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CONFIDENTIAL FILING

P.M.'s dinner for Regional Health Authority Chairmen.

NATIONAL HEALTH.

S 812

July 1986.

Referred to	Date	Referred to	Date	Referred to	Date	Referred to	Date
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cc bg

Prime Minister 4.

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

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

Telephone 01-407 5522

From the Secretary of State for Social Services

P A Bearpark Esq
10 Downing Street

3 November 1986

R4/11

Dear Andy

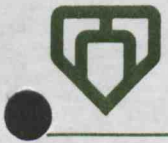
At the dinner with Regional Health Authority Chairmen on 25 September, the Prime Minister asked to see examples of action taken by the Chairmen to publicise good news about the NHS.

I enclose a copy of the 1985/86 Annual Report for the North Western Region which the Prime Minister may wish to see. My Secretary of State's view is that this is an impressive document, combining a great deal of factual information with an attractive lay out.

Yours

Jane McKessack

Jane McKessack
Private Secretary



North Western Regional Health Authority

Gateway House Piccadilly South, Manchester. M60 7LP. Tel. 061 236 9456

Chairman : Sir John Page, O.B.E. General Manager : G.J. Greenshields, B.A., M.Litt., I.P.F.A., M.B.I.M.

With Compliments

NORTH WESTERN HEALTH SERVICES ANNUAL REPORT AND ACCOUNTS 1985/6

"Another year of progress for North Western Health Services."

NORTH WESTERN HEALTH SERVICES ANNUAL REPORT AND ACCOUNTS 1985/6

NORTH WESTERN HEALTH REGION

The North Western Health Region comprises nineteen District Health Authorities and the North Western Regional Health Authority, which is based in Manchester.

CONTENTS

NORTH WESTERN HEALTH SERVICES ANNUAL REPORT AND ACCOUNTS 1985/6

"In the period covered by this Report April, 1985 – March, 1986, health services in the North Western Region have been consolidated and continued the progress and improvements I noted in the report on the previous year.

It is clear from the facts and figures herein that, over the Region as a whole, more patients are being treated, and this includes key 'life-saving' specialties such as cardiac surgery and renal medicine.

We have also seen further encouraging expansion of vital community services for the mentally ill, the mentally handicapped and the elderly.

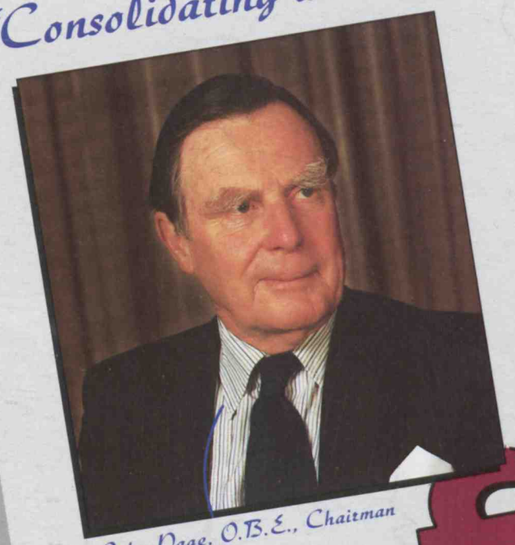
Many much-needed new capital schemes have been successfully completed, providing a better quality of environment for patient care and, in many cases, filling gaps in services.

The National Health Service has regrettably and wrongly come under increasing criticism in recent years. It is generally said that its services have either not improved as they should or that they have deteriorated. This is not true. Here, in the North West, we have the positive tangible evidence that overall services and facilities are steadily improving. Of course, the rate of progress is not necessarily as great in all districts simultaneously and we are also in the process of re-distributing services with the intention of equalising access to health care all over the Region. So it is necessary to view matters in a wide perspective and it is then obvious that there has been considerable improvement and progress.

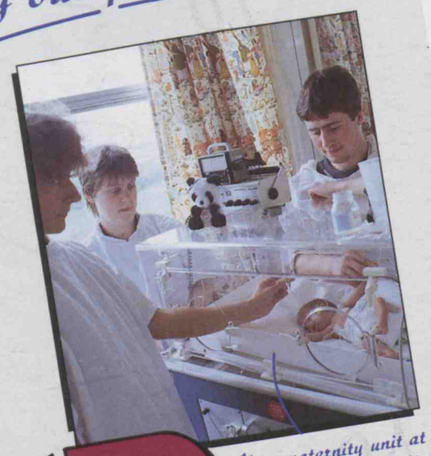
We could always find worthwhile ways of spending more money. Equally, it must be realised that no-one is ever going to be able to give us an open-ended cheque. So we must live within our means which are not unsubstantial – nearly £1,000 million is now spent annually on health services in the Region.

But money spent is only part of the story because the progress and improvements would not have been possible without the efforts of the staff of the NHS at all levels, whether engaged in direct patient care or behind the scenes. To them I offer my sincere thanks for another year of personal and professional dedicated commitment."

"Consolidating and continuing our progress . . ."

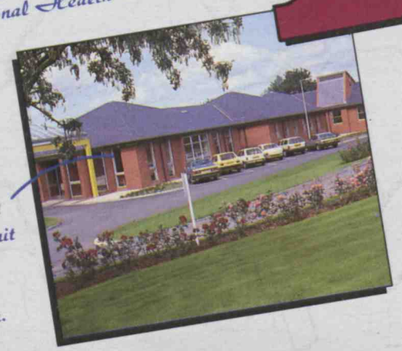


Sir John Page, O.B.E., Chairman North Western Regional Health Authority.

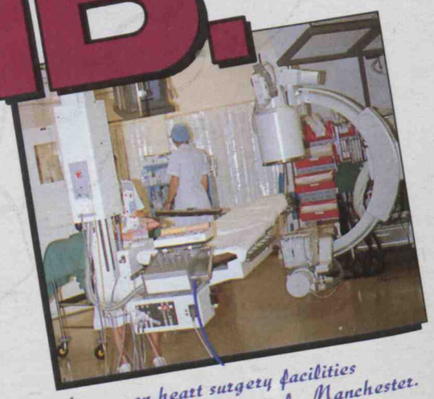


New maternity unit at Shatoe Green hospital, Preston.

£1B.



Elderly Severely Mentally Infirm unit at Fall Birch, Bolton.



New open heart surgery facilities at Wythenshawe hospital, Manchester.

MORE PATIENTS TREATED AND WAITING LISTS REDUCED

As the figures on this page show, the period from 1980 to 1985 has seen a steady increase in the numbers of patients being treated in the North West. During the same time waiting lists for hospital admission have also fallen.

In-patient cases up

Last year 76,000 more in-patient cases were dealt with in our hospitals than in 1980 – a 14% increase.

Out-patient attendances up

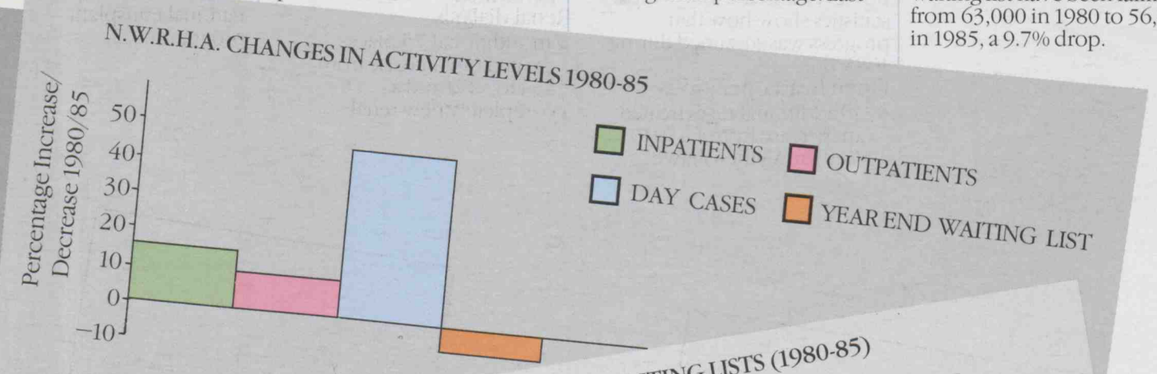
There was also a significant increase in the number of out-patient attendances over the same five-year period. In total they rose by 311,800 (9.5%).

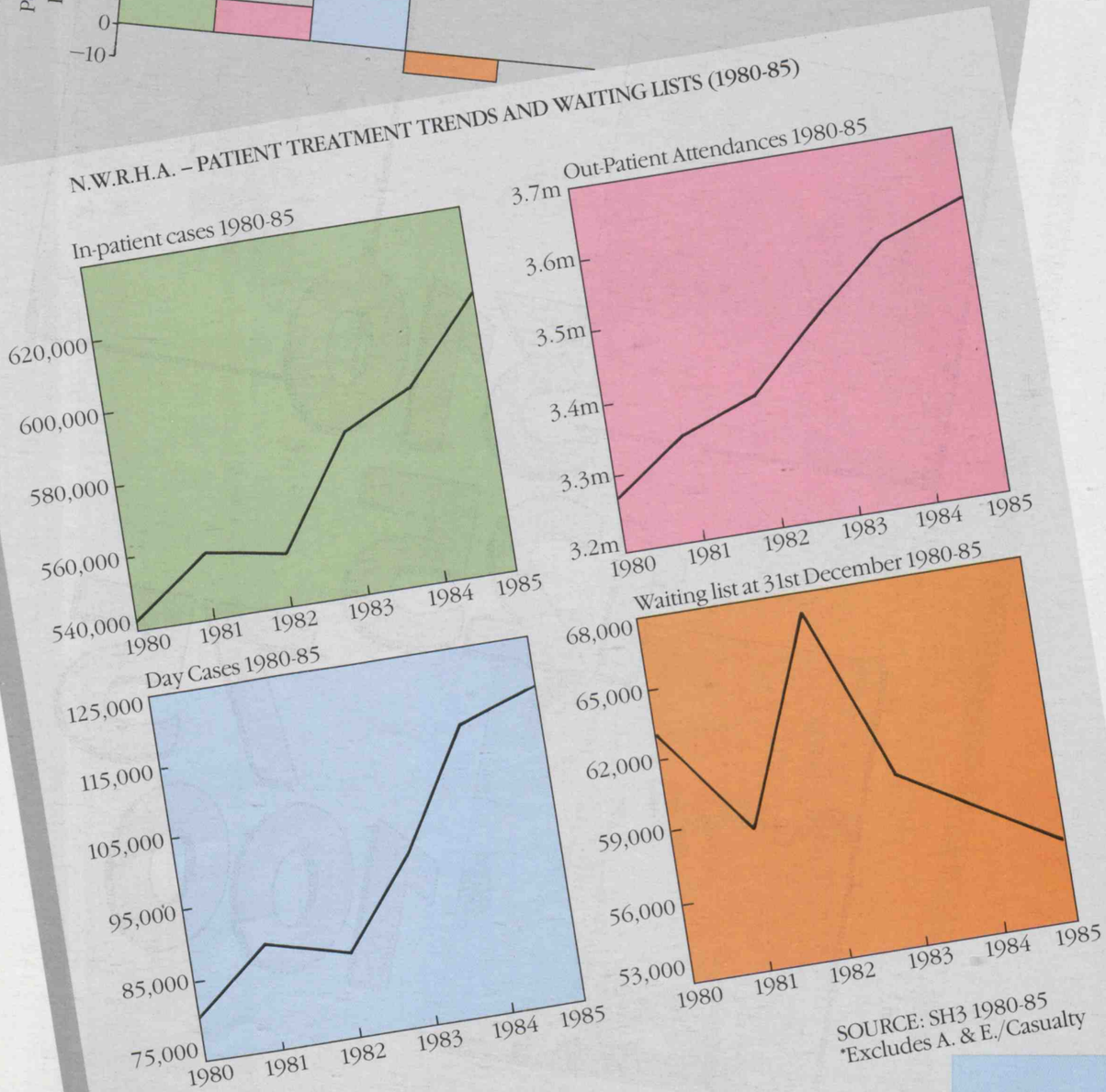
Day cases up

Day cases have risen by an even greater percentage. Last year 116,300 patients received treatment on this basis, compared with 79,300 in 1980. The extra 37,000 cases represent an increase of nearly 47%.

Waiting lists down

Whilst more people have been receiving treatment than ever before, numbers on the waiting list have been falling – from 63,000 in 1980 to 56,900 in 1985, a 9.7% drop.





SOURCE: SH3 1980-85
*Excludes A. & E./Casualty

STRENGTHENING 'LIFE-SAVING' HEART AND KIDNEY TREATMENT SERVICES

More cases dealt with than ever before.

Historically, the North West has not had the resources to meet demand for 'life-saving' treatment of conditions like heart disease and kidney failure. Tremendous strides forward have been made in the past three or four years, however, and the following statistics show how that progress was sustained during 1985/86:

Open heart operations

- 310 additional cases treated (an increase from 1,450 to 1,760) at Wythenshawe Hospital, Manchester Royal Infirmary and Victoria Hospital, Blackpool.

Angioplasties

- 125 cases treated by means of this relatively new procedure for replacing affected arteries.

Pacemaker implants

- 870 pacemaker implants performed.

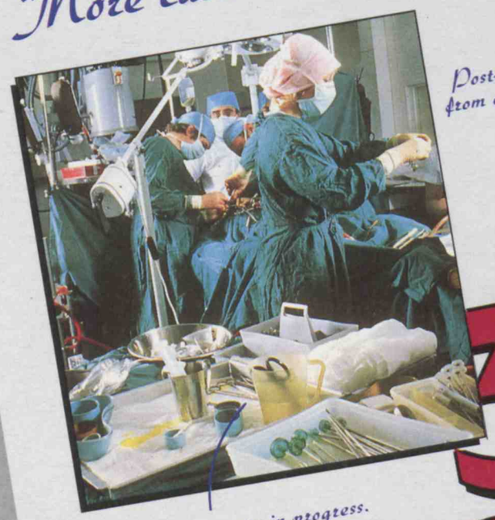
Renal dialysis

- an additional 75 places created (an increase from 454 to 529) and a completely new renal dialysis unit opened at Preston with the intention of providing a further 60 places.

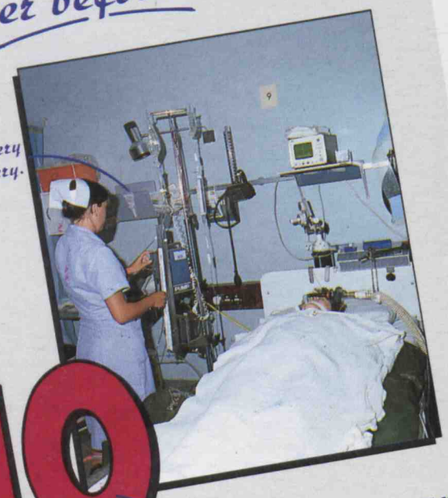
Kidney transpla

- a total of 100 kidney transplants performed – a slight increase on 1984/85 – with the North Western Region also becoming a net contributor of kidneys to the national transplant programme.

"More cases dealt with than ever before..."



Open heart surgery in progress.



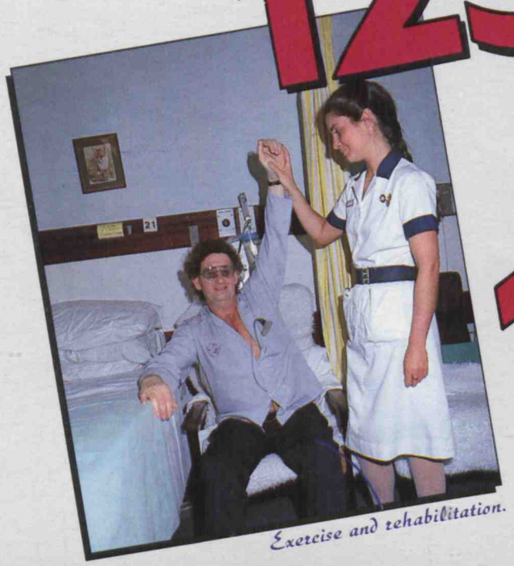
Post-operative recovery from open heart surgery.

310 *310 additional open heart operations.*

125 *125 artery replacement cases treated.*

75 *75 additional renal dialysis places created.*

100 *100 kidney transplants performed.*



Exercise and rehabilitation.

NEW CAPITAL INVESTMENT

A ten-year programme is under way to build new hospitals where there are major gaps in services and to replace and improve existing facilities which are either inadequate or wearing out because of age.

"Filling gaps and improving quality..."

