PREM 19/2333

NHS EXPENDITURE AND EFFICIENCY

In attached folder: Mersey Regional Health Authority Publicity Material.

NATIONAL HEALTH

PART 1: MAY 1979

PART 7: OCT 1986

PREM 19/2333

Referred to	Date	Referred to	Date	Referred to	Date	Referred to	Date
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PART ENDS							

Dd 533270 5M 2/78 8362633 JET

PART 7 ends:-

DRN to NLW 30.1.87

PART 8 begins:-

PUSS/DHSS to PM 10.2.87

TO BE RETAINED AS TOP ENCLOSURE

Cabinet / Cabinet Committee Documents

Reference	Date
CC(86)38th meeting, item 1	20/11/1986

The documents listed above, which were enclosed on this file, have been removed and destroyed. Such documents are the responsibility of the Cabinet Office. When released they are available in the appropriate **CAB** (CABINET OFFICE) CLASSES

Signed Rainford Date 27/2/16

PREM Records Team

DN
COT
NW.

10 DOWNING STREET

NW

Before the PM thinks about promoting Edwina Currie she should know that she is capable of writing such political lunacy as this.

~~I hope it has~~

It has been stopped, of course.

DRW
20/1

Mr Coe

To SIMON ~~DUGDALE~~

PRIME MINISTER'S OFFICE No 10

MRS CURRIE has written the attached for the London Food Commission's paper "London Food". It goes with similar pieces from Labour + the Alliance.

Can you clear it?

Thanks.

Robin Butler

x 7479.

(AFH)

MG2371p

1. In the world at large, more problems are caused by lack of food than by abundance of it. But the western world has known plenty now for fifty years, and the problems of ill health associated with it dominate and threaten the NHS.

2. We have the worst heart and circulatory disease figures in the west (and that means in the world). We have terrible levels of cancer, not just of the lungs but of the digestive tract and other organs. Breast cancer kills an alarming 15,000 women a year: diet may be an element. And even where much progress has been made, in perinatal mortality for example, the diet of the pregnant woman has an effect on her unborn baby's chances of survival and handicap.

3. Conservatives have always put national prosperity and freedom of consumer choice as major planks in our political platform. We are delighted to see our country free from worries about food: indeed it is unusual in our history, to find farmers worrying about over production. But we are also cautious about every aspect of public spending, knowing that there is no such thing as "Government money". It is all taxpayers money and as such has been paid by ordinary working people in what is still one of the most heavily taxed countries in the world. And the taxation paid by businesses could have been put into investment or training to keep them competitive. So there is always another call on the money.

4 Within Government there are always competing demands for the money we spend, now in record amounts, on the NHS. We'd like to spend it on education or on "infrastructure", or on regional aid. We spend rather less of it now on defence, but nuclear or conventional, that is an expensive item (Mr Kinnock would spend more on it but differently). So if we in the NHS can encourage a healthy lifestyle and better diet we can help relieve the burden on our budgets and provide a better service for those unable to benefit from prevention.

5. Traditional Conservatives and many others resent the 'Nanny State' and abhor the Bevanite cradle-to-grave concepts. They sometimes therefore reject our efforts to improve health by exhortation and public education. On the other hand they are keen, as are all Conservatives, on a sense of personal responsibility and not expecting the state to do everything: so a wise lifestyle will appeal to them, I believe, when they have got used to the idea! Socialists, on the other hand, seem a little too willing to restrict the choice available. To me, gentle persistent persuasion is best.

6. In these ways we can help our people to wiser consumption without limiting choice; we can help business by strictly controlling the levels of public spending; and we can help the NHS cope with all the demands placed on it by careful use of the money voted to us.

Mr Coe

TO SIMON ~~DUGDALE~~

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SECRET AND PERSONAL

1) DN 2
2) file

Subject cc master

10 DOWNING STREET

LONDON SW1A 2AA

From the Principal Private Secretary

30 January 1987

Dear Tony,

The Prime Minister held a meeting yesterday with your Secretary of State, the Minister for Health, Sir Kenneth Stowe, Sir Roy Griffiths and Professor Brian Griffiths of the No.10 Policy Unit about current and longer term issues of NHS policy. I have recorded in a separate letter the discussion on current issues.

The following points were made about longer term issues:-

i. It was important to work towards a system where the money went with the patient so as to make the Service's producers more responsible to patients' needs. Hospitals and consultants should lose money if they did not produce a satisfactory output. There needed to be a greater focus on outputs generally.

ii. There needed to be a greater connection between the demand for care, its cost and the method of paying for it. This was linked with patient choice and a system for money following the patient.

iii. One possibility was to link the Service's funding to the health stamp which would need to rise. But many people, it was suggested, would regard the health stamp as no more than taxation in disguise. Against that, it was pointed out that in some countries, for example, Germany, there was a clear perception of the difference between tax and national payments for Health Services. The risk of increasing the NHS stamp was that it would become a progressive tax making it harder for people to afford to pay for private insurance schemes. People were, it was suggested, willing to pay more for the Health Service, but, it was argued, only if they could see themselves personally benefiting from the extra expenditure.

