon. Member have a reply as soon as possible.

Geriatric Patients, Mentally Ill and Mentally Handicapped Persons

Mr. Hordern asked the Secretary of State for Social Services (1) if he will publish a table showing the number of geriatric patients in hospital in England and Wales in 1952, 1962, 1972 and in each of the most recent five years to the latest convenient date, and the proportion that such patients bore to the total number in hospital in each of these years;

(2) how many people were held in homes and institutions for the mentally ill and mentally handicapped in 1952, 1962, 1972, and in each of the most recent five years to the latest convenient date.

Mr. Kenneth Clarke: I shall let my hon. Friend have a reply as soon as possible.

National Health Service (Expenditure)

Mr. Montgomery asked the Secretary of State for Social Services if he will make a statement on National Health Service expenditure and on the outcome of the study of sources of finance for health care.

Mr. Fowler: Between 1978-79 and 1981-82 the Government provided for increases in National Health Service services of 5 per cent. There should be some further growth in services this year. The Government have no plans to change the present system of financing the National Health Service largely from taxation, and will continue to review the scope for introducing more cost-consciousness and consumer choice and for increasing private provision which is already expanding.

Pensions

Mr. Whitehead asked the Secretary of State for Social Services what would be the saving to the Exchequer of raising the female pensionable age to 61, 62, 63, 64 and 65 years, respectively.

Mr. Rossi [*pursuant to his reply*, 9 November 1981, c. *20-1*]: On a set of assumptions designed to complement those made for the central estimates for lowering male pension age, given in reply to my hon. Friend the Member for Horsham and Crawley (Mr. Hordern) on 19 November 1981—[Vol. 13, c. *230-1*]—it is estimated that the net savings to central Government funds for a full year from raising pension age for women would be of the following order:

Raising pension age to	*Saving £ million*
65	400
64	350
63	300
62	250
61	150

MEETING THE DEMANDS OF THE 1980s

Rt Hon Norman Fowler MP, Secretary of State for Social Services

Kenneth Harris's excellent biography of Attlee recalls two views of the new National Health Service given on the same day in July 1948. One was that of Aneurin Bevan who said at a Labour rally:

"We now have the moral leadership of the world and before many years we shall have people coming here as to a modern Mecca learning from us in the twentieth century as they learned from us in the seventeenth century."

The other was Attlee's own view given in a broadcast. Attlee took pride in the new service but warned:

"All social services have to be paid for in one way or another from what is produced by the people of Britain. We cannot create a scheme which gives the nation as a whole more than we put into it ... Only higher output can give us more of the things we all need."

Thirty-five years later what do we find? Certainly the National Health Service has had many successes and made many important advances. But sadly we are still some way from Mecca.

Doubtless some on the Left will say that this shows only a lack of purpose. "If only we had the will all would be achieved." "If only defence spending was cut." "If only the wealthy were taxed more heavily." "If only ... ." But given that over the thirty-five years Labour has been in Government for approaching half that period it is an answer which does not carry much conviction.

A likelier explanation is that all too often over the past thirty-five years Attlee's words have been forgotten. We have sought to devise ways of distributing wealth but not creating it. It has been assumed - particularly in areas like health and social services - that resources would be made available automatically once a need was adequately demonstrated. Economic growth and industrial recovery have been subjects of limited interest in this debate.

In the health service this process has been particularly apparent. In an Exchequer-financed health service all ills can conveniently be blamed upon the Government. Successive Governments therefore have been portrayed as being unreasonable, mean, short-sighted and set on destroying the National Health Service as we know it.

No one should believe for one moment that these are new complaints. It has always been thus. There were complaints about the post-war Labour Government; there were complaints about the following Conservative Government; and there were complaints about the Governments which followed that. A typical example comes from Mr Albert Spanswick:

"The National Health Service is more in danger, more in fear for its very existence than ever before ... . The entire service faces a very severe cutback in its expenditure allocation."

Now although you might think it Mr Spanswick was not in fact talking of this Government. He was talking in 1976 of the last Government and the policies that had to be pursued on the instructions of the IMF.

All this has relevance not only for today but for the demands that there are going to be on the health service and the social services over the next ten years. We should remember that most of the years up to certainly the early 1970s were years of economic growth and expanding world trade. Against such a background it should have been easier to obtain our social goals.

The last years throughout the western world have been years of recession. As a result of this every country in Western Europe is having to look at its social policies. The challenges of rising demand and of limited resources respect neither national frontiers nor the political creed of Governments.

Nor should we be in any doubt about the growth in demand. The numbers of the very elderly are increasing substantially. By 1991 there will be 3½ million people over the age of 75. This will include $^{3}/_{4}$ of a million people over the age of 85. At the other extreme of the age range there are nearly 1½ million children living

in one-parent families. The progress of medical science means that it becomes possible to treat conditions which it was previously beyond our capacity to do.

Taken together these developments put an upward pressure on health and social service spending at a time when fast economic growth can no longer be guaranteed. This poses immediate and difficult problems.

The 1980s will self-evidently be difficult years. We are going to need all our ingenuity and all available sources of social provision to successfully meet the demands that will be made. It is not a question of there being a choice between public and private provision. It is not an "either" - "or" situation. We will need both. The country will need good efficient public services. There is no question of that. Equally there is no question that any Government which was to turn its back upon private provision or the contribution of voluntary organisations would be carrying out an act of social vandalism.

Faced with this prospect the Labour Party - in their policy document Labour's Programme - have simply set out a shopping list of publicly financed aspirations with a price tag of somewhere between £10 and £20 billion. For good measure the same document rejects the concept that voluntary organisations can or ought to take a major responsib - ility for the care of mentally handicapped children leaving hospital: and is quite specific that a Labour Government would remove pay beds from the National Health Service, would prohibit the further development of new private hospitals and "shall ensure that private practice is actively discouraged".

I do not want to take time in discussing this policy document. It is enough that it should become better known.

The Conservative attitude is radically different. Certainly we recognise the contribution that can and must be made by the State. We do not want to follow Labour down the road which says that there is only one way of providing health care or personal social services provision. We are not going to simply put forward the opposite dogma of Labour.

It would be absurd for the argument to polarise so that one party stood for public provision exclusively and the other party stood for private provision exclusively. We have absolutely no intention of turning our back on the National Health Service which successive Conservative Governments have helped to build up. Our aim is to develop the National Health Service and to provide a better service for patients.

We do not "admit to cutting" the NHS (Guardian leader of February 3) because such cuts have not occurred and are not planned. In 1983/84 we will be spending £15½ billion on the health service compared with £7$^{3}/_{4}$ billion in 1978/79. That represents an expansion of services of 7½ per cent.

Only a small part of this expansion has come from efficiency savings. And as regional health authority chairmen have accepted the efficiency targets on resource it is difficult to see why - or on what evidence - the Guardian regards them as a euphemism for cut-backs in patient care.

No one of course denies that there are still formidable problems facing the health service - problems like the services for the elderly, the mentally ill and mentally handicapped people. It is possible for Conservatives to paint the picture of need as vividly as those on the Left. But what should distinguish our attitude is that we also have practical policies which will seek to meet that need. We are not content to provide shopping lists of desirable social measures without being clear that we have the resources to meet those aims. Ultimately no party will get any credit for raising hopes which cannot be realised.

The idealism of the Conservative Party is a practical idealism. We care; we want to meet the social needs of this country; but we are determined to develop practical policies on how we should meet them rather than to make easy promises that not only cannot be fulfilled but will add to the disillusion of those people who have trusted in them.

So first, we believe that the proper starting point for the consideration of social policy is the economy. It is not enough to state that problems exist or to declare that resources must be provided to solve them. We have to implement the policies whereby resources can be created and central to such an economic policy is the reduction of inflation.

Sometimes there are difficult choices to be made inside the social area itself. The health service is the biggest employer inside Western Europe let alone in this country. Every extra 1 per cent on pay means an extra £65 million that has to be provided from the budget. No Government should therefore seek to evade making decisions on what the country can afford. The difference between this Government and the last Government is that we were prepared to face up to such decisions and to stand by them.

The second broad aim of the Conservative Government is to get the best possible value from the amount of money that the taxpayer is providing. All told my Department is now responsible for something like 41 per cent of all public spending. We have a budget of £49 billion for 1983/84. But there is no merit in spending money in itself. What counts is what that money buys. That is why we have made it our purpose to improve efficiency.

We have for the first time established a system of annual regional reviews whereby Ministers check on the progress being made in improving performance by each of the Regional Health Authorities. We have introduced new arrangements for the supply of information on manpower and the setting of manpower targets in a service where some 70 per cent of whose budget is accounted for by pay. We have set up a management inquiry by men of exceptional management skill.

But it is in the third area - private and voluntary contribution - that the difference between the parties becomes most marked. As Conservatives we believe that not everything should or can be done by the State. Help is still given by families and by neighbours on a scale which no amount of national organisation or local authority organisation could ever provide. No sensible Government should ever try to interfere with that. Nor should any sensible Government seek to do other than encourage the magnificent range of voluntary and private organisations in this country.

Conservative and Labour attitudes differ here. But when we come to private health care the difference is fundamental. The underlying attitude of Labour is that it is only Government that can provide or should be allowed to provide any kind of health care. It is only Government that can run hospitals. It is only Government who can have the responsibility for treating patients. It is only Government perhaps aided by local Government who can look after the sick and the disabled and those who need care.

Our case is that that approach is not only absurd. It is totally contrary to the interests of the patient. It is contrary to the interests of the patient because it deliberately rejects a valuable source of health care. For our part we welcome every contribution to the sum of patient care. And to judge whether our approach is right let us remember what the private sector actually is.

There are about 34,000 beds in private hospitals and nursing homes in England and almost 3,000 private beds in health service hospitals. This compares with the provision in the National Health Service of about 350,000 beds in about 2,000 hospitals. But the bulk of private beds in this country are not in private hospitals at all. They are in small nursing homes who in total look after well over 20,000 elderly people. Is it seriously argued that we should turn our back upon provision of care which by any standards is much needed simply because it is provided by the private sector?

The fact is that the private sector is a mixture of voluntary, charitable and commercial enterprise ranging from small nursing homes to modern hospitals capable of undertaking major surgery. Health authorities have had contracts to use some of these facilities for many years. At present something like 3,000 beds in the private sector are used by health service patients.

In the acute sector the major purchasers of care are the non-profit making provident associations. Currently there are something over 4 million people covered by health insurance, mainly by the provident bodies. The picture then is of an informal but growing private sector with a wide variety of provision and a wide range of patients. The largest numbers are accounted for by private nursing home provision for elderly people and the growth in the provident associations.

It is sometimes argued that to welcome the growth of the private sector is to implicitly attack the public service. But that is clearly the most spurious nonsense. We welcome every contribution to the sum of patient care. We do not accept for one moment that to support the private sector is to attack the public sector.

What Britain needs in the 1980s is a developing partnership between all those involved in the provision of care whether in the public sector or private. We need to concentrate most on the objective of the effective delivery of care and less on the sterile debate about who should be allowed to provide it. This vital principle of partnership in care underlies the approach of this Government. It is an approach which meets the needs of the 1980s and it is an approach which combines economic realism with commonsense.

10 February 1983

(This article is based on a speech given to the Bow Group.)

SM

Social Services

✓MAP

DEPARTMENT OF HEALTH & SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY

Telephone 01-407 5522

From the Secretary of State for Social Services

Mike Pattison Esq
Private Secretary
10 Downing Street
LONDON SW1

1 February 1982

Dear Mike

I attach a copy of the Government's response to the 4th Report from the Social Services Committee, which will be published tomorrow at 3.30pm.

I am also sending copies to the Private Secretaries to Members of the Cabinet and Sir Robert Armstrong.

Yours ever
Mary McVerry

MARY McVERRY (MRS)
Private Secretary

cc Press   Nat Health

Prime Minister

MAP 22/1

DEPARTMENT OF HEALTH & SOCIAL SECURITY
Alexander Fleming House, Elephant & Castle, London SE1 6BY
Telephone 01-407 5522
From the Secretary of State for Social Services

22 January 1982

John Kerr Esq
Private Secretary to the
Chancellor of the Exchequer
Treasury Chambers
Great George Street
LONDON
SW1

Dear John

FINANCIAL ACCOUNTABILITY OF HEALTH AUTHORITIES

My Secretary of State thought that the Chancellor might like to see the terms of an announcement he is making today on the subject of accountability for the National Health Service. A copy of this announcement is enclosed.

He has asked me to say that Sir Derek Rayner is aware of, and fully supports, this initiative.

I am copying this letter and enclosure to Mike Pattison, at Number 10.

Yours ever,

David

D J Clark
Private Secretary

ENC.

Friday 22 January 1982
Written Answer

PQ 1401/1981/82
Han Ref Vol
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FINANCIAL ACCOUNTABILITY OF HEALTH AUTHORITIES

113 Mr Edward Du Cann (C. Taunton)

To ask the Secretary of State for Social Services, what action he proposes to take in response to the comments in the seventeenth report from the Committee on Public Accounts about the need for greater accountability of English health authorities to Parliament.

MR NORMAN FOWLER

I am introducing new arrangements to ensure better accountability for the NHS. I believe that it is both desirable and practicable to secure the maximum delegation of responsibility for the delivery of local health services to District Health Authorities while at the same time achieving true accountability from the District Authorities through the Regional Health Authorities.

Accordingly each year Ministers will lead a Departmental review of the long-term plans, objectives and effectiveness of each Region with the Chairmen of the Regional Authorities and Chief Regional Officers. The aims of the new system will be to ensure that each Region is using the resources allocated to it in accordance with the Government's policies - for example giving priority to services for the elderly, the handicapped and the mentally ill - and also to establish agreement with the Chairmen on the progress and development which the Regions will aim to achieve in the ensuing year. Successive reviews will thus enable Ministers to measure the progress made by regions against the agreed plans and objectives, as well as to determine action necessary in the year ahead.

The new system will be established in 1982/3. My Department is also conducting a pilot scheme in one region using indicators of performance in the delivery of health services. These will enable comparison to be made between districts, and so help Ministers and the Regional Chairmen at their annual review meeting to assess the performance of their

CONT'D.

constituent District Health Authorities in using manpower and other resources efficiently. With these arrangements I shall be able to hold Regional Health Authorities to account for the ways in which resources are used in their Regions and for the efficiency with which services are delivered. In turn, the Regional Health Authorities will hold their constituent District Health Authorities to account.

The reviews will concentrate on major issues, leaving District Health Authorities with the primary responsibility for decision-taking in providing local operational services within agreed policies. In addition, in order to ensure that they have adequate influence over certain matters for which the Regional Health Authorities are responsible - for example, the provision of Regionally-managed support services - I have asked the RHAs for reports on the arrangements in the region for involving the Districts in these matters.

The object of these new arrangements is to ensure that the Health Service obtains the maximum amount of direct patient care and the greatest value for money from the resources which the Government has made available to the NHS.

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DEPARTMENT OF HEALTH & SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY
Telephone 01-407 5522
From the Minister for Health

Prime Minister

Mike Pattison Esq
Private Secretary
10 Downing Street

14 July 1981

MAP 15/VII

Dear Mike,

You asked in your letter of 28 May to Mike Tully to be kept in touch with progress on our Low Energy Hospital project. As you know, for some time the United Kingdom has been one of the World's leaders in advanced hospital design and a joint Government and private sector consortium unveiled plans last year to build the first-ever low energy hospital. We think it possible to construct a hospital that would use less than half the energy of the best modern hospitals now in existence without in any way lessening the standards of care for patients.

Because of the importance of maintaining our lead in this field of technological development, Dr Vaughan has now decided that two low energy hospitals should be built in a continuing programme spread over several years. This will enable differing technologies to be tested, valuable comparisons to be made, and allow lessons to be learnt by experience as we proceed. One of the new hospitals will be in the North of England in the Sunderland area, on a site still to be determined. The other will be at Newport, Isle of Wight and building will start there in 1983. There were major presentational difficulties in proceeding only in the South of England and there are political as well as technical advantages in going for two projects.

Detailed design work is already under way and the cost of the hospitals will mainly be met by the health authorities concerned out of their normal allocations. DHSS are providing central design assistance and paying the design fees for the first of the two projects; the EEC are making a contribution towards the costs of the special technological features and monitoring that will be a necessary part of the demonstration.

I should stress that both the Newport and Sunderland Hospitals were due for development anyway so little "new" money is involved in the experiment. We now intend however that the two hospitals should be a showcase for British technology and design.

A public announcement about the two hospitals will be made very shortly and we are, of course, arranging suitable publicity.

Yours sincerely
Jeremy Knight

J E KNIGHT
Private Secretary

16 JUL 1981

FILE

VLB

15 June 1981

Thank you for your letter of 5 June, about the low energy hospital.

The Prime Minister was grateful to have this information, and would like to be kept informed as decisions are reached.

B/F

M A PATTISON

Mrs. Mary McVerry,
Department of Health and Social Security.

4

MG

10 DOWNING STREET

PRIME MINISTER

Stephen Ross mentioned to you the plan for an experimental low energy hospital.

Here is some more background information about the project. It seems that the Isle of Wight is the front runner as the site.

MAP

8 June 1981

YDS

CF?

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
ALEXANDER FLEMING HOUSE
ELEPHANT AND CASTLE LONDON SE1 6BY
TELEPHONE 01-407 5522 EXT

Mike Pattison Esq
Private Secretary
10 Downing Street
London SW1

5 June 1981

Dear Mike

THE LOW ENERGY HOSPITAL

In your letter of 28 May you ask for more background information.

As you know the Government's policy is to encourage the maximum conservation of energy resources. Hospitals are major users of energy and we have been able to achieve savings in energy of the order of 20 per cent by various means of conservation. It was decided to investigate the possibility of further savings and consultants were commissioned to investigate the problem in depth. The results of the study were very promising, up to 50 per cent savings in energy could be made in new hospitals, and it was decided to go ahead to the next stage - the building of a prototype hospital which will incorporate the findings of the consultant team. We are calling this the Low Energy Hospital. Ministers have not yet made up their minds about the best site but it looks as though the Isle of Wight may well be the choice.

Dr Vaughan announced the project last October and you will see from the attached Press release that funds of about £$\frac{3}{4}$ million are being made available by the EEC. We think that the project has commercial potential and recently shared a stand with the Department of Energy and the London Chamber of Commerce at the "Energy 81" exhibition at Essen to demonstrate the project as part of our Export drive and as a flag-waving demonstration of the UK lead in energy technology. UK manufacturers of engineering equipment were also represented.

I also attach a brochure which explains the technical aspects in rather more detail.

Yours ever

Mary McVerry

MARY McVERRY (MRS)
Private Secretary

Enc.

FILE

VLB

Nat Health

BF 11-6-81

28 May 1981

We had a word on the telephone this morning about Mary McVerry's letter to me of 27 May.

As I said to you, I should be grateful for more background information about the Low Energy Hospital proposal. The first the Prime Minister had heard of this was in a discussion about a factory closure with Stephen Ross MP. Mr. Ross said that local officials had been optimistic that Newport, Isle of Wight, would be chosen as the site for the Low Energy Hospital, but that this now appeared to have gone wrong. He understood Sunderland might be in mind now.

The Prime Minister would be interested to know more about this project, if it is indeed one for central decision. She is in no way pressing for the Isle of Wight option, but would simply like to be aware of any impending major investment decision which is likely to be the source of some controversy whatever site is eventually chosen.

M A PATTISON

Mike Tully, Esq.,
Department of Health and Social Security.

GC.

YDS

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DEPARTMENT OF HEALTH AND SOCIAL SECURITY
ALEXANDER FLEMING HOUSE
ELEPHANT AND CASTLE LONDON SE1 6BY

TELEPHONE 01-407 5522 EXT

Mike Pattison Esq
Private Secretary
10 Downing Street
London SW1

27 May 1981

Dear Mike

THE LOW ENERGY HOSPITAL

You ask what weight was given to levels of unemployment in areas where the low energy hospital might be built.

All things being equal we would obviously go for development in an area of high unemployment, but decisions on the building of new hospitals must take account of medical need and the relative priority afforded to the scheme. Each of the fourteen Regional Health Authorities, in association with its Area Health Authorities, is responsible for determining priorities for building schemes within its Region. The role of the Department, in general, is to satisfy itself on the need for any development scheme (and its content and cost) which exceeds £2 million in value.

The low energy hospital is a Departmental prototype and it has been necessary for us to consult the Regional Authorities on possible schemes which met the fairly tight technical criteria we required and which did not unduly distort agreed Regional capital allocations. After a full investigation we were left with only two possibilities and these are being considered.

While recognising the obvious advantages of building in an area of high unemployment we would be reluctant to force a scheme on an Authority which did not meet the requirements of the patients concerned or which was of a low service priority.

Yours ever

Mary McVerry

MARY MCVERRY
Private Secretary

SCOTTISH OFFICE
WHITEHALL, LONDON SW1A 2AU

Rt Hon Leon Brittan MP
Chief Secretary to the Treasury
Treasury Chambers
Parliament Street
LONDON
SW1P 3AG

2 April 1981

NHS: USE OF ACCOUNTANTS

You sent to me a copy of your letter of 20 March to Patrick Jenkin in which you suggested that officials in the Health Departments might examine how private sector accountants or consultants might be used to carry out studies of particular areas of the administration of the health service, where these might be expected to yield economies or improve efficiency.

I would be happy to see these possibilities explored fully. I should record however that we already make considerable use of accountants and consultants to advise on particular aspects of administration and on problems of a specialised kind where they arise within the health service, and several exercises of this kind are at present in train. Your letter envisages assistance to the health service principally in quick one-off exercises concerned with logistic matters. On a slightly different basis, in Scotland we took professional advice in setting up a financial administration within our 15 Health Boards when these were established in 1974. At that time we commissioned from Peat, Marwick, Mitchell and Co a very substantial study and report on the organisation and staffing structure of the Treasurers Departments of the new Boards. A major recommendation of their very thorough report was that within each Treasurer's organisation there should be a number of management accountants to handle the construction of budgets, financial planning, budgetary control, cost effectiveness and cost analysis, and to advise on and review matters concerning financial expenditure and the use of resources. This recommendation has been implemented and there are now some 50 management accountants in the Scottish Health Service charged with ensuring the most effective use of resources and with operating systems of management accounting.

The position therefore is that on the advice of a leading firm of accountants we have a financial management system which to a large extent provides at the centres of administration of the health service the sort of analytical professional expertise which might otherwise be obtainable only from outside consultants. My view is that in the Scottish situation the most appropriate use of outside advice might now be to review the efficacy of this internal financial management system to ensure that it is being given full scope to influence service

provision. I am therefore asking my officials to consider whether an exercise of that kind should not be mounted. Obviously, however, I would also hope that any lessons learned from studies of health services anywhere in Britain would be applied in Scotland as elsewhere.

Copies go to the Prime Minister, Patrick Jenkin and Michael Heseltine.

GEORGE YOUNGER

13 APR

DEPARTMENT OF THE ENVIRONMENT
2 MARSHAM STREET
LONDON SW1P 3EB
01-212 3434

*MINISTER FOR LOCAL GOVERNMENT
AND ENVIRONMENTAL SERVICES*

✓MAP

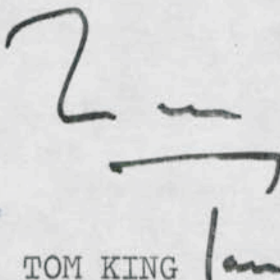
2 April 1981

Dear Patrick,

29/3/81

I have seen Leon Brittan's letter to you about the use of private sector accountants in the Health Service following our recent use of them in the water industry. Michael has already written to you about the importance of proper timing on this, but there are a number of other lessons that we learnt during the work with the water authorities. I think it is most important that these points are understood by any other colleague who is thinking of following the same path. I was therefore writing to say that I would be very happy to talk to you or whoever might be involved, so that our experience can be of help. I think this is particularly important if we are to avoid a backlash from the public finance sector who are clearly concerned about our water exercise and who could be very much more vociferous if the exercise is seen to be repeated very widely and without careful planning.