Schemes started in 1985/86
Important new developments which started on site during the year included:

BOLTON		Date started
*Bolton General Hospital – Mental Illness Unit providing 48 beds	£1.91m	July 1985
*Bolton General Hospital – Communications Centre	£0.90m	November 1985

BURY		Date started
*Fairfield General Hospital – Phase I Development providing 56 acute beds; 46 children's beds; a children's outpatient department; paediatric assessment unit; dental department; antenatal clinic and midwifery training school	£4.98m	August 1985

ROCHDALE		Date started
*Birch Hill Hospital – Unit for the Younger Physically Disabled	£1.15m	November 1985

NORTH MANCHESTER		Date started
*North Manchester General Hospital – District Workshops and Transport Department	£1.21m	September 1985

SOUTH MANCHESTER		Date started
*Withington Hospital – Paediatric Unit	£2.83m	July 1985
*Christie Hospital – Leukaémia Unit	£0.82m	September 1985

BLACKPOOL		Date started
*Fylde Community Hospital, with 96 geriatric beds, 50 geriatric day places and rehabilitation facilities	£5.89m	June 1985

BURNLEY		Date started
*Burnley General Hospital – Unit for the Younger Physically Disabled	£1.38m	April 1985

Schemes completed in 1985/86
Important developments completed or nearing completion during the year included:

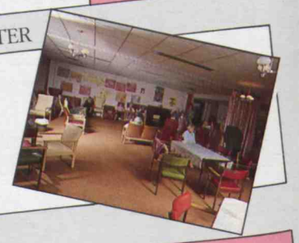
WIGAN		Date completed
*Royal Albert Edward Infirmary – Ward Block Phase I providing 112 acute beds; 3 operating theatres and one minor theatre	£6.64m	May 1986
*Leigh Infirmary Second Mental Illness Unit providing 60 in-patient beds and 80 day places	£2.69m	May 1985
*Leigh Infirmary HSDU, sub-station and roadworks	£1.85m	December 1985

BOLTON		Date completed
*Fall Birch Elderly Severely Mentally Infirm Day Unit with 40 day places and support places	£1.14m	December 1985

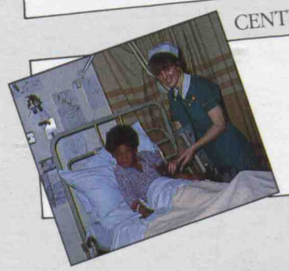
ROCHDALE		Date completed
*Rochdale Infirmary – ESMI Unit with 50 in-patient beds and 50 day places	£2.39m	April 1985
*Birch Hill – Replacement Telephone Installation	£0.64m	November 1985

BURY		Date completed
*Fairfield General Hospital – Boiler House	£1.47m	November 1985
*Fairfield General Hospital – Mental Illness Day Unit with 80 places	£1.32m	April 1986
*Fairfield General Hospital – Communications Complex	£0.46m	July 1985

SALFORD		Date completed
*Prestwich Hospital – Regional Adult Secure Unit with 88 beds	£2.26m	April 1986
*Hope Hospital – Replacement of Main Cold Water Supplies System	£0.47m	May 1986



NORTH MANCHESTER		Date completed
*North Manchester General Hospital – ESMI Day Unit with 50 places	£0.76m	May 1986



CENTRAL MANCHESTER		Date completed
*St Mary's Hospital – Improvements to Paediatric Services	£0.35m	June 1986

Schemes in progress
Other major schemes still in progress include:

BURY		Scheduled completion
*Fairfield General Hospital – Kitchen, Dining Room and HSDU	£3.00m	April 1987

CENTRAL MANCHESTER		Scheduled completion
*Advance Works for Manchester Royal Infirmary Redevelopment Phase II	£1.95m	September 1986

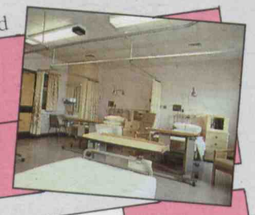
OLDHAM		Scheduled completion
*Oldham District General Hospital – Phase I Redevelopment providing 300 beds; seven operating theatres; an accident and emergency department; a pharmacy and new out-patient and X-ray departments	£17.74m	February 1988

BLACKBURN		Scheduled completion
*Queen's Park Hospital – Phase I Redevelopment	£4.43m	December 1986

TAMESIDE		Scheduled completion
*Tameside General Hospital – Phase II Development providing 139 acute beds; three operating theatres; an accident and emergency unit; an out-patient department and X-ray facilities	£16.44m	July 1987
*Tameside General Hospital Geriatric Unit	£2.62m	September 1986

BURNLEY		Scheduled completion
*Burnley General Hospital – Pharmacy and HSDU	£1.91m	January 1987
*Burnley General Hospital – Extension for Kitchen and Dining Room	£0.97m	September 1986

Schemes completed in 1985/86
Important developments completed or nearing completion during the year included:



TRAFFORD		Date completed
*Park Hospital – Geriatric Unit and Rehabilitation Facilities with 96 in-patient beds and 50 day places	£3.94m	February 1986
*Partington Health Centre Extension	£0.42m	February 1986

SOUTH MANCHESTER		Date completed
*Wythenshawe Hospital – Expansion of Open Heart Surgery Facilities	£0.57m	March 1986
*Withington Hospital – Maxillo Facial Unit Phase I	£0.89m	July 1986

LANCASTER		Date completed
*Queen Victoria Hospital – Phase I Redevelopment providing 48 geriatric beds	£2.59m	April 1986

PRESTON		Date completed
*Sharoe Green Hospital – Conversion of Ward Block to provide 126 maternity beds; central delivery suite; special care baby cots; 12 general practitioner maternity beds; 67 gynaecology beds and out-patient consulting suites	£2.01m	November 1985
*Royal Preston Hospital – Accommodation for Scanner and Haemodialysis Unit	£1.90m	June 1986

BLACKPOOL		Date completed
*Victoria Hospital – Phase IV Development providing 112 acute beds; three operating theatres; one plaster theatre; and a boiler house	£4.73m	April 1986
*Fleetwood ESMI Unit with 56 in-patient beds and 50 day places	£2.57m	April 1986
*Hospice at Bispham with 30 acute beds for terminally ill patients	£0.83m	March 1986
*Victoria Hospital – Extension to Out-patients Department for ENT patients	£0.66m	May 1986

BURNLEY		Date completed
*Burnley General Hospital – Phase III Redevelopment providing 168 acute beds and three operating theatres	£5.90m	August 1986

ESTABLISHING A PATTERN OF COMMUNITY BASED SERVICES FOR THE MENTALLY HANDICAPPED

Strenuous efforts have continued throughout 1985/86 to implement an ambitious programme for re-locating mentally handicapped people from institutions into homes of their own. The target is to provide an extra 3,200 community places by 1993 and to reduce in-patient beds from around 3,600 to less than 300.

No children in hospital any longer

The past year has witnessed the end of an era: there are no longer any mentally handicapped children from the North Western Region resident in hospitals. All are being cared for in the community.

Community places created

In addition, a total of 138 community places were established in a wide range of imaginative local schemes such as:

- two four-place group homes in Rochdale and two in West Lancashire;
- a 'core and cluster' development in Bury designed to provide the necessary infrastructure for the expansion of local services.

Staff Appointments

Sixty-four new 'direct care' community staff for mental handicap were appointed, including nurses, health visitors, team leaders, speech therapists and others who have been specifically trained to support individuals at home and their families.

Communications

Two important "communications" initiatives were launched in a bid to ensure that the momentum behind the implementation of community care policies is not lost and that public understanding and support are obtained:

- A video entitled "A Home of Their Own" was produced and launched by the RHA in October, 1985. Telling the story of four young mentally handicapped women on their journey from life in Calderstones Hospital, Burnley, to an ordinary house in Rochdale, it demonstrates through a documentary format that, with the right planning and facilities, community care can and does become a workable reality.
- In April, 1985, the RHA published the first issue of "Action Line," a regular newsletter giving up-to-date information, facts and figures about progress in the Region towards community-based care. As many as 5,000 copies were distributed to health and local authorities, CHCs and voluntary organisations.

"Good progress maintained . . ."

138 community places created.

3200 extra community places to be established by 1993.

3200

138

64

64 new 'direct care' staff appointed.

3600

0

No mentally handicapped children in hospital any longer.

300

Reduction of in-patient beds from 3600 to less than 300 by 1993.

Mental Handicap Strategic Target (1983-93)

- The number of nurses and carers in community mental handicap services to increase by some 2,000 to approximately 2,420 (wte).

DEVELOPING COMPREHENSIVE CARE FOR THE MENTALLY ILL

Strategy for running down the large institutions

A new and important chapter in the history of care for the mentally ill is about to unfold. In July, 1985, the RHA published a consultative document on its proposed short-term strategy for the run-down of the large mental illness institutions in the Region: Whittingham (Preston); Prestwich (Salford); Lancaster Moor (Lancaster); and the unit at North Manchester General. The aim is to transfer nearly 1,400 patients into the community by 1993/94.

The following guiding principles for the transfer of patients were recommended:

- There must be appropriate local facilities.
- There must be every expectation that the quality of life for each individual will be improved.
- Patients and staff must be adequately prepared.
- Individual programmes of treatment must be worked out.
- Where transfers are not successful, there should be no obstacles to patients returning to their hospital of origin for reassessment.

Development of District-based services

The run-down must, of course, be accompanied by the development of alternative local services. Broadly speaking, the strategy envisaged a mix of facilities:

- **acute units** on District General Hospital sites, preferably in peripheral locations and designed to create as much domesticity as possible;
- **community resource centres** forming the core of a network of local services and possibly incorporating a walk-in centre and a day centre;
- **long term hostels** providing 10-12 places for semi-acute and new 'long-stay' patients and staffed on a 24 hours a day basis;
- **short-term hostels** offering rehabilitation and requiring greater involvement by patients in their day-to-day running;
- **houses or self-contained flats** for patients who can live a predominantly self-sufficient life-style (with some of this accommodation being staffed according to patients' needs);
- **day centres** accommodating up to 20 people each and providing much-needed social support.

The pace of change expected in the next three years

Districts were asked, in conjunction with the large mental illness hospitals, to draw up plans for the resettlement of long-stay patients which would meet the following targets:

1986/87 2.5 places per 100,000 population or 5% of the total District requirement (whichever is the larger);

1987/88 and 1988/89 5 places per 100,000 population; or 10% of the total District requirement (whichever is the larger).

In practice this should mean around 100 transfers taking place during 1986/87.

Districts were also asked to make sure that the patients who are <u>not</u> transferred over the next five years do not suffer from a poorer quality of life and, where possible, benefit from improvements.

Capital schemes

Between 1986/87 and 1994/95 a total of 23 hospital building projects, including new facilities for mentally ill patients, will get under way in Blackpool, Blackburn, Bolton, Burnley, Bury, Central Manchester, Chorley and Lancaster.

Community psychiatric nurses

An additional 37 community psychiatric nurses were appointed during 1985/86, strengthening local services designed to help the mentally ill live independent lives in their own homes.

Facts to remember

From the early 1950's the North West has pioneered the development of comprehensive local mental illness services based on District General Hospitals. Over the past ten years or so regional policies have emphasised:

- the desirability of segregating in-patient and day patient provision for those with senile dementia;
- the possibility of rehabilitating and returning to the community a proportion of the severely institutionalised 'long-stay' patients;
- the importance of not admitting patients to the large hospitals from those Districts with their own services.

Significant progress has therefore been made in building up District-based services:

- Acute services are based at 13 out of 21 District General Hospital sites.
- All Districts have a community psychiatric and out-patient service.
- Separate units for the elderly mentally infirm have been established in 17 Districts. Since 1979, 14 new schemes have been implemented with a total of 810 day places and 792 beds.

"The latest initiatives . . ."

37 more community psychiatric nurses appointed in 1985/86.

Mental Health Strategic Targets (1983-93)

- 3,600 more hospital places for the mentally ill, 600,000 more day attendances a year, 470 more community psychiatric nurses, 900 more beds in District General Hospitals and 2,000 fewer beds in large mental illness institutions.

EXPANDING FACILITIES TO HELP DRUG MISUSERS

The North West has been hit hard over recent years by the scourge of drug misuse. Current estimates suggest that up to 5,000 people may be affected, with particular problems in Greater Manchester, Blackburn, Burnley and the Skelmersdale area of West Lancashire.

Developments in 1985/86

Concerted efforts are being made by health authorities to combat this growing menace. New developments in 1985/86 included:

- a total of £342,000 made available to Districts by the Regional Health Authority to develop locally-based **community services** for drug misusers;
- the first intake of students, in September 1985, to a Manchester Polytechnic course on **drug and alcohol dependency nursing**;
- expansion of the **urine screening service** at Hope Hospital, Salford;
- a drug research project established jointly by the Regional Drug Dependence Unit at Prestwich Hospital, Salford, and the University of Manchester to obtain more accurate information on the numbers and types of misusers.

Community drug teams: an expanding role

The larger role being played by community drug teams in each District has been reflected in a drop in referrals to the Regional Drug Dependence Unit, which fell from 435 in 1984 to 236 in 1985.

The teams act as a first point of contact for many misusers, the majority of whom can be treated locally on an out-patient basis. In-patient treatment facilities have also been established in all Districts, so that only the more difficult cases need be referred to RDDU.

Prevention: the key in the long-term

Contrary to a popular misconception, drug misusers are not all 'drop-outs and delinquents' by any means. Many are normal, ordinary people with potential for leading happy and fulfilling lives if they can be helped at the right time. Preventive action is also being taken to try to ensure that youngsters never start experimenting with drugs – a dangerous game that can ultimately destroy themselves and their families.

"Community teams get to work..."

Figure 1: Drug addicts notified to the Home Office (United Kingdom)

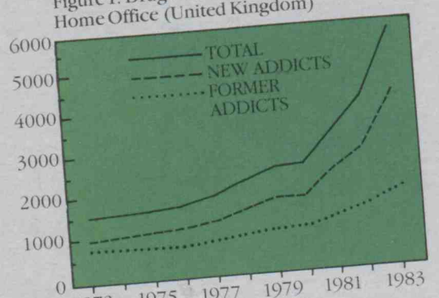
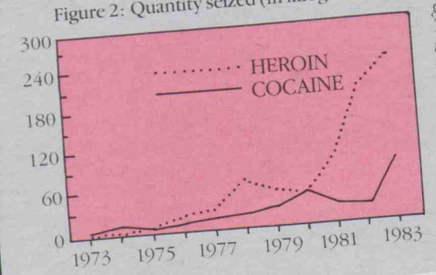
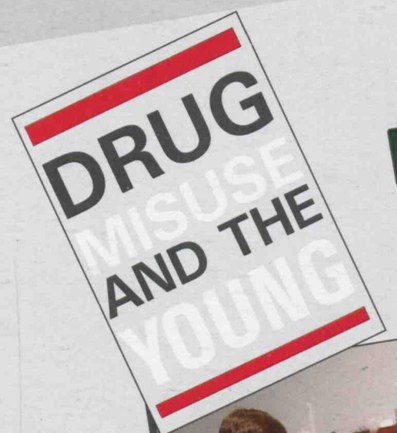


Figure 2: Quantity seized (in kilograms)



Official figures indicate the growth of the drug problem. The actual numbers involved in drug misuse are many times higher.

Source: *Tackling Drug Misuse: a summary of the Government's strategy* – Home Office, March 1985



£1⅓m.

£342,000 available to develop local community services for drug misusers.

Fall in R.D.D.U. referrals from 435 to 236.

Urine screening service expanded at Hope Hospital, Salford.

THE PREVENTIVE APPROACH

With a background of higher than national average numbers of deaths each year from diseases such as cancer and bronchitis, the NHS in the North West must be and is concerned with tackling the root causes. Health authorities, encouraged by the RHA, are increasingly adopting a preventive approach to complement their efforts in improving treatment facilities.

A number of important regionally co-ordinated initiatives took place or got under way during 1985/86. They included:

'Project Smoke-Free'

This three-year smoking prevention programme (announced in last year's annual report) is the most ambitious venture of its kind ever undertaken in the United Kingdom. Its aim is to help reduce the prevalence of cigarette smoking in the North West, where over 7,000 people (one in seven of all deaths) are killed each year from smoking-related diseases.

Supported financially by both the Health Education Council and the Regional Health Authority, the project was launched in September, 1985, and involves four main tasks:

(i) Using the mass media to get the message across that smoking is harmful to health, but that there are many tried and tested ways of giving it up.

(ii) Working with schools to influence children and their families (so that children do not succumb to this addictive habit and parents who smoke are encouraged and helped to give up).

(iii) Working with as many organisations as possible to promote a smoke-free environment in indoor public places (public buildings, shops, cinemas, restaurants, transport, leisure and recreational establishments and so on)

(iv) Working inside the NHS itself by setting an example to the rest of the community (phasing out cigarette sales, extending no-smoking areas in NHS hospitals and other premises and providing help and advice to patients and staff who want to give up).

As Project Smoke Free completes its first twelve months, it can be said to have stimulated considerable interest nationally in pioneering techniques for addressing the smoking problem, including a highly successful 'Smokebuster Club' for school children (now with over 9,000 individual members); the imaginative use of local newspaper advertising offering practical tips on ways of kicking the habit; and the marketing of a non-smoker's 'survival-kit' for those who want to avoid the risks of passive smoking.

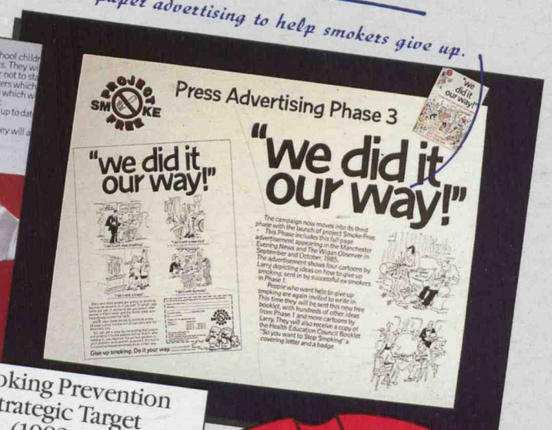
Alcohol Education

The North West has one of the worst alcohol abuse records in the country. Consumption of alcoholic drinks is 25% above the national average and weekly household expenditure, at an average of £7.20, is the highest of any region in England and higher than in Scotland. In 1984, 189 people died of cirrhosis of the liver and the North West leads the list of all regions for admissions to mental illness

"Tackling the root causes of ill-health..."

Already 9000 children have been recruited to the Smokebusters Club.

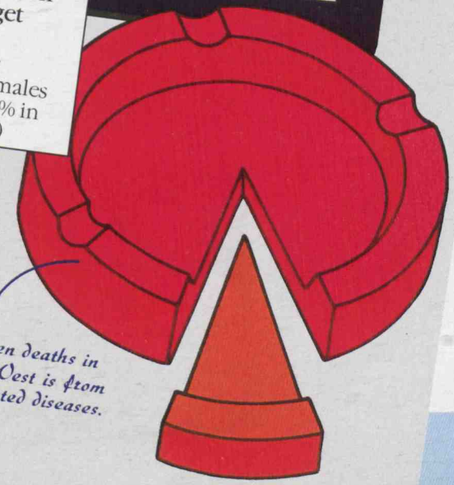
Newspaper advertising to help smokers give up.



Smoking Prevention Strategic Target (1983-93)

* to reduce cigarette smoking to 15% in males (16-74 years) and 13% in females (16-74 years)

One campaign has drawn attention to the dangers of passive smoking.



One in seven deaths in the North West is from smoking related diseases.

hospitals with a primary diagnosis of alcohol dependence.

For all these reasons the RHA has been pleased to collaborate with the Health Education Council and local organisations in planning a three-year alcohol education programme designed to help reverse the worrying trends of the past ten years. Recent months have been spent in working out the initial phases of a major public education campaign to promote the concept of 'sensible drinking' which, in essence, means:

- keeping to a daily limit equivalent to two pints of beer and not drinking every day of the week;
- avoiding alcohol at certain times of the day or in certain situations – at work and when driving a motor vehicle, for example;
- understanding more about alcohol – so that, for example, beer and lager drinkers are not lulled into a sense of false security by some of the popular misconceptions about the relative strengths of a pint of their favourite brew compared with a double of spirits.