SECRET AND PERSONAL

iv. The districts might be given an incentive to raise money from the local community in exchange for improvements in local services. Another possibility was to encourage firms to pay for extra services for their employees.

v. The reforms sought, including the association of outputs with payment, might require a change in the management structure of the Service. Some form of National Health Corporation was one possibility. It was strongly argued that the Goverment should not use the language of business, such as a corporation, when talking about future management structure; a different nomenclature such as a trust or foundation, might be used.

vi. Public opinion needed to be softened up in the next Parliament so that the ground could be prepared for introducing the reforms the Government wished to see. To this end the Government could publish a Green Paper or establish a Royal Commission to prepare the ground. But there was only a four year window of opportunity in any Parliament for the implementation of fundamental reforms. A Royal Commission or other external enquiry would use up at least two years. Whatever the means, the important aim was to open up public discussion, in a way which avoided dogma, about the fundamental problems of the Service.

The Secretary of State said that he would now consider, very quietly, what might be done. The Prime Minister commented that nothing should be said which removed the Government's freedom of action in the next Parliament.

I leave it to you to show copies of this letter to those who attended the meeting from your Department. I am not sending copies direct.

Yours sincerely,
Nigel Wicks

N.L. Wicks

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

CONFIDENTIAL

cc NFJ
cc Prof Griffiths

Subject cc Master

10 DOWNING STREET

LONDON SW1A 2AA

From the Principal Private Secretary

30 January 1987

Dear Tony,

NATIONAL HEALTH SERVICE

The Prime Minister held a meeting yesterday with your Secretary of State, the Minister for Health, Sir Kenneth Stowe, Sir Roy Griffiths and Professor Brian Griffiths of the No.10 Policy Unit, about current issues of NHS policy.

Presentation

The Secretary of State said that presentation had been sharpened up. The Regional Health Authority Chairmen had taken to heart their meeting with the Prime Minister last autumn. Prominent themes in presentation for the next few months would be the increased services available, the record of hospital building, the review of primary health care - which the Prime Minister thought would be better understood if it was referred to as the review of health care and family doctors - the rise in the number of patients treated and the increased number of doctors and nurses. The Parliamentary Under Secretary of State for Health and Social Security would continue to concentrate attention on the importance of health promotion. Presentation would go beyond publicising the Government's record on the NHS and draw attention to the various initiatives which were now underway.

Your Secretary of State then turned to these initiatives.

Waiting Lists

He hoped to make an announcement soon on the waiting lists, along the lines that an extra £25m. would be made available to treat 80,000 more patient cases. There could be no guarantee that this would reduce the waiting lists by 80,000. It was unfortunate that figures would be published next month which showed a small increase in the waiting list. This underlined the importance of highlighting the successes of the new initiative as they come through. The recent poor weather might add to lists.

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The following points were made in discussion:-

i. The work in hand to validate waiting list figures should be pressed ahead.

ii. The authorities should be ready to publicise any restrictive practices or lack of co-operation which inhibited the reduction in lists. There was a case for altering consultants' contracts but that task was not one for the short-term.

iii. Central TV's scheme for broadcasting, during the night, information of jobs vacant might be replicated to publicise hospitals where waiting lists were shorter. GPs in the West Midlands already received weekly lists of waiting times so that they could direct patients to consultants with the shortest lists.

RAWP

The Secretary of State said that the bridging fund was a useful step forward in dealing with some of the problems, including those at sub-regional level and in the inner cities.

Resources

The Secretary of State said that the PES settlement for the NHS 1987/88 had been satisfactory, though demographic pressures were imposing a severe strain. The trend of pay was crucial, especially as some 50 per cent of NHS pay was outside the Government's control.

In answer to a question from the Prime Minister about hospitals' use of agency staff, the Minister for Health said that there was an increasing tendency for nurses to work part-time for an agency in their spare time. £50m was being spent in London alone on agency fees. In parts of London there was a nursing shortage, though this should not be exaggerated. The Service was trying to recruit back former nurses. Talk about an emergency nursing crisis needed to be watched carefully. There were signs that the Royal College of Nursing were taking a more constructive attitude to nursing supply.

Capital

The Secretary of State said that the capital building programme was going well. Publicity needed to draw attention to the decline in hospital building in the 1970s and the rise in the 1980s.