I am copying this letter to recipients of Leon's letter.



TOM KING

The Rt Hon Patrick Jenkin MP

3 APR

CONFIDENTIAL

Nat Health

2 MARSHAM STREET
LONDON SW1P 3EB

My ref:

Your ref:

26 March 1981

Dear Leon

26.3.81

I have seen your letter to Patrick Jenkin. Naturally I very much support the use of private sector consultants to look for economies and value for money in the public sector. I am planning this for local government on a significant scale.

But one crucial point emerges from your letter. The water exercise had to be sandwiched in a very tight period between the wage negotiations - which I didn't want to upset - and the rate fixing meetings. It was a matter of days. Certainly it produced results but it is not the right way to proceed normally.

In the future I intend to do the job properly. There will be not just quick talks with officials but proper in depth analysis of the costs of an individual organisation and - just as important - comparative costings with similar organisations.

In conclusion I very much support your approach but hope you will agree that we should take the advantage of the time available to us to do the job thoroughly.

I am copying this to the recipients of your letter - the Prime Minister, Patrick Jenkin and George Younger.

Yours ever

MICHAEL HESELTINE

Rt Hon Leon Brittan MP

27 MAR 1981

010

CONFIDENTIAL

2

Nat Health

Prime Minister

MAP. 20/3

Treasury Chambers, Parliament Street, SW1P 3AG

Rt Hon Patrick Jenkin MP
Secretary of State
Department of Health and Social Security
Alexander Fleming House
Elephant & Castle
London SE1 8BY

20 March 1981

Dear Patrick,

NHS : USE OF ACCOUNTANTS

At Cabinet on 24 February, it was suggested that the technique used with striking success in the water industry, of bringing in outside accountants to find ways of reducing costs and charges, might usefully be employed more widely, for example in the National Health Service.

I know you have been looking for ways of increasing the efficiency of health authorities, notably by setting up a Management Advisory Service. Trial projects are to be arranged to establish how this could best operate, and I understand it has been suggested that management consultants might play some part in one or more of the trials.

Clearly there are large differences in functions and attitudes between health authorities and water authorities. But Michael Heseltine thinks it worth applying the same technique, of a quick study by a team of outside accountants, in local authorities (Barnet has already had the first trial run) - where there are no commercial accounts or financial targets so that the analogy with health authorities is closer. No doubt DOE or Treasury officials can let your people know in more detail the way these accountants have operated. But briefly, I think the lesson is that with reasonable co-operation from top management, they have been able to talk to people down the line and come forward with some suggestions for economies, not confined to accounting adjustments aimed at reduced rates or charges. This does suggest to me that there may be value in bringing in outsiders for quick studies elsewhere in the public services, and not least in the National Health Service. Clearly this would need to be focussed on some particular authorities or on specific aspects (e.g. purchasing, to supplement the work of your new Supplies Council).

I hope you will agree that officials should examine how this experience might be brought to bear in the NHS context, and should report to us before too long.

I am sending copies of this letter to the Prime Minister, Michael Heseltine, and George Younger.

Yours
Leon

LEON BRITTAN

19 MAR 1981

EXTRACT FROM H/C HANSARD VOL 999 NO. 55 WED 25.2.

COL 395

COL 396

Health and Personal Social Services

Mr. Paul Dean asked the Secretary of State for Social Services when he intends to publish guidance on his policies and priorities for the health and personal social services.

Mr. Patrick Jenkin: I have today published "Care in Action"—a Handbook of Policies and Priorities for the Health and Personal Social Services in England. Copies of the handbook are available in the Vote Office.

The Government's immediate concern on taking office was to streamline the administration of the National Health Service, along the lines recommended by the Royal Commission. This is now under way and the new district health authorities to be appointed during 1981 will, in most parts of England, assume responsibilty in April 1982.

It is, therefore, timely that the Government should set out for the new health authorities, for local government and for the voluntary movement, the policies and priorities which should guide them in their work.

The handbook is intended to be a practical document. It deals with national policies reflecting, for example, the emphasis we place on prevention and on the priority to be given to certain groups and services. It also emphasises that decisions affecting a particular locality, and the way to achieve them, are best made locally. This blend of national policy with local responsibility for decision-taking is the theme of the current reorganisation of the National Health Service, and it is carried forward in the handbook.

The priorities set out in the handbook in general follow those of sucessive Governments in recent years. As well as prevention, they include services for the elderly, the mentally handicapped, the mentally ill and the physically and sensorily handicapped; other priority services are those for maternity care, neonatal care, primary care, and services related to the care of young children at risk and to the care and treatment of juvenile offenders. We also emphasise the individual's responsibility for his own health; the importance of the family and of the whole network of support available within the community and through the voluntary services; and also the importance of a proper partnership with the private health sector.

We want to see close collaboration between health authorities and local government and with the voluntary sector.

Another theme in the handbook is the need to improve efficiency. Until the economy improves, we cannot afford to spend more than already planned. This makes it doubly important to secure the best value we can for the money spent.

The provision of health and personal social services at a time of economic difficulty presents a challenge to us all. I hope that "Care in Action" will help us to meet that challenge.

Nat Health

cc HO
CDL
CWO
CO

Now
Health

10 DOWNING STREET

From the Private Secretary

19 February 1981

Priorities and policies for health and personal social services

Following her talk with your Secretary of State about staff numbers in the NHS, the Prime Minister has now agreed that his document on priorities and policies for health and personal social services should be published with an oral statement. At present, we are content that this should be planned for 25 February, but the timing will have to be finally settled in the light of competing claims for statements which may arise as a result of present industrial issues. You will no doubt be circulating the draft of a statement early next week.

I am sending copies of this letter to Stephen Boys-Smith (Home Office), Nick Huxtable (Chancellor of the Duchy of Lancaster's Office), Murdo Maclean (Chief Whip's Office) and David Wright (Cabinet Office).

M. A. PATTISON

Don Brereton, Esq.,
Department of Health and Social Security.

10 DOWNING STREET

PRIME MINISTER

You have now had a discussion with Mr Jenkin about NHS staff numbers.

Are you now ready to approve publication of the "Priorities and Policies" Document on 25 February, with an oral statement that day?

MAP

Yes mt

18 February, 1981

PERSONAL AND CONFIDENTIAL

Original on Nat Health:
Feb 81
NHS Manpower

10 DOWNING STREET

From the Principal Private Secretary

16 February, 1981.

The Prime Minister has asked me to thank your Secretary of State for his Secret and Personal minute of 13 February, 1981, about manpower in the public services.

Like Mr. Heseltine, the Prime Minister is most disturbed about the increase in National Health Service manpower, and your Secretary of State might like to see, as a measure of her concern, the attached copies of some correspondence about Mr. Jenkin's proposal to publish a document setting out national priorities and policies for the Health and Personal Social Services.

The Prime Minister understands that Mr. Jenkin will be letting her have very shortly a note on the apparent increase of 25,000 in the staff of the National Health Service.

B/F 26/2/81

C. A. WHITMORE

David Edmonds, Esq.,
Department of the Environment.

PERSONAL AND CONFIDENTIAL

Original on Nat. Health: Feb 81
NHS Manpower

10 DOWNING STREET

MR. WHITMORE

I see that Mr. Heseltine has approached the Prime Minister on a personal basis about the NHS staff increase. Do you want to send him a copy of my letter below on a personal basis, to show that the Prime Minister is taking the matter seriously? There is no other basis for copying to him without copying to the whole of Cabinet.

M. A. PATTISON

16 February 1981

Original on Nat. Health: Feb 81
NHS Manpower

file

10 DOWNING STREET

From the Private Secretary

16 February 1981

SF 23.2.81

We had a word this morning about your Secretary of State's letter of 12 February covering the draft document on priorities and policies for the health and personal social services.

As I told you, the Prime Minister wants to understand the basis on which the National Health Service staff count has apparently increased by some 25,000 since the Government came to power. She is not ready to approve publication of the document until she has seen the staffing points satisfactorily clarified.

I am sending copies of this letter to Peter Jenkins (H.M. Treasury), Stephen Boys-Smith (Home Office), Jim Buckley (Lord President's Office), Nick Huxtable (Office of the Chancellor of the Duchy of Lancaster), Murdo Maclean (Chief Whip's Office) and David Wright (Cabinet Office).

M. A. PATTISON

Don Brereton, Esq.,
Department of Health and Social Security.

1,

1. MR. SANDERS MS

2. PRIME MINISTER

Patrick Jenkin proposes to publish on 25 February the attached document setting out national priorities and policies for the health and personal social services. He has in mind an oral statement that day.

The paper has been very thoroughly worked over in the Department, and has been cleared through H Committee. The exercise started as one of setting priorities. In current circumstances, it is no longer obviously that. The Department now prefer to see it as an over-view of the field, which would, for instance, enable an incoming Chairman of a health authority to decide what questions he should be asking about the provision of services in his region.

I have not been through it in detail. I suggest that you look at the covering letter sent to H Committee (Flag A), the foreword (Flag B), perhaps Chapter 1 - Setting the Scene - (Flag C), and Chapter 3 - The Voluntary Sector - (Flag D).

Content in principle for Mr. Jenkin to publish with an oral statement, subject to competing business at the time and clearance of the text of the statement?

We were all amazed to learn that the NHS had increased by 25,000 while we have been in power.

MAP

Before approving this document, I think we should learn more about how that increase happened. MT

13 February 1981

cjt

010

DEPARTMENT OF HEALTH & SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY

Telephone 01-407 5522

From the Secretary of State for Social Services

The Rt Hon Francis Pym MC MP
Chancellor of the Duchy of Lancaster
Privy Council Offices
Whitehall
London SW1

12 February 1981

Dear Francis,

PRIORITIES AND POLICIES FOR HEALTH AND PERSONAL SOCIAL SERVICES

I am planning to publish on 25 February a document setting out national priorities and policies for the health and personal social services. A draft of the document has been cleared in writing with H Committee. I enclose a copy of my letter to Willie Whitelaw and of the draft which accompanied it. There have naturally been changes subsequently.

The intention to issue such a document is well known and it has aroused continuing interest in the House - particularly, but by no means exclusively, among the Members of the Select Committee on the Social Services. I would therefore judge it appropriate to accompany publication by an Oral Statement. I see great advantage in getting firm messages on the record in my own words, and in fore-stalling any misconceptions as they arise.

I should be grateful to have your agreement to my making a statement as outlined above.

I am copying this letter and enclosure to the Prime Minister and the Chief Whip and the letter only to members of H Committee and Sir Robert Armstrong.

Yours ever
Patrick

encl

MG

A

DEPARTMENT OF HEALTH & SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY

Telephone 01-407 5522

From the Secretary of State for Social Services

The Rt Hon William Whitelaw CH MC MP
Secretary of State for the Home Department
50 Queen Anne's Gate
London SW1

30 January 1981

Dear Willie,

PRIORITIES AND POLICIES FOR HEALTH AND PERSONAL SOCIAL SERVICES

I have undertaken to publish early this year a document setting out national priorities and policies for the health and personal social services in England. My officials have been preparing the document and have consulted other interested Departments. I am writing to enclose the final version of the document, which I should now like, subject to the agreement of my colleagues in H Committee, to publish.

The letters which precede the text make clear that publication takes the form of a 'handbook' addressed in particular to the Chairmen and Members of the new District Health Authorities, but it is also relevant to the Chairmen and members of the Local Authority Social Services Committees. I am leaving much to local initiative and collaboration and I am avoiding the prescriptive guidance contained in the previous Administration's priorities statements, although we are continuing their priorities, notably for the development of the "cinderella" services. The document is not, therefore, a detailed guide for the professional officers of the authorities, but rather aims to assist the Chairmen and Members who will in some cases be relatively inexperienced.

I have also had in mind the criticisms which the Social Services Committee made in their Third Report of the 1979/80 Session of the overall policy-making of my Department. I intend therefore to make it quite clear from the outset that, while the Document is intended to be an overall statement of the Department's policies with regard to the development of health and personal social services in England, it does not purport to be a statement of the overall social policies, including the whole social security field, which are the responsibility of my Department.

ENC

E.R.

For presentational reasons I should like this to come out before the White Paper on the Elderly, and propose to publish this handbook at the end of February and the White Paper about a week later. I shall therefore be grateful to receive any comments from colleagues by 9 February.

Copies of this letter and the document go to all members of H Committee and Sir Robert Armstrong.

Yours ever

Patrick

We are still thinking about the best title.

P.

MG

B

To the Chairman and Members of
District Health Authorities

/Date/

/Dear Chairman /facsimile//

This letter is addressed to the Chairmen and Members of the new District Health Authorities.

The handbook sets out the main policies and priorities which Ministers will look to you to follow in running the services for which you are responsible. We want to give you as much freedom as possible to decide how to pursue these policies and priorities in your own localities. Local initiative, local decisions, and local responsibility are what we want to encourage. This is the main purpose of the current reorganisation of the structure and management of the National Health Service. It was the theme underlying the Local Government Planning and Land Act 1980.

You have therefore a wider opportunity than your predecessors to plan and develop services in the light of local needs and circumstances. But, as Secretary of State, I am entitled to ask that in making your plans and decisions, you should have regard to the national policies and priorities set out in this handbook.

The handbook does not of course stand alone. You will find in it references to many other sources which should be referred to for fuller guidance. More are to come. For instance, we shall shortly be publishing a White Paper on the Elderly covering not only health and personal social services, but also social security, housing, transport and other matters as they affect elderly people.

You will see that I am not asking district health authorities to make any abrupt changes of direction. The main emphasis of our priorities continues to be along the lines on which your predecessors were already working, and include giving a high priority both to the prevention of ill health and to the so-called "Cinderella" services for the elderly and for people who are mentally ill or handicapped.

Although addressed to you as Chairmen and Members, we want the handbook to be widely available. There are messages I want everyone to heed. The handbook reminds us that we have a personal responsibility for our own health. We also have a duty to help one another, and this message is stressed in Chapter
on "The Voluntary Sector".

You will see I have referred to health and social services together. Although run by different authorities, they are part of the broad spectrum of care, stretching from the acute and emergency hospital services, through to domiciliary care and support in the community. I want to see as close a collaboration between health authorities and local government as possible. How this should be done must be for you and your colleagues in Local Government to decide in the light of local circumstances. I also attach importance to the theme of collaboration with the voluntary services and with the private sector.

I am sure you do not need reminding that the Government's top priority must be to get the economy right; for that reason, spending on health and social services can grow only slowly. You will find that clinicians and others working in the health services are anxious to make the best use of resources, to cut out waste and to find ways (through, for instance, local budgetting) to use money more effectively. I hope that you will feel it right to give them every encouragement.

The provision of these services at a time of economic difficulty presents a challenge to Ministers, to you as Chairmen and Members of authorities, and to all who serve the public, whether in the statutory or in the voluntary services or in the private sector. It is my hope that the policies and priorities set out in this handbook will help us all to meet that challenge.

/Yours etc
FASCIMILE/

Secretary of State for
Social Services

MG

<u>To the Chairman and Members</u>
<u>of Social Services Committee</u>

[Date]

[Dear Chairman [Fascimile]]

This handbook I have prepared provides national guidance for health and personal social services. In commending it to you, I thought you would also wish to see the letter with which I have accompanied it to await the Chairmen and Members of the District Health Authorities on taking up their new posts of responsibility. I feel sure that you are looking forward to working with them.

Although the health and social services are run by different authorities, they are part of the broad spectrum of care, stretching from the acute and emergency hospital services, through to domiciliary care and support in the community. I want to see as close collaboration between health authorities and local government as possible. How this should be done must be for you and your opposite numbers in the health service to decide in the light of local circumstances.

The policies and priorities that we are aiming at in the health service and the personal social services are widely known in local government. I hope that you will find the way that they have been set out in the handbook is helpful, especially as you work together with the new District Health Authorities and with the voluntary sector, to achieve shared goals of better services for those who need them most.

[Yours etc
FASCIMILE]

Secretary of State for
Social Services

RESTRICTED

A HANDBOOK OF POLICIES AND PRIORITIES
FOR THE HEALTH AND PERSONAL
SOCIAL SERVICES IN ENGLAND

Department of Health & Social Security

RESTRICTED

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RESTRICTED

C

CHAPTER 1 - SETTING THE SCENE

1.1 New health authorities and their partners in local government will face a common challenge in providing the best possible services within the limits of available resources. Local circumstances will vary but certain national trends and constraints will affect all to some degree. This chapter outlines the more important of these factors, and is intended to help chairmen and members see the national context in which they will have to establish local priorities within the guidance set out in later chapters. For guidance on the role of chairmen and members see Appendix 1.

POPULATION

1.2 In mid-1980 the population of England was nearly 46.5 million, and it is expected to grow by almost one million over the next ten years. Figure 1 shows the latest available breakdown by age groups, and figure 2 the changes over the last decade and those projected in the next for each age group. The changes which will have most effect upon the health and personal social services are:

a. Increase in the numbers of very elderly people. The numbers of people aged 65 and over will continue to increase but at a much slower rate than in the past. There will be about 7.2 million at the end of the decade compared with 7.0 million now. However, within this group the numbers aged 75-84 are projected to increase by nearly 300,000 to 2.4 million and very elderly people aged 85+ are expected to increase by 150,000 to 625,000. People in these age groups make significantly greater use of both health and social services than younger people.

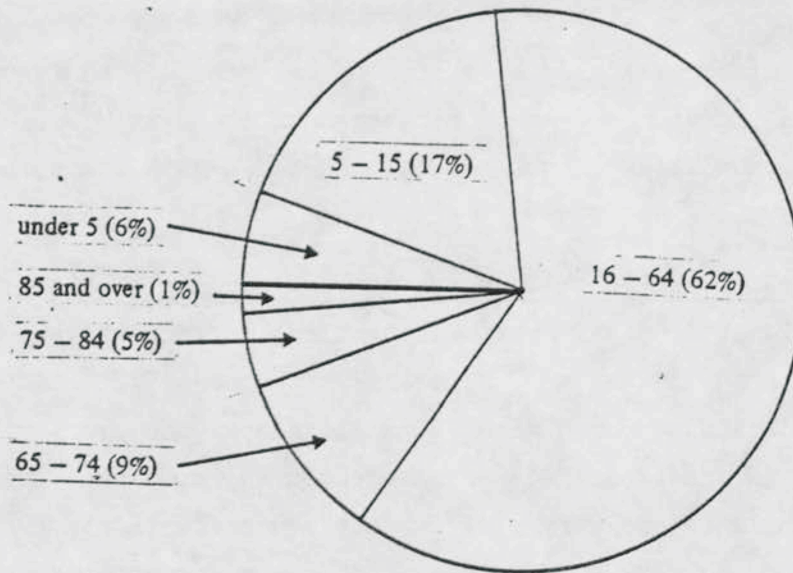
b. Increase in the numbers of young children. In 1978 the birth rate began to rise again after falling for 13 years and the latest figures show that this trend is continuing. By 1990 the number of children under five is projected to be 800,000 higher at 3.6 million and the annual number of births may rise by 130,000 to 750,000.

Over one million people with physical or sensory handicaps are registered with local authorities - a number which certainly understates the total who have a significant disability. Physical, sensory and mental impairment increase with age; and there are therefore important consequences for the health and personal social services from an increase in the numbers of very elderly people.

RESTRICTED

Figure 1:

The percentage of the population in the key age groups: England 1979



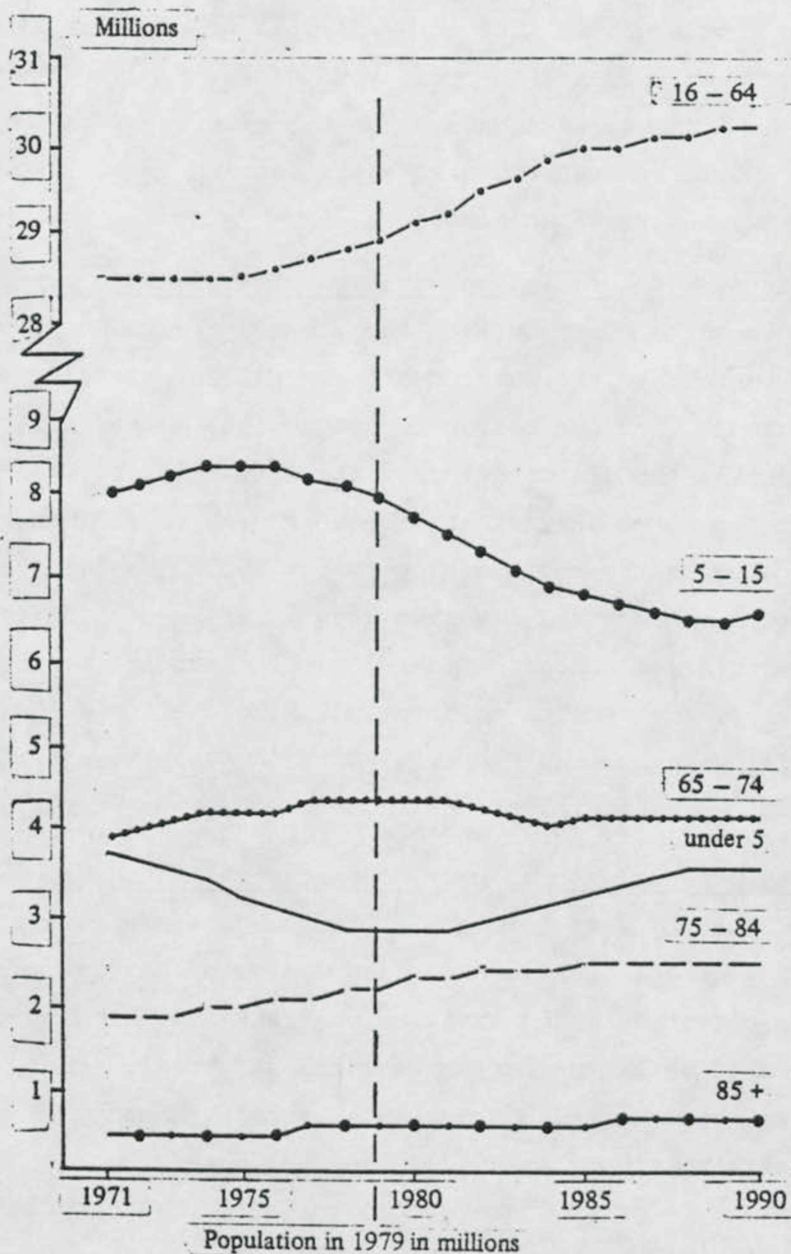


Figure 2:
Population estimates 1971 – 1979; 1979 based projections to 1990
Millions
31
30
29
28
9
8
7
6
5
4
3
2
1
16 – 64
5 – 15
65 – 74
under 5
75 – 84
85 +
1971
1975
1980
1985
1990
Population in 1979 in millions

FINANCE

1.3 Recent and present expenditure on health and personal social services is summarised in Table 1. The Government's expenditure plans for the period up to 1983/84 will be published in March. Currently the position is as follows:

(a) NHS spending. Net spending on the NHS in 1980/81 accounts for about 11% of all public expenditure. Over two-thirds of this goes on current expenditure in the hospital and community health services and most of the remainder on the family practitioner services. Although the Government's aim is to reduce public spending overall, the expenditure plans published in the last Public Expenditure White Paper, Cmnd 7841[1], allowed for a growth in gross NHS spending in England from £7820 million in 1978/79 to £8380 million in 1982/83 (November 1979 prices) an increase in real terms of 7%. In November 1980 the Chancellor of the Exchequer announced that £25 million of the planned growth for 1981/82 should be found through efficiency savings. Decisions for further years have not yet been announced.