Food and Health

In association with Manchester Polytechnic, the Regional Health Authority has initiated a two-year 'Food and Health' project. The aim is to gather information on food topics in the North West and to provide a service to health policy-makers and practitioners by:

(i) putting together the experiences of current policies in action to see what lessons can be learned; and

(ii) helping to make links between the different sectors of the food system and assessing their combined influence on the consumer.

Topics being explored include:

- food manufacture in the region;
- food-related diseases;
- public attitudes to nutrition;
- catering at work;
- food availability, price and purchasing;
- purchasing policies and food costs in the NHS;
- current education policies in schools and colleges on nutrition.

Dental Health

Health authorities in the North West have been addressing the big problem of tooth decay (together with neighbouring Mersey region, we have the worst dental health record in England) and are actively exploring the potential for extending the considerable benefits which fluoridation of water supplies has brought to other parts of the country.

A survey of Manchester and Newcastle five-year olds carried out in July, 1985, revealed the enormous gap between these two industrial cities. At this age, children in non-fluoridated Manchester have two and a half times as much tooth decay as those from fluoridated Newcastle.

Over the past year all nineteen North Western health districts have affirmed their support for the principle of fluoridation. Every family practitioner committee has done likewise. Opinion research has also been undertaken in most parts of the region, with results indicating that an average of 75 per cent of people questioned in representative samples of the population think fluoride should be added to water if it can reduce tooth decay.

A video to promote the benefits of fluoridation has been produced by a North Western regional co-ordinating group in collaboration with the Health Education Council and the British Fluoridation Society. Entitled "Look What You're Missing," it reviews the scientific and medical evidence in favour of this important public health measure.

"Health for All Week": 10th to 14th March, 1985

Public participation was very much the theme of "Health for All Week" in March, 1985, when the three Manchester districts, Manchester City Council, Project Smoke-Free, North West ASH and the Hospital Arts Project pooled their resources to mount a series of exhibitions, special events and live performances on a wide range of health issues in the Arndale shopping centre, including smoking, diet, exercise for the middle aged and the elderly and health care for ethnic minorities.

The aim was for the RHA to work collaboratively with local organisations in priority areas of health promotion, whilst testing out ideas on public participation in the WHO 'Health for All 2000' statement.

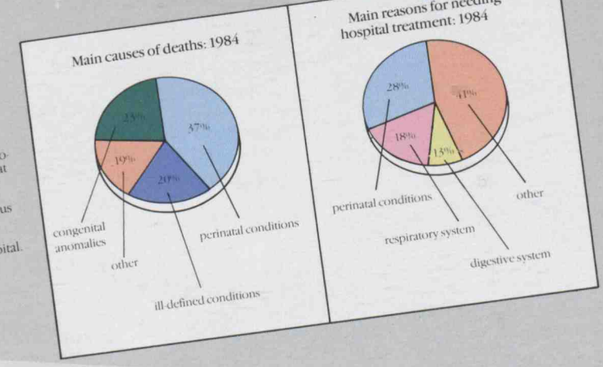
HEALTH IN THE NORTH WEST
Scope for action

As we said in our ten-year strategic plan published last year, we want to help people become healthier so that they can avoid having to become our 'customers' in the first place. We also want to make sure that they can get NHS treatment services when they need them.

The figures on page five of this report show the improvements being made in providing treatment. But what are the main causes of ill health and what is the scope for preventing avoidable diseases and deaths?

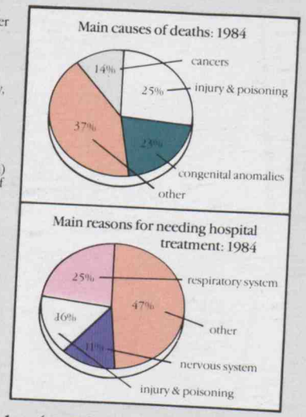
Infants aged under one year

- Congenital anomalies are responsible for nearly one quarter of infant deaths. Some of these are preventable, like chromosomal abnormalities and spina bifida, the incidence of which is declining.
- However, perinatal conditions are still the most important cause of death and a significant cause of infants being admitted to hospital. Many of these conditions are related to low birth weight and are preventable by mothers not smoking, having an adequate diet, cutting out alcohol and receiving early and regular antenatal care.
- Respiratory diseases in infants are higher in children whose parents smoke.
- Diseases of the digestive system include mild gastro-enteritis. We are looking at ways of encouraging the management of these children at home and thus avoiding the social and family disruption of admitting them to hospital.



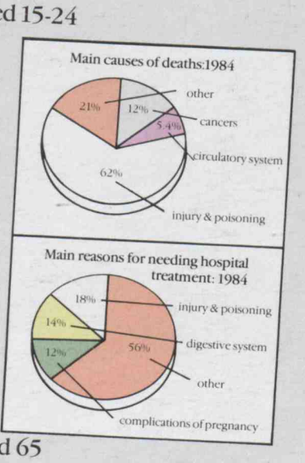
Young children aged 1-4

- Injury and poisoning are responsible for one quarter of the deaths of young children, and for a high proportion of hospital admissions. These are virtually all preventable by, for example, home safety measures and the use of childproof containers of pills and medicines.
- Congenital anomalies and cancers (such as leukaemia) remain significant causes of death and may not be preventable.
- However, a quarter of hospital admissions of young children are due to respiratory diseases, many of which would be preventable if parents did not smoke.



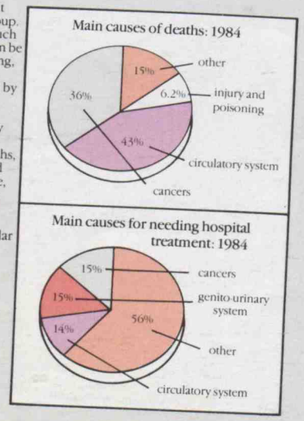
Young adults aged 15-24

- Nearly two thirds of deaths of young adults are due to injury and poisoning.
- Road traffic accidents, particularly involving inexperienced road users, are very much to blame and are often associated with alcohol abuse. Greater emphasis on road safety teaching, coupled with the 'don't drink and drive' message, would help reduce deaths.
- Complications of pregnancy are a significant cause of young women coming into hospital. This is particularly true of teenage mothers. Contraception and better family planning are the most obvious ways of reducing the risks.



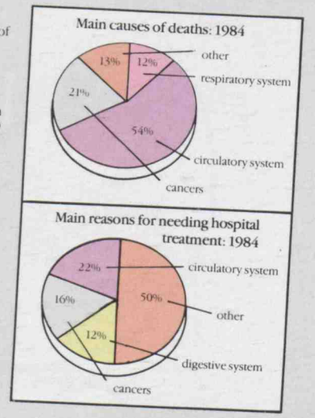
Middle-aged adults 45-54

- Cancers are an important cause of death in this group. Many are preventable, such as lung cancer, which can be prevented by not smoking, and cancer of the cervix, which can be minimised by screening and early detection.
- Diseases of the circulatory system account for the largest proportion of deaths, many of which are caused by ischaemic heart disease, hypertension and strokes. Non-smoking, sensible drinking, a diet low in fat and high in fibre and regular exercise can all help to reduce both deaths and hospital admissions.



Elderly people aged 65 and over

- Over half the deaths in the elderly are due to diseases of the circulatory system. These could be prevented by the same measures applicable to younger age groups.
- In elderly men, deaths from cancer are very often due to cancer of the lung, which should be almost entirely preventable.
- Diseases of the digestive system include peptic ulcers, which can also be prevented by not smoking.



INCREASED DEMANDS ON BLOOD TRANSFUSION SERVICE

Opening of new centre

A new £6.5 million Regional Blood Transfusion Centre was officially opened by HRH The Princess Alexandra on 3rd June, 1985 in Plymouth Grove, Manchester.

Incorporating up-to-date laboratories and sophisticated scientific equipment, the centre has been designed to support a much-needed expansion of blood transfusion services in the North West, particularly in the manufacture of specialised products such as Factor VIII (used in the treatment of haemophiliacs to control bleeding) and in meeting the increased demands of hospitals for blood for complex operations like open-heart surgery.

The purpose-built facility – not far from the famous Manchester Royal Infirmary – has also solved the previous problems arising from BTS staff working in three separate locations in the city.

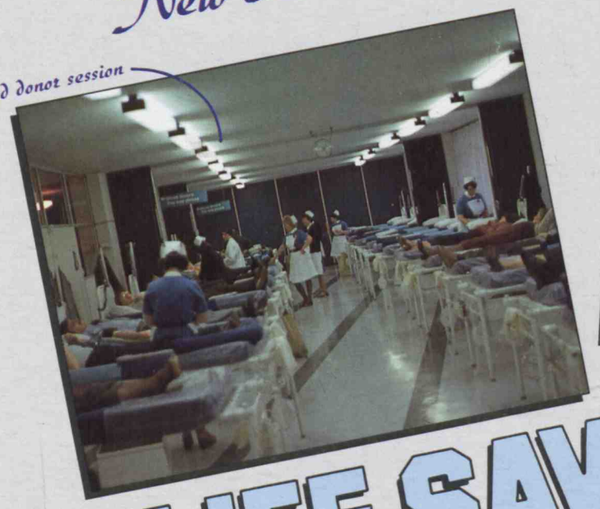
Campaign for new donors

The Royal opening coincided with the start of a campaign known as "LIFESAVER 85" to recruit up to 10,000 new blood donors.

The urgent need for extra recruits was emphasised last winter, when BTS managers had to appeal for the help of the public as stocks fell to low levels and deliveries of blood to hospitals began exceeding collections by around one hundred units a day.

The campaign resulted in a 115% increase in donations in Greater Manchester and a 52% increase in Lancashire.

"New centre and new campaigns . . ."



Blood donor session

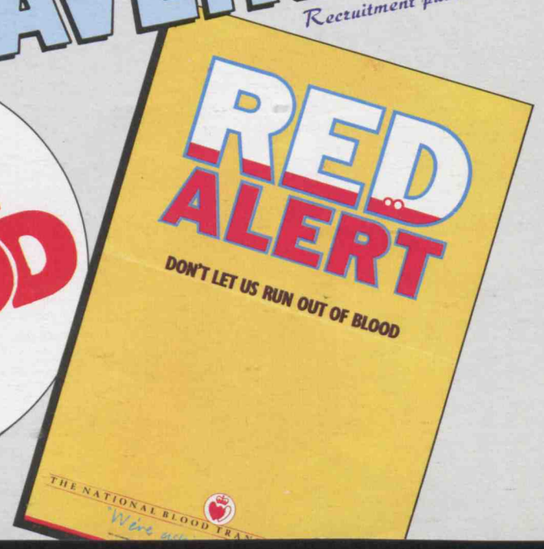
Please
GIVE BLOOD

New donors are constantly needed to help save lives. Please contact either of our two main centres for details:
Greater Manchester
TEL 061-273 7181
Lancashire
TEL: Lancaster
(0524) 63456

"LIFE SAVERS 85"

Recruitment publicity material

GIVE BLOOD



IMPROVING MANAGEMENT EFFICIENCY FOR BETTER PATIENT CARE

Putting the consumer first:

Considerable emphasis has been put during the year on improving and streamlining management systems in order to release resources for re-investment in patient care and to provide a better quality of service to NHS users by cutting out bureaucracy.

Providing more cost-effective services

Maintaining the quality of existing services whilst seeking ways of providing them more 'cost-effectively' where possible has been,and remains,a major objective for health authorities.
Collectively, during the year, they have succeeded in releasing a total of £10.5 million which can be re-invested in future priority areas of health care. A further £3.1 million was also saved on a one-year basis only.

Such 'cost improvements' have arisen from a wide range of measures including competitive tendering for 'hotel services,' implementation of Rayner scrutiny recommendations, energy-saving and rationalisation of services.

The RHA headquarters has itself contributed directly to the creation of this investment pool, with cost improvements of some £750,000 resulting from a slimming down of its own workforce, higher efficiency and the implementation of a regional supplies and stores policy to get maximum return from the purchasing power of the NHS across the region.

Higher efficiency

Progress was made in implementing plans to computerise patient and staff records in the region and generally to improve the efficiency of services through the use of high technology.
The overall strategy, which will see a total of £11 million invested by the end of the current year, is designed to:

- streamline and speed up procedures for retrieving vital clinical information about patient care;
- enable managers to make better use of the 74,000 NHS staff employed in the North West;
- control the use of drugs more effectively; and
- provide better stock control.

Speeding up administration and enhancing the quality of service

Rochdale was the first of the nineteen districts to introduce a fully computerised medical records system for hospital and clinic patients. By November, 1985, a total of 283,000 individual records had been transferred from the previous manual system on to a master index accessible through terminals at Rochdale Infirmary and Birch Hill Hospital.

Target date for completing the installation of the new patient administration system is June, 1987, by which time some nine million records in over one hundred hospitals will have been put on to computers. When fully operational, the system will help staff responsible for patient care to obtain up-to-the-minute details of individuals' medical histories, reducing both the time involved and the potential for mistakes.

In this way health authorities in the North West will be making full use of modern technology in their bid to use existing resources to maximum effect and enhance the quality of service provided to the consumer.

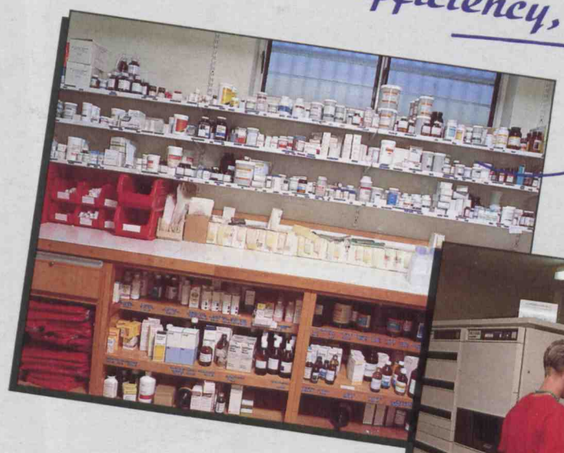
Reducing bureaucracy and cutting costs

Running almost in tandem has been the implementation of a £5 million 'integrated personnel system' to give managers more comprehensive and more accurate information about their staff. Trafford was the pilot district for this scheme, with the remainder of the region having now also received the new computer-based package.

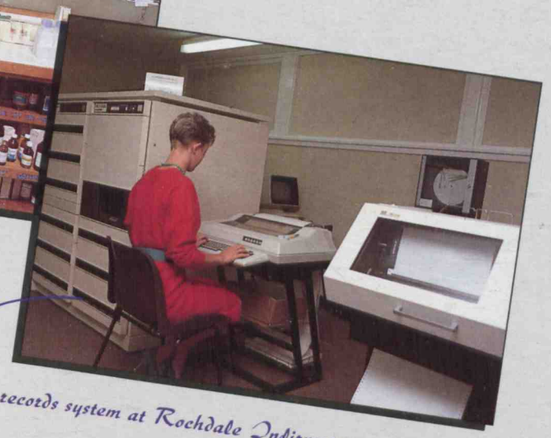
In addition to manpower planning – making sure the right staff are in the right places to provide an appropriate level of service – the system is capable of offering better information on general stock expenditure trends, essential supplies in stock and the costing of drugs and pharmaceutical items.

The end result will, it is intended, reduce unnecessary bureaucracy in record-keeping and make sure that the cost of management and support services is kept to an absolute minimum.

"Computerised efficiency, better control . . ."



New technology is helping to improve the control of drug usage.



Computerised medical records system at Rochdale Infirmary

SPOTLIGHT ON THE DISTRICTS

This section of the report looks at a few key developments in each of the nineteen District Health Authorities in the region. Necessarily – in a report about the Health Service in the whole of the North West – it is only possible to give a brief glimpse of the achievements recorded in any one district.

More detailed information may be obtained by writing to the District General Manager concerned.

1. Lancaster

LANCASTER
- additional community places established for mentally ill and mentally handicapped people being resettled from Lancaster Moor Hospital and the Royal Albert Hospital;
- other developments: a 20-place mental illness day hospital in the city centre and a 48-bed unit with day places for elderly and ESMI patients at Queen Victoria Hospital, Morecambe.
- appointment of an additional consultant paediatrician specialising in neonatal care;
- ophthalmic laser for treatment of disorders of the retina – of particular benefit in maintaining the sight of the elderly and diabetics.

2. Blackpool, Wyre and Fylde

BLACKPOOL, WYRE AND FYLDE
- new community places for mentally handicapped people at Fleetwood and Rossall;
- consultant child psychiatrist appointed to develop home service;
- good progress on Fairhaven nursing home project – with benefits to elderly patients needing long-term continuous care;
- ESMI unit at Fleetwood completed.

3. Blackburn, Hyndburn and Ribble Valley

BLACKBURN, HYNDBURN AND RIBBLE VALLEY
- multi-disciplinary community drugs team established to provide treatment and education;
- purpose-designed dental unit completed at a cost of £300,000;
- phase one of Queen's Park Hospital in progress, together with Roman Road Health Centre.

4. Burnley, Pendle and Rossendale

BURNLEY, PENDLE AND ROSSENDALE
- 20 Calderstones mentally handicapped residents resettled into the community as part of a 'partnership scheme' between the health authority and local authority housing and social services departments;
- doubling of available day places for pre- school children with mental handicaps at the Warner Street Clinic at Haslingden.

5. Preston

PRESTON
- new obstetric and gynaecology facilities opened on Sharoe Green Hospital site after £2 million upgrading scheme;
- £1½ million unit to house scanner and haemodialysis facilities for kidney patients opened at Royal Preston Hospital;
- extension to Royal Preston Hospital acute psychiatric unit completed.

6. Chorley and South Ribble

CHORLEY AND SOUTH RIBBLE
- an innovative 25-bed mental health unit established providing 'round the clock' support and advice for clients and families;
- expansion of community psychiatric nursing service, with patients visited having doubled from 620 in 1984 to over 1,250 in 1985.

7. West Lancashire

WEST LANCASHIRE
- a second community home for the mentally handicapped opened in Skelmersdale;
- community drug team established;
- throughput of in-patients and day cases up by 12% (and by 80% for ENT patients);
- £450,000 refurbishment and upgrading of pathology laboratories at Ormskirk and District General Hospital and Wrightington Hospital.