Cancer Screening

The Forrest Report would say that breast screening of women in the 50-64 age group would reduce deaths by one-third. Such a programme was an important priority. He

was discussing with the Chief Secretary how it should be funded, for example by transferring funds from the Family Practitioner Service.

Syringes for Diabetics

The Prime Minister said that she was impressed by the case put forward by Mr Michael Hurst, M.P., and others for making syringes for diabetics available on prescription. The Secretary of State said that he was considering this. The difficulty was the cost, some £10m.

NHS Management Accounts

The Prime Minister said that she found the progress on inter-region and inter-district charging (which were described in your letter of 23 January) to be disappointingly slow and cautious. She believed that a greater priority should be attached to this issue and would like a report on progress made in six months' time.

I am sending copies of this letter to the Private Secretaries to the Minister for Health and to Sir Kenneth Stowe, Sir Roy Griffiths and Professor Brian Griffiths.

Yours sincerely

Nigel Wicks

N.L. Wicks

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

PRIME MINISTER

MEETING WITH MR. FOWLER

You have read all the papers in the folder below except David's note attached to this minute. The draft Radical Options paper (at Flag H) stands as the final version. Mr. Fowler is not submitting a paper on presentation. He believes that effective publicity in the months ahead depends on the positive presentation of the various initiatives at Flags C, D, E and F.

David Norgrove has produced a valuable analysis of Mr. Fowler's Radical Options paper. David's important point is, in my view, in the last two paragraphs. The aim should be to create a constituency for more radical change. Such a constituency exists in education. It does not yet exist in health. Our task over the next few years should be to create a constituency for radical change without frightening off the public.

This is the last meeting which Ken Stowe will attend with you before he moves from DHSS. You might want a brief word with him after the meeting.

N.L.W.

N.L. WICKS
28 January 1987

BM2BCE

PERSONAL AND CONFIDENTIAL

PRIME MINISTER

TOWARDS BETTER HEALTH CARE: A CASE FOR CHANGE

No-one could disagree with the diagnosis that the pressure of demand for better health services will continue to increase. In economic terms, health care is almost certainly a luxury good, where demand rises more than proportionately with income. There is considerable scope for higher productivity in our health service. But this is likely always to be captured to help pay for increased output or to meet the amount by which pay increases exceed provision in the public expenditure plans.

The paper for discussion tomorrow is interesting and stimulating. But it seems to me to suffer from a confusion of objectives. In assessing the options it describes the key factors as their effect on the tax burden and their ability to generate additional resources for the health care sector as a whole. The thrust generally is to try to find less painful ways of financing more health care.

This is, however, to start from the wrong end. The starting point should be to ask how signals can be created both for those who use the health services and those who provide them which would allow them to take an undistorted view of the level of services which can be afforded. If a real market cannot be created we need to mimic it as far as possible. The problem of the health service is seen in the paper as a macro problem of financing. The true problem is a micro problem: that individuals cannot feel the costs of health care, or even know what they are.

This is illustrated in the distinction the paper draws between a tax-based system and an insurance-based system. The essence of a tax-based system is that finance is provided according to income and without regard to the individual's actual use of the health service or an assessment of the risk

that he may need to use it. The insurance-based system is likely to be identical in nearly every respect (both in the way it is perceived and in its economic effects) unless contributions are based on actuarial assessments and the health record of the person concerned or a contribution record buys a higher standard of service (as National Insurance Contributions do).

Turning to the individual options discussed in the Annex, the paper suggests that the buoyancy of the National Insurance Fund could be used to finance some or all of the demand-led part of the NHS. "This would not affect the level of public expenditure but might reduce the PSBR".

As the paper says, more financing through the National Insurance Fund need not affect expenditure, though only provided the change in financing has no effect on the total of expenditure. But in that case I do not see how there could be any effect on the PSBR.

The advantage of using the National Insurance Fund in this way would be much as for any form of hypothecation: it would secure greater transparency of the link between expenditure and revenue. Pressure for higher spending would feed directly into a need for higher revenue. The weakness of the proposal is that, unless insurance contributions were paid on actuarial and health record considerations, there would be no strengthening of the link between expenditure and contributions at the level of the individual. More important, with rising incomes and falling unemployment, the National Insurance Fund is likely in the coming years to be very buoyant. A surplus on the National Insurance Fund could easily become a highly potent source of pressure for higher spending on the NHS.

The proposal to raise more revenue through hotel charges would reduce public expenditure and create an incentive for individuals to be sparing in their use of health service

resources. Appendix A, however, suggests that the potential income is likely to be less than £1 billion at the very outside. It is not likely to be a buoyant source of income, nor would it fundamentally change the nature of the financing of the health service. It may be worth doing for its own sake but it is not a solution to the long-term problem of the demand for health care.