(b) Local authority personal social services current spending. Local authorities are expected to contribute to the planned reduction in public expenditure and to conform to the Government's target for spending overall. No service can be exempt from the search for economies, although it is for authorities to determine the distribution of their spending between services. Current spending on the personal social services rose by more than 4% in real terms in 1979/80, and the revised budgets for 1980/81 submitted in August 1980 suggest that the level may have been maintained this year, when local authorities were asked to reduce their overall spending to about 2% below that for 1978/79. It remains to be seen what decisions authorities will make on priorities in subsequent years, in which they have been asked to reduce their total expenditure further (just over 3% in 1981/82).

(c) Local authority personal social services: capital spending. Capital spending in 1979/80 rose by some 3½% in real terms. A somewhat similar out-turn is expected in 1980/81. In 1981/82 a new system of capital expenditure controls comes into operation under which allocations have been made in 5 major service blocks of which the personal social services is one. Social Services authorities' bids exceeded the planned total by about 13% and allocations to some authorities have had to be restricted, but as individual authorities will have freedom to transfer capital resources between service programmes the final outcome is uncertain.

(d) Joint Finance. A portion of health expenditure is set aside nationally each year, primarily for collaborative projects in the personal social services field which are also of benefit to the health service. In 1980/81 this sum is £54 million; increasing to £56 million in 1981/82 and £58 million in 1982/83.

TABLE 1 : HEALTH AND PERSONAL SOCIAL SERVICES: GROSS EXPENDITURE

England. £m at 1980 survey prices

	1978-79	1979-80	Planned 1980-81	Planned 1981-82
Health				
Hospital and community health services				
- current	5400	5410	5560	5640
- capital	430	400	450	450
Family practitioner services	1700	1700	1740	1790
Central health services	290	300	340	340
Total Health	7820	7810	8100	8210
Personal Social Services (1)				
Local authority				
- current	1440	1490	1370	1360
- capital	60	60	70	70
Central government	10	10	10	10
Total PSS	1500	1550	1450	1440
Total HPSS	9330	9360	9550	9660

(1) Figures for 1980-81 and 1981-82 are tentative as distribution of total local authority expenditure is for individual local authorities to determine.

Discrepancies in totals are due to rounding

BUILDINGS

1.4 Although in the last two decades major new construction work has been carried out on about 300 hospital sites, a significant proportion of hospital care is still provided in old and outmoded buildings. However, health authorities are currently planning to carry out by 1990 work on 350 hospital sites with a contract value in each instance of over £1 million. The policy of previous Governments has been to concentrate most of the general acute services, together with some geriatric and mental illness services, in district general hospitals. In recent years some of these district general hospitals have been planned to reach well over 1,000 beds. The Government favours a return to smaller district general hospitals, supported by local hospitals which will include both acute and long-stay services. A consultative document, 'The Future Pattern of Hospital Provision in England',[2] was published in May 1980. Comments are being considered.

MANPOWER

1.5 Nearly one million people work in the NHS and 200,000 in social services departments of local authorities. The main staff groups employed in the NHS, and the change from 1976 to 1979 (whole-time equivalent) are shown in Table 2. Some two-thirds of administration and clerical staff are engaged in operational activities mostly in support of clinical activity. The remaining one-third, together with small proportions in other disciplines are engaged in management. The numbers so engaged have been reduced, and will be reduced further. Table 3 shows the change in the numbers of social workers and other staff employed in local authority social services departments.

TABLE 2: NHS DIRECTLY EMPLOYED STAFF: ENGLAND

Category of Staff	'000 WTE		Average Annual % change
	1976	1979 (Provisional)	1976-79
Medical and Dental Staff[1]: Hospital community and school health medical & dental staff and locums	34.0	37.1	2.9
Nursing and Midwifery Staff: Hospital community, school health, blood transfusion and agency staff	341.7	356.0	1.4
Professional and Technical Staff: Hospital pharmacists and opticians, scientific, technical, dental ancillary and remedial staff	52.5	59.9	4.5
Works	5.3	5.6	1.5
Maintenance	19.7	19.8	0.3
Administrative & Clerical Staff: Administrators clerical staff, support service managers etc	98.5	102.2	1.2
Ambulance Staff: Ambulance officers, control assistants and ambulancemen/women	17.2	17.0	-0.4
Ancillary Staff and Others: Catering. laundry domestic, portering etc staff	173.6	170.9	-0.5
TOTAL EMPLOYED STAFF	742.5	768.5	1.2

NOTES: 1. Excludes hospital practitioners, part-time medical officers (clinical assistants), general medical practitioners participating in Hospital Staff Funds and occasional sessional staff in the Community Health Services.

TABLE 3: STAFF EMPLOYED IN LOCAL AUTHORITY SOCIAL SERVICES DEPARTMENTS: ENGLAND

	'000 WTE		Average annual % change
	1976	1979 (Provisional)	1976-79
Social Workers (1)	21.2	22.8	2.44
Other Local Authority Social Services Staff (2)	162.7	171.8	1.83
Total	183.9	194.6	1.90

1. "Social Workers" includes Senior Social Workers, other social workers, community workers, trainee social workers and Social Work (Welfare) Assistants .

2. Directing, management, administrative, clerical/support, residential, and day care and other staff.

VOLUNTARY SERVICES

1.6 Most people who need help or care rely in the first instance on family and friends. Some 95% of elderly people live in the community, supported in this way where necessary. Voluntary and statutory resources are available if needed. The Wolfenden report[3] estimated that in 1976 the size of the volunteer force in personal social services was roughly equivalent to 250,000 full-time staff - more than the total employed in all social services departments. The Personal Social Services Council calculated that in 1975 there were in addition 15-20,000 paid staff in voluntary organisations. The Wolfenden Committee put the total income of voluntary organisations in the fields of social and environmental services at about £1,000 million mostly from private sources. In the health field volunteers co-ordinated by about 300 voluntary service organisers, make a valuable contribution in hospitals, in care of the sick and handicapped in the community, in first aid and in fund-raising.

PRIVATE HEALTH CARE

1.7 Private health care includes private treatment for acute medical or surgical conditions, long-term nursing home care, general practitioner services and private prescriptions for drugs and dressings. It amounts to about 3% of total spending on health care.

1.8 About 31,500 beds are provided in private hospitals and nursing homes which may be profit-making or charitable organisations. They include about:

(a) 5,500 acute beds in hospitals.

(b) 3,500 beds in hospitals or nursing homes for those suffering from mental illness or disability.

(c) 22,500 long-stay beds in hospitals and nursing homes, primarily used by elderly people.

In addition, about 2,400 beds in NHS hospitals are designated as 'pay beds', and private out-patient facilities are available in many NHS hospitals. In 1979 over 90,000 people were treated in pay beds and there were over 160,000

private out-patients or day care attendances. To put these figures in perspective, about 130,000 acute beds are provided in NHS hospitals, treating annually about 4 million patients.

1.9 About half of those who seek private acute hospital medical or surgical treatment are covered by medical insurance. Figure 3 shows for the UK the increase in subscriptions and benefits over recent years and in the numbers of persons insured. At the end of December 1980 3.6 million people were covered by private medical insurance, often through group schemes.

TEXTUAL REFERENCES

1. Treasury. The Government's Expenditure Plans 1980-81 to 1983-84. Cmnd 7841. HMSO. 1980.

2. Department of Health and Social Security. The Future Pattern of Hospital Provision in England - A Consultation Paper. DHSS. 1980.

3. Committee on Voluntary Organisations. The Future of Voluntary Organisations: Report of the Wolfenden Committee. Croom Helm. 1977.

OTHER REFERENCES

1. Department of Health and Social Security. Health and Personal Social Services Statistics for England, 1978. HMSO. 1980.

Copies of publications referred to above and elsewhere in this document may be obtained from NHS or other libraries. The Department publishes "Current Literature on Health Services" a monthly listing of new official, commercial and NHS monographs, periodical articles and research trends, and "Health Trends" a quarterly periodical on subjects relevant to the management of medical work and/or for administrative planning in the NHS.

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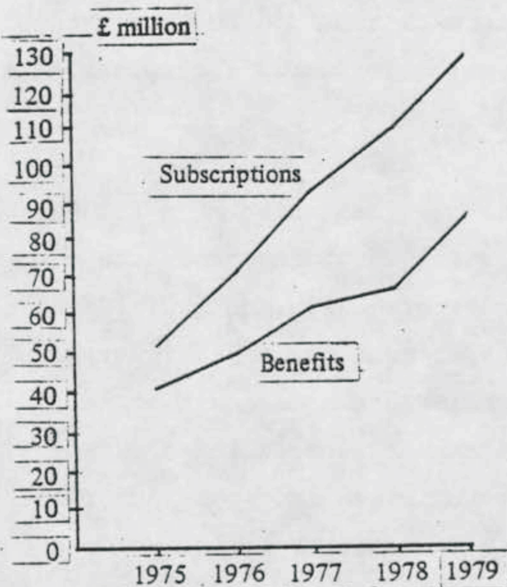
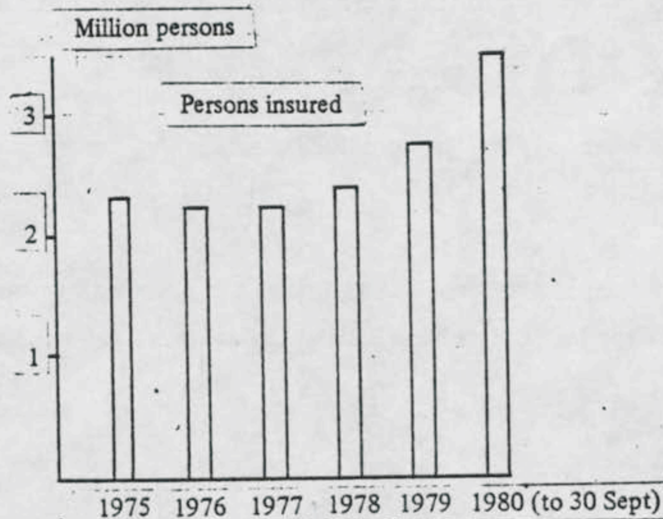
Figure 3:
UK private medical care; provident associations



There is a time lag between taking out insurance and the uptake of private treatment.



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CHAPTER 2 - PREVENTION

2.1 The prevention of mental and physical ill-health is a prime objective and an area in which the individual has clear responsibilities. No one can wholly escape illness or injury, but there are many risks to health which are within the individual's power to reduce or avoid. Individuals often endanger their health through ignorance or social pressures. Public action can give the individual the information needed to make sensible decisions about his own health, and encourage in the community a responsible attitude towards health matters.

2.2 The preventive role of NHS services is to make information available about risks to health and to develop services and create conditions in which such risks are reduced and good health and social functioning is made possible and encouraged. The Department has a special responsibility for ensuring that health factors are taken into account at national level. The preventive role of personal social services includes support for families to forestall the need to receive children into care and to help sick, handicapped or elderly people to maintain their independence.

2.3 In recent years there have been significant changes of public attitude and awareness towards, for example, cigarette smoking, exercise, diet and family planning. The NHS, voluntary organisations and the Government have all contributed to these changes. The task now is to:

(a) Reinforce and build upon such changes at Government level and in the NHS.

(b) Develop complementary strategies of preventive action by other public bodies, commercial organisations and voluntary agencies.

THE GOVERNMENT'S ROLE

2.4 Most of the work in preventing ill-health, whether by counselling, immunisation or education, has to be undertaken locally. Health authorities are best placed to know the needs of the population they serve. But there

is an important Government role in creating the conditions and climate of opinion which make local effort more effective, or in some cases possible. The prevention of ill-health is the subject of a series of booklets published by the Department, the first of which was entitled 'Prevention and Health: Everybody's Business[1]. There will be further booklets in this series. The Government continues to support the work of the Royal Commission on Environmental Pollution and the Health and Safety Commission which make important contributions to prevention of ill-health and accidents. The Ministry of Transport is promoting legislation relating to road safety. These examples illustrate the national dimension to work on prevention.

2.5 The Health Education Council acts for the Government in educating people in ways of staying healthy, and will continue to sponsor national programmes and assist the NHS by providing health education training and materials. It has concentrated particularly on discouraging smoking and the Government has increased its budget to help support such measures.

THE ROLE OF HEALTH AUTHORITIES

2.6 Health promotion and preventive medicine programmes will not always be welcomed by those called upon to change their personal behaviour or their commerical activities. Health authorities should not be deterred by this. They can play their part by:

(a) Insisting that the NHS develops a commitment to policies on health promotion and preventive medicine.

(b) Ensuring that resources are directed to these purposes.

(c) Establishing priorities for programmes which meet the health interests of the local population served.

Community Health Councils have a right to expect authorities to show a marked and continuing investment in prevention and can help to transmit the preventive message to the public. Many have already done so.

2.7 The community dental services have made substantial advances since 1974 and there is further ground to be gained. Their future functions, along with the whole question of preventive dentistry, including fluoridation, is being considered by the Dental Strategy Review Group, recently set up by the Secretary of State, and due to report in 1981.

A LOCAL STRATEGY

2.8 A general aim should be to help people to appreciate that much illness is avoidable; and that avoidable illness pre-empts resources needed for the treatment of those who are unavoidably sick. A local strategy of health promotion and preventive medicine should include:

(a) A defined policy on cigarette smoking in NHS premises as in HC(77)3[2]; and putting pressure locally on, for example, those who manage theatres, cinemas, and other public places to accept that not smoking is the norm.

(b) Improving the availability of genetic counselling; encouraging early and regular attendance for ante-natal care, including appropriate screening; post-natal care, including advocacy of breast feeding; screening for disabilities in young children; dental care for children; and family planning.

(c) Maintaining liaison with the education authority to ensure adequate arrangements for the health surveillance of children.

(d) Maintaining and, where necessary, raising the level of community protection against those infectious diseases preventible by immunisation programmes.

(e) Working with local authority and with professional and other organisations on measures to reduce the incidence of heart disease and strokes, eg through the encouragement of exercise and sensible diet, and measures to discourage smoking referred to above.

(f) Supporting the Education Authority on health education in schools and colleges on key health topics, including smoking, alcohol use, mental health, care of elderly people, nutrition, exercise and preparation for parenthood.

(g) Seeking, with local authorities and voluntary organisations, measures to reduce accidents on the road and in the home, especially to children and elderly people, and to study the effects of these measures.

(h) Seeking to create a climate of local opinion in favour of fluoridation of water supplies as a key measure towards the prevention of dental decay.

(i) Creating awareness by voluntary, community and commerical organisations of the need to harmonise their efforts to ensure that the community has a positive approach to health promotion and preventive medicine.

2.9 A well-organised preventive programme will need to make the fullest use of those who are in closest contact with the public - the doctors, health visitors, nurses, midwives, and the host of other workers in the health, social services and education field. Health visitors, with their specialised training in prevention and health education, and with access, in particular, to the homes of the healthy, have a special role to play and authorities should consider carefully possibilities for expansion of this service. The deployment of staff to undertake the programmes will need to be carefully considered in the light of local needs and circumstances but because of their special training in prevention, community physicians are bound to be prominantly involved.

2.10 An effective health education service can help to mobilise all these efforts and increase their effectiveness. Since 1974 a number of health authorities, have introduced, or improved, their health education services, have seconded staff for training, and have provided support, at comparatively moderate costs. But resources, both of trained manpower and of materials, are short and authorities will have to consider carefully how they may best be deployed, at least in the short term, without damaging services scarcely yet fully established.

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2.11 The effectiveness of a preventive strategy will depend on two factors. First, efficient organisation of services; and, second, information to and motivation of the community to use these services. Many health authorities are already implementing such a strategy, but there is room for improvement in breadth, in depth, and in efficiency. This will not happen by chance, and to ensure that health promotion and preventive programmes are developed for all care groups and in all districts, planning and commitment will be needed.

2.12 It must be for authorities to determine the resources they can make available for prevention, but there may be both short and longer term benefits from preventive measures which cannot easily be calculated. Thus, family planning services can reduce the demand for abortion, and effective ante-natal services the incidence of both physical and mental handicap. Where fresh programmes are introduced locally they will need to be well researched and planned, their cost estimated, and their success or failure assessed. Joint finance can be made available if authorities so decide for programmes of research and development in health promotion and preventive medicine, whether projects are directed at health, or social objectives, or both.

TEXTUAL REFERENCES

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2. Department of Health and Social Security. Non-Smoking in Health Premises. HC(77)3. DHSS 1977.

3. Department of Health and Social Security. Prevention in the Child Health Services.

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OTHER REFERENCES

1. Department of Health and Social Security. Prevention and Health.

   (a) Reducing the Risk: Safer Pregnancy and Childbirth: A Discussion Paper prepared by the Health Departments of Great Britain and Northern Ireland. HMSO 1977.

   (b) Eating for Health: A Discussion Booklet prepared by the Health Departments of Great Britain and Northern Ireland. HMSO 1978.

2. Health and Safety Commission - Prevention and Health, Occupational Health Services: The Way Ahead: A discussion document issued by the Health and Safety Commission. HMSO. 1977.

3. Department of Health and Social Security - 'Patients First': Report of a Working Party on the Dental Aspects DA(80)20 DHSS 1980.

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CHAPTER 3 - THE VOLUNTARY SECTOR

3.1 There is a vigorous tradition of voluntary service in this country. Some of our present statutory services originated from causes taken up by voluntary organisations - from rescuing abandoned and neglected children to providing meals on wheels. The work of local, regional and national voluntary organisations is often directed towards innovative work at the boundaries of existing services. It can bring a dimension of commitment, diversity and experiment which enhances the quality of life. But voluntary organisations need support and help in their work. Most of all they need the time and money of the public, whether volunteering and contributing as individuals or as members of religious, professional, business and other groups.

3.2 The spirit of voluntary service is demonstrated in less formal ways, such as the support offered by neighbours to the isolated elderly. Neighbourhood care groups have developed spontaneously to discover who needs support and to bring together the people willing to provide it. The number and range of mutual aid groups have also steadily grown. These bring together people who have a problem in common and enable each member to contribute to as well as take from the group. The playgroup movement is a magnificent example: some 350,000 children can now go to play groups organised by the community. There are many problems on a smaller scale, sometimes of less immediate concern to the community as a whole, which can benefit from the same kind of approach.

LINKS WITH STATUTORY SERVICES

3.3 The statutory services are essential for those who lack other forms of support or whose support is inadequate. Equally important, but less well recognised, they can help the community to make the fullest use of the whole range of informal and voluntary resources. This is particularly so in the personal social services. Social services departments use voluntary organisations as their agents to provide services for a wide range of clients. They appoint voluntary services co-ordinators to work with local groups, and they make use of individual volunteers and community workers. Some have been developing forms of organisation which are explicitly directed towards unlocking and supporting resources in the community, for instance by deploying field staff to work in 'patches'[1] of around 5-10,000 population.

3.4 This emphasis on the mutual support of statutory and voluntary services is to be welcomed and social services departments, while continuing to provide services for which they have direct responsibility, should do their best to encourage it. This involves identifying all the resources in the informal and organised voluntary sectors, the private sector and the statutory services, and enabling them to operate together in a concerted way. It means offering support to voluntary effort at the right time and in the right way. But this has to be done without crushing the commitment and spontaneity of the informal and voluntary contribution.

3.5 By completing the activities of NHS staff both in hospital and in the community, volunteers can help to provide a better service. The larger organisations, such as the British Red Cross and St John's Ambulance Brigade, and the Women's Royal Voluntary Service provide services which lie beyond the scope of the NHS. The individual volunteer can provide friendship, practical assistance and personal attention to the lonely and isolated patient. In between are many organisations, mutual aid groups and leagues of friends of varying size and degree of formality. One example is the Cross Roads Scheme which has enabled many people who would otherwise require hospital care to regain or retain their independence. Continuity and reliability are essential; voluntary work organisers can help to ensure this and to channel the good will and endeavour of individual volunteers into activities which help to support the health services.

3.6 Children and young people in trouble can also benefit from voluntary effort. Sharing a particular skill or activity with a volunteer can help a youngster. Increasing use is being made of volunteers in this way in schemes of Intermediate Treatment (IT) (see also Chapter 5). The IT Fund will continue with grants from monies provided by the Department and from voluntary and charitable sources. In various parts of the country firms and local shops, in partnership with social services departments, are helping youngsters in trouble or at risk to get used to doing a job. There is further scope for stimulating local initiatives of this kind. Independent groups, hostels or clubs may be the most effective way of tackling amongst adolescents problems such as alienation, drug abuse, or racial conflict.

FINANCE

3.7 In 1979/80 health authorities' income from donations, bequests and other sources was approaching £40 million. This sum, though not large compared with authorities' total expenditure, provides important flexibility, and the Health Services Act 1980 [2] and subsequent Health Circular[3] gives authorities the freedom to raise funds themselves. There are impressive recent examples of the willingness of the public and of private firms to subscribe in cash or in kind to imaginatively presented schemes. They include the substantial sums raised for rebuilding part of Stoke Mandeville hospital, as well as funding on a more modest scale, for example by chambers of commerce. Concessions in the 1980 Finance Act[4] on the tax position of charities will give a boost to voluntary donation generally, and it has been agreed that funds donated to the NHS should not be offset against those voted by Parliament.

3.8 Both health and personal social services authorities may decide to make grants to voluntary bodies, or to support worthwhile voluntary schemes. Such grants might match voluntary fund raising for a particular scheme, or be used to get it started, but longer term funding need not be ruled out. Between 1978/79 and 1979/80, the total amount paid by social services departments in grants to voluntary organisations rose by 8% in real terms and the total amount paid for services provided by voluntary organisations and "registered private persons" by 5%. The Department itself makes grants direct to some voluntary bodies, in the main those whose activities are national in scope. Its contribution has increased considerably over the years and, despite the current severe pressure on its own resources, the total available for such grants is being maintained in real terms.

3.9 Finally, while the strength of the voluntary sector lies partly in its ability to meet needs as they are perceived, the planning of the statutory services should take account of it, and so far as possible voluntary services should be involved in the planning process. Community Health Councils include representatives of local organisations and may have a useful role here. The contribution of voluntary organisations will be greatest where they can complement and collaborate with the statutory services.

TEXTUAL REFERENCES

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2. Health Services Act 1980. HMSO

3. Department of Health and Social Security. Health Services Management: Health Services Act 1980: Fund Raising by NHS Authorities HC(80)11. DHSS.

4. Finance Act 1980. HMSO.

OTHER REFERENCES

1. Department of Health and Social Security. Voluntary Help and the New Health Authorities. HSC(IS)27. DHSS 1974.

CHAPTER 4 - THE STATUTORY SERVICES

4.1 This Chapter is about the statutory services and the general considerations which will govern the way they are provided locally.

4.2 In the past 'The Way Forward'[1] and the annual planning guidelines[2] set priorities and policies for the health and personal social services, and gave guidance on levels of provision. National guidance is necessary on the difficult choices authorities have to face in deploying limited resources, but, as the Royal Commission on the NHS[3] said, 'the Health Departments have no monopoly of wisdom'. The Government's reply[4] to the Third Report, session 1979-80, of the Select Committee on Social Services[5] said:

> 'The Government see their role as essentially strategic. They have responsibility for the level of funding of the NHS and Ministers will continue to give strategic guidance relating to national policies and priorities, broadly indicating ways in which they look for development in the Service and where economies should be sought. But if the Government's policy of giving greater responsibility to the new district health authorities is to be effective, it is essential that those authorities should have adequate flexibility in applying national guidelines in a way that takes proper account of local needs and circumstances. In the case of management costs specific limits have been set; in general, however, guidance will be less detailed and precise than in the past.'