8. Wigan

WIGAN
- new community places created for the mentally handicapped in Leigh as part of a 'core and cluster' scheme;
- sixty ESMI in-patient beds and eighty day places created at Leigh Infirmary;
- 12-bed unit for younger chronic sick opened at Astley Hospital on 30th September, 1985;
- phase one of the Royal Albert Edward Infirmary redevelopment completed, with 112 adult acute beds and three major operating theatres.

9. Bolton

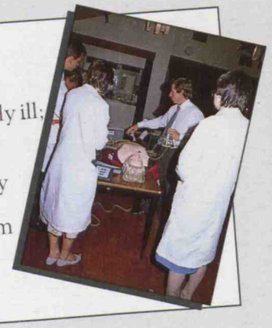
BOLTON
- a 96-bed geriatric ward opened at Bolton General Hospital;
- a 24-place geriatric day unit opened at Hulton Hospital in May, 1985;
- a 56-bed ESMI unit with 50 geriatric day places opened at Bolton General Hospital and a 40-place ESMI day unit at Fall Birch Hospital;
- 25 extra community nurses and health visitors appointed;
- 25 mentally handicapped people resettled during the year as part of the Bolton 'neighbourhood network scheme' and a further 50 patients assessed;
- Asian mother and baby campaign launched and additional ultra- sound department opened in maternity unit;
- new consultants appointed in anaesthetics, geriatrics and radiology.

10. Bury

BURY
- 80-place mental illness day unit opened in April, 1986;
- local authority adult training centre for the mentally handicapped extended through 'joint funding' to care for those with additional special needs;
- fully automated boiler house commissioned at Fairfield General Hospital to meet energy and incineration needs of planned developments.

11. Rochdale

ROCHDALE
- 30 extra community places for the mentally ill;
- opening of ESMI unit with 56 beds and 50 day places;
- patient satisfaction survey of gynaecology services undertaken;
- fully-equipped resuscitation training room established at Birch Hill Hospital.



12. Oldham

OLDHAM
- work started in April, 1986, on new £2 million hospital sterilising and disinfection unit at Oldham and District General Hospital;
- savings of £479,000 achieved through competitive tendering on catering and other services, revision of bonus schemes and other efficiency measures.

13. Tameside and Glossop

TAMESIDE AND GLOSSOP
- start of £700,000 improvement and extension programme to local clinics;
- 12 mentally handicapped patients transferred from long stay hospitals to the community;
- extra orthopaedic theatre sessions started on Saturdays to reduce waiting lists;
- accident and emergency consultant appointed.

14. Stockport

STOCKPORT
- completion of a £400,000 day case unit at Stepping Hill Hospital which, by June 1986, was treating about 260 patients a month.

15. North Manchester

NORTH MANCHESTER
- an ESMI day unit opened on 13th November, 1985;
- new out-patient department at Booth Hall Children's Hospital;
- new geriatric ward at Monsall Hospital and introduction of a 'shared care' ward for elderly orthopaedic patients at Ancoats Hospital;
- ultra-sound scanner (purchased by public donations) brought into use by HRH Duke of Gloucester on 11th March, 1986.

16. Central Manchester

CENTRAL MANCHESTER
- Ross Place opened as a day resource centre for mentally handicapped young adults;
- Rawnsley Building opened on Central Manchester Hospital site with 50-day places and out-patient facilities;
- estimated annual savings of £250,000 from competitive tendering for catering, cleaning and other 'hotel' services;
- dispensing optician's shop opened at the Royal Eye Hospital as one of a series of income-generating initiatives.

17. South Manchester

SOUTH MANCHESTER
- drug misuse team established jointly with social services and education departments in Wythenshawe;
- short-term residential accommodation opened in Northenden for mentally handicapped adolescents and young adults;
- facilities transferred to new paediatric unit at Withington Hospital from Duchess of York Hospital.

18. Salford

SALFORD

- Kendal day unit opened at Prestwich Hospital, providing 50 places for elderly patients with mental infirmities;
- an additional 16 community places established for mentally ill residents in long-stay institutions;
- completion of £¾ million scheme to upgrade kitchen and restaurant at Ladywell Hospital.

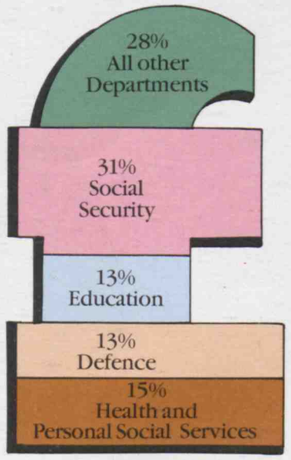
19. Trafford

TRAFFORD
- 22-bed acute ward opened at Park Hospital for day cases and 'five-day' cases;
- new 96-bed geriatric unit and rehabilitation department brought into full use in May, 1986;
- ESMI facilities increased by the opening of a 24-bed ward at Bridgewater Hospital.

FINANCIAL COMMENTARY

The vast majority of funds used by the National Health Service are generated through taxation and are voted on each year by Parliament. The NHS competes with other government departments for funding as the following diagram illustrates:

% allocation of funds to Government Departments, 1985/6



Funds for the NHS are allocated by the DHSS over the 14 English Regional Health Authorities by use of a formula. The formula reflects various criteria, examples being the number of people living within each Region, their demographic characteristics (age structure, percentages of men and women, mortality, etc) and the treatment within a Region of people living outside its boundary.

The North Western Regional Health Authority received initial allocations in 1985-86 totalling £920m (£850m revenue, £70m capital) which, as the year progressed, were subject to relatively minor amendments. These allocations included growth of 1% above allowances for pay and price increases. The table shows how this allocation compares with those of other Regions.

Region	Total Allocation £m	%
Northern	656	7
Yorkshire	746	7
Trent	910	9
East Anglian	377	4
North West Thames	755	8
North East Thames	952	10
South East Thames	839	8
South West Thames	642	6
Wessex	565	6
Oxford	422	4
South Western	657	7
West Midlands	1047	10
Mersey	534	5
North Western	920	9
	10022	100

The RHA reallocated these funds to Districts by taking as a starting point the previous year's allocations and adjusting them up or down to reflect agreed changes in the level or range of services to be provided.

As part of the continuing drive for improved efficiency, Cost Improvement Programmes were established which achieved savings in all Districts and resources of £13.6m were released.

These savings were re-invested into priority areas of the Service. Overall, the service levels were maintained or increased as demonstrated in the other sections of this Report.

The financial out-turn for the year showed an underspending of £0.2m, representing an underspend on revenue of £6.4m and an overspend on capital of £6.2m.

The position reflects decisions taken by the RHA during the year to divert resources into much needed capital schemes.

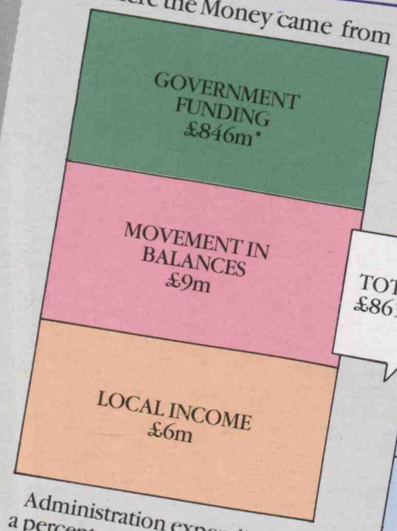
This is a recognition of the importance of these schemes to achieving the RHA strategic aim of providing growth in the volume of patient care services while ensuring equality of access throughout the Region.

REVENUE EXPENDITURE 1985/86

£861 million was spent on running health services in the North Western Region in 1985/86 compared with £814 million in the previous year, an increase of 5.7%.

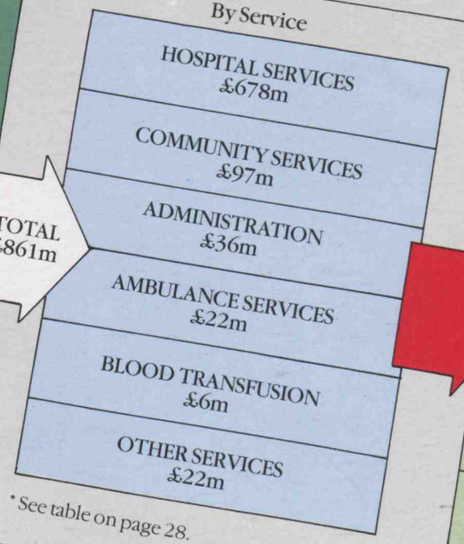
"How much it costs to run the NHS in the North West..."

Where the Money came from

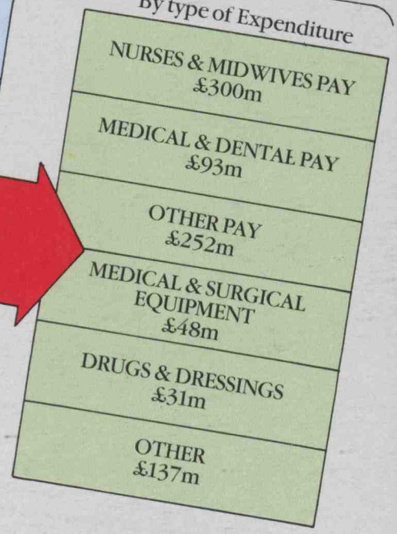


Where the money was spent

By Service

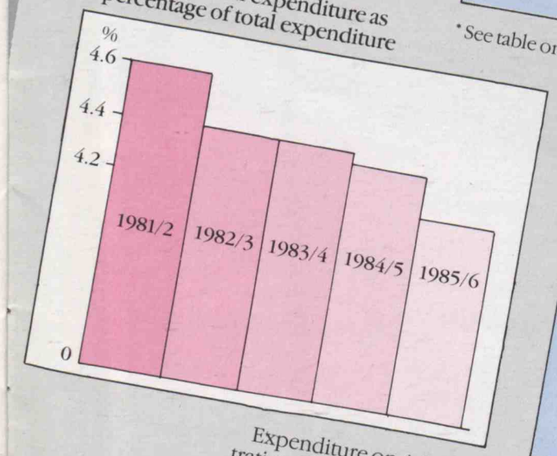


By type of Expenditure



* See table on page 28.

Administration expenditure as a percentage of total expenditure



Expenditure on Administration has been falling steadily as a proportion of total expenditure in recent years and now represents only 4.2 per cent of expenditure, making the NHS one of the most cost-effective health care systems in the Western world in terms of the proportion of expenditure on direct patient care.

How do these expenditures compare?

	1985/6 Expend. £m	With Last Year: 1984/5 Expend. £m	With Last Year: Change %	And With 4 Years Ago: 1981/2 Expend £m	And With 4 Years Ago: Change %
Hospitals	678	644	5.1	543	24.8
Community	97	89	8.9	70	39.2
Administration	36	36	0.2	31	15.4
Other*	22	19	15.9	13	67.8
Blood transfusion	6	5	18.7	4	43.8
Ambulance	22	21	4.3	19	18.1
	861	814	5.7	680	26.6

*'Other' includes Contractual Hospitals, Joint Finance, Occupational Health, Research and Development etc.

How much was spent by each district? District Health Authorities are responsible for managing local hospital and community health services. The Regional Health Authority is responsible for strategic planning, resource allocation, management of the Blood Transfusion and Greater Manchester Metropolitan Ambulance Services and a number of centralised professional support services.

This table shows which health authority spent what:

Total spending by health authorities in the North West

Health Authority	Hospitals £m	Community Health £m	Administration & Support Services £m	Other £m	Total 1985/86 £m	Total 1984/85 £m
Lancaster	35.8	3.2	1.2	0.4	40.6	39.5
Blackpool	38.9	7.8	1.3	0.8	48.8	45.2
Preston	47.4	4.4	1.7	3.9	57.4	54.6
Blackburn	46.2	6.8	1.3	0.1	54.4	51.7
Burnley	41.6	5.5	1.2	0.4	48.7	45.6
West Lancashire	18.0	2.6	0.8	0.1	21.5	21.5
Chorley	7.6	4.0	0.7	0.9	13.2	12.4
Bolton	30.2	6.0	1.4	1.1	38.7	36.7
Bury	17.3	3.5	0.8	0.4	22.0	21.5
North Manchester	47.0	4.3	1.4	1.8	54.5	52.4
Central Manchester	53.6	4.1	1.4	0.8	59.9	55.6
South Manchester	73.1	4.2	2.2	1.4	80.9	76.9
Oldham	24.1	5.8	1.2	0.4	31.5	29.4
Rochdale	20.3	5.2	1.1	0.6	27.2	25.7
Salford	64.8	5.6	1.9	1.2	73.5	68.9
Stockport	35.9	5.9	1.1	0.7	43.6	42.8
Tameside	22.3	5.1	1.1	0.6	29.1	28.0
Trafford	19.9	5.3	1.2	0.6	27.0	25.8
Wigan	33.6	6.7	1.4	0.6	42.3	40.2
North Western R.H.A.	–	0.4	11.3	5.3	17.0*	13.3
	677.6	96.4	35.7	22.1	831.8	787.7
			Ambulance Services		22.4	21.5
			Blood Transfusion Service		6.3	5.3
			TOTAL		860.5	814.5

*Included within the £17m is £3m expenditure resulting from the transfer of the supplies function from Districts to the RHA.

How much it costs to treat each patient.
This table shows how much it cost the Region to treat each patient in 1985/86.

Hospital Type	IN PATIENTS COST PER DAY £	IN PATIENTS COST PER CASE £	OUT PAT'S COST PER ATT. £	A & E COST PER ATT. £
Acute–over 100 beds	91	660	25	17
Acute–51-100 beds	91	629	25	17
Acute–under 50 beds	72	655	18	7
Mainly Acute	75	714	21	18
Partly Acute	68	771	23	17
Mainly Long Stay	42	–	145	–
Long Stay	37	–	23	–
Geriatric	39	–	14	–
Pre-Convalescent	40	951	–	–
Maternity	85	336	–	–
Mental Illness	41	–	44	–
Mental Handicap	36	–	36	–
Orthopaedic	86	–	21	14
Children's	132	676	36	22
Eye	95	449	16	10
Other	77	–	19	11

Has the level of balances changed? This table shows the movement between 1984/85 and 1985/86 of the balances held. These represent the monies owed to or by the Health Authorities within the Region and their stock holdings.

	1985/6 £'000	1984/5 £'000	Movements £'000
Balances Held (Assets)			
DHSS	23,007	11,215	+11,792
Stocks	18,622	19,911	–1,289
Debtors	25,551	25,930	–379
	67,180	57,056	+10,124
Money Owed (Liabilities)			
Creditors	62,905	55,125	+7,780
Cash overdrawn	4,275	1,931	+2,344
	67,180	57,056	+10,124

What were the sources of local income?

Revenue	£m
From Patients for supply of drugs and appliances	0.5
From Private Patients	3.8
Charges for Road Traffic Accidents	0.6
Other	0.7
Capital	5.6
Sale of land and buildings	2.7
Other	0.1
	2.8
Total Income	8.4

Trust Funds

Health Authorities are empowered by Acts of Parliament to accept, hold and adminster property on trust for any purpose relating to health services. As such gifts, donations and legacies are accepted and used for the provision of services and amenities for patients and staff. The accounts are shown below:

	Income and Expenditure 1985/86 £000's	1984/85 £000's
Income		
Subscriptions and donations	4,540	3,340
Legacies	1,621	1,521
Dividends	1,257	1,767
	7,418	6,628
Expenditure		
Welfare and Amenities	1,807	1,450
Research	1,969	1,427
Contributions to Capital	1,173	1,032
Other Expenditure	2,089	1,461
	7,038	5,370
Surplus for year	380	1,258

	Balance Sheet March 86 £000's	March 85 £000's
Accumulated Fund	1,151	739
Capital in Perpetuity	19,600	16,989
Other Funds	20,751	17,728
Represented by:		
Investments	18,287	16,144
Stocks	28	62
Debtors	1,433	1,409
Cash	2,899	1,134
Creditors	1,896	1,021
	20,751	17,728

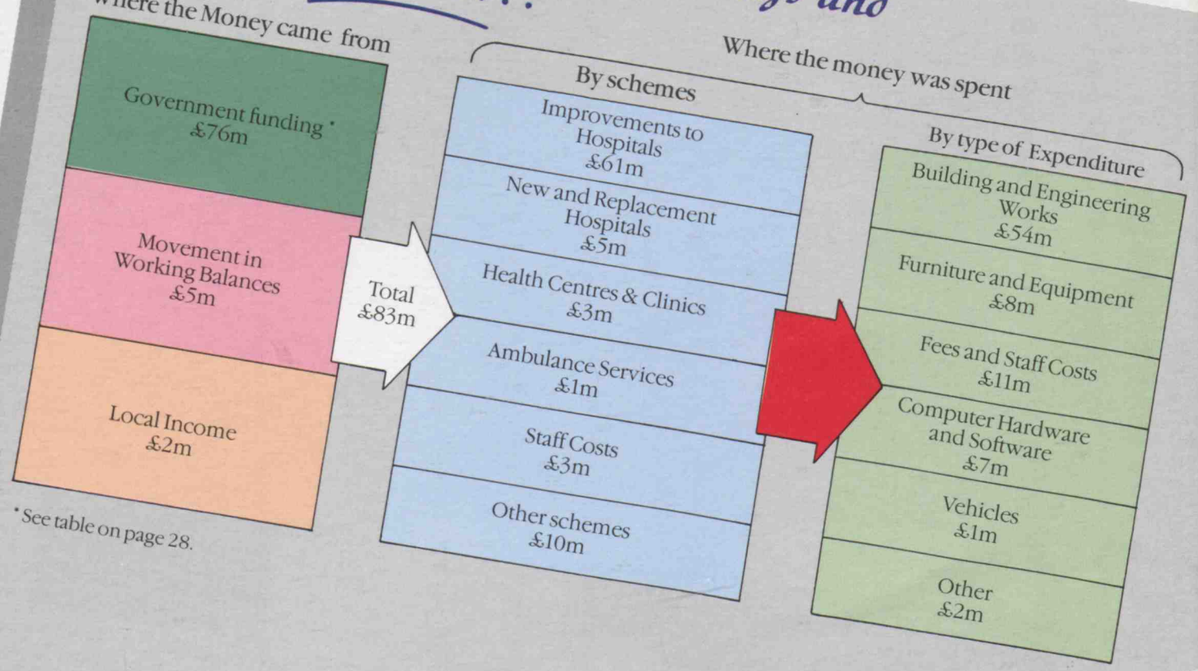
CAPITAL EXPENDITURE 1985/86

Overall spending by the RHA and Districts

Over £83 million was spent in 1985/86 on building new hospitals, health centres and clinics; adapting and improving existing facilities; and major purchases of equipment.