The proposal for increased revenue through commercial activity is certainly worth developing.

The proposal for introducing greater choice includes a suggestion for a voucher or capitation fee system. This would accord well with your approach towards education reform.

The proposal for the introduction of private capital would need to meet the usual criteria.

The proposals under the insurance-based strategy would need to answer the question how far they were truly insurance-based and how far they were in reality tax-based.

I wonder whether the time is yet right to pursue the more radical options. The ground has not been prepared. Equally important, the machinery is nowhere near in place to put them into effect: it would be pointless to start lengthy controversial discussions about options which would not be put into effect in the next Parliament. The need now is to make a start on the information needed before more radical changes can be considered. In particular, inter-region and inter-district charging is worthwhile in its own right and a necessary starting point for more radical change: insurance, vouchers, capitation fees, etc., all have to be based on a knowledge of costs. The DHSS could be asked to pursue this with greater urgency and to propose a timetable for its full introduction.

On less radical options:

- greater use of National Insurance Contributions needs to be discussed with the Chancellor;

- you will have your own views about the political feasibility of hotel charges;

- Mr. Fowler could produce more detailed proposals on possible commercial activities;

- proposals for the introduction of private capital cannot be discussed without specific examples.

N.L.W.

DAVID NORGROVE

28 January 1987

L04AJD

PRIME MINISTER

You are meeting Mr. Fowler, Mr. Newton and Sir Kenneth Stowe (and possibly Sir Roy Griffiths) to follow up the discussions last year on NHS policy.

Mr. Fowler will have just returned from his AIDS tour of the USA. He will no doubt mention that. But you will want to make sure that AIDS does not dominate the meeting. I suggest for the agenda:

(1) Presentation: Mr. Fowler will submit a paper (at flag A to come). Presentation seems to have improved since Ministers' discussion in the summer (recorded at flag B), especially following Mr. Fowler's Conference speech. What more needs to be done between now and the Election?

(2) Health Authorities' expenditure and priorities for 1987-88 (at flag C).

(3) RAWP (flag D).

(4) Action to reduce waiting lists (flag E).

(5) Cancer screening for women (flag F).

(6) NHS Management Accounts (flag G) on which progress looks awfully slow. Can't Mr. Fowler speed up the pace?

Mr. Fowler will also produce a paper on longer term reorganisation. A pirate copy of Ken Stowe's draft (please protect) is at flag H. I will submit a note later in the week when we have the final version.

Records of the earlier discussions are at flags I and J.

N.L.W.

N.L. WICKS
23 January 1987

CONFIDENTIAL

CCBY
CCBVP.

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

N L Wicks Esq CBE
Principal Private Secretary
10 Downing Street

23 January 1987

Dear Nigel,

THE NEXT MOVES FORWARD ON THE NATIONAL HEALTH SERVICE

My Secretary of State is meeting the Prime Minister on 29 January to continue their discussions of last July and September on the National Health Service. We agreed to provide short reports on the main current issues referred to in your letter of 28 October leaving the discussion to concentrate on options for the longer term. I now attach these reports covering:

- health authorities' expenditure and priorities: an overview of the prospects for 1987/88;
- RAWP;
- action to reduce waiting lists;
- cancer screening.

I will let you have a paper on presentation early next week following the Secretary of State's return from the USA this weekend. We are in touch about the paper on future options.

Yours ever

A Laurance
Private Secretary

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HEALTH AUTHORITIES EXPENDITURE AND PRIORITIES 1987-88

In 1987-88 Authorities will receive £10,972 million, an increase of £628 million over 1986-87 - 6 per cent more in cash, 2.2 per cent more than forecast general inflation. After allowing for some centrally-funded projects, and the £25 million waiting list and £15 million resource bridging funds, there was about 5.65 per cent available for general distribution under the RAWP formula. Regions received increases of between 7.3 per cent (E. Anglia) and 4.6 per cent (N E Thames) in basic allocations. All Regions will expect to benefit from the waiting list fund and the 4 Thames Regions, Mersey and North Western from the resource bridging fund. The latter will raise the cash increase for each of the 4 Thames Regions to 5.1 per cent.

2. Health authorities are expected to plan for new cash releasing cost improvement programmes worth £150 million. This is the same as this year's plans but represents a harder target because most of the savings through competitive tendering will have been achieved this year. The cumulative value of cash releasing efficiency savings will be £650 million in 1987-88. There have been significant productivity improvements as well.