4.3 Statutory responsibility for the personal social services rests with elected local government. The Government indicates broad national policies, issues guidance where necessary and has a general concern for standards. There are only a small number of direct controls and these are being reduced as a matter of general Government policy towards local authorities.

4.4 In the recommendations on priorities which follow, it should be recognised that, while Governments have regularly identified services or groups as requiring priority nationally, there may be locally one particular group or service within the priority field which requires most attention.

There are, too, other groups and services which authorities should not ignore, for example, renal services, and which in some local circumstances may have a prior claim on resources. In addition the identified priority groups overlap, and they vary in the use made of services - as Chapter 5 points out, for example, elderly people are major users of the general acute services as well as of the geriatric and psychiatric services. The priorities which are set out below need to be considered in the light of these factors.

PRIORITIES

4.5 The Secretary of State expects authorities to give priority to the further development of services, both statutory and voluntary, for the needs, as locally assessed, of the following priority groups:

(a) Elderly people, especially the most vulnerable and frail. As mentioned in Chapter 1, the number of people over 75 is increasing, and those who need care have often been provided with unacceptably low standards of service, particularly in some aspects of long-term care.

(b) Mentally ill people. This group is frequently provided with services of inadequate standard and services need developing in more accessible facilities.

(c) Mentally handicapped people. This group also is often not provided with services of adequate standard, and many services need developing in more appropriate locations and on a different model.

(d) Physically and sensorily handicapped people. Services to meet the needs of this group are frequently inadequate.

4.6 The Secretary of State also expects attention to be given to the further development, in accordance with local assessment of requirements, of the following priority services:-

(a) Maternity services and neonatal care. The aim is to reduce further the number of perinatal deaths and handicaps;

(b) Primary care services. These are effective in many parts of the country but the object should be to raise standards elsewhere;

(c) Services related to the care of young children at risk and to the care and treatment of juvenile offenders. As the number of young children increases (see paragraph 1.2 (b)) the emphasis should be on social and health services needed to protect those most at risk. These services should in the long run make a major contribution to the maintenance of law and order.

4.7 The next Chapter provides additional background for each priority area. The emphasis on these groups and services continues the priority given to them in recent years, and the Secretary of State recognises that authorities in many parts of the country have already made considerable progress. As the growth of financial resources is severely limited and the priority groups are large, further progress cannot be rapid and will depend largely on skilful use of innovative approaches, including greater use of what the voluntary and private sectors can contribute. Authorities will face conflicting pressures, and the need to expand and improve services for growing numbers of elderly people and the emphasis on care in the community are coupled with rapidly rising costs in some sectors of health - particularly hospital - and welfare services.

4.8 The general acute hospital services, taken as a whole, are under pressure and are treating increasing numbers of people. The growth in the number of elderly patients is particularly marked. The trend of waiting lists and waiting times has been upwards for some years. Authorities will need to reappraise priorities within the acute sector. Trends in general acute services and in hospital services for the elderly have been the subject of two studies[6,7] undertaken in the Department which will be issued for consultation shortly.

COMMUNITY CARE

4.9 It has been a major policy objective for many years to foster and develop community care for the main client groups - elderly, mentally ill, mentally handicapped and disabled people and children - as well as for the special and smaller groups such as alcoholics. The Department will shortly

be publishing the report of a study on community care[8] - a summary of that report is at Appendix 2 - which makes it clear that the specific objectives of community care policies are different for the different client groups; but the general aim is to maintain an individual's link with his family and friends and normal life, and to offer the support that meets his or her particular needs.

4.10 We need to know more about the extent to which it is realistic to expect the development of community care in the years ahead to be able to prevent the admission of so many people in old age, or suffering from mental illness or handicap, to residential or hospital care. The Department's study highlights the essential contribution of the voluntary sector, in particular the variety of informal ways in which individual people can help care for others in the community. It focuses particularly on what community care can do to meet the needs of some relatively small groups of people whose frailty, social circumstances, or general dependency put them on the borderline between long-term residential or hospital care and care within the community. The study suggests that the development of community services has not so far been specifically directed at those groups of people who require a particularly intensive degree of support if they are not to be taken into long term care. The study has also confirmed that community care is not necessarily cheaper than care in an institution. As is well known, the scale of support that some people require if they are to live at home is considerable, and the burden on their families can be heavy. The Department intends to consult authorities and other interests about the findings; no firm policy decisions have been taken on the basis of what is said.

PRIMARY AND DOMICILIARY CARE

4.11 In the NHS the benefits of a strong primary health care service include early detection of illness, swift treatment to prevent deterioration, the care of people in the community rather than in hospital, and drawing on the resources of the family, neighbours and voluntary groups rather than relying on the expensive services of full-time professionals in hospital. There is evidence[9] that people in Social Classes IV and V make as much use of primary

care services as others: more for some kinds of ill-health. It is therefore important, for people in these social classes, that staffing levels and premises for primary care services should be adequate. Health centres may have a role to play in improving services in some deprived areas, but the case for each new health centre should be rigorously examined in the light of the criteria set out in HC(80)6.[10]

4.12 More health visitors and district nurses are needed in many places to strengthen the primary health care services. Authorities should aim at increasing secondments for training. There is substantial variation in the ratios of health visitors and district nurses to population in different parts of the country, but this may partly reflect differences in need, so the precise rate of increase must be left for each health authority to decide in the light of its own local circumstances. A review by the London Health Planning Consortium Primary Care Study Group,[11] and one into the work of the primary health care team by a Joint Working Group of the Standing Medical and the Standing Nursing and Midwifery Advisory Committees,[12] will be available soon as guides to local action. The Office of Population Censuses and Surveys will shortly be publishing a survey on access to primary health care,[13] and are now doing a study of nurses working in the community.

4.13 In the personal social services social workers have the task of helping to secure and co-ordinate services for people who need them and of assisting individuals and families with both immediate and longer term personal and social problems. Pressures on these functions during the decade since social services departments were formed has meant that the development of preventive work, particularly through supporting and stimulating caring networks in the community, has been slower than hoped for. This should now be given the highest priority that the discharge of statutory duties allows.

4.14 Among the domiciliary services home helps provide varied and flexible services for people with a wide range of needs. Local voluntary organisations contribute to day care for a number of client groups. The volume of domiciliary service depends on resources available, but there may well be ways of further developing its major preventive role.

PLANNING AND COLLABORATION

4.15 Health and local authorities have a statutory duty to co-operate to 'secure and advance the health and welfare' of the population.[14] This collaboration will continue to be important when the new district health authorities are established. Joint consultative committees remain a legal requirement and informal machinery involving bodies will continue to be needed as well.

4.16 Health authorities also have a statutory duty to provide services to local authorities to enable them to discharge their functions relating to social services, education and public health.[14]

4.17 The planning arrangements for health and local authorities, including those for joint planning, are an important part of the machinery for assessing alternatives. The original NHS planning system was cumbersome and the Department is proposing a simplified system.[15]

4.18 The joint finance arrangements make NHS funds available for agreed social services schemes. But additional ways are needed of transferring resources to the personal social services to provide for people who would be better cared for outside hospital. It is intended to issue a consultative document later this year.

4.19 There is a statutory requirement that facilities should be provided for clinical teaching and research. Health authorities, particularly those within which there are universities with medical or dental schools, carry the main burden of responsibility. HN(80)40[16] invited views on the most appropriate ways of ensuring that the needs of medical education are fully taken into account in the planning and management of the service. /Outcome of consultations - one sentence/.

FINANCE

4.20 For local government, national resources are made available to supplement income from rates and other sources through the rate support grant. Financial management is a major task for local government and there is no need to amplify it here. The following details on NHS finance may however be helpful.

4.21 The Department distributes revenue and capital funds to regional health authorities on the basis of the principles established by the Resource Allocation Working Party (RAWP).[17] The Working Party saw its underlying objective as securing, through resource allocation, equal opportunity of access to health care for people at equal risk. Thus, revenue allocation to regional health authorities are based on a formula of which the main criterion is population weighted to reflect relative health care need. Regional health authorities are expected to apply similar principles in making sub-regional allocations. Research is continuing into some aspects of the resource allocation process.

4.22 The revenue and capital allocation to regional health authorities are for hospital and community health services and are subject to strict cash limits. They include an increment designed to cover changes in pay and prices in the year ahead. Allocations to areas and districts are in turn cash limited. Authorities must contain their cash expenditure within the limits set and if necessary must reduce expenditure - by making economies or by reducing the volume of services provided. Expenditure on family practitioner services is regarded as being demand-determined and cannot therefore be directly controlled by pre-determined cash limits. The size of the annual drug bill - approaching £800 million in 1979 - makes it important to secure efficiency and economy in prescribing. The Department helps general practitioners to keep themselves informed about the effectiveness and the costs of drugs, and about the individual practitioner's own prescribing habits. This is done in a number of ways: for example through this Department's Regional Medical Service and through the British National Formulary and other publications. Drugs and dressings dispensed through hospitals are subject to cost limits in the usual way.

4.23 Within their total cash limits, regional health authorities may maintain reserves and vary the allocations for district health authorities as they judge necessary. To encourage the most efficient use of resources the Department, with the agreement of the Treasury, operates arrangements which enable regional health authorities to carry over to the next year up to 1% of their revenue cash limit and to the next-but-one year any capital underspending

up to 10% of their capital cash limit. They can also transfer within any single financial year up to 1% of revenue to capital and up to 10% of capital revenue but this facility should not be used to distort the national priorities for capital and revenue expenditure. These arrangements may be extended as appropriate to district health authorities. In addition to their cash limits health authorities retain income from private patients and other charges. Health authorities will be expected to distribute their resources to budget holders and to develop budgetary procedures to ensure adequate financial control; for example through unit and functional budgets and by the development of clinical or specialty budgets.

4.24 Full account should be taken of the economic value of the land and buildings held for the NHS. Acquisition of new property has to be balanced against other priorities for capital expenditure. NHS planning and estate management needs to make full use of all NHS property, by rationalising holdings, upgrading or extending suitable buildings and identifying any land or buildings which are under-used or for which there is no firmly planned NHS use in immediate prospect. Every effort must be made to sell surplus land and buildings. This reduces the cost of maintaining the estate and brings in useful capital from the proceeds which are retained by the NHS.

MANPOWER

4.25 Changes in management, national negotiations on pay and conditions of service and other factors, will effect the use of manpower, but most changes will be marginal and gradual, the product of many small decisions taken locally. Local managers will need to be alert to ways of achieving greater efficiency in the use of staff and of experimenting with different mixes of staff, including those employed on contract, particularly when there are local shortages. Effective training can extend the skills of managers and staff, and spread understanding of local objectives.

4.26 The flexible use of staff depends heavily on good industrial relations and effective personnel policies. The authority's policies on industrial relations issues need to be known and consistently applied, and there should

be early consultations with staff about decisions on the running of the services in which they themselves work.

4.27 Manpower planning needs to be integrated with the planning of services, particularly in respect of professionally qualified staff for whom decisions on training intake levels have to be taken many years ahead of manpower requirements. A start has been made on this in the NHS; it must be consolidated and extended locally, regionally and centrally. Although the primary responsibility for planning and controlling manpower use rests with individual health authorities the Department works closely with the NHS in promoting effective and economical manpower planning. There is a Joint Manpower Planning and Information Working Group (MAPLIN) which brings together local manpower planners and representatives of the Department. This has provided a useful forum for promoting the development and manpower information systems and fostering a collective approach to manpower problems.

4.28 There are a number of important factors relating to medical staffing:

(a) For a number of reasons - a principal one being changes in registration arrangements - there may be a reduction in the number of overseas doctors entering the country. This could exacerbate the shortage of doctors in particular specialties; for example those concerned with elderly epople and mental illness; in community medicine and in important support services such as pathology and radiology.

(b) There is geographical maldistribution with some areas persistently unable to attract sufficient hospital doctors and/or general medical and dental practitioners.

(c) The Government is taking up initiatives with health authorities and the profession in pursuit of the firmly established policy that patients should be cared for as far as possible by fully trained doctors. Specifically the concern is with increasing the proportion of consultants.

4.29 There remains a shortage of nurses in certain fields - mental illness, mental handicap - and of qualified children's nurses as well as midwives in some localities. A shortage of theatre nurses is the greatest obstacle in some areas in reducing waiting lists. Recruitment is at present inadequate in health visiting and perhaps also in district nursing. The recent reduction in the nurses' working week - 37½ hours - could require staff increases of about 6% to fulfil present service commitments. Whether and how much nursing school intakes should increase to cope with change will depend on how successful local management is in reorganising work to minimise the need for extra staff.

4.30 A number of staff groups in the NHS will be affected by retirement bulges in the 1980s: there is a high proportion of older general practitioners in inner city practices and older doctors are heavily over-represented in certain hospital specialties and in community medicine. Retirements may add to existing shortages of chiropodists unless numbers in training are increased. Recruitment over the decade may be affected for some groups by a reduction in the number of school leavers, although this may be off-set by wider movements in the employment field. Authorities may need to rely more on recruiting older men and women, on making it easier for trained staff with family commitments to stay at work or return after a break, and on inducing those who have left NHS employment to return.

QUALITY AND EFFICIENCY OF SERVICES

District Health Authorities

4.31 Authorities should attach the greatest importance to using their resources as efficiently as possible, particularly at a time when public expenditure as a whole is being reduced and NHS expenditure is nevertheless being maintained at planning levels. Authorities will rely heavily on the experience and knowledge of their professional staff to provide good quality and efficient services but each authority itself must ensure that the systems introduced both achieve these means and provide relevant information to authority members.

4.32 The changes announced in HC(80)8[19] are designed to make the service more responsive to local needs and to place greater responsibility on staff at the operational level where most decisions affecting the way resources are used are taken. Proposals set out in HN(81)-15 for simplification of the NHS planning system should enable the planning of service developments to be more closely linked with day to day management, and the information for planning to be economically assembled and assessed. The Department is considering possible changes in the procedures for approval of major capital developments and also how current investment appraisal procedures can be improved. Current experiments in locally based budgets, and improved costing information for clinicians[20] may also provide tools for improved use of resources.

4.33. A key element in improvement is adequate, relevant and timely information. The Steering Group on Health Services Information chaired by Mrs Körner, vice-chairman of the South Western RHA, has been established to look at NHS activity, manpower and other data, and a linked group has been set up to review NHS financial and costing data. The objectives of both reviews are to ensure that the information collected is more relevant to the Department's needs; to reduce the administrative burden imposed by the collection of statistical returns; and to improve the accuracy and timeliness of information by basing it, as far as possible, on data required locally by authorities, by management and by professional staff.

4.34 The Department is considering possible pilot schemes for introducing to the whole health service a form of monitoring, perhaps to be called a 'Management Advisory Service', as indicated in the reply to the Select Committee[4]. The extent of such a service will not finally be determined until after the pilot schemes have been completed and their usefulness and cost effectiveness evaluated. The pilot schemes will be capable of examining all aspects of management - they will be looking at efficiency and quality across a broad spectrum. A Management Advisory Service could therefore include the elimination of inefficiency among its aims; draw attention to examples of waste and disseminate good practice. One of the purposes of the pilot studies is to assess whether a regular visiting system or a programme of work based on selective studies of particular aspects of

the service would be the more fruitful approach.

4.35 Authorities may also look to a variety of outside sources for advice and help.

(a) Health Advisory Service, which looks at long-stay services other than for the mentally handicapped and, in conjunction with the Department's Social Work Service, at corresponding social service facilities.

(b) Development Team for the Mentally Handicapped, which can advise authorities on all aspects of their services.

(c) National Development Group for the mentally handicapped was disbanded in 1980 but its publications continue to be available free of charge. They set out guidance and help to authorities on the services to be provided, and the Group's final publication 'A Checklist of Standards [21] will help authorities in monitoring their services for mentally handicapped people.

(d) The Health Service Supply Council which will be a source of help to health authorities in obtaining value for money when purchasing equipment and supplies for the NHS.

(e) The Department's Catering and Diabetics and Domestic Services Branches provide a range of consultancy to health authorities on request [22].

(f) National and Regional Management Services; results of national efficiency studies are published and reports of O and M and other relevant studies carried out in other Regions may also be obtained.

(g) Publications by research and other bodies, including the British Institute of Management Services and the Royal Institute of Public Administration.

Many authorities also find it useful to establish links with local University and other research facilities.

4.36 The task of assessing an authority's performance will be a major management responsibility for the authority and its officers. A programme of visits and review of district services will help authority members to judge the quality of services provided. National measures may provide a guide to what can be achieved, but are unlikely to be applicable locally in full. It is important that authorities are aware of developments elsewhere, although statistical comparison with other authorities needs to be undertaken with care. An annual report by district health autorities would provide an opportunity for each authority to consider and account for the standards of services provided. Appendix 3 sets out in more detail measures which authorities have taken, or might take, to increase efficiency.

Personal Social Services

4.37 Local authorities' responsibilities for personal social services are, of course, only a part of their much wider responsibilities. They have various sources of advise available to them on the efficiency of their services including the Local Government Audit Service. The Social Work Service of the Department, among its other functions, carries out inspections of a range of services provided by Social Services Departments, and is ready to advise them and voluntary organisations on social services matters.

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CHAPTER 5 - PRIORITY GROUPS AND SERVICES

5.1 This Chapter considers provision for the priority groups and services referred to in the last Chapter. It does not attempt to prescribe in detail how they are to be developed which must be for local decision, but it indicates the broad approaches which the Secretary of State wishes authorities to follow.

ELDERLY PEOPLE

5.2 The Government will publish a White Paper on elderly people[1], and authorities will be able to develop their services in that broader context. The White Paper will cover all aspects of support and care for elderly people including community care services and care in hospital.

5.3 The whole community should be involved in providing adequate support and care for elderly people. Public authorities will not command the resources to deal with it alone. Nor could official help meet all those needs which go beyond the provision of material benefits.

5.4 The objectives for health and local authorities should be to:

(a) Strengthen the primary and community care services, together with neighbourhood and voluntary support, to enable elderly people to live at home. Some elderly people may need the additional support and cover of sheltered accommodation but this form of housing provision will be available only for a relatively small number.

(b) Encourage an active approach to treatment and rehabilitation to enable elderly to return to the community from hospital wherever possible. The development of acute geriatric units in district general hospitals enables acutely ill elderly people, who require the special expertise available in departments of geriatric medicine, to be cared for by a consultant in that specialty. These departments are centres of expertise for others involved in the care of elderly people in the hospital service and in the community;

(c) Maintain capacity in the general acute sector to deal with the increasing number of elderly patients. Two-thirds of all non-psychiatric hospital in-patients aged 75 and over are currently treated in general acute beds. It is in this age group that numbers are expected to increase considerably, and in which treatment needs are generally more complex - because there may be several conditions which need treatment at the same age - and rehabilitation is more difficult than for other age groups.

(d) Maintain an adequate provision for the minority of elderly people requiring long-term care in hospital or residential homes.

5.5 The studies referred to in Chapter 4 throw some light on these objectives. The study of the general acute sector[2] of the NHS shows that most of the increased activity over the last 10 years in that sector has been in treating elderly people. The increase has been greater than would have been required to keep pace with the increase in the number of elderly people. The study of hospital services for the elderly shows that despite the expansion of specialised departments of geriatric medicine, and the high levels of activity they have achieved, the pressure of demographic change means that a major burden of provision for elderly patients will continue to fall on the general acute services. It identifies a need to examine alternative ways of increasing medical manpower for geriatric medicine and a need for medical and surgical specialities to develop specific policies for the effective treatment and rehabilitation of the growing numbers of elderly patients they will be called upon to treat.

5.6 A comprehensive geriatric service is not likely to be practicable over the country as a whole within the next 10 years because of inadequate recruitment to geriatric medicine. The general acute services will therefore continue to be responsible for the treatment of a correspondingly greater number of elderly patients, and this will need to be taken into account in planning hospital services. The impact of the short-fall in provision for elderly patients in departments of geriatric medicine on nurse manpower in general acute wards and on remedial services requirements will need to be considered. Admission and discharge procedures in many specialties must reflect the problems of elderly people, especially those living alone or with elderly relatives who are themselves

frail or infirm. Staff working in general acute wards should be trained in the special needs of elderly patients and be able to obtain advice and guidance from the multi-disciplinary geriatric team.

SERVICES FOR THE MENTALLY ILL

5.7 The planned development of services for the mentally ill is broadly as set out in the 1975 White Paper, 'Better Services for the Mentally Ill'[3]. Its advice was supplemented by the 1980 Report of the Working Group on Organisation and Management Problems of Mental Illness Hospitals[4] (the Nodder report). The aim is for people to be able to use the service they need with the minimum of formality and delay, and without losing touch with their normal lives. Services should be readily accessible and, subject to needs. These should be separate from other NHS and social service provision only to the extent that patients' or clients' needs dictate, and the NHS, local authorities and voluntary bodies will need to develop co-ordinated and complementary services. For example, facilities for the care and rehabilitation of those disabled by chronic mental illness need to be provided by both health and social services working together.

5.8 Social services departments and the voluntary sector provide essential services for mentally ill people and their families, including residential and day care and other support and rehabilitation facilities. They also provide a link with all other services a community provides.

5.9 NHS services are patchy. Over the country as a whole the most urgent tasks are to:

(a) Create as quickly as possible a local service in those districts that still have little local provision. This will imply reducing the catchment areas of mental illness hospitals to their own districts, as proposed in the Nodder Report;

(b) Provide in every district enough suitable accommodation for the care of the elderly severely mentally infirm, taking account of the likely increase in numbers; and of the same time ensure that every district has a consultant psychiatrist with a special interest in the elderly, who can play a key role in developing psychiatric services for elderly people.

(c) Make arrangements satisfactory to patients and staff locally for the closure over the next 10 years or so of those mental illness hospitals which are not well placed to provide a service reaching out into the community and are already near the end of their useful life. Such closures should provide a source of staff, capital and revenue to support the development of the new pattern of health services for the mentally ill; including community psychiatric nursing and perhaps help to support the development of services provided by local authorities.

5.10 The care of patients who are difficult to manage, including those who have committed an offence, is part of the responsibility of NHS psychiatric and mental handicap services. These patients fit less easily into the new pattern of services. Many psychiatric hospitals and units and mental handicap hospitals provide an adequate service for them but it is important that others should develop such facilities. It remains Government policy for each region, using central funds, to establish in addition a regional secure unit (and secure facilities in the interim) to accommodate those who, while not requiring treatment under conditions of security such as are only to be found in special hospitals, cannot be managed satisfactorily in an ordinary NHS hospital or unit. These secure facilities should be seen as part of a continuum of care in local psychiatric services, but experience has shown that without a strong lead from the authority, they are difficult to establish. The Royal College of Psychiatrists has recently published a report 'Secure Facilities For Psychiatric Patients - A Comprehensive Policy'[5].

SERVICES FOR THE MENTALLY HANDICAPPED

5.11 The path of development of services for mentally handicapped people remains broadly as set out in the 1971 White Paper 'Better Services for the Mentally Handicapped'.[6] A recent Departmental review of mental handicap policy 'Progress, Problems and Priorities'[7] shows that there has been an encouraging increase in day services but that too many resources are still concentrated in large, badly located buildings and in services that do not best meet the needs of the people they are intended to serve. The Government has accepted in principle the model of care set out in the Report of the Committee on Mental Handicap Nursing and Care[8] (Jay Committee) but has indicated the need for further consideration of the best way of providing

for the special needs of the relatively small numbers of the most severely multiply handicapped people. The main aims for authorities should be to:

(a) Provide a locally based service that enables mentally handicapped people to live with their families where possible, or failing that in a local community setting.