Out of £83 million, £66 million was spent on new and replacement hospitals and improvements to existing hospitals.

"How much was spent on buildings and major expenditure . . ."



* See table on page 28.

How much was spent in each District?

In this table the £83m is analysed by District between expenditure incurred by the RHA on major developments (£56m), and by the Districts (£27m) themselves on their own smaller schemes.

The RHA expenditure provides facilities which are used and managed by Districts. In addition, some services are managed directly by the RHA itself, e.g., blood transfusion, ambulance service and central computer developments.

District	Expenditure By District £'000s	Expenditure By RHA £000's	Total Expenditure in District £000's
Lancaster	1,104	1,228	2,332
Blackpool	1,990	4,836	6,826
Preston	3,675	1,288	4,963
Blackburn	911	2,707	3,618
Burnley	1,196	5,496	6,692
West Lancashire	445	990	1,435
Chorley	412	35	447
Bolton	882	1,891	2,773
Bury	592	3,515	4,107
North Manchester	2,135	1,409	3,544
Central Manchester	2,613	1,501	4,114
South Manchester	2,845	2,494	5,339
Oldham	1,351	4,037	5,388
Rochdale	576	1,422	1,998
Salford	1,566	1,303	2,869
Stockport	1,473	220	1,693
Tameside	736	6,981	7,717
Trafford	1,179	1,387	2,566
Wigan	1,350	2,596	3,946
RHA	–	10,821	10,821
TOTAL	27,031	56,157	83,188

ACCOUNTING PRINCIPLES

1. General Note
The accounts have been prepared in accordance with the published Standard Accounting Practices for the NHS approved by the Secretary of State. The revenue and capital accounts are prepared on an income and expenditure basis, but there are certain departures from the normal "accruals" concept:

(a) The main source of funding for health authorities, cash advances from the Department of Health and Social Security within an approved cash limit for hospital and community health services, is not recorded in the accounts on an accruals basis. The accounts show expenditure net of direct credits.

(b) The accounts record the annual capital expenditure and income: there is no record in the balance sheet of capital assets, nor is there any provision for the depreciation of such assets in the revenue accounts.

2. Cash Limit
The accounts of health authorities are subject to cash limit controls. A cash limit is a pre-determined limit on the spending (in cash terms) of health authorities. Each Health Authority is required to contain its net revenue/capital outgoings in the year within the approved cash limit.

(a) The DHSS issues cash limits formally to Regional Health Authorities (RHAs) who, in turn, issue cash limits to individual District Health Authorities. RHAs may make local arrangements with individual Health Authorities regarding transfers between revenue and capital allocations and the carry forward of underspendings on the cash limits.

(b) A statement of the net over/underspending of the North Western Region against the approved cash limits for the year ended 31st March, 1986 is set out below:

	Revenue £'000	Capital £'000
Cash Limit	852,568	69,511
Charge against Cash Limit	846,141	75,770
Over/Underspending	−6,427	+6,259

3. Accounting Policies
The accounting policies followed for dealing with items which are judged material or critical in determining the correctness of the accounts and in stating the financial position are:-

(a) Stocks
Computerised stocks have been valued at average cost, other stocks on a First In First Out basis.

(b) Debtors and Creditors:-
Debtors and Creditors have been assessed on the basis of goods and services supplied or received on or before 31st March, 1986 for which payment had not been received or made by that date.

(c) Losses, Compensation and Legal Costs:-
These items are generally charged to the relevant functional headings.
(i) Stocks and cash losses are written off to revenue in the year they are incurred at cost.
(ii) Bad debts written off have been adjusted against the income.
(iii) Other losses and compensation payments and legal costs are charged to revenue at cost when determined.
(iv) Included are certain losses which would have been made good through insurance cover had the Health Authority not been bearing its own risks. In that case the insurance premiums would have been included as normal revenue expenditure.

(d) Capital Expenditure:-
The following expenditure has been classified as capital expenditure:-
(i) Acquisition of land premises;
(ii) Individual works schemes costing £15,000 or more;
(iii) Complete individual items of medical, dental or computer equipment costing £7,500 or more (before deduction of any sum obtained for a replaced item);
(iv) All purchases of vehicles;
(v) Pay and directly related expenses of works officers and the staff of their departments who are fully or mainly engaged on spending charged to capital.

4. Prior Year Adjustments
Statement of Balances
Balances brought forward from 1984/85 have, in accordance with Standard Accounting Practices for the NHS, have been shown exactly as the closing balances recorded in the annual accounts for that year.

5. Auditors' Certificate.
These Accounts are subject to audit.

A DECADE OF CHANGE

The Health Service has seen great changes in the first half of the 1980s. Health authorities have gone through a major reorganisation, new style management has been introduced and the way we provide for certain patient groups has altered considerably.

But while the Health Service might change, the people within it do not. There is still the same degree of skill and dedication as there ever was.

Doctors, nurses, ambulancemen, technicians, caterers, porters, administrators and many more besides have all played their part in maintaining and improving the quality of care.

And we must remember those who give their time freely: Regional and District Health Authority members take the decisions that guide the NHS along its course and make it responsive to the needs of the people it serves. Community Health Council Members seek also to ensure that full account is taken of the consumer's point of view.

I hope our report has succeeded in giving you an insight into the continuing progress being made by the North Western health service. Looking into the future, the signs are good. Half way through our decade of change, we have made great strides, enough to face the coming challenges with confidence.

Gordon Greenshields
Regional General Manager

Membership of the Regional Health Authority during the financial year 1985/86.

Sir John Page, O.B.E. Chairman
Mr. M.A. Brennan, M.B.,Ch.B.,F.R.C.S.Eng
County Councillor Mrs. M.P. Case, B.A.,B.A.(Econ)
Dr. S.S. Chatterjee, O.B.E.,J.P.,F.R.C.P.,F.R.C.R.E.,F.C.C.P. (U.S.A.)
Mrs. E. Garvey
Professor I.E. Gillespie, M.D.(Glas),M.Sc.,F.R.C.S.
Mrs. C.M. Harrison,J.P.
Mr. R.E. Hodd, C.B.E.,B.Sc.,Dip.Ed.,Barrister at Law (Vice Chairman)
Councillor K. Hornby
Dr. S.A.P. Jenkins M.B.,Ch.B.,F.R.C.G.P.
Councillor J.B. Leck,J.P.,A.I.H.,F.B.I.M.
Councillor G. Macdonald,J.P.,D.L.
Miss H.M. Miller, B.A.,R.G.N.,S.C.M.,M.T.D.,DN(Lond) Q.N.
Mrs. G. Oates, S.R.N.,C.N.B.,D.M.S.,F.B.I.M.
Councillor Mrs. S.D. Oldham,J.P.
Mr. R.T. Parkinson, B.Sc.Tech,A.H.C.T. (Vice Chairman)
Mr. K.M.A. Walker
Mr. G.R. Ward, M.A.(Cantab).,F.C.A.

Note: Since then, Mr.M.A. Brennan, Dr. S.S. Chatterjee, Professor I.E. Gillespie, Councillor K. Hornby, Mrs. G. Oates, Councillor Mrs. S.D. Oldham, Mr. R.T. Parkinson, and Mr. K.M.A. Walker have ceased to be Members. With effect from 1st October, 1986, the Membership of the Authority now includes Dr. A.K. Banerjee, M.B.B.S., F.R.C.P., Councillor N.W. Barrett, B.Com.,F.C.A., F.I.D.,M.I.P., Mr. C.L. Davies, B.Jur., Mrs. A. Fishwick, Ll.M.DL., Professor L.A. Turnberg, M.D.,F.R.C.P., and Mr. K.R. Wade.

Notes

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From THE CHAIRMAN: BRYAN ASKEW

Ref: BA/MJC/KML

29 September 1986

R30

The Right Honourable Margaret Thatcher MP
Prime Minister
10 Downing Street
London
SW1 2AA

4

Dear Prime Minister,

Many thanks indeed for an excellent dinner last Thursday. It was a great pleasure and privilege and I was particularly pleased by your introductory remarks about the hip replacement activity in the York District.

I am delighted to pass on to Mr De Boer how pleased you are with his efforts. We can use him as an example throughout the Region.

Yours sincerely,

Bryan

SUBJECT cc MASTER

10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

26 September 1986

Dear Tony,

DINNER WITH REGIONAL HEALTH AUTHORITY CHAIRMEN

The Prime Minister yesterday held a dinner for Regional Health Authority Chairmen. The guestlist is attached. The tone of the discussion was relaxed and positive.

Having welcomed the Chairmen, the Prime Minister said the objective must be to achieve the best possible service to patients. The achievements of the NHS were often too little recognised. Surveys showed that most people were very satisfied with the service they received. Nevertheless, it was clear that sometimes the NHS was failing to make the best possible use of resources. It was important that the NHS should be defended in public by the Regional Chairmen and others against criticism which was often unjustified.

Better service for the patient, including the problem of waiting lists

Introducing the discussion, Mr. R. D. Wilson, Chairman of the Mersey Health Authority, recognised that the problem of waiting lists had to be tackled with great energy. Some progress was being made by weeding out people who should not properly be on the lists. Beyond that, there was a need to provide people with a choice, and some authorities were investigating how to provide opportunities for patients to move between districts. Some districts were now opening on Saturday mornings and more was being done by means of out-patient treatments. It was also worth noting that not all waiting lists for particular operations represented serious problems. (The waiting list for plastic surgery to remove tattoos was mentioned later as an example.) More generally, a greater effort was being made to improve service to patients and help had been sought from companies including British Airways and Trust House Forte. A huge training effort was needed. There was a tendency for people to blame the Health Service, even when changes were being made which would lead to improvements, for example, the closure of old facilities as new ones were opened. But there was also criticism from within the Health Service, particularly from specialised groups, which did untold harm when it became public.

In discussion it was suggested that a particular concern was the delay between a GP referral and an appointment with a

consultant. This was a time of great anxiety and delay should be reduced as much as possible. There was a need to inform GPs about the different waiting periods in different areas, through GPs themselves often had direct links with particular consultants. It would be worth considering whether to make information about waiting lists more widely available to the public. The information need not be confined to particular districts or even regions: the NHS was a national service. It would be important that when patients were transferred between areas, the area providing the operation should receive proper payment. This would, among other things, allow the NHS more easily to buy service from private facilities. It was suggested that GPs maintained their own informal waiting lists. The more waiting lists in hospitals were reduced, the more people would be put forward by GPs. This could however be seen as a counsel of despair. Finally, it was noted that public criticism voiced from within the NHS often came from specialised consultants who might well have been refused resources by a peer group review. It was important to try to give them a wider perspective on their position.

It was agreed that all concerned should make every effort to rebut unjustified criticism of the NHS. People should, where necessary, be encouraged to take courses in how to handle relations with the media.

Improving management and efficiency

Sir Gordon Roberts, Oxford Health Authority, drew attention to the progress which had been made through the introduction of fixed term contracts and performance-related pay. Cost-improvement programmes were already releasing £150 million a year. However, progress was unlikely to continue at the rate of the past few years. There was still great scope for more contracting out. The analogy of the car industry with its many suppliers showed what might be possible. Contracts had themselves to be properly managed and NHS managers needed to improve their ability both to do this and to manage their staff. Management had overall improved immeasurably in the past five years.

In discussion, it was recognised that efficiency sometimes meant closing down small units. These should be offered to the local community to be run as charities. They could, in turn, sometimes provide useful back-up for the NHS.

Personnel and manpower

Mr. J. G. Ackers, West Midlands Health Authority, pointed out that the NHS now each year redeployed 1.4 percent of its staff. The scope for cutting manpower was limited: in many cases the people were the service.

It was noted in discussion that the NHS had made considerable strides in changing the composition of its employees. There was a need now to give people a greater sense of achievement.

Capital programme and estate management

Sir Peter Baldwin, South-East Thames Health Authority, drew attention to the importance to the NHS of sales of land and buildings. But arrangements had to be made for the NHS to move to a different site before existing sites could be sold. This called for skill in marshalling resources. The past few years had been relatively easy because individual sales had tended to be small, for example, residential property. They would now tend to be lumpier. The NHS would need to employ private consultants and to improve its own ability to manage such sales. Sir Peter also noted that maintenance had tended to be starved of funds in the past few years. There were still substantial gains to be made, for example, by action to improve fuel economy.

Hospital equipment and exports

The Prime Minister pointed to the need for greater standardisation of equipment ordering if the UK was to fulfil its potential for winning exports. Sir Michael Carlisle, Trent Health Authority, agreed that there was a huge opportunity for improvement. Information about equipment usage would be a tremendous help in deciding which areas to target. (The need for better information to be available to managers was in fact a theme throughout the discussion.) Proposals were in hand which would allow better prediction of capital needs. The management of NHS capital assets was "dreadful" and better plans for replacement were needed. Better management of smaller items was also a priority and a number of regions had opened new distribution centres. Standards were being reviewed. It would help if Government departments were to put pressure on European Community partners in this area. The quality of staff in purchasing was a major limitation which would need to be tackled.

In a discussion of the redistribution of resources brought about by RAWP, it was suggested that areas receiving resources showed little gratitude, while areas losing resources were loud in their complaints. On the other hand, many of the Regional Chairmen present agreed that RAWP had brought substantial benefits and should be continued. (Sir Peter Baldwin, however, while praising RAWP suggested that it was coming towards its end.)

The Prime Minister thanked the Regional Chairmen most warmly for the discussion.

Yours,

David

(DAVID NORGROVE)

Tony Laurance, Esq.,
Department of Health and Social Security.

MR. NORGROVE

Dinner for Regional Health Authority Chairmen on Thursday, 25 September

I attach the list of guests attending the dinner tomorrow evening for the Regional Health Authority Chairmen tomorrow evening together with a draft seating plan.

Sue Goodchild

24 September 1986

cc Mr. Nigel Wicks
Professor Brian Griffiths

28 guests

LIST OF GUESTS ATTENDING THE DINNER TO BE GIVEN BY THE PRIME MINISTER FOR REGIONAL HEALTH AUTHORITY CHAIRMEN ON THURSDAY 25 SEPTEMBER 1986 AT 7.30 PM FOR 8.00 PM INFORMAL

The Prime Minister	
Professor B.E. Tomlinson	Northern Regional Health Authority
Mr. Bryan Askew	Yorkshire Regional Heath Authority
Sir Michael Carlisle	Trent Regional Health Authority
Sir Arthur South	East Anglian Regional Health Authority
Mr. W.R. Doughty	North West Thames Regional Health Authority
Mr. David Berriman	North East Thames Regional Authority
Sir Antony Driver	South West Thames Regional Health Authority
Sir Peter Baldwin	South East Thames Regional Health Authority
Professor Sir Bryan Thwaites	Wessex Regional Health Authority
Sir Gordon Roberts	Oxford Regional Health Authority
Mr. W.V.S. Seccombe	South Western Regional Health Authority
Mr. J.G. Ackers	West Midlands Regional Health Authority
Mr. R.D. Wilson	Mersey Regional Health Authority
Sir John Page	North Western Regional Health Authority
Mr. Brian Edwards	General Manager, Trent Regional Health Authority
Rt. Hon. Norman Fowler, MP	
Mr. Tony Newton, MP	
Mrs. Edwina Currie, MP	
The Baroness Trumpington	
Sir Kenneth Stowe	
Sir Donald Acheson	

Mr. Len Peach	
Mrs. A.A.B. Poole	Chief Nursing Officer
Miss Kate Jenkins	Efficiency Unit
10 Downing Street	
Mr. Nigel Wicks	
Professor Brian Griffiths	
Mr. David Norgrove	

CCEG

PRIME MINISTER

DINNER FOR HEALTH CHAIRMEN

The papers are:

A Note by Bernard.
B Note by Brian Griffiths.
C Letter from Dr. Bridges of South West Surrey (who seems to have a connection through Carol).
D DHSS briefing.
E Guest list and seating plan.

A possible outline for your introductory remarks would be:

- congratulations on what NHS has achieved in the past seven years (eg almost 1 million extra in-patient cases);

- real resources have increased, by 24 per cent, but rising efficiency is increasingly important (now £150 million a year);

- surveys show great satisfaction among patients, but equally there is public concern;

- partly whipped up (to get more money), partly real;

- extra resources (which are being provided) only small part of the answer;

- need to stop the damaging denigration;

- but above all need to get the benefits of the new management attitudes and structure: that is purpose of the dinner.

The discussion will then be structured under five headings, each to be introduced by a Chairman, as follows:

1. Better service for the patient, including the problem of waiting lists. Mr. R.D. Wilson (Mersey RHA)

2. Improving management and efficiency Sir Gordon Roberts (Oxford RHA)

3. Personnel and Manpower Mr. Ackers (West Midlands RHA)

4. Capital Programme and Estate Management
Sir Peter Baldwin (South East Thames RHA)

5. Common Design of Hospital Equipment bearing in mind exports Sir Michael Carlisle (Trent RHA)

OTHER POSSIBLE QUESTIONS:

Brian has suggested a host of questions. Others might include:

1. Is it worth thinking about a move towards an internal market for the NHS? One clearly attainable possibility would be for health authorities to buy services from each other as you have suggested in the past. (More radical, why not move gradually to financing regions solely on the basis of their population and then leave them to buy services as they see fit? The mind boggles - but if education, why not also think about health?).

2. Why is there such a divide between hospitals and GPs? Would it be cost effective eg to have local x-ray facilities? Could there be mobile units for minor surgery?

3. Do some consultants keep their waiting lists up in order to help their claims for greater resources and to increase their private practices? How can that be stopped?

4. Are the demarcation lines between doctors, nurses, midwives etc. restrictive practices? How can more use be made of more junior staff?

Would you like to have possible questions summarised and put on cards which you could have by you? If so, would you like to tick questions you are interested in pursuing so that I can consolidate them?

One comment. The diversity of equipment ordering in the NHS no doubt protects the fragmented UK industry, with its many small, specialised firms. Too fast a move towards standard equipment could open the way to large American firms which would put British firms out of business.