3. The table below indicates broadly how authorities are expected to use their additional resources.

	%		%
Additional Exchequer funding	6	Full year costs 1986 Review Bodies	1.0
Cost improvement	1.5	Demography	1.0
		Waiting Lists/RAWP	0.35
		General Inflation	3.75
TOTAL	7.5	TOTAL	6.1

Thus 1.4 per cent is available to meet any pay increases above 3.75 per cent, and to meet all service priorities.

4. Neither Review Body awards nor negotiated Whitley settlements are likely to be held at all near 3.75 per cent. Staging of Review Body awards is again an option, but authorities will certainly have to meet part of the excess costs and there is likely to be pressure for access to the Reserve. The minimum additional contribution from authorities is £40 million (0.4 per cent). This would leave 1.0 per cent (£100 million) for all service improvement.

5. The next table lists the main service improvements and pressures on authorities.

1.	Renal services (specific target)	6
2.	Supra-regional services (specified)	4
3.	General medical advance (at least ½ per cent a year; covers targets for hip replacements, heart surgery, cataracts, etc.)	50
4.	AIDS (additional costs for counselling, testing, local public education and treatment, part centrally funded)	12
5.	Call and recall arrangements for cervical cancer by April 1988	3
6.	Community care (transitional costs of closing mental hospitals and improved standards of long-term care)	15
7.	Implementation of Korner report on information (computers, staffing)	15
8.	Other pressures (eg medical career structure, resource management)	15
	TOTAL	120

6. Thus measurable demands already exceed the resources which (on an optimistic assumption about 1987 pay) authorities may be expected to have available. They will have, therefore, to make additional general improvements in efficiency to meet these priorities.

7. No provision is included for implementing the Forest report on breast cancer screening. This requires £6 million in 1987-88, rising to nearly £20 million in 1989-90, but is estimated eventually to save 5000 lives a year.

DD

RAWP

1. Aim of policy: to ensure that - over time - health services are made available where the "customers" are.

Background

2. "RAWP" is actually a two-stage process:

(i) target allocations for a health authority area are calculated using a formula which reflects the population served (including an allowance for patients coming from other authorities for treatment). The formula also takes account of factors affecting need for health services (eg age; variations in mortality as a proxy for variations in the incidence of sickness across the country) and of factors affecting the cost of service provision (extra costs of teaching hospitals; higher staff costs in London);

(ii) decisions are then taken each year on what should be the pace of change towards those targets.

3. There are two aspects of RAWP:

(i) "national" RAWP - the allocation of resources to NHS regions;

(ii) "sub-regional RAWP" - the allocation of resources by regions to their constituent districts.

Why is RAWP necessary?

4. The way health services have developed (especially pre-NHS, but reinforced by the "incremental" approach to funding in the earlier years of the NHS) left hospitals very unevenly provided across the country. And the location of services also needs to respond population shifts.

KL

5. Providing the bulk of hospital services nearer the "customers" is increasingly important given an ageing population. It also makes it possible to treat more patients as outpatients or day cases, which is more efficient - but which would be difficult if they had to travel long distances.

6. Abandoning RAWP would mean either returning to a system of incremental funding, or a bidding system, or specific, centralised planning. Incremental funding would not be responsive to changes in the location or the needs of populations. Areas of the country which are relatively well-provided with resources would have less incentive to increase efficiency. A bidding system would result in funding going to the noisiest lobbies - not always the most efficient - and would lead to increased public controversy about NHS funding. Centralised planning would not be feasible for a large, decentralised organisation like the NHS.

7. The NHS Management Board's review of the RAWP formula - with majority health service membership (including four RHA Chairmen) on the Steering Group, endorsed both the principles of RAWP and the need for a national formula.

8. There are also very strong pressures from the "below target" districts - including the Home Counties - for new services. Stopping RAWP would dismay this group.

Problem issues

9. These fall into two main groups:

(i) doubts about the adequacy of the formula;

(ii) doubts about pace of change, especially for sub-regional RAWP.

Action in hand

10. Doubts about the formula: the NHSMB's review showed that there was no "off-the-peg" research that could be used to improve the national formula. New work is therefore now under way to improve

We must not fall into the same trap as with the RSG formula - over complication to no purpose.

certain aspects of the formula, especially on the way it reflects "need" for health services (eg in inner cities and other "deprived" areas) and on the adequacy of the allowance for the extra costs of teaching hospitals. The adjustments for treating patients from another area and for higher labour costs in London and the South East are also under scrutiny. The Board plans a final report by the end of 1987.

11. A number of regions are exploring ways of improving the formula they use for calculating the sub-regional targets, so as to reflect local circumstances. Regions generally will also benefit from the new research being carried out to improve the national formula. Some are also exploring the idea of negotiated "payments" between authorities to take account of cross-boundary flows.