(b) Help develop the capabilities of each individual so that he or she can live as independent a life as possible.

(c) Support those looking after mentally handicapped people at home by providing day services, and short-term residential care for training, relief and holiday purposes.

5.12 The 1971 White Paper[6] set as a target the introduction of necessary changes within 20 years. Resource constraints will make this more difficult to achieve, and developing joint planning between health and social services authorities, and close involvement of voluntary bodies and other agencies such as education and housing authorities will be essential. Joint funding, referred to in Chapter 4, facilitates joint co-operation between health and local authorities on important projects. Funds may also become available from disposal of redundant hospitals.

5.13 Some mentally handicapped children and adults, will require residential care in a health setting, but the aim must be to limit this to those who have clear medical and nursing needs, and any new provision should be in smaller and more local units than envisaged in the 1971 White Paper.[6] Large hospitals do not provide a favourable environment for children to grow up in, and it is clear that the White Paper considerably over-estimated the numbers of children who would require this care. A range of alternatives to care in mental handicap hospitals is being developed and should be taken into account in planning children's services.

SERVICES FOR PHYSICALLY DISABLED AND SENSORILY IMPAIRED PEOPLE

5.14 Chapter 2 referred to the screening and other methods which will help prevent disability. Services for people who are physically disabled or sensorily impaired should have the general aim of enabling them to lead full and purposeful lives if possible in the community, and preventing or

reducing the effects of their conditions. Social services departments will need to provide social work, home helps, meals on wheels, aids to daily living etc; and, in co-operation with housing departments, home adaptations. Health authorities will need to provide district nursing and incontinence services, remedial therapy, speech therapy services and chiropody. Voluntary bodies, often acting as agents of local authorities, can provide such services as care attendant schemes, holiday homes, counselling and information.

5.15 Health and local authorities should aim to:

(a) Relieve pressures on caring relatives through more short-term care and treatment (including day care), development of services for the incontinent, care attendant schemes and perhaps through the development by voluntary bodies and community groups of other supporting services for disabled people and their families;

(b) Further improve arrangements for caring for younger disabled people separately from the elderly;

(c) Help those with hearing impairments to make the best use of the improvedrange of aids, in particular by the recruitment and training of additional hearing therapists;

(d) Improve co-operation between authorities to ensure that visually handicapped people, particularly the elderly, are aware of and can benefit from the services and advice which should be available to them. Services for newly blind people should be improved. They should be able to receive teaching in daily living skills and the support necessary to achieve independence in the community.

5.16 Good rehabilitation services minimise the impact of disabling accident and illness; they should be fostered. Referral arrangements between health and employment services need particular attention: a recent report of the National Advisory Council on Employment of Disabled People is being issued for consultation.[9]

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SERVICES FOR CHILDREN

National Health Service

5.17 A Paper entitled 'Prevention in the Child Health Services'[10] was made available in March 1980 outlining the main objectives and content of the preventive child health services. It also suggested a basic programme of surveillance and stressed the importance of health education. A crucial need is to improve take-up of child health services since it is often those who need these services most who use them least; but as the scope for the expansion of these services is limited, any additional resources should be directed towards areas of high social stress, high infant mortality or low take-up of preventive services.

5.18 The Government has endorsed the overall philosophy of the Court Committee Report,[11] has reaffirmed the principles set out in HC(78)5,[12] and has stated it's concern that health authorities should develop plans for an integrated child health services as soon as resources permit. It has also been reaffirmed that all acutely ill children in hospital should be treated in comprehensive children's departments under the general oversight of a consultant paediatrician and that those departments should be staffed by suitably qualified nurses. The Consumers Association's excellent report on 'Children in Hospital',[13] published in June 1980, was recently commended to health authorities.

5.19 In August 1980 the Government published the White Paper 'Special Needs in Education' (Cmnd 7996) announcing its intention to introduce legislation to reform the statutory framework of special education in line with the recommendations of the Warnock Report. The concept of special educational treatment appropriate to certain defined categories of handicap will be replaced by a new concept of provision to meet special educational needs. The Government's approach envisages a substantial contribution from the health and personal social services, and medical and other staff will play an important role inthe assessment of children's needs.

Personal Social Services

5.20 A prime objective of both statutory and voluntary services should be to encourage the development of self-help and community activities involving children, and through these to help parents look after their children better. The development of play groups, family centres and home visiting schemes can all make a significant contribution. There are, nevertheless, 100,000 children in the care

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of local authorities. While some of these children are best cared for in residential homes, far more of them could benefit from living in a family environment with foster parents. More, too, could be adopted by suitable families. Fostering and adoption not only benefit the child; they are also an economic use of resources when compared to high-cost residential homes. Voluntary agencies have always played an important role in services for children, and local authorities should build on this in the development of their own services.

5.21 Local authorities have a statutory responsibility to provide adequate care and protection for youngsters in trouble or at risk of getting into trouble with the courts or police. Detailed plans were announced in the White Paper on Young Offenders[14] for strengthening magistrates courts by giving them powers to make 2 new orders. The Residential Care Order will enable them to require that a youngster who offends while already in local authority care as a result of an earlier offence shall not live at home for a defined period. This will provide magistrates with a real alternative to a custodial sentence in certain circumstances. The Supervision Order will be strengthened to enable them to require a young offender to participate in an agreed programme of supervised activities such as intermediate treatment (IT) and is part of the current commitment to promoting community-based ways of dealing with disadvantaged young people so as to keep them in contact with their families, friends and home environment. Local authorities have been asked to protect their IT expenditure, while the Department is encouraging voluntary organisations to participate in IT by giving grant aid.

MATERNITY SERVICES

5.22 Notable achievements have been made over recent years in reducing perinatal and neonatal mortality and associated handicaps. The Government's Reply, Cmnd 8084,[15] to the Second Report from the Social Services Committee for the 1979-80 session[16] reaffirmed the priority they attach to further reduction through the improvement of maternity and neonatal services. They believe that the best way of effecting this is for health authorities to consider the great majority of the Committee's recommendations which concern the National Health Service. Authorities have been sent copies of the Committee's Report and the Government's reply and have been asked to study them in the light of local circumstances and needs to give priority to implementing those recommendations which they judge most urgent as part of a sustained campaign to improve services in each area.

5.23 The Committee recommended the introduction of national standards and norms, for staffing and equipment in the maternity and neonatal services. The Secretary of State intends to establish minimum standards which are

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attainable within a reasonable time and with reasonable staffing and finance: discussions are being held with the relevant professional bodies about the fields in which standards should apply and how they should be defined.

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CHAPTER 6 - PARTNERSHIP WITH THE PRIVATE SECTOR

6.1 Part of the health care of this country has always been provided by the private sector - private hospitals and nursing homes, private care in general practice, and health schemes related to employment. The size and scope of the private sector were briefly described in Chapter 1. Public and private medicine are closely inter-related. Those who use private medicine usually continue to use the NHS for certain services, and many doctors work in both sectors. In the past Governments have too often neglected or ignored the opportunities for co-operation between the private and public sectors.

PRIVATE PATIENT USE OF NHS FACILITIES

6.2 The Health Services Act 1980[1] dissolved the Health Services Board and halted the enforced withdrawal of private facilities from NHS hospitals. Where there is local demand new facilities will be authorised, subject to the statutory requirement that NHS patients should not be significantly disadvantaged as a result. The arrangements are set out in HC(80)10.[2] Provided that arrangements for admission and treatment are fair to all concerned, private practice and the income it generates should be to the benefit of NHS hospitals. In addition to the statutory safeguard, principles of good practice have been agreed with the medical profession which cover such matters as common standards of care and services, the prevention of out-patient queue jumping, and common waiting lists for urgent admissions and the seriously ill and for highly specialised diagnosis and treatment. If the present trend towards treatment of private patients suffering from routine surgical conditions in independent hospitals continues, the importance of equal access to specialised facilities will increase. Revised consultants' contracts permit highly skilled medical staff to use their time efficiently and flexibly both in the public and private sectors.

PRIVATE HOSPITALS

6.3 The Government have retained powers to check that the NHS is not harmed by large new private sector developments. Health authorities are responsible

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for ensuring that adequate standards are maintained in private hospitals. Apart from these controls the private sector is free to find its own level. The growth of independent hospitals shows the demand for their services. As the Royal Commission on the National Health Service[3] noted, they can respond more directly to patients' needs, and provide pointers to areas where the NHS is deficient. For example, lengthy NHS waiting times for minor surgery have led to development of facilities in the private sector. A close working relationship between health authority and private developer from the planning stage onwards will help to ensure that private facilities complement those provided by the NHS. In much the same way planning of new NHS hospitals should take account of private institutions.

6.4 The expansion of the private sector should not be confined to acute facilities in hospitals. The growing importance of prevention and of the provision of nursing care for elderly people has been made clear elsewhere in this Document, and most of it will be outside hospital. There is plenty of room for growth in this area.

THE NHS AND THE PRIVATE SECTOR

6.5 The present constraints on the resources available to the NHS should encourage a more imaginative approach to the possibilities of planning and providing services in partnership with the private sector where it is economical to do so. Interchange or sharing of private sector and NHS staffing may eventually be possible. In some places contractual arrangements for the use of independent hospitals and nursing homes to provide services for NHS patients are in integral part of NHS services.[4] They provide flexibility by adding to the options open to health authorities. Where there is a bottleneck in the provision of health services, the possibility of temporary or longer term contractual arrangements may be worth considering. For example, a long waiting list caused by a shortage of theatre facilities may be helped by a short term contract to reduce the backlog. A shortage of capital to provide an expensive item of equipment might be met by encouraging a private developer to provide the equipment under contract. In certain circumstances either party could benefit from the use of facilities at full capacity, whereas facilities provided separately might be under-used.

PRIVATE CARE IN THE PSS

6.6 Outside hospital the contribution of the private sector to the care of our growing number of elderly people is becoming steadily more important, particularly in areas with high proportions of retired and elderly people, where the statutory services are already hard pressed. The private and voluntary sectors provide about 30% of residential care available for elderly people. Local authorities may make arrangements with registered private homes for the care of elderly or infirm people, and many do so. Charges for such 'sponsored' residents are assessed on the same basis as for residents in an authority's own homes.

6.7 Local authorities may make arrangements with private concerns and individuals for provision of holidays, for fostering children and for the periodic relief of families caring for elderly people; and some individuals make private arrangements for domiciliary support (such as domestic cleaning and nursing care). But there is so far little interest in the private sector in providing a basic range of support services for people living in their own homes who could afford to pay for it; and only a few private firms have shown an interest in sheltered housing arrangements.

6.8 Private enterprise plays a useful part in providing children's homes and here too there is room for development. There are about 170 private children's homes in England and Wales which, in return for a fee, accommodate children in the care of local authorities. Many specialise in taking family groups or the older or more difficult children. /The Government favours the idea, when opportunity permits of private children's homes being brought into line with other accommodation for children in care, by requiring them to register and conform to adequate standards./

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NEXT STEPS

Neither at region nor district in the NHS, nor in social services departments, will it be necessary to engage in a fresh round of planning, as a result of these guidelines. Their message will be best reflected in the continuing re-assessment of services and opportune decision-taking by members and their senior officers. It is intended that they, and professional groups, should study the document and consider how its message can best be developed and implemented for their local circumstances. There is not be be a formal consultation process for this document but the Department will be pleased to receive any comments, general or particular, from national or local bodies.

As authorities proceed with assessment and self-audit, and whether in reports of progress or in drafting and publishing plans, convey to their own community and staff their assessments and their proposals for action, the Department will seek to review the overall pattern. It will be able to discuss with national bodies and representative groups, including the voluntary organisations, and learn their views of progress. The NHS planning system is being simplified and its requirements reduced (consultation is going on about this), and in its modified form this will provide an important means of assessing how the strategy is generally being applied within the new DHAs. Regular statistical returns

to the Department, which are to be substantially cut, will provide a quantified account of some objectively measurable items.

It will be important that those who are responsible for local services, and those who represent the users, should make sure that local standards are maintained, especially for the vulnerable groups. Pilot studies of the best means of monitoring quality and efficiency are being launched. However, much of the desirable improvement proposed by the present document, such as developments in the voluntary sector, and in the balance of health and social services, can only be subjectively and qualitatively assessed. Thus, responsibility lies especially on chairmen and members of authorities to see that they carry the strategy into effect. Ministers are conficent that they will give a good account of their stewardship.

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APPENDIX I

ROLE OF CHAIRMEN AND MEMBERS OF HEALTH AND LOCAL AUTHORITIES

1. The Chairmen and members of each DHA will corporately be responsible for the provision, planning, and management of the health care services in their district within national and regional guidelines. They will employ full-time staff to carry out these functions on behalf of the Authority, to whom the officers are accountable. The Authority's Chairman and members will, in turn, be accountable for their decisions through Regional Health Authorities to the Secretary of State.

2. Advice on the role and functions of health authority members was given in Circular HRC(73)22. This will be restated and amplified in a new circular on appointments to District Health Authorities to be issued in the Spring of 1981. There is also a useful chapter on the member's role in NAHA's "NHS Handbook" (published in May 1980).

3. The Local Government Act 1972, sets out in general terms the roles and function of chairmen and members of local authorities. Other legislation relates to specific functions of local authorities including their social services departments.

Appendix 2

REPORT ON A STUDY OF COMMUNITY CARE

SUMMARY

1. The terms of reference of the study were

"To clarify policies for the development of community care for the HPSS in terms of the resources now expected to be available, including self-help, the contribution of the voluntary sector, and the contribution of the private sector, and focusing on the patterns of service and interactions between the NHS and the PSS".

In the time available, it was necessary to limit the scope of the study to a number of specific areas. In view of the emphasis in the terms of reference on the interaction between NHS and PSS provision, one main focus of the study is an assessment of the shift in the balance of care away from long-term hospital or residential provision for certain people whose needs put them on the boundary between long-term institutional and other modes of care. The Study looks particularly at those relatively small groups of elderly, mentally ill and mentally handicapped people whose level of dependency, circumstances or frailty require especially intensive care. These groups are referred to throughout the report as 'boundary groups'. Consideration of much of the work which is carried out in the community by health and social services staff has been deliberately excluded - for example, much of the preventive work carried out by general practitioners, health visitors and district nurses and the episodic type of intervention undertaken by these staff as well as by social workers.

2. The other main area highlighted in the report is the contribution of the voluntary sector. The vital role of the voluntary and informal sectors to the network of community based support available is striking. The option of home based care is often only available where voluntary and informal effort provide the major contribution to caring for people. Given the paucity of data available on the extent of the private (as opposed to the voluntary) contribution to community based packages of care, it was decided to exclude consideration of this area.

3. Community care in relation to specific client groups has been the subject of considerable attention but much less effort has been devoted to an overall analysis of the development of community care. Even within the specific areas chosen for particular attention in this study, much of the ground was uncharted and it has not been possible to draw firm conclusions. The report concentrates on identifying those questions which would seem to require further consideration either by the Department or by key people in the field. It should be emphasised that it was not the purpose of the study to question the philosophy of community-based care. There is little doubt about the benefits to be gained from providing for people's needs in a flexible way which

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maintains their links with ordinary life, family and friends, wherever possible, and offers greater choice. The intention of the study was to document progress so far in the specific areas chosen for detailed examination and to indicate possible problem areas in the implementation of policy which require attention in order to maximise the potential of community care.

4. The main points which have emerged and the questions raised are:

(a) The concept

The term 'community care' is used in a variety of ways and may be misinterpreted. It may describe the services and resources which are involved (eg community care is those services provided outside of institutions ...) or an objective of service delivery (eg community care in minimising the disruption of ordinary living...) Although it would not seem fruitful to offer one all-purpose definition it is important to specify what is meant wherever the term is used.

(b) Cost-effectiveness of community care

i. community based packages of care may not always be a less expensive or more effective alternative to hospital or residential provision, particularly for those living alone;

ii. their 'cost-effectiveness' often depends on the contribution of informal carers (relatives, friends and neighbours) who may shoulder considerable financial, social and emotional burdens as a result;

iii. health and social services authorities need to consider <u>all</u> the public expenditure costs involved in determining patterns of service for particular groups although their decisions are likely to be particularly influenced by consideration of those resources for which they are themselves responsible; and

iv. few studies have compared <u>both</u> the cost <u>and</u> the effectiveness of different packages of care. More research is needed in this area but it would be a mistake to underestimate the methodological difficulties.

(c) Developments in community care: the boundary groups

(i) there seems to have been little identifiable shift away from hospital and residential care for elderly people on the margins of institutional and community based care although increased community services such as home helps, meals on wheels and district nursing have clearly benefited those whose needs are not yet such as to put them into this group;

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(ii) there may have been a tendency to underestimate the core of elderly people who will always require long-term residential care and reviews by authorities of their need for residential home places may be appropriate;

(iii) the average age of admission to residential homes, and possibly the level of dependency of new residents, has risen. No firm conclusion on reasons for these changes is drawn but one possibility is that they are a consequence of increasing pressure on residential homes resulting from demographic and social factors;

(iv) in relation to the mentally handicapped, there has been a shift away from long-term hospital care to residential home provision but resource constraints seem to have hampered the development at the rate envisaged of other alternatives;

(v) for the mentally ill, progress towards the White Paper targets for the run-down of large, isolated psychiatric hospitals and the provision of community-based packages of care has been considerable but there are bottlenecks eg the lack of day centres; and

(vi) For all these groups, community based alternatives to long-term institutional care require a package of provision with input from health and social services staff as well as from the voluntary sector. This reinforces the importance of close collaboration between health and social services authorities and between these and the different parts of the voluntary sector.

(d) The role of the voluntary sector

(i) It is important to distinguish between the different components of the voluntary sector. A broad classification runs from informal covers (family, friends and neighbours) through mutual aid groups, neighbourhood care groups and volunteers to formally constituted voluntary organisations;

(ii) the informal sector is vital to community based care and needs to be sustained and strengthened;

(iii) however, it is important not to assume that the amount of informal care can be limitlessly increased. The organised voluntary sector and statutory agencies must aim to supplement natural networks where these are absent or deficient;

(iv) further work is required to identify constraints on the development of community based services which could be eased by concentrated action by volunteers and voluntary organisations;

(v) different ways in which social services departments might organise themselves and deploy their staff in order to work most effectively with both the organised voluntary and informal sectors should be explored; and

(vi) voluntary service co-ordinators in the health service might be encouraged to give greater priority to voluntary effort in support of community health services.

(e) Early discharge schemes, day surgery and other developments

A number of issues which are not directly related to the Study's main themes are noted:

i. Early discharge and day surgery schemes require adequate district nursing support and such schemes should not be introduced without full consideration of their impact on the workload of district nurse teams. One of the most important factors in the success of such schemes is the availability of informal care. In most schemes informal care has been the sine qua non of a patient's inclusion.

ii. There is some evidence that some district nurse functions might be performed by other less highly qualified members of the team and that there may be some overlap between the services provided by the district nurse team (particularly nursing auxiliaries) and home helps. Both these issues raise questions for the organisation and operation of district nurse teams and the latter for the relationship between these teams and home help services. It is suggested that tney merit further study.

iii. The respective roles of day hospitals and day centres need clarification in order to ensure that the best possible use is being made of available facilities. The overall level of day hospital and day centre provision may need to be reviewed.

(f) Prospects for future developments

(i) If Departmental policies are to continue to seek a move away from long-term hospital care wherever this is appropriate to people's needs and wishes, ways must be found to ensure that the balance of resources between the NHS and PSS reflects the desired rate of change in responsibilities. There would of course be other factors - outside the remit of this study - which would need to be considered, not all of which would point in the direction of changes as between the NHS and PSS. In some cases, for example, it may be more important to achieve a shift within NHS expenditure from hospital in-patient to community health services.

(ii) manpower constraints on the development of community based packages of care may become as important as financial constraints. There may be particular problems in relation to trained community nurses and in recruiting for those groups eg nursing auxiliaries and home helps which draw on the same pool of manpower, particularly female manpower;

(iii) the indications are that demand for all community-based care will continue to increase over the next decade. The growing number of elderly people, particularly the very elderly, will present the main challenge to all those engaged, directly and indirectly in providing care.

More generally, there would seem to be a case for authorities to review the priority they attach to different aspects of community-based services. It appears that increases in provision since 1975 have not been geared directly to providing a genuine alternative to those on the margins of institutional care. It may be that other objectives of community services are considered more important eg improving the quality of life for people for whom there is no need for institutional care or dealing with episodic illness in the community. However, given current and foreseeable resource constraints, the ability of the statutory authorities to pursue all these objectives simultaneously must be in doubt. In these circumstances it is particularly important for authorities to be clear about their priorities.

1. Paragraphs 4.30 to 4.35 of the handbook consider some of the existing arrangements and changes in hand to enable Authorities to achieve a better use of resources. Those paragraphs do not cover in any detail what an Authority might or should do to improve efficiency.

2. The purpose of this Appendix is to suggest some specific areas where Authorities might take action. In the main, it is a matter of continuing and developing existing approaches and extending to other Districts ideas which have already worked well in particular places. For example:

(a) plain good housekeeping - more efficient cleaning programmes, review of transport arrangements etc (A handbook for NHS transport managers will be issued shortly);

(b) reduced catering costs - introduction of continental breakfasts, reductions in choice of menus, use of vending machines, elimination of waitress service;

(c) administrative savings - reduced use of agency staff, economies in advertising, postal, telephone and photocopying expenditure;

(d) purchase of supplies including renegotiation of bulk supply contracts;

(e) stock control, including the possible use of computers in pharmaceutical stock control;

(f) equipment savings - strict control over replacement and maintenance;

(g) energy savings - use of lower grade fuel, stricter control of room and ward temperatures;

(h) review of drugs usage and costs, including establishing lists of generic drugs; and

(i) seizing those opportunities which happen to present themselves for releasing resources e.g. by the sale of surplus assets such as hospital land.

3. As suggested above, many authorities have already taken measures to eliminate inefficiency. One authority, for example, introduced a scheme designed to encourage

both staff and patients to make proposals for saving £1 a day. Another launched a 'War on Waste' which included, in addition to measures mentioned in paragraph 2 above:

(a) an automatic one month delay (except in exceptional circumstances) in filling permanent vacancies;

(b) the employment of temporary staff only in exceptional circumstances; and

(c) a critical examination of overtime and bonus schemes. The study, undertaken largely in relation to ambulance staff, has now merged into work on the areas for savings highlighted by the Clegg Commission.

4. It is important for authorities who have been successful in improving efficiency to share their ideas and techniques with others. The National Association of Health Authorities (NAHA) is planning to produce an Index of measures to reduce waste. Pilot studies have been completed, and the Index will be available later this year. The NAHA Index is intended to help people in the NHS to become more aware of what is going on in different parts of the country and of different methods for tackling common problems. All member authorities will be asked to inform NAHA of methods for reducing waste which have been tried, tested and found successful. NAHA will then circulate the details with the names, in each case, of the officer and the authority who initiated the study. It is hoped that authorities will make the most of this opportunity both to contribute to, and draw from, this pool of experience.

YDS

Nat Health

DEPARTMENT OF HEALTH & SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY

Telephone 01-407 5522

From the Secretary of State for Social Services

G Robson Esq
Private Secretary
Secretary of State for Scotland
New St Andrews House
St James Centre
Edinburgh
EH1 3SX

30 May 1980

Dear Godfrey,

WASTE IN THE NATIONAL HEALTH SERVICE

Thank you for your letter of 25 April in which you describe a suggested variation on the recurring theme of a limited list of drugs prescribable under the NHS.