C. [illegible] Duty Clerk.

PP DAVID NORGROVE
24 September 1986

JA2AEE

PRIME MINISTER

REGIONAL HEALTH CHAIRMEN

In presentational terms, I think you need to make the following points to them:

- there is a gap between the facts - 24% increase in real resources for the NHS and great satisfaction among patients who have been treated by it - and the public's perception of cuts and more cuts

- that perception has not been promoted by the Government, but the Government has provided the increase in real resources and staff

- it is time that the NHS began to take pride in its many achievements (see attached fact sheet); this is a managerial problem

- instead of taking pride in itself the NHS is the target of its so-called "ardent supporters" who miss no opportunity to run it down; their purpose is, of course, to try to force the Government to divert resources from other deserving causes to their pay packets or, putting it at its highest, towards particular treatments

- NHS management needs to get a grip on this deliberate campaign to denigrate the NHS (along with the Government) for it raises questions not merely of staff morale but of public confidence in the service.

BERNARD INGHAM
24 September 1986

NATIONAL HEALTH SERVICE IN GREAT BRITAIN: KEY POINTS

ACTIVITY: 1978-84	Almost 1 million extra in-patient cases.
	Well over 1/3 million extra day cases.
	Over 3 3/4 million extra out-patient cases.
	Double the number of patients receiving kidney treatment (UK).
	Nearly three times as many coronary artery by-pass grafts.
	15 million more prescriptions dispensed (1978-85).
	Over 5 1/4 million extra courses of dental treatment (1978-85).
	Almost 3 million extra sight tests.
EXPENDITURE:	Increased by about 24 per cent in real terms (1978-79 to 1986-87).
	Over 96 per cent funded from tax and NHS contributions (roughly 3 per cent charges).
MANPOWER:	5,500 more hospital doctors and dentists (1978-85).
	63,000 more hospital nurses and midwives (1978-85) (roughly 29,200 of the increase due to a reduction in the nurses' working week).
	Over 3,500 more general practitioners (1978-85).

August 1986

KW/0585a/1

PRIME MINISTER 24 September 1986

REGIONAL HEALTH AUTHORITY DINNER

This is turning out to be a most elaborately stage managed occasion: not only have the RHA Chairmen been selected to open (followed by a seconder) on each of the five subjects allotted to them by DHSS but there is to be a full scale dress rehearsal on Thursday afternoon!

To avoid the evening being a bland public relations exercise (including a specially prepared book of graphs) you need to encourage them to throw away their scripts and speak their minds.

The Agenda

Some suggested questions for the agenda

Item 1 Better service for the patient, including the problem of waiting lists.
and
Item 2 Improving Management and Efficiency

1. Although there is rising output and major improvements in the NHS the public perception is of cuts. This is reinforced and seriously worsened by complaints in public by doctors - which would never be allowed in Shell, ICI or M & S. What are the Chairmen doing to restrain criticism by doctors in their regions?

2. Better service depends on better management of existing resources and this means knowing how much things cost. Do DHAs and RHAs have the data on treatment costs to enable commercial type management?

3. What are the major reasons for differences in performance between DHAs within their region? How can the lessons of the most efficient be applied to the least efficient?

4. Accountability is fundamental to good management. Who determines the remit for RHA and DHA Chairmen? Do Chairmen agree with their General Managers their job descriptions and set them goals?

5. Many Regional General Managers were administrators. Are they changing their culture or goals? Are they of the right quality?

6. Do Chairman encourage their Regional General Managers to put business plans to the RHA?

7. How much contracting out is taking place in the ancilliary services - laundry, food, cleaning, plant maintenance?

Hospital Doctors

- doctors are the main initiators of health care spending

- and they assume unrestrained clinical freedom to determine the care and treatment of the individual patient

- there is thus an apparent incompatability with cash limits

- despite this, doctors are not easily persuaded that they have a role in the management of resources

- the Authority which employs doctors (the Region) is not the Authority for which they work (the District)

8. Should the contracts of hospital doctors be held by DHAs, not by RHAs? Would this enable greater supervision?

9. A key task of General Management is to persuade doctors of the need to take a more considered interest in the quality and cost effectiveness of their treatments. How is this being done?

10. Are consultants' job descriptions reviewed periodically?

11. Are budgets assigned to consultants and medical audits carried out? Who does clinical budgeting.

Item 3 Personnel and Manpower

12. Pay Review Bodies tend to grant across-the-board increases. Are the differentials between different kinds of staff leading to shortages? If so what needs changing?

Item 4 Capital Program and Estate Management

13. What incentives does a DHA or RHA have to economise on land and buildings? Can they be improved?

14. How much further do RHA's have to go in selling surplus land?.

BRIAN GRIFFITHS

F

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
Alexander Fleming House, Elephant & Castle, London SE1 6BY
Telephone 01-407 5522 ext 6981
From the Permanent Secretary
Sir Kenneth Stowe GCB CVO

24. September.

Dear Nigel.

It occurs to me that the P.M. might be interested to see, in her briefing for her dinner with RHA Chairmen the attached copies of the first two issues of the NHS Management Board's bulletin for all NHS general managers.

The need for a vehicle like this emerged very clearly in the 1982 NHS dispute. I have had to go a very long way round to get it. And we only have it now thanks to Len Peach: he is the architect and designer. It is

easy to underrate his personality so it might be helpful to see some evidence of how he operates.

Yours ever.

Ken.

The Hospital and Community Health Services

Some facts about performance

The Hospital and Community Health Services

Better Services

Improving Management and Efficiency

Personnel and Manpower

Capital and the Estate

Medical Equipment

Better Services

Fig.1

NHS Hospital Activities 1974–1985 (England)

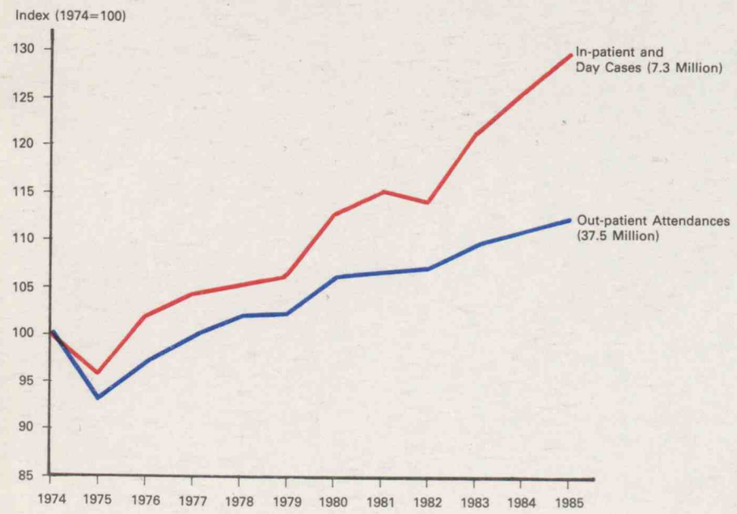
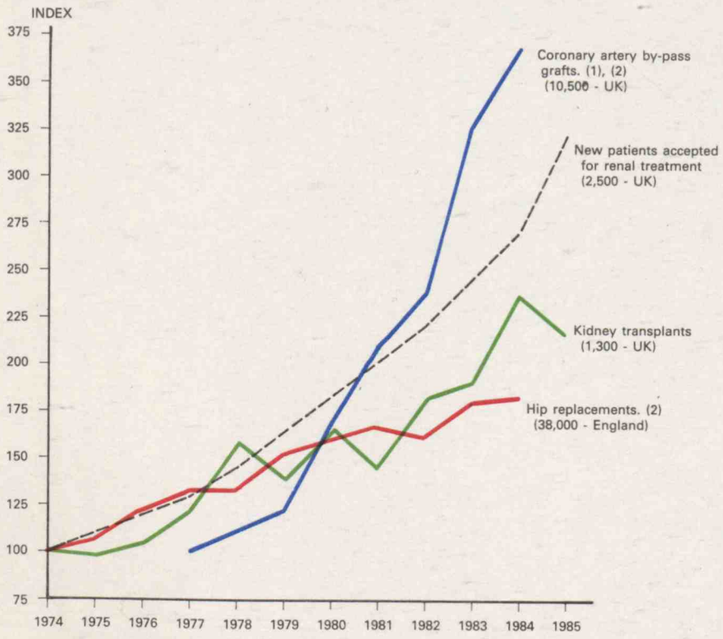


Fig. 2

Increases in Priority Acute Treatments (1974 – 1985)



(1) Figures for years before 1977 not available. (2) Figures not yet available for 1985.

Fig. 3

In-patient Waiting Lists – England 1973 – 1986
(March 1986 Figure Provisional)

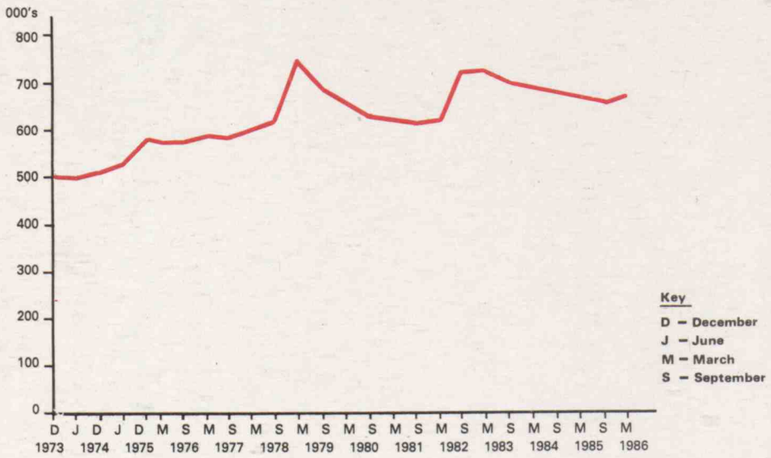


Fig. 4

Perinatal Deaths per 1,000 Live Births – England 1974 – 1984

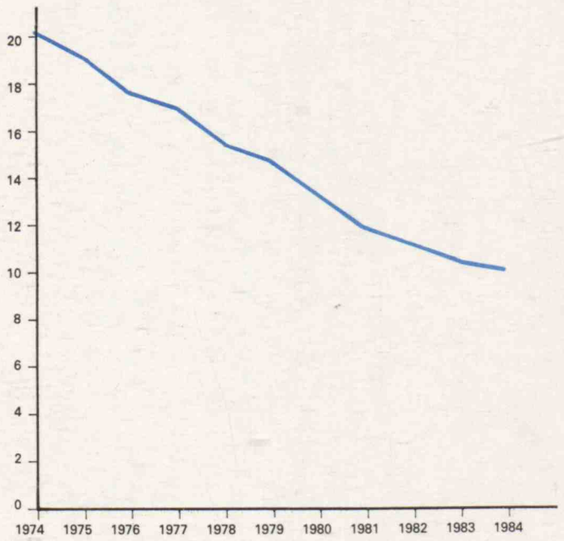
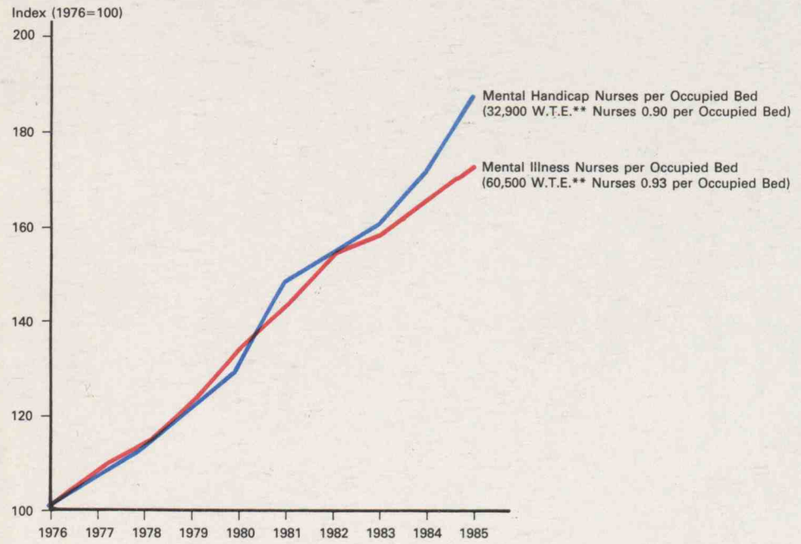


Fig. 5

Hospital Services for Mentally ill and Mentally Handicapped People 1976 – 1985 England

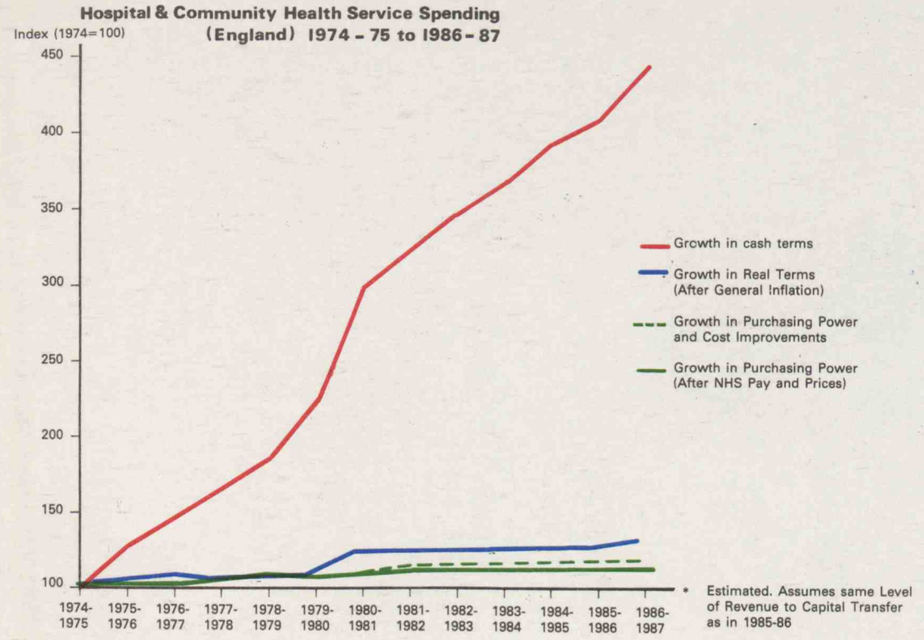
* Figures for earlier Years Not Available
** W.T.E. = Whole Time Equivalents



Improving Management and Efficiency

Fig.6

Hospital & Community Health Service Spending (England) 1974 - 75 to 1986 - 87



* Estimated. Assumes same Level of Revenue to Capital Transfer as in 1985-86

Fig.7

HCHS Cash Releasing Cost Improvements 1980-81 to 1986-87

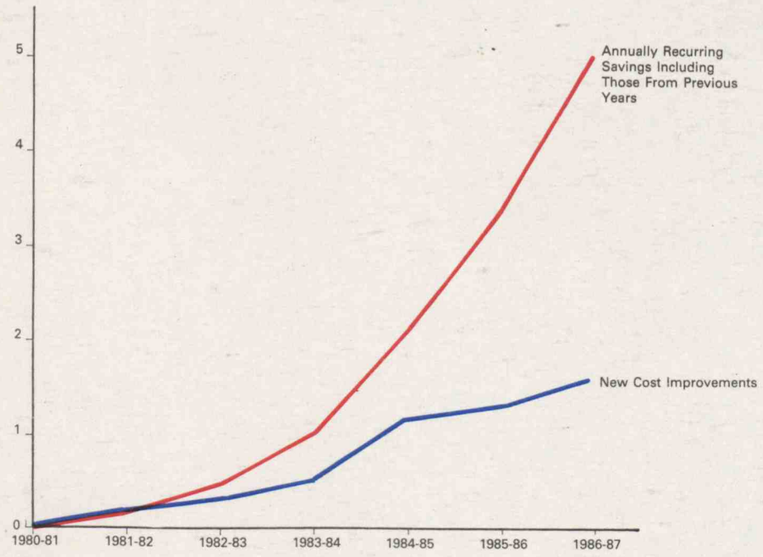
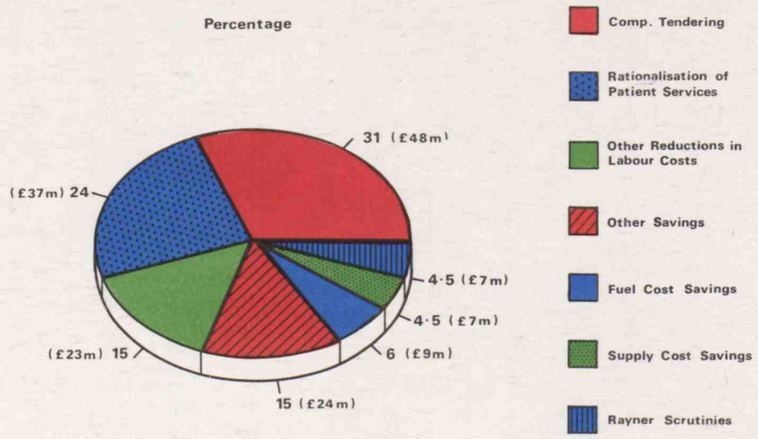


Fig. 8
HCHS Cost Improvement Programme 1986–87
Cash releasing element



Personnel and Manpower

Fig. 9
Acute Hospital Services - 1974 – 1985 England
(1985 Figures Provisional)