12. Doubts about pace of change

(i) sub-regionally: planning guidelines to regions will re-emphasise the importance of having manageable plans for services, incorporating a feasible pace of change - with bridging arrangements where necessary. Ministers and the Board will follow this up through the planning and review systems and take further action if necessary;

(ii) the £30 million special fund, announced to ease transitional problems in regions receiving less than average increases in resources (the Thames Regions, North Western and Mersey), will assist pace of change and bridging problems sub-regionally, and also helps with the presentation of pace of change nationally.

E

WAITING LISTS AND TIMES

The problem

Waiting lists for in-patient treatment remained at around 500,000 from 1948 until the early 1970s, when they began to increase reaching a record high of 752,000 in March 1979. The latest published figure is some 80,000 below that, and the proportion of patients waiting over 1 year for treatment (24%) is lower than at any time in the past decade. Nevertheless, unless action is taken, the underlying trend is upward, despite the fact that the NHS is treating more patients than ever before. The real problem is not so much the size of the list but the length of time that too many patients have to wait.

2. The reasons, and the extent of the problem, vary from district to district and specialty to specialty. The ageing population and the greater availability of medical and surgical treatment are major factors. In part the problem can be solved at the local level by more efficient use of resources and facilities. Improvements through management action are both possible and necessary. However the existence of a £50m Waiting List Fund has been a strong spur to management to take that action and will enable more rapid progress to be made.

The Waiting List/Time Initiative

3. The national initiative was launched in July 1986. The aim is to reduce excessive waiting lists and times over the next 3 years, with the emphasis on early action. Chairmen of Regional Health Authorities were asked to lead their districts in a review of the nature, extent and causes of waiting list and time problems and to report to the Secretary of State by the end of October. These reports were to set out the action already under way and that planned for 1986/87 and following years. All reports were received on time and regions received an individual response within the month, identifying areas for management priority where the action proposed was weak or inadequate. We emphasised the scope for improvements within existing funds and the need to make reductions by March 1987.

4. Early in November the Government announced the Waiting List Fund of £50m over the years 1987/8 and 1988/9. RHAs were invited to bid for funds, and all bids were received by the first week in January. Most of the regional bids are well targeted at specific problems where rapid progress can be made at marginal costs. By the end of January Sir Roy Griffiths and senior officials will have discussed the strength and weaknesses of each of the reports and the detailed bids with the Regional General Managers concerned. Decisions on the allocation of the Fund will reflect judgments on the extent to which regions have already taken effective action within existing resources, the magnitude of their problems and the impact likely to be made by the projects funded.

5. Points stressed to regions include the need to give more and better information to General Practitioners, the necessity of ensuring the co-operation and commitment of clinicians, the regional role in matching spare capacity in one hospital with excessive waiting lists in other districts and the scope for making cost-effective use of the private sector.

6. As a result of the activities, reduction of waiting lists and times is now accepted as a top priority by health authorities and their general managers. The availability of additional funds has done much to stimulate action and to obtain the support and co-operation of consultants, without whom

little progress will be made. Health authorities have shown imagination in producing innovative solutions, some of which will be capable of use on a national scale. The best targeted bids and plans will have major impact for relatively small cost by focusing on problems which relieve bottlenecks and allow greater throughput of patients.

The next steps

7. The allocations from the Waiting List Fund will be announced in early February. Sir Roy Griffiths is leading the Departmental team which will monitor closely health authorities' achievement of their action programmes and the projects funded. The need to improve waiting lists and times will remain high on the agenda of health authorities and management. The quality and speed of the work done so far means that significant improvements should be achieved during 1987/8. The size of the waiting list is determined by many factors quite apart from additional patients treated, so it would be unwise to predict the impact of the initiative on the total size of the list. Very significant impact should however be achieved, since initial estimates are that about 80,000 additional cases will be treated in 1987/8 as a result of the Waiting List Fund. We are aiming for an even greater impact on waiting times because action is being targeted on blackspots where excessive waiting is occurring.

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CANCER SCREENING

Background

a. Cervical Cancer

1. Cervical cancer can be prevented if abnormalities are detected and dealt with at the pre-cancerous stage. Nearly 2,000 women a year die from cervical cancer at present in England, 94 per cent of them aged 35 or over. The existing screening service is not reaching large numbers of the population at risk, particularly older women. Computerised call and recall systems are being introduced (operating in 109 health districts by March this year and planned for the remaining 82 by March next year). Women will receive a personal screening invitation, usually from their own GPs.