As you say, my Secretary of State has so far taken the view that such a list would not necessarily be in the best interests of patients, and you will be familiar with the arguments which led to this conclusion. This is not to say that we have completely shut the door on the idea. Indeed our CMO has written earlier this month to the BMA and RCGP (copy letter enclosed) suggesting the setting up of an informal group comprising representatives of the profession and of the Department, which would look at the whole range of prescribing related topics. I have no doubt that the possibility of adopting some form of limited list in the NHS would be one of the proposals that such a group would want to consider.

We find the conclusions of the National Medical Consultative Committee (NMCC) particularly interesting because, as you may know, my Secretary of State has been seeking to encourage the more widespread establishment of the Drug and Therapeutics Committees which already exist in some areas. Many hospitals do of course have their own arrangements which effectively limit the choice of drugs available, and while such arrangements are facilitated by the particular circumstances of hospital practice (not least the ability of hospital pharmacies to negotiate favourable discounts when ordering in bulk), there is no reason in principle why similar arrangements should not be established in general practice. The object of the Drug and Therapeutic Committees is to promote the cause of rational drug therapy

within the community, and if they engender a spirit of co-operation between hospitals and general practitioners the result is likely to be some form of voluntary restriction on the range of drugs prescribed.

Such agreements, if they should develop in the way we hope, would be directed at, and influenced by, the health needs of the local community. I am not sure whether that is what the NMCC were contemplating, or whether they had in mind the adoption of a single, national limited list. The latter would, we think, present more of a problem, even though the professions would of course be involved in its formulation. However, if our proposed Working Group address themselves to this question they will doubtless consider the practicalities as well as the principle.

I am copying this letter to Tim Lankester and the other recipients of our previous correspondence.

Yours ever

Don Brereton.

-2 JUN 1980

NEW ST. ANDREWS HOUSE
ST. JAMES CENTRE
EDINBURGH EH1 3SX

MAP

D Brereton Esq
Private Secretary
Secretary of State for Social Services
Alexander Fleming House
Elephant and Castle
LONDON
SE1 6BY

25 April 1980

Dear Don,

WASTE IN THE NHS

You wrote to Tim Lankester on 5 March outlining the efforts being made to attack waste and inefficiency in the NHS.

My Secretary of State was naturally interested in the extent to which similar action can be or is being taken in the slightly different circumstances of the Scottish Health Service, where we have both the benefits and sometimes the cost penalties of a smaller scale of operating. He therefore asked that the various points raised in your letter be considered. In practice there seems no difficulty in keeping closely in line with the various initiatives that are in hand, and at official level close contact is being maintained between SHHD and DHSS.

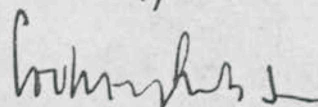
There is however one important issue arising from the Royal Commission's report which is not directly mentioned in your letter - the possibility of curbing the drug bill by limiting the range of prescribable drugs. In spite of the considerable effort devoted to the education of clinicians on the cost of prescribing (and this effort has been of considerable value) there is some disposition in Scotland to look sympathetically at the Royal Commission's approach. Representatives of the medical profession in Scotland, meeting in the National Medical Consultative Committee (a statutory advisory body whose members are appointed by the profession itself and which has no exact equivalent south of the Border) recently concluded that:-

> "Measures require to be taken to reduce the national drug bill. A limited list of essential and effective drugs should be prepared. The list should not be imposed by Health Boards but agreed by hospital doctors and general practitioners in concert".

We do not know if doctors elsewhere in the UK would be prepared to endorse that attitude. If the profession as a whole could however be induced to accept the view that a limited list of drugs - preferably a list which the profession itself had a major part in compiling - could meet the requirements of the great majority of cases, the potential saving would be considerable. Patients could also benefit from a more rational approach to prescribing. Your Secretary of State has of course already indicated that he does not favour the Royal Commission's recommendation for a limited list. I wonder if a variant on the idea, which gave the profession a major role, allowed scope for local agreements on the basis of medical and pharmaceutical preference, did not preclude the use of other drugs where a doctor was prepared to defend his professional judgment to his colleagues, and used the argument of therapeutic caution as well as financial saving, would commend itself? Obviously this idea would have greater prospects of success if pursued on a UK basis. There would be less point in pursuing it simply as a Caledonian idiosyncrasy.

I have copied this to Tim Lankester and the other recipients of your letter.

Yours sincerely,



GODFREY ROBSON
Private Secretary

DC Press

Nut Health

10 DOWNING STREET

From the Private Secretary

23 April 1980

Department of Health and Social Services Northern Ireland: Summary of Health and Social Services Accounts 1978-1979

Thank you for your letter of 23 April. We have no objection to the timetable you propose.

I am copying this letter to Richard Prescott (Paymaster General's Office), Peter Moore (Chief Whip's Office) and Petra Laidlaw (Chancellor of the Duchy of Lancaster's Office).

N. J. SANDERS

M.G. Howard, Esq.,
Northern Ireland Office.

CC

NORTHERN IRELAND OFFICE
GREAT GEORGE STREET,
LONDON SWIP 3AJ

N Sanders Esq
10 Downing Street
LONDON
SW1

23 April 1980

Dear Mr Sanders

DEPARTMENT OF HEALTH AND SOCIAL SERVICES NORTHERN IRELAND:
SUMMARY OF HEALTH AND SOCIAL SERVICES ACCOUNTS 1978-1979

I enclose a copy of the above Summary of Accounts which are to be laid as a Command Paper on Monday 28 April. I should be grateful if you would confirm that there are no objections to this.

I am sending a copy of this letter to Mr Prescott in the Paymaster General's Office.

Yours sincerely

MAURICE G HOWARD
Parliamentary Section

Enc:

JDH

CS

National Health.

PRIME MINISTER 4.

Sir Derek Rayner will let you have his reactions next week.

MAP 7/3.

DEPARTMENT OF HEALTH & SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY

Telephone 01-407 5522

From the Secretary of State for Social Services

Tim Lankester Esq
Private Secretary
10 Downing Street
London
SW1

5 March 1980

Dear Tim,

WASTE AND THE NATIONAL HEALTH SERVICE

You wrote to me on 16 May last about the problem of waste in the public sector, outside central Government. In my reply of 7 June I explained that the Secretary of State wanted to follow up our initial response with a more comprehensive report on the efforts which the Department and the NHS together are making to tackle inefficiency at all levels in the Health Service.

We have felt it right to delay this further report until we had had time to consider the analysis and recommendations of the Royal Commission on the NHS. The Royal Commission was specifically charged with considering the best use and management of resources in the NHS, and we needed to take their views into account in reviewing our measures for dealing with inefficiency and waste in the NHS.

The Secretary of State has been urging health authorities to review their efforts to improve the use of resources in the NHS. The purpose of this report is to set out:-

a. what the Department and the NHS has been able to achieve so far; and

b. what we are planning to do to ensure that the NHS is run more efficiently.

WHAT WE MEAN BY WASTE

I should make clear what we mean by waste in this report. The Department has, for some years, been seeking to ensure that resources are applied where they are most needed. The establishment of major policy priorities, the introduction of the NHS planning system, and the implementation of the Resource Allocation Working Party report are examples of major initiatives designed to ensure that resources are allocated to policy objectives endorsed by Government after the fullest consultation with all concerned within and outside the NHS. That is the first step in seeing to it that the taxpayers' money is well spent.

E.R.

The second step - and the main focus of this report - is securing maximum efficiency in the use of resources once they have been allocated. While the Government determines the level of expenditure on the NHS, and national policies and priorities influence the broad disposition of resources, the ways in which money is spent and staff resources used are largely determined by the day to day decisions of doctors, nurses and other staff at the operational level. Any attack on waste has to reach - and influence - those decisions.

ACTION ON THREE BROAD FRONTS

It is against this background that the Department has developed its approach to reducing waste. Action is being taken on three broad fronts as follows:-

a. encouragement to local management to secure greater efficiency;

b. central initiatives to control particular costs;

c. further developments in management and control systems.

The action under way or proposed on each front is described in the report annexed to this letter; but it may be helpful to set out the wider policy framework:-

a. Responsibilities of local management

The Government's proposals for making changes to the organisation and management of the NHS - published last December in "Patients First" - will simplify the structure of health authorities (removing the area tier) and strengthen unit management (greater delegation to the hospital and the community services). Thus the service will be more responsive to local needs and greater responsibility will be placed on staff at the operational level, where most decisions on the way money is spent are taken. In the meantime Ministers and NHS management have increased their efforts to foster local initiatives designed to improve the running of the service.

b. Central initiatives to control particular costs

Greater delegation to the operational level requires central Government and the Regional tier to withdraw from detailed intervention in local matters. But the statutory responsibilities of Ministers and the functions of the Accounting Officer put an obligation on the Department to take the lead in introducing major measures to encourage a better use of resources. Recent examples of this are the target of £30 million savings from streamlining the NHS; the tighter guidelines for controlling management costs; and the decision to establish the NHS Supply Council. The Department must also identify and disseminate examples of "good practice" (as in the drive to achieve energy savings).

c. Developments in management and control systems

The Department, in partnership with the NHS, is continuing to develop systems to give managers better information and better budgeting and control mechanisms - better information systems is the goal of the Steering Group on Health Services Information; better budgeting and control mechanisms through locally based budgets and experiments with incentive budgeting. Much of the work in this area is directed at administrators, but health professionals, particularly doctors, must be - and are - involved.

E.R.

The Secretary of State hopes that this letter and its enclosure set out clearly the 'efficiency strategy' the Department is following. The Government's pledge to maintain planned expenditure on the Health Service brings with it an obligation to ensure that every effort is made to cut out waste. There is still much to be done on all three fronts referred to above:-

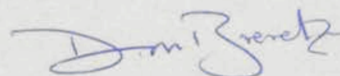
- fostering to the full local initiatives;
- giving priority to curbing the growth of particular costs; and
- maintaining the best possible systems for effective management.

But - as summarised in the Appendix - there are special factors which distinguish the NHS from other large organisations, and it is relevant to make what comparisons are possible with the health services of other countries.

The Secretary of State and his colleagues will continue to keep a close personal eye on progress.

I am sending copies of this letter to John Wiggins (Treasury), Geoffrey Green (Civil Service Department), Godfrey Robson (Scottish Office), George Craig (Welsh Office), Sir Robert Armstrong, Sir Derek Rayner, and Sir Kenneth Berrill.

Yours ever



D. BRERETON

ENC

REPORT ON THE MEASURES TAKEN OR PLANNED TO ELIMINATE WASTE AND INCREASE EFFIENCY

A. RESPONSIBILITIES OF LOCAL MANAGEMENT FOR EFFICIENCY

The aim is to release resources for much needed improvements to patient services by eliminating inefficiency and waste wherever possible. In a decentralised service like the NHS it is essential to foster effective motivation in local management - through the ways set out below - if this aim is to be achieved.

i. Changes in structure and management of NHS

Criticisms of the 1974 reorganisation of the NHS were summed up by the Royal Commission as:

- too many tiers;
- too many administrators, in all disciplines;
- failure to take quick decisions;
- money wasted.

The major objectives of the Government's proposals for change, described in the Consultative Paper, "Patients First", are:

a. The strengthening of management arrangements at the local level with greater delegation of responsibility to those in the hospital and in the community services;

b. Simplification of the structure of the service in England, by the removal of the area tier in most of the country and the establishment of district health authorities;

c. Simplification of the professional advisory machinery so that the views of clinical doctors, nurses and of the other professionals will be better heard by the health authorities;

d. Simplification of the planning system in a way which will ensure that regional plans are fully sensitive to district needs.

These proposals lie at the heart of Ministers' strategy for improving efficiency. Any attack on waste depends on strengthening local management and giving them greater responsibility for the efficient use of the resources available to them.

ii. Cash Limits

The Royal Commission noted that NHS administrators and treasurers welcome the additional discipline imposed by cash limits; they make authorities decide on priorities and enforce economy. To assist sensible management of cash limits and to discourage a year end spending spree, there is an arrangement that authorities can carry over up to 1% of revenue underspend into the following financial year. It is open to question whether this is enough but too much flexibility could detract from the discipline of cash limits. A balance must be struck and it is intended to keep this under review. It is for health authorities to ensure that wasteful expenditure is avoided in the final stage of the financial year.

iii. Local initiatives

There are many instances of local initiative which have identified and achieved significant savings. For example:-

a. A Barnsley consultant analysed the routine investigations carried out annually for his clinic. He found that only 1% of haematology and urinary tests had any influence on diagnosis although the tests cost £7,800 per year. By discontinuing such tests where clinical history or examination indicated the diagnosis, he has achieved an annual saving of £2,800.

b. At St Bartholomew's annual expenditure on parenteral feeding was reduced from £13,000 to £5,000 following a decision that it could be introduced, except for those in intensive care, only after prior assessment by or on behalf of a consultant gastro-enterologist.

c. Restrictions on the use of agency staff. Merton, Sutton and Wandsworth AHA(T), for example, have estimated that in a full year they will achieve savings of some £200,000 as a result of restricting the use of agency staff, particularly medical staff, while preserving levels of service.

What is significant about these examples is neither the sums involved - which in isolation are modest - nor the precise way in which the savings were achieved, but the fact that the initiatives were taken locally. The current constraints on public expenditure have brought home more widely the need for positive action to seek out inefficiency. The specialist health press, including the medical and nursing journals, has recently published a number of articles demonstrating scope for economies. The Department is considering how local initiatives might be further encouraged, over and above the introduction of more conducive management arrangements as outlined in i. above. Some action has already been taken:

- The National Association of Health Authorities is producing a guide to good practice - a register of ideas developed in the NHS for improving effectiveness and efficiency.

- Ministers have been given their personal encouragement to individual staff initiatives designed to improve the running of the service. For example, the Minister for Health met the Savings Committee of Beckenham Hospital set up on the initiative of a consultant surgeon to see what savings could be made by making staff cost conscious, cutting down waste and making economies wherever possible. The Minister's visit helped to publicise the venture and will, it is hoped, encourage similar initiatives elsewhere.

- The Department has been encouraging more authorities to introduce staff suggestion schemes. The North East District of the Kensington, Chelsea and Westminster AHA(T) has just launched an imaginative scheme, along these lines, designed to encourage both staff and patients to make proposals for saving £1 a day. The underlying assumption is that, however conscientious managers are in seeking economies, staff providing services are often in a better position to suggest ways of doing the work more efficiently.

CENTRAL INITIATIVES TO CONTROL PARTICULAR COSTS

i. Management costs

In 1976 the previous administration launched a review of management costs. The objectives were:

a. A national reduction of 5% (£11 million at 1976 pay levels) over the period to March 1980.

b. Each RHA to reduce the proportion of its resources devoted to management over the same period from a national average of nearly $5\frac{3}{4}\%$ to $5\frac{1}{4}\%$ or less.

Both targets have been met - £16 million at 1976 pay levels has been saved and the national managerial proportion has been reduced to under 5.2%. These reductions have enabled resources to be switched to direct patient care.

Further action is planned on 2 fronts:

- Continued restraint on management costs throughout the transitional period from the present management arrangements to the introduction of the new structure (ie at least until the end of 1983).

- Over the next 3 to 4 years, a reduction in the costs of management of up to 10% through streamlining the structure of the NHS. Much of the reduction will come directly from abolishing a tier of administration, some will result from improved management arrangements within authorities and the remainder from the Government's general drive for greater efficiency.

ii. NHS supplies

The purchase of supplies for the NHS accounts for roughly 1/6 of health authority spending. In 1978 the Salmon Committee identified a number of short-comings of the supplies arrangements:

- An unnecessarily fragmented organisation suffering from poor

co-ordination, lack of information, bad communication and inadequate staffing.

- Inefficient local purchasing and storage arrangements.

- The lack at all levels of essential management information to develop effective supplies policies.

The Department has been working towards -

a. More effective and wider co-ordination of purchasing (it is estimated that at least £30 million could be saved by co-ordinated purchasing arrangements*).

b. More economical storage arrangements;

c. More accurate forecasting in respect of equipment requirements, coupled with common equipment standards.

In January the Secretary of State announced his decision to establish a National Health Service Supply Council to carry forward the work under (a) to (c) above. The major responsibility for NHS supplies policies will be transferred from the Department to the new Council which draws its membership mainly from the NHS. The Council has been charged with carrying out its function in such a way as to encourage a strong and innovative UK health industry, capable of satisfying the needs of the NHS and of building up a successful export market.

iii. Energy consumption

The cost of energy used in the NHS is running at about £160 million a year. The Departmental Works Group has been involved in encouraging health authorities to reduce their energy consumption. There have been some successes:-

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* Essex AHA, a multi-district Area, provides an example of what can be achieved. As a result of centralising supplies it has been able to redistribute, on a recurring basis, extra revenue allocations amounting to some £250,000 a year. This saving has made possible the opening of 3 additional wards - for geriatrics, orthopaedics and a 5-day female surgery ward. Further savings are expected when the single Area store for Essex is in full operation with its computer assisted stock control and information system.

- A 10% reduction in boiler fuel consumption from 1972/73 levels.

- A 7% reduction in electricity consumption over the same period.

Potential savings in the next decade are estimated at 25% to 30% of the 1972/73 consumption levels - or about £40 million a year at current price levels. This concern with controlling energy costs has led to research and development work from which it is hoped to derive performance indicators for monitoring NHS energy consumption.

iv. Standardisation of hospital design

The Department's Works Group has produced standard plans for new health building, with the intention of reducing the time and effort spent at the design and planning stage. The 'Nucleus' design, for example, has led to a reduction in the planning and design time of 6-18 months per project. Its main features are:-

- Utmost economy in capital and running costs consistent with acceptable clinical and service standards.

- Limited choice of content, but sufficient flexibility so that hospitals can be tailored to different service planning priorities.

- Strict adherence to cost limits.

Development costs of Nucleus up to 1981/82 are running at about £3.4 million. Over 40 health authority schemes are using or considering using Nucleus design in full or in part. Taking account of expected savings in fees and project time, the Department is already in credit to the tune of about £800,000 and this will grow as the number of Nucleus projects increases.

In addition the Works Group is attempting to bring together its initiatives on energy consumption and low cost design. It has set up a consortium of private firms to examine ways of developing a low energy Nucleus design by incorporating building and engineering devices which minimise energy consumption.

v. Wasteful working practices amongst ancillary staff and ambulancemen

In 1977 the Controller and Auditor General reported on deficiencies in the management of ancillary staff, in particular:

- Inefficient rosters.

- Inadequate arrangements for recording, certifying and paying overtime.

The Department asked authorities to review all aspects of overtime, stressing the need to tighten procedures for recording, certifying and checking overtime and to take action to curb abuse of overtime arrangements. Subsequently quarterly returns were called for from Regions on the percentage of the total ancillary wage bill paid for overtime. Since 1977 this percentage has held pretty steady at about 7%.

Following a clear lead given in evidence to the Clegg Commission by the NHS Management Sides concerned, the Commission (August 1979) was critical of continued inefficient working practices among ancillary staff and also among ambulancemen. While the onus to correct deficiences (unnecessary overtime, unsound incentive bonus schemes, working practises designed to boost earnings) lies with local management, Government cannot leave it to them entirely. The following action has been taken:

a. The cost of pay awards recommended by Clegg was offset by £3.4 million in 1979/80 to reflect the need for health authorities to take effective action to stamp out inefficiencies;

b. The Department has asked authorities to report on the savings possible in 1980/81

and

c. The Department has suggested to authorities a review of the ambulance services to consider their role and long-term management structure, including the possibility of a two-tier service.

vi. Use of private contractors

The Department is considering ways in which the greater employment of private contractors might reduce the cost and increase the efficiency of

catering, domestic and laundry services for the NHS. It is examining the experience of authorities who already use their discretion to put these services out to contract. Ministers are anxious to see authorities using this discretion more freely.

C. DEVELOPMENTS IN MANAGEMENT AND CONTROL SYSTEMS TO ENCOURAGE EFFICIENCY

i. Audit

Departmental staff responsible for auditing and certifying health authority accounts have been placing greater emphasis in recent years on the more efficient use of resources - identifying wasteful practices and securing action, through improved management systems, to prevent recurrences. Savings achieved in 1978/79 as a result of recent audit recommendations totalled over £10 million. Where in future the measures taken by health authorities are inadequate, Ministers intend to write to the Chairmen concerned to ask them personally to take action.

ii. Central Management Services

The Department's Central Management Services staff undertake O&M assignments in the NHS designed to produce advice on:

- More efficient management systems.

- Better use of existing resources.

Two recent studies, for example, identified potential savings from more efficient management practices:

a. A review of the range and purpose of the transport services (excluding ambulance services) provided in the NHS and of the ways in which they are organised, managed, controlled and maintained. An initial study has already identified, in a selected number of units, potential savings of the order of 10%.

b. A study of the documentation used in FPC Ophthalmic Departments identified potential savings in staff and machinery costs of some £200,000 a year.

iii. Investment appraisal

Some 6% (£367 million 1978/79 out-turn) of total NHS expenditure is devoted to capital developments in the NHS. Adequate procedures for making and handling investment decisions are therefore essential if this sum is to be used cost effectively. Following a Review of Health Capital in 1979 the Department commended to health authorities an approach to investment appraisal based on:

- A systematic identification of alternative ways of meeting service objectives;

- Explicit consideration of all the major costs and benefits of alternatives

- Subsequent evaluation of the outcome of investments against the expectations and assumptions which guided the decision to invest.

The Department is now assisting health authorities in a number of pilot appraisals designed to test the feasibility of introducing the techniques more widely in the NHS.

iv. Review of health services information

A Departmental survey of systems for collecting information from the NHS revealed:-

- High costs.

- Relative inefficiency.

- Lack of co-ordination.

As a result the Department has set up a Steering Group on Health Services Information with members drawn mainly from the NHS. The overall objective is to reduce the demands made on Health Authorities while at the same time:

- Giving greater priority to the information needs of local managers;

- Improving compatibility and reducing duplication between information systems;

- Improving the timeliness and accuracy of information provided.

The Royal Commission cast doubt on the quality of the financial information currently collected. A linked study is reviewing costing and financial accounting systems.

v. Locally based budgets

At present local budgets are largely based on a system of functional budgets which are often controlled at least one remove from the main hospital or community activities on which the money is spent. It is envisaged that the changes in management structures proposed for the NHS in "Patients First" should be accompanied by the introduction of hospital based budgets - an important element in the efficient running of hospitals and associated community health care facilities.

The Department is also discussing with private medical organisations - the Nuffield Nursing Homes Trust, American Medical International and the Hyatt Corporation - the management methods, including cost control and information systems, employed in private hospitals to see whether there is scope for importing any of these into the NHS.

vi. Incentive and Review budgeting

In addition to strengthening unit management and moving towards hospital based budgets, the Department is considering further steps to stimulate a greater personal interest by NHS staff in the resource implications of their activities. For example:-

a. The Royal Commission recommended experiments with systems to allow budget holders to redeploy part of any savings they achieved.

b. Review budgeting - budget holders would be required at intervals to identify how they would cope with a given percentage reduction in their budget. To be fully effective, this approach would probably need to include positive incentives.

Both possibilities will be pursued on an experimental basis.

vii. Improved costing information for clinicians

Doctors must be at the centre of a strategy to improve efficiency in the NHS. General Practitioners treat 90% of illness presented to them, and the average cost of drugs prescribed per GP each year is £37,000. Consultants and their staff determine which patients need hospital care, decide on the investigation and treatment of individual cases, and influence the way other health workers are used. But there is considerable concern - not only in the Department and among health service administrators, but among clinicians themselves - about the extent to which doctors do not know, and therefore cannot take into account, the cost of the decisions they make.