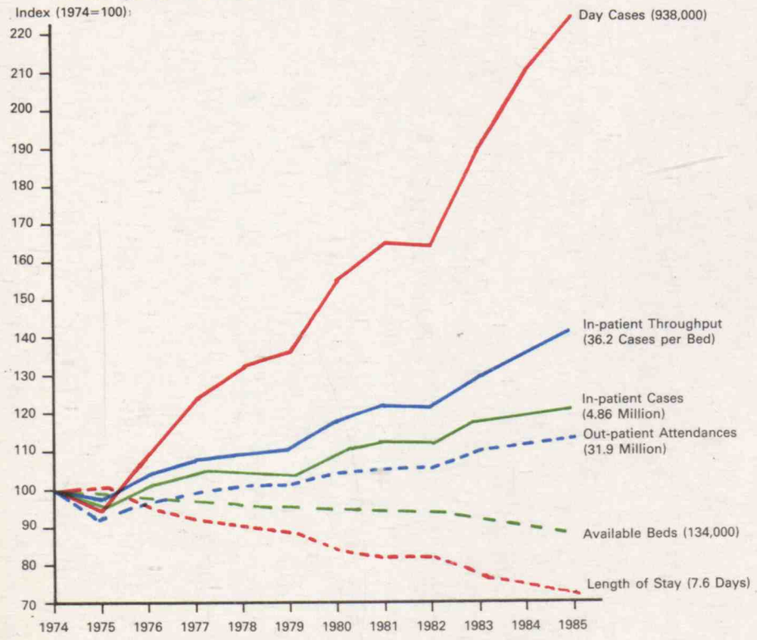
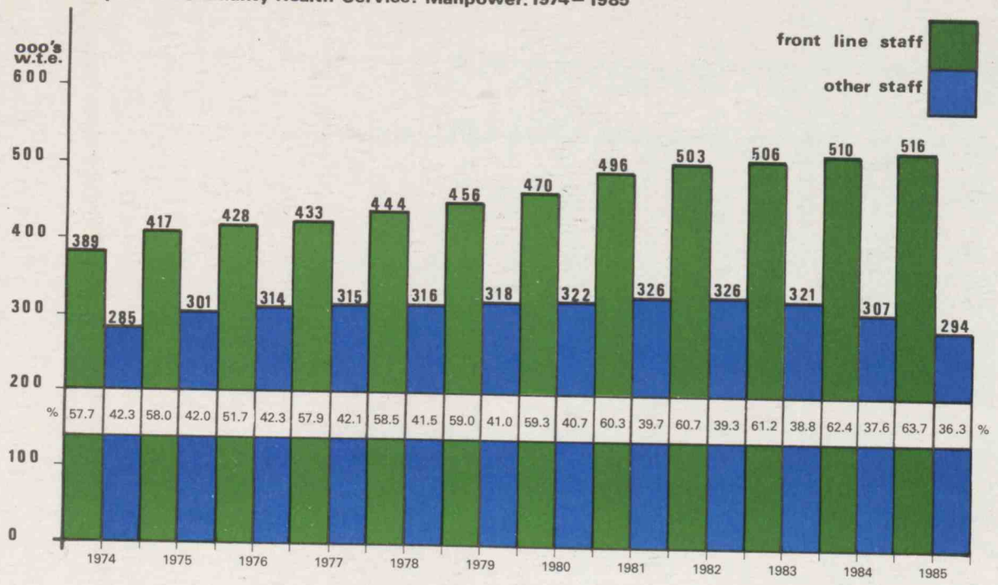


Fig.10
Hospital & Community Health Service: Manpower. 1974 – 1985



w.t.e. = whole time equivalents

Fig. 11

Pay Settlements And Earnings In The N.H.S. And The Rest Of The Economy

NHS and SECTORAL PAY SETTLEMENTS: Cumulative % increases

	Financial years 1978/79 to 1985/86	Financial years 1980/81 to 1985/86	1986/87 settlement (latest figures*)
NHS:			
DDRB	131.8	40.3	7.6
N&M	110.8	39.0	7.8
Whitley	81.3	29.8	6.0
Public Sector: (services)	84.7(1)	34.4	6.75*
Private Sector:	95.1(1)	37.8	5.75*
Whole Economy:	91.6(1)	36.5	6.25*
RPI(2)	87.2	39.0	2.4

Notes

(1) Figures not available for 1978-79. An estimate of 20% increase in the financial year 1979/80 was used, to reflect Clegg awards.

(2) Based on financial year averages, latest estimate for 1986-87.

NHS and SECTORAL EARNINGS (1): Cumulative % increases

	April 1979 to April 1985 (Includes Clegg awards)	April 1981 to April 1985 (Excludes Clegg awards)
NHS:		
DDRB	-	-
N&M	98.1	30.7
Whitley (2)	77.6	26.0
Public Sector: (services)	93.4	30.7
Private Sector:	93.7	43.5
Whole Economy:	91.9	37.7
RPI(3)	76.8	31.3

Notes

(1) Department of Employment "New Earnings Survey".

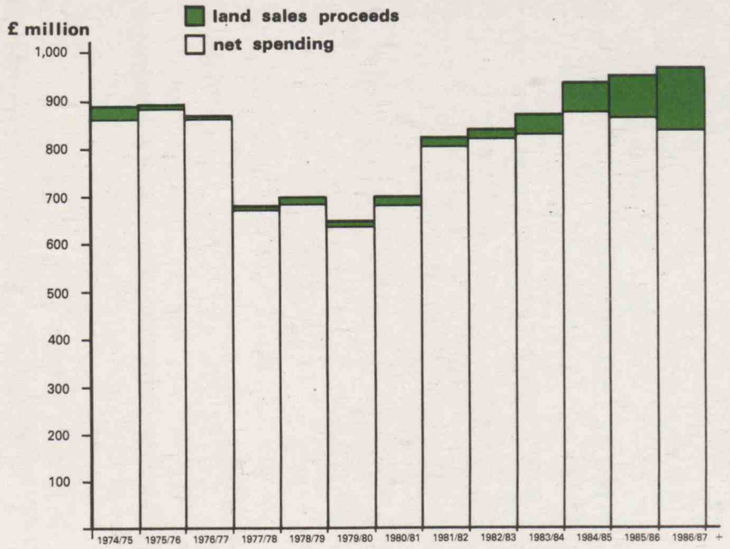
(2) Figures available only for Administrative, Clerical, Ambulance and Ancillary Staff (over 75% of Whitley Staff).

(3) Based on financial year averages.

Capital and the Estate

Fig.12

N.H.S. CAPITAL SPENDING (England) – Purchasing Power at 1986 – 87 Prices



+ Assuming revenue to capital transfer of £42m in 1986-87 (at a similar level to transfer in 1985-86).

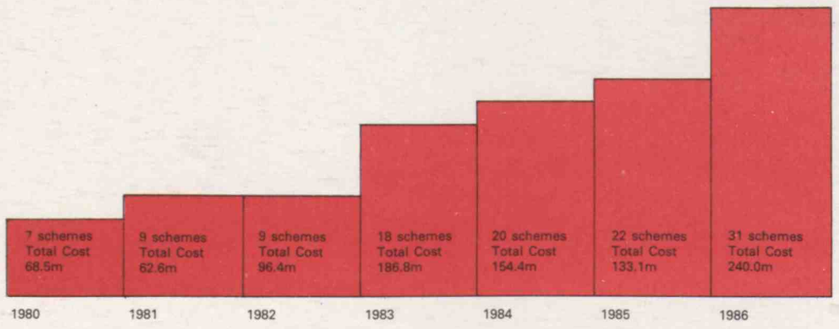
Fig.13

Health Authorities' Building Performance[1]

	1977-79	1980 to date
Average cost overrun	11.6%	1.7%[2]
Average time overrun	29.7%	4.2%[3]

1. Based on samples of major (over £5million) completed schemes
2. Equivalent to average cost overrun of £100,000.
3. Equivalent to average time overrun of six weeks

Fig 14
Annual number of schemes in excess of £2M completed 1980–85
Plus estimated for 1986 **ENGLAND**



TOTAL COST - BUILDING AND ENGINEERING COST PLUS ESTIMATED SUM FOR FEES AND EQUIPMENT

Medical Equipment

Fig.15
ESTIMATED WORLD MARKET FOR MEDICAL EQUIPMENT, BY AREA

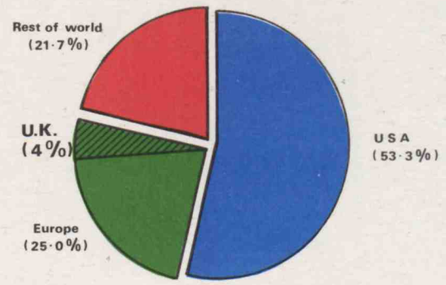
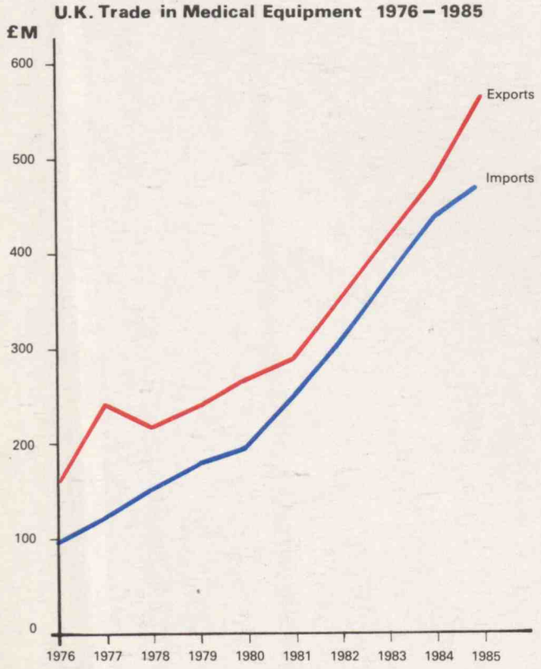


Fig. 16
U.K. Trade in Medical Equipment 1976 – 1985



cc DHSS 24/9

SOUTH WEST SURREY HEALTH AUTHORITY

Please reply to:

Chairman

R24/9

DISTRICT HEADQUARTERS
FARNHAM ROAD HOSPITAL
FARNHAM ROAD, GUILDFORD
SURREY GU2 5LX.

Person dealing with correspondence: Dr. A.J. Bridge

Telephone: 61612
Guildford ~~XXXXX~~ Ext. 201

Our Ref:

Your Ref:

23rd September 1986

Dear Mrs. Thatcher,

I understand that you will be entertaining the Regional Health Authority Chairmen to dinner at No. 10 during this next week. I would much appreciate it if you could take note of what Sir Antony Driver, Chairman of the S.W. Thames Region has to say, particularly in relation to the funding of acute services. He has the backing of all 13 District Chairmen, every one of whom is having great difficulty in funding their acute services and, indeed, the vast majority are having to cut them.

In the case of S.W. Surrey, application of the National and Regional policies has resulted in a real reduction in funding of £1.3millions p.a. (3½%) in the last four years. Efficiency savings have been made to the tune of £2.4millions p.a. but with that well running dry, we are now faced with the problem of reducing expenditure by a further £1million p.a. We are, therefore, faced with the dilemma of slowing development of the priority services (mental illness, mental health, care of the elderly, care of the young chronic sick) or cutting back hospital acute services. At the same time we are trying to bring down the waiting lists while patient numbers are actually increasing -17% over the last four years.

As a Borough Councillor and County Councillor, I find it very embarrassing when canvassing to be told, when I tell people that there has been a 24% increase in funding in real terms in the NHS either that I am lying or I do not know what I am talking about as "all we can see in our area is reducing services".

I have to tell you that now that the topic of funding the GCSE has been resolved by the Surrey County Council's input of £1million, the NHS has moved to the top of the discussion list. Sir Antony's comments will no doubt address this concern.

My best regards to your husband and to Carol. It seems a very long time since Anne and Carol were at Queenswood together and I was practising at 57 Harley Street. Problems don't get any easier to solve with the passing years, do they ?

With my best wishes.

Yours sincerely,

Arthur Bridge

Arthur Bridge
Chairman

The Rt. Hon. Margaret Thatcher, MP.,
Prime Minister
10 Downing Street
London SW1

DA6

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

David Norgrove Esq
Private Secretary
10 Downing Street

22 September 1986

Dear David,

DINNER WITH RHA CHAIRMEN: THURSDAY 25 SEPTEMBER

I attach the background papers for this dinner:

(a) an agenda note;

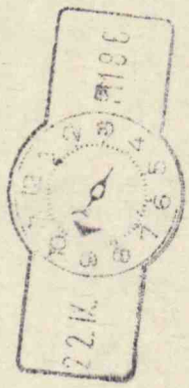
(b) supporting booklet;

(c) notes on the 14 RHA Chairmen.

I am also enclosing a suggested seating plan.

Yours

A Laurance
Private Secretary



cc K. Jenkins

DINNER FOR REGIONAL HEALTH AUTHORITY CHAIRMEN

The agenda agreed by the Prime Minister contains five items, set out below. One of the Chairmen will speak briefly to introduce each agenda item. The attached booklet contains some of the main facts relevant to each item.

2. The discussion might usefully cover:

(a) achievements so far;

(b) problem areas;

(c) proposals for action.

3. Item 1 on the agenda is Better service for the patient, including the problem of waiting lists. Mr R D Wilson (Mersey RHA) will introduce this topic. Important points include:

- rising output, especially since 1982 (Figure 1 in the booklet);

- large increases in priority acute treatments, especially coronary artery by-pass grafts and cases of renal failure (Figure 2);

- halving of perinatal mortality in a decade (Figure 4);

- major improvement in staffing of mental illness and mental handicap hospitals signifying better quality of care (Figure 5);

- waiting lists down from the 1979 peak, but still too high (Figure 3) - the Secretary of State's initiative aims at a substantial impact over the next three years;

- the service needs to be more responsive to the individual patient's circumstances - how can we make it more personal and "customer-orientated"?

4. Item 2 is Improving management and efficiency. Sir Gordon Roberts (Oxford RHA) will introduce this. Figures 6 - 9 in the booklet are relevant. Important points:

- major contribution to the NHS made by the cost improvement programme (£150 million cash to be released this year);

- full-year savings from competitive tendering for support services already estimated at £62 million;

- increasingly efficient use of clinical facilities as patient throughput is raised (Figure 9);

- in order to maintain and improve performance, we shall need to enlist the full support of NHS staff for change.

5. Item 3 is Personnel and Manpower. Mr Ackers (West Midlands RHA) will introduce this. Figures 10 - 11 in the booklet are relevant. Important points include:

- staff account for 73 per cent of hospital costs;

- NHS manpower is now under control - since 1982, while output has risen, total numbers of staff have fallen and the proportion of "front-line" staff has risen (Figure 10);

- half of NHS staff are now covered by Review Bodies, and the funding of pay awards continues to present problems;

- staff morale is central to the quality of the NHS and to the public perception of the NHS (NHS staff can be its sternest critics).

6. Item 4 is the Capital Programme and Estate Management. Sir Peter Baldwin (South East Thames RHA) will speak on this. Figures 12 - 14 in the booklet are relevant. Important points include:

- capital spending has risen steadily since 1979;

- sales of surplus land and buildings are at highest ever levels;

- the NHS is now building much more efficiently than in the past (Figure 13);

- more major schemes are being completed (Figure 14).

7. Item 5 is the Common Design of Hospital Equipment bearing in mind exports. Sir Michael Carlisle (Trent RHA) will introduce this. Figures 15 and 16 in the booklet are relevant. Important points are:

- the small size of the UK as a home market in a very sophisticated area of technology, dominated by USA (Figure 15);

- we are just about holding our own, with a small positive balance of payments;

- ACARD has drawn attention to the need for the NHS to be more sensitive to industry's needs;

- common standards and specifications, and aggregated buying, would improve the opportunities for good UK firms to prosper in the home market.

JAMES (JIM) ACKERS (AGE 51. Reappointed 1986 for 4 years)

WEST MIDLANDS. Largest RHA, covering Birmingham conurbation, Hereford, Shropshire, Staffs, Worcester, Warwick. Population 5.2m. Revenue £1039m. Capital £86m for 1986/87.

Chairman of own haulage business and of W Midland Chambers of Industry and Commerce. Member Monopolies and Mergers Commission. Former Conservative candidate.

A dynamic Chairman who is committed to developing strong locally based services in a big growth Region. With over 5m population spread across 22 Districts, W Midlands presents a tough management job. Since 1978 acute cases have risen by over 20%, day cases by over 60%. Has largest Regional capital programme but the Region faces problems in its capital cash flow (Mr Ackers would like to do more, earlier).

BRIAN ASKEW (AGE 56. Reappointed Aug '86 for 2 years).

YORKSHIRE. Yorkshire north of Sheffield, Humberside. 3.6m pop; Rev £740m, Cap £56m.

Personnel Director of Brewery (Tadcaster).

Inherited a Region where central influence and key officers were traditionally weak and this was illustrated in comments on handling of Stanley Royd food poisoning outbreak. Had a slow start, but with a new RGM (from business) he is now beginning to assert RHA control and to tighten regional strategies. In-patient cases up 20%, day cases up 38% since 1978.

SIR PETER BALDWIN KCB (AGE 63. Appointed 1983 for 4 years).

SOUTH EAST THAMES. SE quadrant of London plus E Sussex, Kent, including Guys, Thomas's, Kings. Pop 3.6m, Rev £836m, Cap £52m.

Formerly Permanent Secretary of Department of Transport. Chairman Physically Handicapped and Able Bodies Association.

A strong Chairman whose prime task is to secure and pace the movement of resources form the inner city Districts and their acute hospitals to provide for the growing population outside (new DGHs were started this year in Medway, Eastbourne and Hastings), and to strengthen inner city community services.

DAVID BERRIMAN (AGE 57. Appointed 1984 for 4 years).

NORTH EAST THAMES. NE quadrant of London plus Essex; including Bloomsbury, Royal Free, Barts. Pop 3.7m, Rev £956m, Cap £54m.

Former Merchant Banker and Director Guiness Mahon. Formerly Chairman Lewisham and North Southwark HA.

Successful DHA Chairman, who has still to impress his stamp on a Region facing major planning and presentational problems including Bloomsbury and shift of resources towards Essex and the community priority services. Is pursuing a "Caring Region" policy, with open presentation of change and achievements.

SIR MICHAEL CARLISLE (AGE 56. Reappointed in Aug 1986 to 1990).

TRENT. S Yorkshire, Derbys, Notts, Leicester and Lincolnshire. Pop 4.6m, Rev £907m, Cap £65m.

Director of several Engineering companies. Ex-Chairman Sheffield Health Authority. Member of courts of Sheffield and Nottingham Universities, past Governor Sheffield Polytechnic.

Sharp businesslike approach to running large RHA with heavy programme of capital development.

WILLIAM DOUGHTY (AGE 61. Appointed 1984 to July 1988).

NORTH WEST THAMES. NW quadrant of London plus Beds and Herts. Pop 3.5m (after boundary changes 1982), Rev £757m, Cap £45m.

Businessman (Group MD Cape Industries till 1984). CBI Council Member. Member SHA for Hpl Sick Children (Gt Ormond Street).

An able tough Chairman who has pressed hard to sharpen up the RHA's strategic and short term plans to improve access to services in the shire counties and develop community services.

SIR ANTONY DRIVER BSC (ENG) (AGE 66. Reappointed Aug '86 for 2 years).

SOUTH WEST THAMES. SW quadrant of London plus Surrey, W Sussex, including St Georges, Queen Mary's Roehampton. Pop 2.9m, Rev £637m, Cap £42m.

Formerly Director, Personnel and Administration, BP Oil Ltd. Residual business interests in the city.