2. The Department's expert advisory committee has recommended screening every three years instead of every five. Ministers have decided not to accept this at present since they feel it is more important to concentrate first on trying to reach all the population at risk. The Committee also recommended that call and recall systems be extended to cover all women aged 20 to 65, not just the priority group of women aged 35 and over; Ministers have accepted this. Authorities will also be asked to place responsibility for the efficiency of the service on a specific named individual.

b. Breast Cancer

3. 15,000 die a year from breast cancer in the UK. A working group set up by the UK health ministers under the chairmanship of Professor Sir Patrick Forrest to report on Breast Cancer Screening has now reported. The group concluded that research has demonstrated that breast cancer screening by mammography for women aged 50 to 64 could reduce deaths by at least one third and has suggested that for the present screening should take place at three-yearly intervals for women in that age group. He also pointed out that specialised back-up facilities (for diagnosis and treatment) would be needed to take advantage of the screening.

4. Ministers are proposing that such a service should be set up in England and should be fully operational by March 1990. This should mean that all eligible women would have been screened at least once by March 1993. The estimated costs of setting up and running such a screening service are

	87/88 £m	88/89 £m	89/90 £m	90/91 and after £m
Capital	4	6	6	-
Revenue	2	7	13	15
	6	13	19	15
No of centres by year end	14	54	100	100

In addition, the health authorities will have to find a total of about £12m over the initial screening period to cover the cost of treating the additional cases thrown up by the screening. Once the initial screening process is complete the number of cases requiring treatment should revert to previous levels.

5. Ministers in the other three countries are likely to take a similar approach.

6. The Chief Secretary has been asked to agree that savings which are planned to be made in the Family Practitioner Services can be transferred to the health authorities vote to cover the cost of setting up the first phase of the screening service in 1987/88. The cost of implementing the remainder of the screening programme will be considered in the forthcoming Survey. Health authorities will probably have to meet consequential additional treatment costs from their existing allocations.

Action Proposed

7. Once the Chief Secretary's agreement has been obtained for the transfer of funds (see para 6 above) an announcement is proposed on both breast and cervical cancer screening. It would say that the Forrest Report is being published [it is being held until the announcement is made] and that the Government has decided to implement a breast cancer screening service throughout the UK. Each Regional Health Authority in England should have one screening centre established by March 1988. A few of these centres will be designated to provide training for staff and a general demonstration of how a service might be run. A full system should be in place by March 1990. On cervical cancer, reference will be made to the computerised call and recall system and arrangements for monitoring its effectiveness. Health authorities will be asked to rationalise arrangements to cover all women between 20 and 64 and to place responsibility for the organisation and effectiveness of the service on one, named, individual. The concentration will be on reaching as many women as possible in the age groups concerned rather than on increasing the frequency of screening for those who are symptom-free. The screening interval will, therefore, remain at five years for the present, but this will be monitored and reviewed in the light of progress in reaching more women under the existing arrangements.

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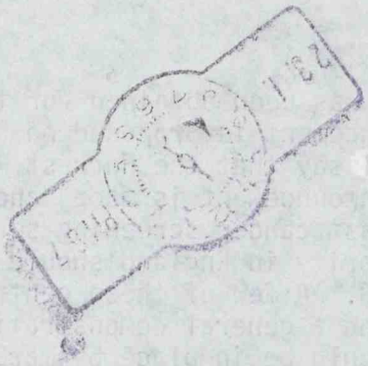

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DEPARTMENT OF HEALTH AND SOCIAL SECURITY

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

Telephone 01-407 5522

From the Secretary of State for Social Services

David Norgrove Esq
Private Secretary
10 Downing Street

23 January 1987

Prime Minister

This seems very slow and cautious. Agree to ask why they aren't prepared to move faster?

DRS
23/1

Dear David,

NHS MANAGEMENT ACCOUNTS

You asked in your letter of 17 December where matters now stood on the issue of inter-region and inter-district charging.

Our present endeavours are concentrated on what can be achieved within broadly the existing framework. Historically the approach has been to rely on two mechanisms - adjustment of targets for the effect of cross-boundary flows, and special funding arrangements at national or regional level for the most complex forms of treatment, such as transplant surgery, the neurosciences and cardiac services. These still have an important role to play, but as the discussion in September and the complaints from the Christie Hospital show, the strains caused by cross-boundary movements are being more keenly felt. This reflects both the tighter financial disciplines on authorities and the increase in the numbers of more complex treatments available.

We are already exploring with a number of Regions arrangements for formal agreements between two authorities for one to provide an agreed level of service to the other's patients at an agreed cost and with direct transfer of funds. The NHS Management Board's report on resource allocation recommends further experiments and we shall be taking this forward. The object in doing so will be to arrange transfers - of service responsibility and of funding - in a way that maintains financial discipline.

Looking slightly further ahead, our work with health authorities on resource management will provide much improved information on the costs of different types of treatment. This in turn should open new opportunities for cost effective cross-charging arrangements.