The Department in partnership with the NHS, is determined to take advantage of the present climate to improve the information available to clinicians. Action in four areas is already being taken:

a. An experiment to test the feasibility of using computers in prescription pricing so that comprehensive information about prescribing costs may be readily available;

b. Further research into devising a practicable system of specialty costing - that is, the identification by individual medical specialty of costs of hospital treatment. The present hospital costing system is limited to identification by type of hospital and does not provide the information necessary to monitor high cost areas;

c. Clinical budgets - a pilot scheme in four or five districts to make clinicians aware of the costs of their clinical decisions. A budget is agreed for each group of consultants and financial information fed back monthly to allow the clinicians to take corrective action as necessary;

d. Action to spread awareness among clinicians of the relevance of costing and budgeting techniques to their work. For example, in the last two years over one hundred educational events have been held, involving nearly 2,000 consultants and senior registrars, aimed at helping them make a better use of their resources and a more effective impact on the organisation and

planning of the NHS. One aspect of this activity has been to promote better understanding between consultants and treasurers. A seminar for consultants and treasurers held in May 1977 resulted in a report entitled "Hospital Costing and the Clinician". It has been re-printed three times and over 4,000 copies distributed to the NHS.

APPENDIX

The appendix to this report summarises the special features of the NHS which distinguish it from other large organisations and makes some comparisons with health services of other countries. This is the background against which the initiatives described in this report are being taken.

APPENDIX

SPECIAL FEATURES OF THE NHS AND INTERNATIONAL COMPARISONS

Size and structure of the NHS

1. Over 800,000 staff from a wide range of professions and skills work in the NHS. Its size, and the nature of the services it provides, make managing the organisation a demanding task. Its management structure is unusual; it is neither directly administered like Social Security nor as decentralised as the local authority personal social services. Differences in the need for health care over the country and in the existing levels of provision call for local variety and flexibility and the greatest possible delegation of managerial authority.

2. Although day to day responsibility for providing services and administering them is delegated to Regional and Area Health Authorities, the Secretary of State and the Permanent Secretary, as Accounting Officer, are fully and personally accountable to Parliament for the NHS. The Accounting Officer's letter of appointment makes it clear that there is an accountability to Parliament not only for probity, but also for efficiency and economy in t he use of resources and generally for good management. In discharging their responsibilities the Secretary of State and Permanent Secretary have to take account of the factors summarised in paragraph 1 and the features of the service set out below.

Professional Staff

3. The NHS Acts, consolidated in 1977, provide the statutory basis of the NHS but the origins of the services provided through hospitals, general practitioners and other community health services are much older than the Acts; they rest on a professional relationship between doctor (or dentist, nurse etc) and patient. In particular, the clinical freedom enjoyed by doctors enables them to make decisions about the clinical care of individual patients without direction from health authorities.

4. In addition to doctors there is a wide range of professional staff working in the NHS whose activities influence the way resources are used - dentists, nurses, midwives, pharmacists, opticians, chiropodists, medical laboratory technicians, occupational therapists, physiotherapitsts, radiographers architects, engineers etc. Their different roles and responsibilities have to be taken into account in determining workable management arrangements for the NHS.

Major components of NHS resources

5. NHS manpower, finance and buildings have to be used properly if resources are not to be wasted;

- Manpower. Manpower costs represent 73% of the total revenue spending of health authorities and 63% of total NHS expenditure. Figure 2 in this appendix shows the broad disposition of NHS manpower.

- Finance. Figures 1 and 3 show the major uses of NHS finance. In recent years an objective measure of comparative health care needs, devised by the Resource Allocation Working Party, has been used to allocate resources.

- Buildings. The hospital stock reflects its 19th century origins - 35% having been built before 1900 and only 25% since 1948 (see figure 4). Many of the older buildings are ill-suited to the delivery of modern forms of treatment.

Reacting to change

6. The planning and use of resources in the NHS has to take account of constant change - eg in demography, the incidence of specific medical conditions, the socio-economic climate and trends in the provision of complementary services, particularly social services and housing. Avoiding or eliminating waste is partly a process of anticipating and adapting to these changing circumstances. There are inherent problems which limit the ability of the service to match facilities precisely to changing requirements. For example, changes in the birth rate are difficult to predict accurately and this has implications for the scale of maternity services. Moreover changes in the use, re-location or replacement of hospitals (eg large mental hospitals) can only be accomplished slowly, often in the face of industrial relations problems. The NHS planning system is designed to assist local management to accomplish such changes as economically and as smoothly as possible.

International comparisons

7. It is difficult to reach firm conclusions from international comparisons of health care costs because of differences in statistical definitions and health care systems. The tables below draw on the latest information available:

Table 1 - Expenditure/Doctors/Nurses

1974 or near date

Country	Per Capita total expenditure on health US $	% Trend GDP(1)	Doctors (per 10,000 1974)	Nurses (per 10,000 1974)
Australia	308	6.5	13.9	54.1
Canada	408	6.8	16.6	57.8
Finland	265	5.8	13.3	46.0
France	352	6.9	13.9	23.7
Italy	191	6.0	19.9	7.8
Japan	166	4.0	11.6	16.1
Netherlands	312	7.3	14.9	22.5
Norway	270	5.6	16.5	46.4
Sweden	416	7.3	16.2	58.6
USA	491	7.4	16.5	40.4
W. Germany	336	6.7	19.4	27.6
England and Wales)	212)	5.2)	13.1	33.7
Scotland)		)	16.1	45.6
N. Ireland)		)	15.3	36.6

Source: Report of the Royal Commission on the NHS, 1979

(1) Trend GDP is used to avoid the influence of cyclical business fluctuations on the level of output, which could distort the measured share of health expenditure in that output.

Table 2 - Prescriptions

1975 or near date

Country	Prescription items per head per year	
Netherlands	4.5	) GPs not paid fee for service
UK	6.3	)
Denmark	6.9	)
Belgium	9.0	) GPs paid fee for service
France	10.5	)
Germany	11.0	)
Italy	21.0	)

Source: EEC Paper, October 1978 "Pharmaceutical Consumption"

Table 3 - General Administrative Costs as a Percentage of Total Benefits

1974 or near date

Country	Per Cent
Austria	4.0
Belgium	10.6
Canada	2.5
Denmark	6.4
France	10.8
Germany	5.0
Italy	6.5
Japan	2.6
Netherlands	2.8
Sweden	7.6
UK	2.6
US	5.3

Source: OECD Report "Public Expenditure on Health"

These are the general administrative costs related to co-ordination of the system, collecting contributions, making reimbursements, paying service providers etc. They do not include hospital administrative costs.

MAJOR COMPONENTS AND USES OF NATIONAL HEALTH RESOURCES

HEALTH AUTHORITY EXPENDITURE 1978-79

SOURCE - HA ACCOUNTS 1978-79

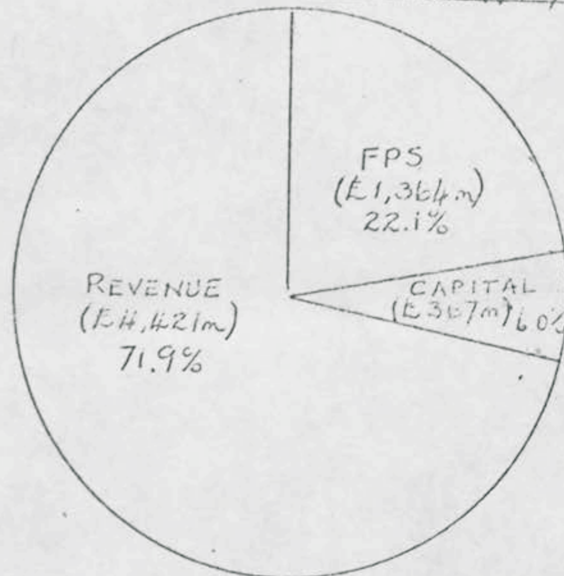


FIGURE 1

HEALTH AUTHORITY REVENUE EXPENDITURE

BY PAY GROUP AND NON-PAY TOTAL

SOURCE - SUBJECTIVE ANALYSIS OF REVENUE EXPENDITURE

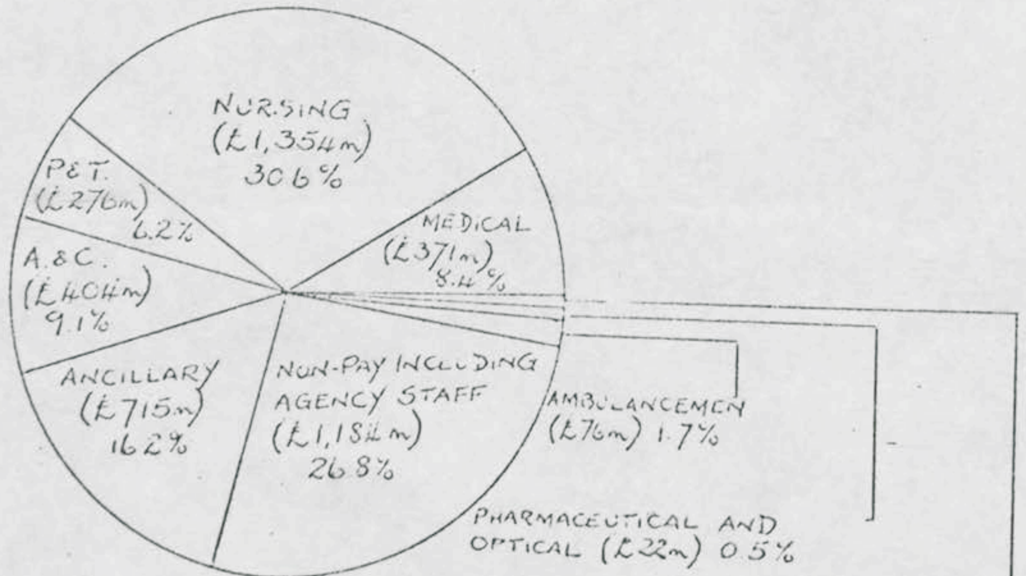


FIGURE 2

HEALTH AUTHORITY REVENUE EXPENDITURE BY FUNCTION/SERVICE

SOURCE - H A ACCOUNTS 1978-79

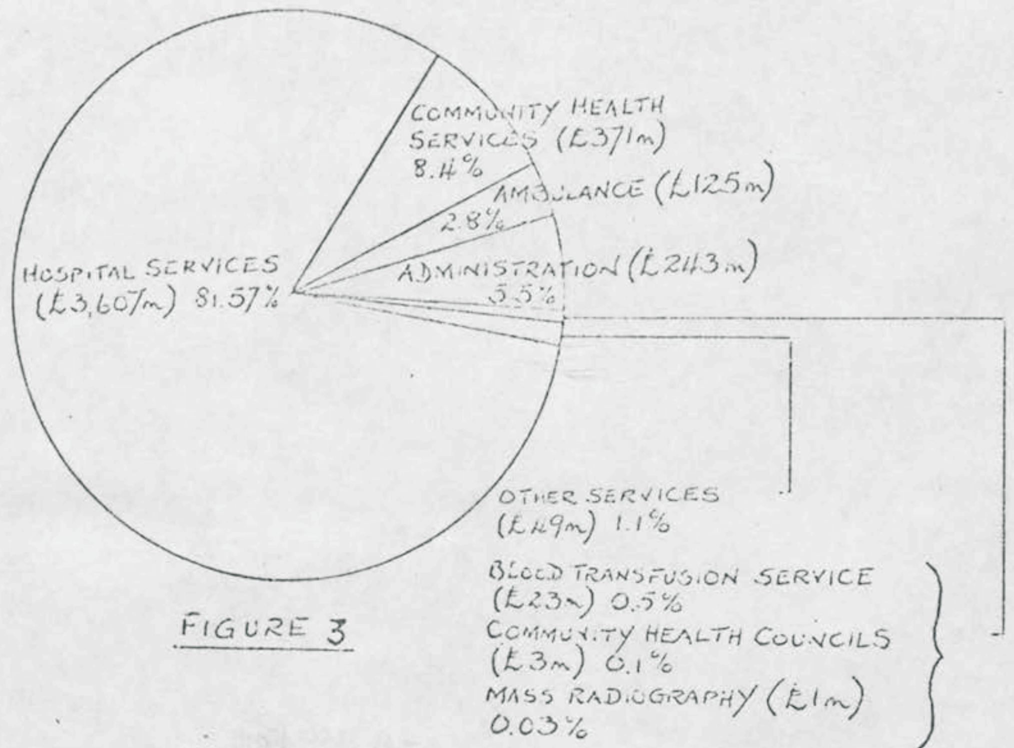


FIGURE 3

THE NATIONAL HOSPITAL STOCK

SOURCE - REVIEW OF HEALTH CAPITAL

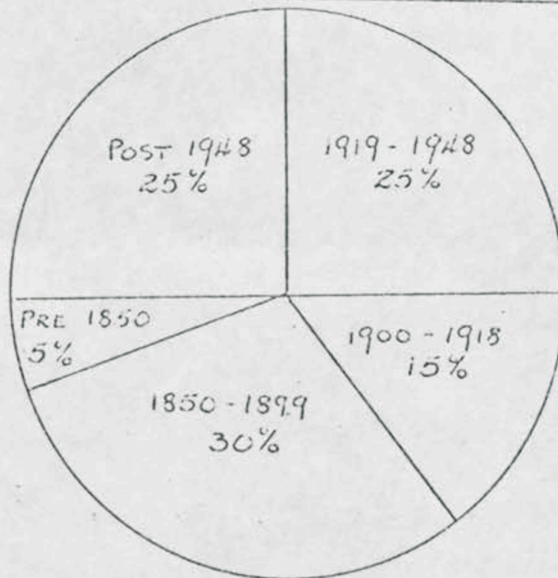
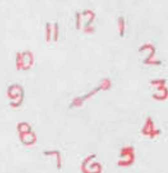


FIGURE 4.

- 6 MAR 1980



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Lds Hansard 825

Nat Health

DEPARTMENT OF HEALTH & SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY

Telephone 01-407 5522

From the Secretary of State for Social Services

Mike Pattison Esq
Private Secretary
10 Downing Street
London SW1

9 November 1979

Dear Mike

NHS OUTPUT INDICATORS

I thought I had better write to you about the correspondence you have been having with Zoe Spencer about input and output indicators (the latest being your letter of 12 October) as we see some danger of the underlying issues becoming confused in our exchange of data.

There are two main issues:

the measurement of health service output and its relation to changing inputs; and,

value for money, better management and reduction of waste.

On the second we are preparing a response for you on avoiding waste and promoting effectiveness and efficiency in the NHS. Our response will broadly be in terms of the right role for central government (maintaining accountability without detailed intervention and "nannying") encouragement of local initiatives (through incentives and the lessons to be learned from research and the private sector) and the criteria for assessing effective management (better rather than nessarily cheaper management). Linked to this, is action on the structure and management of the NHS following the report of the Royal Commission. The objective is a simplified and streamlined NHS, with responsibility for day to day management at the lowest effective point; and by strengthening management at the operational level, while keeping control of management costs, through a continuation of the cost-cutting exercise which we have been running for the past few years.

Turning to the first issue, is it clear that we are using words in the same way? I do not think you mean to imply that the final output of NHS can be adequately measured in terms of deaths/discharges and outpatients. Measures of final output are very difficult to come by, as the vast literature on this subject demonstrates. And even where they exist, eg perinatal and other mortality rates, major factors besides health care contribute. A few outputs are in terms of improvement of quality of life (eg for mental handicap) where some simple measures of, for example, ability to perform certain tasks have been devised. But there is a long way to go and the problem becomes all the more difficult if we try to link results to the level of financial resources. An output measure implies a casual

relationship between output and the activity related to it. For example, for NHS hospital services it should link activity (in terms of treatment or care given to patients) efficiency (in terms of the throughput) and outcome (in terms of the results of the activity taken); and should properly reflect such issues as the quality of health care and the interaction of hospital services with other related sectors, such as primary health care and personal social services. This is all complicated enough without making heroic assumptions on the impact of particular inputs such as administrative and clerical staff. But, taking the example you quote of discharges and deaths, it is possible to show that available beds and the average duration of stay dropped while discharges and deaths (total and per available bed) for most acute specialties in NHS hospitals and day care and outpatient attendance all rose between 1972 and 1977 by varying amounts. Such changes could be taken as indications of efficiency but they are far from adequate indicators: for example, they do not answer the question, what is the "right" level of resources for the NHS; and they say nothing about what is the right marginal input. Using beds more intensely requires more intensive use of professional and managerial skills but no one would expect the link between changes in activity rates and the numbers of staff to follow a simple proportional relationship. All of this underlines the danger of making quick, superficial comparisons.

You asked about possible comparisons between the NHS and the private sector and with other countries. Because the nature of the service delivered is all important, comparisons with the private sector (which deals only with a small range of conditions) are not very meaningful. Even on the international scene, the different ways of collecting statistics and delivering services make comparisons difficult, as WHO, the EEC and the Council of Europe have recently discovered to their cost. But we are involved in a number of international studies relevant to this; and even at this early stage it might be worth recording, for example, that within the EEC we have fewer doctors per 100,000 population, fewer doctors per bed and probably more hospital cases per doctor than any other country, with lower administrative costs.

You seem to be particularly concerned about the growth in administrative and clerical staff. In our view, the overall A and C figures combine so many different elements as to make them a very unreliable indicator. But we do look at all increases in staff, including doctors and nurses which you seem content to accept. And, as I think Tony Smith has already explained, the reasons for growth in the A and C sector include:

transfer of work from professional staff (eg more secretarial support for clinicians, more ward clerks and more appointments and record clerks in surgeries and clinics);

new functions following NHS reorganisation (eg new management responsibilities for NHS authorities and servicing of CHCs);

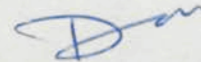
improving managing capacity (eg more finance staff to provide greater financial control, more planning and management services staff to secure improved efficiency and more industrial relations staff to cope with the changing industrial climate).

The report of the Royal Commission on the NHS puts the more ill informed comment about administrative numbers into perspective.

Perhaps you will let me know, in the light of what I have said, whether you will be pursuing any of these topics further. I might add that questions of performance, efficiency and the like are frequently discussed between DHSS and Treasury. I understand that Treasury will shortly be putting out for discussion in PESC a general paper describing present approaches to output measurement, commending this kind of activity and drawing attention to some of our detailed work.

I have deliberately replied in general terms. While I would be happy to commission further work in the Department on particular matters, it really does seem to me important to clarify the hypothesis we are trying to test before exchanging data and conclusions (if only to ensure we get value for money for the time of our own administrative and professional staff in the face of increasing pressure on financial resources and staff cuts!).

Yours ~~sincerely~~ ever



D BRERETON
Private Secretary

PERSONAL AND CONFIDENTIAL

FILE

Nat Health

12 October 1979

Thank you for your letters of 5 and 8 October, with statistics quantifying aspects of input and output in the N.H.S.. As you will know, I have discussed some points arising from this material with your colleagues this week.

As a result of these conversations, we have agreed that the most appropriate figures to use as a measure of output are those for discharges and deaths, coupled with the outpatients figures. In respect of staff numbers, I have taken note of the comments in the Merrison Report about the requirement for and performance of administrative and clerical staff. It is clear from this that none of these figures can be used in isolation as a commentary on trends in the health service.

Nevertheless, there are still some questions which we would like to try to pursue further. The table enclosed with your letter of 5 October showed, on the manpower side, an increase in the latest four year period of around 20 per cent in administrative and clerical staff, whilst the medical staff and nursing and midwifery staff showed roughly 10 per cent increases. The Department has pointed out that some part of the increase in supporting staff was designed to release time of the professional staff for professional duties by eliminating administrative demands on them. It is further argued that there were significant shortages in professional staff which remained to be filled.

The increases in staff overall still seem significantly larger than the increase in output, to the extent that the figures you have offered provide some rough and ready measurement of output. Are there comparisons which can be drawn between staff resources and output in public and private sectors? I appreciate that it may not be easy to find this, given the demands on N.H.S. hospital staff for out-patient services which may not be mirrored in the private sector. Are there comparative statistics for staff compared with output in one or two other industrialised countries? Any further points of comparison which you could offer would be of considerable interest to us.

/ As you know,

As you know, these questions were initiated by the article in "Now" magazine about waste in the N.H.S.. What I have in mind is whether recent performance in the N.H.S. demonstrates that management rather than money should be the top priority. Given the growing vociferousness of the "anti cuts" groups, it would be very helpful to be able to show that there is no simple correlation between the level of finance available and output at any one time. Increased finance in recent years cannot be shown to have produced equivalent increases in output. The arguments in the Merrison Report point in this direction, although their statistics tend to be a snapshot of a particular time, not time series.

Yours ever

Mike Pattison

Miss Zoe Spencer,
Department of Health and Social Security.

SH

DEPARTMENT OF HEALTH & SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY

Telephone 01-407 5522

From the Minister of State (Health)

Mike Pattison Esq
Private Secretary
10 Downing Street
London SW1

8 October 1979

Dear Mike

You asked for some further statistics quantifying the work done in the NHS. I enclose a copy of a table which I hope will be helpful:-

The first line is the total number of beds in the NHS.

The second line is the total number of patients who pass through hospital in-patient services.

The third line is the total out-patient attendances (including double counting for multiple attendances).

This is of course not a complete picture of the NHS eg we do not have the figures quickly available for attendances to GPs, but I hope it will be useful.

Zoë Spencer

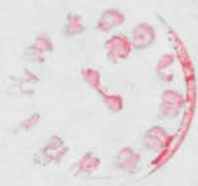
ZOE SPENCER
Private Secretary

IV NHS HOSPITAL ADMINISTRATIVE STATISTICS

Hospitals: Number of beds and patient flow for broad specialty or departmental group

TABLE 4.2 — Great Britain — Thousands

	1959	1969	1970	1971	1972	1973	1974	1975	1976	1977
All specialties										
In-patients										
Beds—allocated	548	526	521	516	508	502	491	483	475	463
—average available daily	540	518	513	508	501	491	483	473	468	459
—average occupied daily	467	435	426	421	415	400	393	382	380	375
Discharges and deaths	4,554	5,975	6,028	6,207	6,278	6,158	6,219	5,994	6,294	6,391
Waiting list	..	614	607	578	563	606	610	681	699	692
Day cases[2]										
Attendances	..	..	..	..	387	425	468	439	559	633
Outpatients[3]										
New patients	..	9,113	9,279	9,319	9,336	9,353	9,246	8,301	8,929	9,053
Total attendances	31,609	37,393	38,095	38,678	38,795	38,944	38,972	36,419	38,039	38,924



8 OCT 1979

LMS

Mr Wolfson
Do you need anything more?
MAP 5/x.

DEPARTMENT OF HEALTH & SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY

Telephone 01-407 5522

From the Minister of State (Health)

Mike Pattison
Private Secretary
10 Downing Street
London SW1

5 October 1979

Dear Mike,

You asked for a brief summary of NHS staffing levels broken down into categories of workers. I attach a table accordingly. It should be noted that this applies to Great Britain only and omits N. Ireland, figures for which are not readily available and if required will I am afraid take time to assemble.

You also asked for a note on the article about NHS "overspending" in "Now" on 28 September. The attached background note covers the examples mentioned in the article in the order in which they occur, pointing out where it is inaccurate.

In addition to these examples, Dr Vaughan has asked me to let you know of an instance of expenditure on administration facilities by a Health Authority, which was not reported in "Now". Correspondence with a Community Health Council in June drew attention to Lincolnshire AHA's plans to rationalise office accommodation in Lincoln by extending existing offices at a cost of c. £100,000. Their plans were intended to give them greater efficiency and were expected to release revenue resources in the longer term. Dr Vaughan asked the Area Health Authority to reconsider their decision in the light of the heavy pressures in the current year on NHS resources which make it necessary in some places to reduce patient services. They abandoned their scheme, and are now looking at ways of providing other necessary office accommodation without making unnecessary inroads into resources needed to treat patients.