SW Thames has smallest share of London's adjustments but Sir Antony has had to lead thorny negotiations on resource redistribution from some of the London and Surrey Districts to traditionally under-resourced ones in West Surrey/North East Hampshire and West Sussex. His personnel experience tends to direct his priorities though he turned this approach to good effect in guiding the Region through the massive decanting exercise from the large mental hospitals in the "Epsom Cluster" - the largest scale problem of its kind in the country. Set up innovative intra-regional competitions for "clean hospital kitchens" and "good catering".

SIR JOHN PAGE OBE (AGE 71). Reappointed Aug '86 for 1 year).

NORTH WESTERN. Lancashire and Manchester conurbation. Pop 4m, Rev £904m, Cap £72m.

Formerly Chairman and Chief Executive of Mersey Docks and Harbour Board. Long experience in oil business (Middle East etc) after RAF service.

Experienced shrewd and determined, with firm ideas on what he requires. He has pioneered good relationships with local Social Service Departments to promote community care.

SIR GORDON ROBERTS CBE JP (AGE 65. Reappointed Aug '86 for 2 years).

OXFORD. Oxford, Berks, Bucks, Northants. Pop 2.4m, Rev £425m, Cap 26m.

Formerly with British Rail. Member New Towns Commission. NHS work since 1955 (formerly Chairman Northampton AHA). Parliamentary candidate (Labour) in 1970. Can appear low key, but is an effective, businesslike Chairman who works well with his Regional Manager (a doctor) and a bright young team. Region has very high and growing output which is generating its own problems of financial and staff (eg nurse) management.

W VERNON S SECCOMBE JP (AGE 58. Reappointed Aug '86 for 4 years).

SOUTH WESTERN. Cornwall, Devon, Gloucester, Somerset, Avon (excl Bath). Pop 3.1m, Rev £649m, Cap £51m.

Was Chairman of own electronics firm.

A very committed, go ahead and extrovert Chairman, whose Regional Manager was formerly Regional Nursing Officer. Strong practical bias. Has asserted Regional influence in geographically spread Region with benefit to strategic and short term planning and use of resources.

SIR ARTHUR SOUTH JP (AGE 71. Chairman 1978; reappointed Aug '86 for 1 year).

EAST ANGLIAN. Norfolk, Suffolk and Cambridge. Pop 1.9m, Rev £381m, Cap £24m.

Manages own business (furriers). Member and Chairman of District/Area Health Committees from 1948 onwards. Former Labour Mayor, and Council Leader, of Norwich, and ex-Chairman Norwich City FC.

Shrewd, at times outspoken, gets things done his way.

PROFESSOR SIR BRYAN THWAITES MA PhD (AGE 62. Reappointed Aug '86 for 2 years.)

WESSEX. Hants, Dorset, Wilts, IOW, E Avon. Pop 2.8m, Rev £542m. Cap £57m.

Former Principal Westfield College, NHS work since 1970 (formerly Chairman Brent and Harrow HA).

Intelligent and urbane. This Region's reputation for an innovative approach stems from a partnership with his able and independently minded General Manager. Occasional lapses of judgement, but a loyal supporter of Government's policies for the Service.

PROFESSOR B E TOMLINSON CBE (AGE 66. Reappointed Aug '86 for 2 years.)

NORTHERN. Tyne/Wear, Cleveland, Cumbria, Durham, Northumberland. Pop 3m, Rev £658m, Cap £43m.

Retired Consultant, neuropathologist at Newcastle Teaching District. Personal Chair of Pathology at Newcastle University.

Has rather precise and self-effacing manner but is a perceptive, determined and businesslike Chairman whose insights are well based.

R D (DON) WILSON (AGE 64). Reappointed 1986 for 4 years.

MERSEY. Liverpool, Cheshire. Pop 2.4m, Rev £534m, Cap £39m.

Farmer and Company Director. Member NW Electricity Board, Chairman West Cheshire Cons. Curo-constituency.

Energetic, sound and progressive. Now spokesman of RHA Chairman. Manages a tight ship, with imagination and sensitivity in difficult political circumstances, and is getting firm grip on the District Authorities. Wants to see Mersey become the model Region in the NHS. Is assisted by able Regional General Manager who is also non Executive Director on NHS Management Board.

MS2CIV

cABG

10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

9 September 1986

DINNER FOR REGIONAL HEALTH AUTHORITY CHAIRMEN

Thank you for your letter of 31 July. The proposed attendance at the dinner is acceptable though as we have agreed Miss Romola Christopherson will not be coming.

The Prime Minister has considered the suggested agenda and has decided on a somewhat expanded version as follows:-

(i) how to get better service for the patient, including particularly reducing waiting lists and waiting times;

(ii) improving management and efficiency;

(iii) common design of products for hospital equipment, bearing in mind the possibilities for exports;

(iv) capital programme and estate management;

(v) personnel and manpower.

BF // The Prime Minister would I am sure be grateful for the short background material which you mention and it would be helpful to have this please by Monday 22 September.

David Norgrove

Tony Laurance Esq
Department of Health and Social Security.

MRS CUMMINGS

DINNER FOR REGIONAL HEALTH AUTHORITY CHAIRMEN

Sue Goodchild sent me a minute on 18 August with a list of guests. This is agreed except that Miss Romola Christopherson will not be coming. Representation from No.10 will be Brian Griffiths, Nigel Wicks and myself.

I have replied to Tony Laurance.

David Norgrove

9 September 1986

SRWAIH

PRIME MINISTER

DINNER FOR REGIONAL HEALTH AUTHORITY CHAIRMEN

You clearly wish to make explicit some of the points which could have been covered under the general topics originally proposed. Could I suggest some amalgamation of the two approaches along the following lines:

(i) the patient as customer including particularly reducing waiting lists and waiting times;
(ii) improving management and efficiency, [including decision making structures];
(iii) common design of products for hospital equipment, bearing in mind possibilities for exports;
(iv) the capital programme and estate management;
(v) personnel and manpower;
[(vi) your problems with DHSS; ours with RHAs].

On (i), the patient as customer is a more general area than waiting lists and waiting times, including for example the way doctors relate to their patients and the amount of information they give to them.

On (ii), this explicit mention of decision making structures is likely to invite a discussion of the role of the management board and what went wrong with the previous chairman of the management board. This is tricky ground with Mr. Fowler, Ken Stowe and Len Peach present with so many others.
I recommend that the words in square brackets should not be included. Agree?

On (iv) which you deleted, Mr. Fowler is very keen that the capital programme should be discussed. Indeed, he wanted it first on the agenda. He believes the Government is not making enough of the amount that is being spent on NHS capital and wants to encourage regional chairmen to be more positive in their public presentation.

On (vi), I wonder whether it would be better to let problems between DHSS and the RHAs emerge during discussion rather than to make it an explicit agenda item. It would risk becoming either a grousing session, possibly ill-tempered, or empty, with neither side wishing to criticise the other in front of you.

agree deletion - but we must discuss it.

Do you wish to retain or delete "including decision making structures" in (ii), and agenda item (vi)?

Otherwise, content with the agenda above?

(DAVID NORGROVE)
8 September 1986

Dinner for Regional Health Chairmen:
NAT HEALTH.
July '86.

E.R.

1

PRIME MINISTER

DINNER FOR REGIONAL HEALTH AUTHORITY CHAIRMEN

You agreed to give dinner to the Regional Health Authority Chairmen on 25 September.

The DHSS have proposed the guestlist set out on the attached sheet. (Mr. Brian Edwards, the Regional General Manager of Trent, would be invited as Chairman of the group of Regional General Managers.)

From No.10 I suggest Brian Griffiths, Nigel Wicks and myself. David Willetts is I am afraid away on a study tour in the United States.

Mr. Fowler has suggested four broad items for discussion:

(i) ~~the patient as customer;~~ reducing waiting lists and waiting times.

(ii) ~~the capital programme and estate management~~; common design + products for hospital equipment

(iii) improving management and efficiency;

(iv) personnel and manpower. including decision making structures. The scope is mixed possibilities for export.

(v) Your problems with DHSS - Ours with R.H.A's

(The DHSS letter to me proposed that "the patient as customer" should come fourth in this list!) A regional Chairman would speak for perhaps three or four minutes to introduce each topic. The topics seem to me to cover the ground, and to give an opportunity to raise with the Regional Chairmen the concerns you have expressed to Mr. Fowler and others in the past.

DHSS and the Policy Unit will be providing briefing.

Content? No - a pity David Willetts not here

MT

DLN

David Norgrove

3 September 1986

JA2ADX

? 24

LIST OF GUESTS ATTENDING THE DINNER TO BE GIVEN BY THE PRIME MINISTER FOR REGIONAL HEALTH AUTHORITY CHAIRMEN ON THURSDAY 25 SEPTEMBER 1986

The Prime Minister	
Professor B.E. Tomlinson	Northern Regional Health Authority
Mr. Bryan Askey	Yorkshire Regional Heath Authroity
Sir Michael Carlisle	Trent Regional Health Authority
Sir Arthur South	East Anglian Regional Health Authority
Mr. W.R. Doughty	North West Thames Regional Health Authority
Mr. David Berriman	North East Thames Regional Authority
Sir Antony Driver	South West Thames Regional Health Authority
?Sir Peter Baldwin	South East Thames Regional Health Authority
Professor Sir Bryan Thwaites	Wessex Regional Health Authority
Sir Gordon Roberts	Oxford Regional Health Authority
Mr. W.V.S. Seccombe	South Western Regional Health Authority
Mr. J.G. Ackers	West Midlands Regional Health Authority
Mr. R.D. Wilson	Mersey Regional Health Authority
Sir John Page	North Western Regional Health Authority
Mr. Brian Edwards	General Manager, Trent Regional Health Authority
Rt. Hon. Norman Fowler, MP	
Rt. Hon. Barney Hayhoe, MP	
?Mr. Ray Whitney, MP	
The Baroness Trumpington	
Sir Kenneth Stowe	
Sir Donald Acheson	
Mr. Len Peach	

Graham Hart Federal-2511

MR. NORGROVE

Dinner for Regional Health Authority Chairmen
Thursday, 25 September

Please see the attached letter from DHSS of 31 July.

We have sent invitations to all those listed in pars 2 and 3 ofTony Laurance's letter.

DHSS are awaiting your comments on four broad agenda topics - para. 4.

No. 10 Representation

Could you please let us know the No. 10 representatives. Maximum number is 32.

Sue Goodchild

18 August 1986

LIST OF GUESTS ATTENDING THE DINNER TO BE GIVEN BY THE PRIME MINISTER FOR REGIONAL HEALTH AUTHORITY CHAIRMEN ON THURSDAY 25 SEPTEMBER 1986

The Prime Minister	
Professor B.E. Tomlinson	Northern Regional Health Authority
Mr. Bryan Askey	Yorkshire Regional Heath Authroity
Sir Michael Carlisle	Trent Regional Health Authority
Sir Arthur South	East Anglian Regional Health Authority
Mr. W.R. Doughty	North West Thames Regional Health Authority
Mr. David Berriman	North East Thames Regional Authority
Sir Antony Driver	South West Thames Regional Health Authority
?Sir Peter Baldwin	South East Thames Regional Health Authority
Professor Sir Bryan Thwaites	Wessex Regional Health Authority
Sir Gordon Roberts	Oxford Regional Health Authority
Mr. W.V.S. Seccombe	South Western Regional Health Authority
Mr. J.G. Ackers	West Midlands Regional Health Authority
Mr. R.D. Wilson	Mersey Regional Health Authority
Sir John Page	North Western Regional Health Authority
Mr. Brian Edwards	General Manager, Trent Regional Health Authority
Rt. Hon. Norman Fowler, MP	
Rt. Hon. Barney Hayhoe, MP	
?Mr. Ray Whitney, MP	
The Baroness Trumpington	
Sir Kenneth Stowe	
Sir Donald Acheson	
Mr. Len Peach	

Mr. Len Peach

Miss Romola Christopherson (Director

Mr. Fleshes GL52
The numbers are OK.
32 is absolute maximum
SG 2/8

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

David Norgrove Esq
Private Secretary
10 Downing Street

31/8

31 July 1986

Sue
Tell DHSS
OK.
Bf to DN on his return.

Dear David,

DINNER FOR REGIONAL HEALTH AUTHORITY CHAIRMEN

Further to my letter of 18 July, I am writing with suggestions for the agenda and attendance from the Department.

The arrangements you propose for the dinner are very acceptable. We would like to suggest that, in addition to RHA Chairmen, it would be a good idea to invite Mr Brian Edwards, the Regional General Manager of Trent, who is the Chairman of the group of RGMs and who is known to the Policy Unit.

So far as DHSS representation is concerned, my Secretary of State would like you to invite the four Health Ministers, Sir Kenneth Stowe, Sir Donald Acheson, Mr Len Peach and Miss Romola Christopherson (our new Director of Information).

We agree that it would be helpful to focus the discussion by identifying four broad agenda topics. Our suggestions are as follows.

First, the capital programme and estate management.

Second, improving management and efficiency.

Third, personnel and manpower.

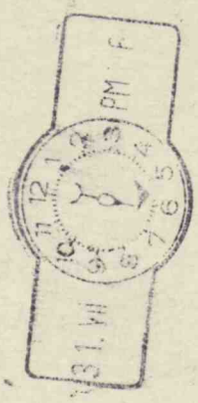
Fourth, the patient as customer.

If this is broadly acceptable, we would ask a Regional Chairman to speak for perhaps three or four minutes to introduce each topic: we would also like to provide the Prime Minister with some short background material before the dinner.

Yours

Tony Laurance

A Laurance
Private Secretary


PM
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10 DOWNING STREET

From the Principal Private Secretary

15 July 1986

DINNER FOR REGIONAL HEALTH AUTHORITY CHAIRMEN

As you know, the Prime Minister has decided to invite the Regional Health Authority Chairmen to dinner on Thursday 25 September. You told me they are coming to the Department for a meeting tomorrow and that this invitation would be mentioned to them then. I should be grateful for a list of their names and addresses so that we can issue the formal invitations.

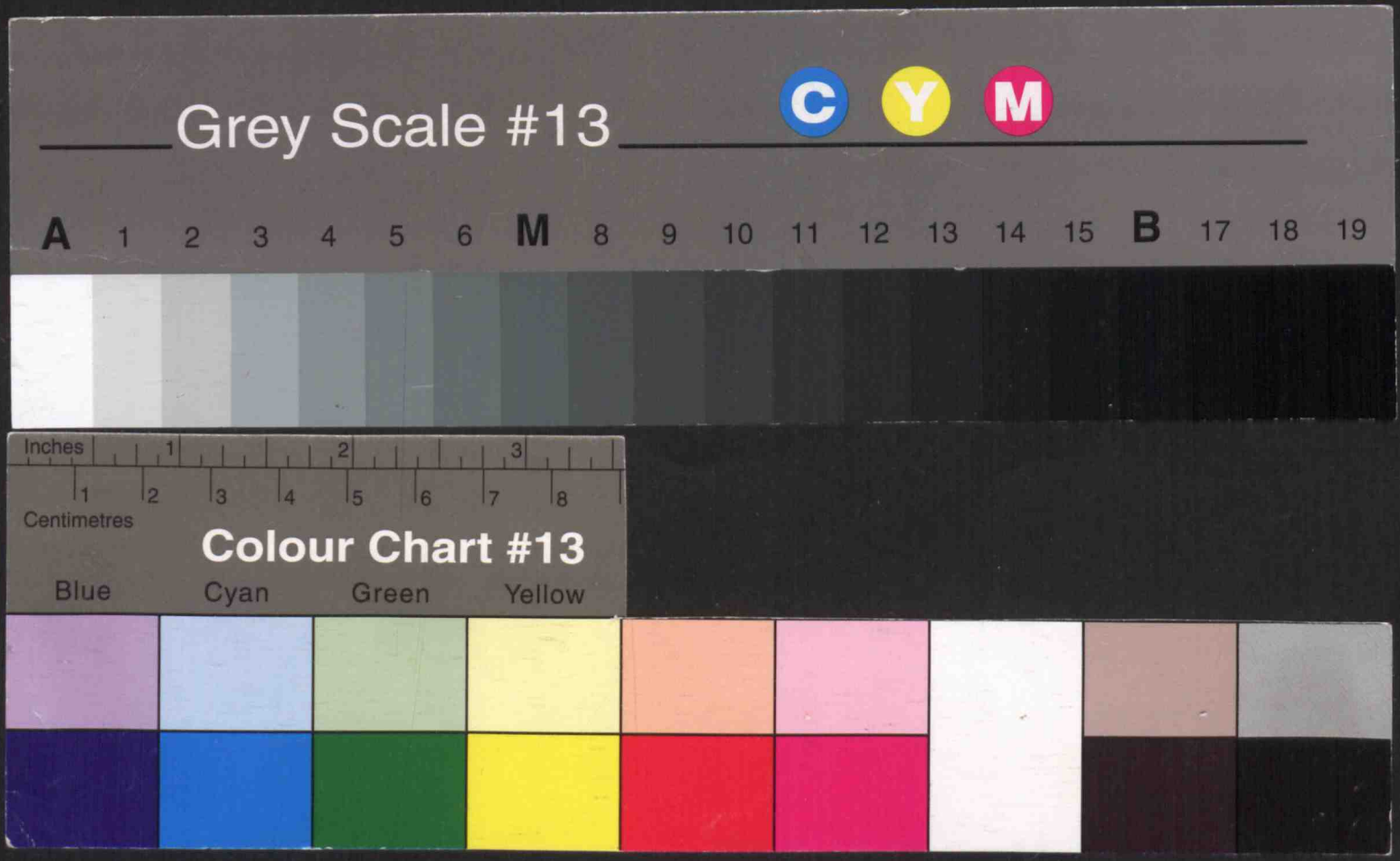
I expect that up to a maximum of 6 people will attend from No 10, including the Prime Minister, though the number is more likely to be 4. I should be grateful to know your suggestions for the people to attend from the Department.

The usual form on these occasions is for discussion of business to come with the coffee, and it might last for an hour or so. One possibility would be to choose 3 or 4 subjects, each to be introduced by one of the Chairmen. I should be grateful for advice on this to put to the Prime Minister and also for suggestions on subjects for discussion.

DAVID NORGROVE

Tony Laurence, Esq.,
Department of Health and Social Security

CJ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Colour Chart #13
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Cyan
Green
Yellow