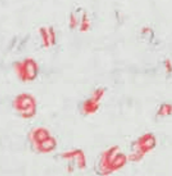
In addition, a point that has struck him in going round hospitals is that extravagances of expenditure resulting from decisions taken in the past are now coming to light as new hospitals are brought into use eg some computer facilities. Dr Vaughan is determined that the NHS should now look carefully at the implications for the future of decisions which have to be taken now.

Yours sincerely

Zoë Spencer

ZOË SPENCER

-5 OCT 1979



1. The reference to "a report in a provincial newspaper" is in fact to an article in the Daily Mirror dated 13 September (copy enclosed). The plan is for the provision of a multi-storey car park providing 770 places (together with surface parking providing in all 868 places). It forms an integral part of the modern Queen's Medical Centre development at Nottingham.

2. King's Lynn

The King's Lynn reference is to a development at the North Cambridgeshire District Hospital which East Anglia Regional Health Authority propose to develop from a 92 to a 140 bed hospital. The first phase of this redevelopment was the replacement and enlarging of the kitchens to take account of the hospital's increased number of beds. The kitchen redevelopment was partly to be met from non-exchequer funds. Dr Vaughan visited the hospital and was shown wards which while cramped appeared to be in good repair. As a part of the total redevelopment, he questioned the need to demolish and replace these wards given the present financial state of the NHS.

The "Now" article says that the proposals have been dropped. This is incorrect. The level of expenditure put at around £2 million puts the project below the level normally controlled by the DHSS and so is for the Region to decide.

3. Oxford

The article refers to a £2 million scheme dropped as the result of discreet prodding.

Neither the Department nor the Region has any knowledge of this. It would seem to be a case of straight misreporting.

4. Newham Health District were planning to move accommodation. This would have cost around £1 million but was vetoed by the RHA who are currently considering other options.

5. Wessex

This Region proposed to provide additional accommodation on its existing HQ site at a cost of some £840,000. However, Dr Vaughan wrote to the RHA expressing concern at the proposed expenditure, and as a result, and on receipt of tenders for the work the RHA has decided not to proceed with its original proposals but to examine alternative solutions to its accommodation problems. The "Now" article is correct on this.

6. South Western RHA

The £500,000 quoted for the RHA's plans to undertake adaptations to an office block, the freehold of which was purchased last year at a cost of £1 million, is a budget figure and not a costed proposal. When the proposal has been properly costed, the RHA Chairman will discuss the matter with Dr Vaughan. The article is not inaccurate but could have presented a truer picture had more detail been included.

7. Cheshire Area Health Authority

In July 1978, Mersey RHA approved a scheme for alterations to existing office accommodation with some extensions for Cheshire AHA HQ at a capital cost of £400,000 to be provided from the 1978/79 and 1979/80 AHA revenue allocation under the terms of the flexibility arrangements. This approval was subject to the provision that a permanent reallocation of resources be made from administration expenditure to patient care expenditure from 1980/81 onwards. Work is currently in progress and is expected to be completed by early next year. The article is incorrect in suggesting that this scheme has been dropped.

8. West Midlands RHA

The RHA has now approved a proposal to lease additional accommodation close to the existing HQ (at a cost of £80,000 pa and a capital outlay of £250,000) in order to rationalise existing accommodation and relieve overcrowding. The article is incorrect in suggesting that this scheme has been dropped.

9. Oxford Area Health Authority (Teaching)

The facts as reported are broadly correct concerning the £100,000 expenditure. The proposals relate to complicated NHS/University manoeuvring of office accommodation associated with a plan to provide recreational facilities for clinical medical students. The AHA has decided to further consider this scheme.

The Daily Mirror Thursday September 13th 1979.

Hospital car park 'scandal'

THE "scandal" of a new hospital's £1·3 million car park was slammed yesterday.

MP Frank Haynes also hit out at the spending of nearly £500,000 on administrative offices complete with chandeliers near the University Hospital in Nottingham.

"Patients will go without services they desperately need to provide these luxuries," said Mr. Haynes, Labour MP for Ashfield, Notts.

Health and personal social services manpower summary 30 September

TABLE **3.1** *(continued)* Great Britain

	Unit	1971	1972	1973	1974	1975	1976	1977
Family Practitioner Committee services:								
Practitioners: Total	No.	44,402	45,142	45,691	45,985	46,688	47,439	48,283
General medical practitioners[11]: Total	No.	24,668	25,183	25,580	25,844	26,127	26,418	26,810
Unrestricted principals		23,252	23,722	23,965	24,255	24,464	24,657	24,939
Restricted principals		455	423	374	338	340	323	315
Assistants		657	633	639	526	441	450	435
Trainees		304	405	602	725	882	988	1,121
General dental practitioners: Total	No.	12,054	12,332	12,520	12,704	12,921	13,254	13,564
Principals		11,592	11,911	12,124	12,383	12,620	13,015	13,359
Assistants		462	421	396	321	301	239	205
Ophthalmic medical practitioners[12]	No.	986	988	980	918	943	948	949
Ophthalmic opticians[12]	No.	5,384	5,281	5,219	5,141	5,184	5,218	5,235
Dispensing opticians[12]	No.	1,310	1,358	1,392	1,378	1,509	1,601	1,725
Dental Estimates Board staff[13]: Total	W.t.e.	1,479	1,454	1,417	1,484	1,598	1,611	1,588
Professional and technical staff		4	4	5	6	4	6	6
Administrative and clerical staff		1,438	1,410	1,366	1,431	1,548	1,507	1,538
Ancillary and other staff		37	40	46	48	46	48	44
Presciption Pricing Authority/Prescription Pricing Division staff[14]: Total	W.t.e	2,184	2,127	1,983	2,318	2,435	2,533	2,501
Administrative and clerical staff		2,146	2,087	1,940	2,275	2,386	2,475	2,448
Ancillary and other staff		38	40	42	43	49	58	53

Note: See Appendix I (Section III: Tables 3.1–3.4).

Source: Department of Health and Social Security. Scottish Health Services Common Services Agency. Welsh Office.

[1] Common Service Agency Staff in Scotland are included from 1974 onwards.
[2] Figures exclude locum staff, hospital practitioner appointments and doctors holding paragraph 94 appointments and dentists holding paragraph 107 appointments under the Terms and Conditions of Service of Hospital Medical and Dental staff.
[3] Includes staff working in Blood Transfusion Centres and Mass Radiography Units.
[4] Figures for 1971–1973 exclude community health staff in Scotland.
[5] Includes community health service doctors, school health service doctors and, up to 1973, Regional Hospital Boards' administrative medical staff; figures for the school health service 1971–1973 relate to 31 December; figures from 1974 exclude occasional sessional staff for whom no w.t.e. was collected. From 1976 locum and temporary staff are excluded.
[6] Includes community health service dentists and school health service dentists; figures for the school health service 1971–1973, relate to 31 December; figures from 1974 exclude occasional sessional staff for whom no w.t.e. was collected. From 1976 locum and temporary staff are excluded.
[7] Figures relate to 31 December for community health staff in Scotland for 1971–1973.
[8] Hospital social workers are included up to 1973—responsibility for these staff was transferred to Local Authority Social Service on 1 April 1974.
[9] Figures exclude ambulance officers.
[10] Includes Family Practitioner Service administrative and clerical staff.
[11] Figures relate to 1 October.
[12] Figures relate to 31 December.
[13] The figures for the Dental Estimates Board in Scotland for 1971–1973 are numbers instead of whole-time equivalents. The figures for England relate to 31 December for 1975.
[14] The Prescription Pricing Authority in England and Wales is synonymous with the Prescription Pricing Division in Scotland. Figures for the Prescription Pricing Division relate to 30 November and are numbers instead of whole-time equivalents.

III MANPOWER

Health and personal social services manpower summary
30 September

TABLE **3.1**

Great Britain

	Unit	1971	1972	1973	1974	1975	1976	1977
Health Service staff and practitioners: Total	("whole time equivalent")	799,673	831,753	843,119	859,468	914,068	945,877	950,498
Regional and Area Health Authorities/Boards and Boards of Governors staff: Total[1]	W.t.e.	751,608	783,030	794,028	809,681	863,347	894,294	898,127
Medical staff: Total	W.t.e.	30,482	31,952	33,329	34,338	36,217	37,257	38,224
Hospital medical staff: Total[2,3]	W.t.e.	27,958	29,372	30,594	31,486	33,017	33,909	34,821
Consultants		10,133	10,510	11,064	11,463	11,781	12,221	12,392
S.h.m.o. with allowance		87	81	22	14	12	10	8
S.h.m.o. without allowance		288	278	244	203	189	93	85
Medical assistant		1,040	1,068	1,039	1,065	1,106	1,072	1,069
Senior registrar		1,997	2,147	2,248	2,327	2,419	2,530	2,639
Registrar		5,527	5,595	5,661	5,626	6,036	6,165	6,266
J.h.m.o.		12	7	3	..	..	..	..
S.h.o.		5,888	6,573	7,361	7,762	8,396	8,670	9,111
House officer		2,961	3,085	2,941	2,996	3,051	3,119	3,237
Other staff		26	28	10	30	27	23	15
Community health medical staff[4,5]	W.t.e.	2,524	2,580	2,735	2,852	3,200	3,348	3,403
Dental staff: Total	W.t.e.	2,419	2,478	2,535	2,745	2,935	2,957	3,019
Hospital dental staff: Total[2]	W.t.e.	907	938	943	996	1,057	1,078	1,118
Consultant		325	333	354	373	381	395	417
S.h.d.o. with allowance		12	12	4	3	3	2	2
S.h.d.o. without allowance		50	47	41	32	27	19	16
Assistant dental surgeon		52	60	65	59	78	83	86
Senior registrar		76	87	96	91	109	109	108
Registrar		141	141	145	152	167	160	175
Senior house officer		92	97	102	134	132	150	157
Dental house officer		140	142	135	152	159	158	157
Other staff		20	19	2	1	1	1	-
Community health dental staff[4,6]	W.t.e.	1,512	1,540	1,592	1,749	1,878	1,879	1,901
Nursing and midwifery staff: Total[7]	W.t.e.	343,642	364,434	370,595	377,633	405,817	414,961	415,694
Qualified nurses and midwives	W.t.e.	175,839	183,388	185,119	189,567	202,464	213,225	219,900
Student and pupil nurses and midwives		87,494	92,955	95,321	93,285	95,461	98,961	94,939
Other nursing and midwifery staff		73,606	81,560	84,246	90,219	103,679	99,822	99,675
Nursing cadets		6,703	6,532	5,910	4,563	4,212	2,953	1,181
Professional and technical (excluding works) staff[4,8]	W.t.e.	48,368	51,028	53,552	52,828	57,025	63,539	65,405
Works and maintenance staff	W.t.e.	26,844	27,042	26,656	27,445	29,457	30,042	30,493
Administrative and clerical staff[4,9,10]	W.t.e.	78,796	83,708	87,406	94,798	105,781	112,982	113,757
Ambulance officers, ambulancemen/women and other ambulance staff	W.t.e.	18,207	18,757	19,164	19,255	20,425	20,170	20,383
Ancillary and other staff	W.t.e.	202,850	203,631	200,791	200,639	205,690	212,386	211,153

With public sector economies very much in the air A HOSPITAL MEDICAL SECRETARY suggests how

Nat Health

In the NHS, we could take care of the pennies . . .

Daily Telegraph Wednesday 25 July 1979.

IF my typewriter was used 24 hours a day by a series of shift-workers, it would still not require servicing three times a year. Yet not only has our hospital a typewriter maintenance contract but when my typewriter needed a couple of minutes of a technician's time I was presented with a "job completion" form that quoted a charge of £36 + VAT.

The job had been simple: to reconnect the tensioning band (a bit of elastic). I knew where it fixed on, but neither I nor a number of doctors could discover how it should be routed in order to get the correct balance.

I had therefore asked the Principal Medical Secretary if I might borrow another machine and if, when there was a typewriter technician in the hospital, my machine could have its tensioning band fixed. Some days later I was greeted by the news that "there's been a man to look at your typewriter — he was in and out again in a couple of minutes."

I queried the £36 bill and was told it was "in order." I insisted on further investigation and was told the bill was "quite correct." My consultant then joined in and asked for an explanation. We were told that my machine was going to be taken away at some unspecified date in the future for a full overhaul. But the form was a "job *completion*" *form*. What was more the typewriter didn't require anything else. I said so. That, I was given to understand, was indicative of my ignorance of such matters.

"Right," I said. "I hold the certificate for the fastest typewriting test there is. I am quite prepared to take that test again, using this machine. Perhaps that will indicate whether it requires further work?"

The bill was cancelled.

★

What dismayed me more than anything else was the total lack of interest displayed by the great majority of people to whom I spoke about this matter. There is an apathy throughout the Health Service which has led to people—even those in responsible positions —being ready to sign anything and to accept anything without protest. "That's the way things are . . . You can't fight the system . . ."

Every day we see evidence of profligacy beyond belief. To start with we now have some seven Administrators where not very long ago we had one (male) Hospital Secretary assisted by his incredibly-efficient (female) secretary. Such problems as did not come under Matron were solved, within a matter of hours at the longest, by reference to the Hospital Secretary. Now, weeks, months and quite often years go by before anything happens at all: there is no-one "with whom the buck stops."

Unlimited money is apparently available for such idiotic schemes as a fitted carpet ("of top quality because of the wear it would get") in a casualty department, and for gimmicky office equipment such as a twirly stand for rubber stamps. One finds, over and over again, that almost any *thing* can be replaced, but if the doctors need some new instrument, or something additional to their establishment, this is said to be "impossible."

The bottomless well of replacement funds is such that no effort is made to teach staff how to care for anything. What is more, old machinery is sometimes deliberately installed in a new hospital simply because there are no funds for new equipment unless it can be from the "replacement" funds.

Restoration of old equipment is something that might well be done by the youngsters who have for a long time now been going round the hospital, in pairs, working under the Job Creation Scheme. To date I have found them doing many strange things, including measuring every door in the hospital. Another job which roused my interest was counting manholes. The door-measurement was a lovely winter job, they told me, but counting manholes is ideal for summer. "It's doing a lot of good for me," said one youth. "I'm really enjoying myself. You see, I have a psychiatric problem."

In one hospital Job Creation included counting the number of lights and light switches in each room. Ask any Ward Sister about the wastage that comes within her orbit and about which she is powerless to take action.

There is only one new appointment for which hospital staff are crying out. That is the appointment of someone who is there solely to prevent waste and to encourage economy. Someone to whom we can go, in our despair, and know that action will follow. Someone who will start by cancelling that contract for servicing every typewriter in the hospital three times a year! (Indeed, having watched the "mechanic" doing the job, I can see that it involves no more than any competent secretary does herself.)

We want someone to make sure that adequate instruction is given to staff so that one does not see, as I saw recently, 1,100 letters intended for the normal second-class post being franked 97p. This was done by an untrained young typist sent to the post room to help out in a crisis. She had been franking stick-on labels for parcels, which needed an expensive stamp. When some one gave her a late batch of letters she shoved them through without adjusting the machine.

She simply had not appreciated that the franking which appeared on each envelope or sticky-label was totalled inside the machine and the cost came out of Health Service funds.

We have no system of instruction or training for incoming staff. There is a Handbook for House Officers in which the young doctors can find information on the entire spectrum of their work. Why is there nothing of this sort for medical secretaries and clerks?

Patients' record folders go from one department to another in specially - produced envelopes which are box-printed for re-use up to 108 times. The economy-conscious will re-use them, but most staff simply discard each one as it comes and pick another new envelope to send the same record folder on its next internal journey.

Lack of instruction; lack of thought; lack of team-spirit — all these play their part, but particularly demoralising is the lack of example. Such economies as one may oneself institute — re-using ordinary old envelopes for internal letters, for example — seem pretty pointless when one receives a batch of *new* envelopes in the internal mail from "Admin." Often they could come not in envelopes at all: more than half don't need any covering. Why waste time folding and enclosing?

And we don't even collect our waste paper for sale!

★

Meanwhile there *are* so-called economies in the hospital service. It is because of "economy" in the employment of nursing staff, for instance, that we quite often have operating theatres, surgeons, anaesthetists and equipment standing idle. It is illegal for any procedure to take place under general anaesthesia without three nurses in the theatre. Thus the actual cost of saving one nurse's salary can very easily run into tens of thousands of pounds if a theatre nurse is off and there isn't a spare nurse to be found in the hospital — as is often the case.

Because we employ too few nurses, wards stand empty. The story is that the wards are due for re-decoration, but painting a ward and its environs wouldn't take any "do it yourself" team the full six weeks that is the normal closure period in our hospital. And it is quite often two wards that are standing empty. Rotatory closure of wards enables the quota of nurses to be trimmed.

And so the waiting lists grow. We can't admit patients because we have too few beds; we can't operate on a "day-case" requiring general anaesthesia. We can only stand by and apologise.

DEPARTMENT OF HEALTH & SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY

Telephone 01-407 5522

From the Secretary of State for Social Services

7 June 1979

Tim Lankester Esq
Private Secretary
10 Downing Street
LONDON
SW1

Dear Tim,

WASTE

I am sorry that I am a little late in replying to your letter dated 16 May about the problem of waste in the public sector, outside central Government. My Secretary of State is convinced that there are opportunities for improving the use of resources in the National Health Service and has asked the Department to make detailed proposals covering the main areas of NHS expenditure. He would like to provide a more comprehensive reply on the strategy for tackling waste later this year. The paragraphs below set out in broad terms the direction which a strategy to cut out waste might take.

We know of no evidence, other than the anecdotal sort which is told about any large scale enterprise, that there is much "sheer waste" in the NHS. But efficiency can undoubtedly be improved in every aspect of the organisation. For example, considerable attention has been paid, in the past, to improving efficiency in "support services" such as supplies, works, energy, catering and domestic services. There have been some remarkable results. For example in 1978 the cost of energy consumption of the NHS is estimated to have been about £150 million. Without energy conservation measures put in hand over a number of years we estimate that this figure would have been £30 million higher. Another example has been the review of management costs over the last two years, through which expenditure on management has fallen from over 5.6 per cent of total revenue, to below 5.2 per cent. In real terms this has freed at least £16 million per annum from expenditure on management, making it available for services more directly concerned with patient care.

Looking to the future the following factors will be important:-

(i) The continuing restraint on cash limits, reinforced by the contribution of £24 million that NHS Authorities have to make this year towards the cost of pay awards, is exerting a steady pressure to cut waste.

E. R.

(ii) We are expecting the Report of the Royal Commission on the National Health Service in about six weeks. The Secretary of State has decided not to take any specific initiative on structural simplification, until he sees what the Report recommends. In the longer term, however, he will be looking for three advantages from a simpler structure with more local economy -

Nothing helpful.

(a) fewer management tiers will reduce the number of people not directly engaged on patient care;

(b) more autonomy will underline management responsibility for getting value for money;

(c) it will become possible to extend the use of incentive budgeting to help managements at all levels to find the most economical ways of providing services.

(iii) We are hoping to have Sir Derek Rayner's help in due course, because he has had direct experience with the DHSS Management Review Team, and he has indicated that he could help to show where substantial improvements can be made in resource usage within the National Health Service, especially in the field of purchasing.

(iv) In the context of our commitment not to cut the provision for the National Health Service, the Secretary of State intends to make it clear to Health Authorities that the serious deficiencies in the service can only be attacked by saving money elsewhere and channelling it into patient care. The Secretary of State will want to make it plain the NHS exists to provide care for patients, not jobs for staff.

I am copying this letter to Sorenson (Department of Environment), Kenneth MacKenzie (Scottish Office) and George Craig (Welsh Office).

Yours sincerely

Don Brereton

D Brereton
Private Secretary

cc Cab Off

10 DOWNING STREET

From the Private Secretary

B/F 23.5.79.

16 May 1979

Copied to : Local. Auth'y May 79 : Waste

Nat Health

Waste

The Prime Minister has been considering the problem of waste in the public sector outside central government. She regards this as an important area for study, in its own right, and as a way of helping the local authorities and the NHS to absorb the costs of recent pay increases while still living within their cash limits. As you know, she has appointed Sir Derek Rayner to adviser her on the general question of 'waste': but he intends to concentrate initially at any rate on central government. The Prime Minister would therefore be glad to have your Secretary of State's own views on the best way of attacking the problem.

I am sending copies of this letter, with a similar request, to Don Brereton (Department of Health and Social Security), Kenneth MacKenzie (Scottish Office) and George Craig (Welsh Office).

K.E.C. Sorensen, Esq.,
Department of the Environment.

Top copy on:
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May 79: Waste

Ref: A09553

MR. LANKESTER

Pay and Cash Limits

In your minute to me of 8th May in which you conveyed the Prime Minister's comments on Sir John Hunt's brief of 4th May on pay and cash limits, you asked for draft letters to the Departments of the Environment and of Health and Social Security commissioning reports on ways in which the problem of waste in local authority and NHS expenditure might be tackled.

I attach a draft herewith.

(M. J. Vile)

14th May 1979

DRAFT LETTER FROM TIM LANKESTER TO ERIC SORENSEN, DOE

Waste

The Prime Minister has been considering the problem of waste in the public sector outside central government. She regards this as an important area for study, in its own right, and as a way of helping the local authorities and the NHS to absorb the costs of recent pay increases while still living within their cash limits. As you know, she has appointed Sir Derek Rayner to advise her on the general question of 'waste': but he intends to concentrate initially at any rate on central government. The Prime Minister would therefore be glad to have your Secretary of State's own views on the best way of attacking the problem.

I am sending copies of this letter, with a similar request, to Don Brereton (DHSS) Kenneth Mackenzie (Scottish Office) and George Craig (Welsh Office).

SECRET

File

Mr. Stowe
b.c: Mr. Wolfson
Mr. Ridley
Mr. Ryder

Original on Economic Policy: Strategy May 79

10 DOWNING STREET

From the Private Secretary

MR. VILE

PAY AND CASH LIMITS

The Prime Minister has now read Sir John Hunt's brief of 4 May on the above subject. She has made the following comments:

(i) On teachers' pay, she thinks the previous Administration were quite right to oppose the teachers' request that their comparability study should be no more than an up-date of Houghton. She thinks the previous Administration were quite right to insist on "an honest comparability study done with full weight given to the non-pay terms and conditions of teachers service".

(ii) On PAR, she has commented that the PAR studies were well nigh useless and took up a lot of time.

(iii) On paragraph 7, the Prime Minister agrees that it would be highly desirable to conduct early reviews of local authority expenditure and NHS expenditure with a view to identifying - and getting rid of - waste. I will be commissioning reports from DOE and DHSS respectively on these; but no doubt Sir Derek Rayner will also have an important role to play here.

See separate files under Local Govt & Nat Health.

(iv) On comparability, the Prime Minister cannot confirm that comparability is the key to establishing public service pay. (She has of course already commented on this - see my note of 6 May.)

/The Prime Minister

SECRET

The Prime Minister agrees with Sir John Hunt's conclusion - that Ministers or Ministerial Committees will need to be asked at an early stage to produce papers and proposals on the various issues touched on in the brief, but she would first like to have a general discussion in Cabinet, and with this in mind she would be grateful for an annotated agenda which could be circulated to colleagues.

R.

P.S.

As regards the reports from DOE and DHSS ((iii) above) I would be grateful if you would let me have drafts of the commissioning letters for me to send.

8 May 1979

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