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We are keeping these developments under review, and are ready to intervene if Regions cannot reach amicable agreements. The particular problem at the Christie Hospital has one unusual dimension in that it involves patient flows from Wales, which may require adjustments between Welsh Office and DHSS programmes; this too is being investigated.

Yours ever

A Laurance
Private Secretary

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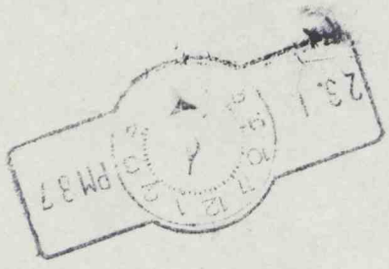

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PRIME MINISTER

The draft below is a sort of radical options paper for the health service. My first impression is that it rushes too much into mechanisms, organisation and schemes without enough consideration of objectives. But I will put in some more detailed comments when Mr. Fowler submits the final version.

N.L.W.

N.L. WICKS
23 January 1987

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E.R.

Copy No. 2 of 4

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TOWARDS BETTER HEALTH CARE: A CASE FOR CHANGE

1 Resources

1.1 Public expectations about the quantity and quality of health care which should be available are rising all the time. This, along with demographic change and medical advance, is putting more and more pressure on available resources.

1.2 As the demand for services rises, so probably will costs also rise and faster than inflation. In particular, the rapid increase in the pay of skilled staff in other sectors is likely to create pressure for higher pay within the health sector, especially among the main professional groups.

1.3 International comparisons show that we spend less as a nation on health care than any other comparable nation (see Figure 1). We probably get better value for it, but sustained criticism too for not spending more. The public seems willing to have more spent on health care. But the present NHS financing arrangements mean that those who are financially able and willing to pay more are not actually able to buy better services within the NHS. And many in this group also live in districts which are losing resources under the RAWP formula. So there is both frustration and grievance.

1.4 It is important not to undermine the basic level of services available for the disadvantaged, nor to lose the gains we have made in encouraging a more equitable geographic distribution of services. Is it, however, desirable and possible to offer greater scope for those who wish to pay more for a better service from the NHS without undermining, or overwhelming, the private sector (which at present provides only a small proportion of all available health care)?

Contd.....

2 Management and Organisation

2.1 The quality of service available from the NHS is very variable. There is obviously potential for improvement within existing resources by better use management. Detailed health issues are in consequence absorbing more and more of Ministers' - and Parliament's - time, despite the fact that considerable effort has gone into both improving the quality of NHS Management and devolving responsibility to local health authorities. This detailed involvement is inevitable whilst Ministers have to account to Parliament for all health service expenditure. There would be real advantages in distancing the operation and management of the NHS from Government. Could it be done?

2.2 One approach would be to create an independent corporation, which could be given a great deal of discretion to provide services in terms of its day-to-day operation, but could also be contracted to deliver a specific package of services in a cost-effective way. But such independence and discretion could only survive if the body had its own source of finance which it could control. Alternatively, exchequer-financed local health care providers, such as Regional and District Health Authorities, could be given freedom to raise additional funds from non-governmental sources, and central funding could be limited to an agreed basic level of service.

3 Options for change

3.1 The Annex briefly describes some possible new ways of financing health services. The options can be packaged in different ways to meet different objectives and needs. The key factors are their effect on the tax burden and their ability to generate additional resources for the health care sector as a whole. In working up options, questions which would have to be borne in mind are:

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* would the option create new financial resources for health care or lead only to a switch of resources within the health care sector?

* would the option safeguard standards and above that encourage uniformity or diversity in the provision of services?

* what would be the reaction of the professions and what consultation would be needed?

* what legislative changes would be needed?

* what would be the timetable for implementation?

3.2 There is a fundamental difference between the concept of a new tax-based strategy geared to reducing the tax burden whilst maintaining or increasing the funds available, and a new insurance-based system, which could be one route to an independent corporation with its own source of finance, rather than, or as well as, a method of reducing public expenditure. Should we pursue further either or both of these approaches?

4 The way forward

4.1 The NHS is seen as one of our great national institutions. There is, as yet, no Manifesto commitment to radical reform, and no expectation of it in the deeply entrenched clinical professions. The development and implementation of any of the options presented in the attached paper would require much public discussion and massive negotiations. We would have to act early in the next Parliament. We might, for instance, issue a Green Paper early in Year 1, legislate in Year 2, and implement in Years 3/4. Even this timetable allows little scope for demonstrating effectiveness in the lifetime of a single

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Parliament. A different approach would be to float the ideas early in the new Parliament, allowing a full public discussion with a view to instituting progressive experimentation and change.

23 January 1987

Percentage share of health expenditure in GDP, 1983.

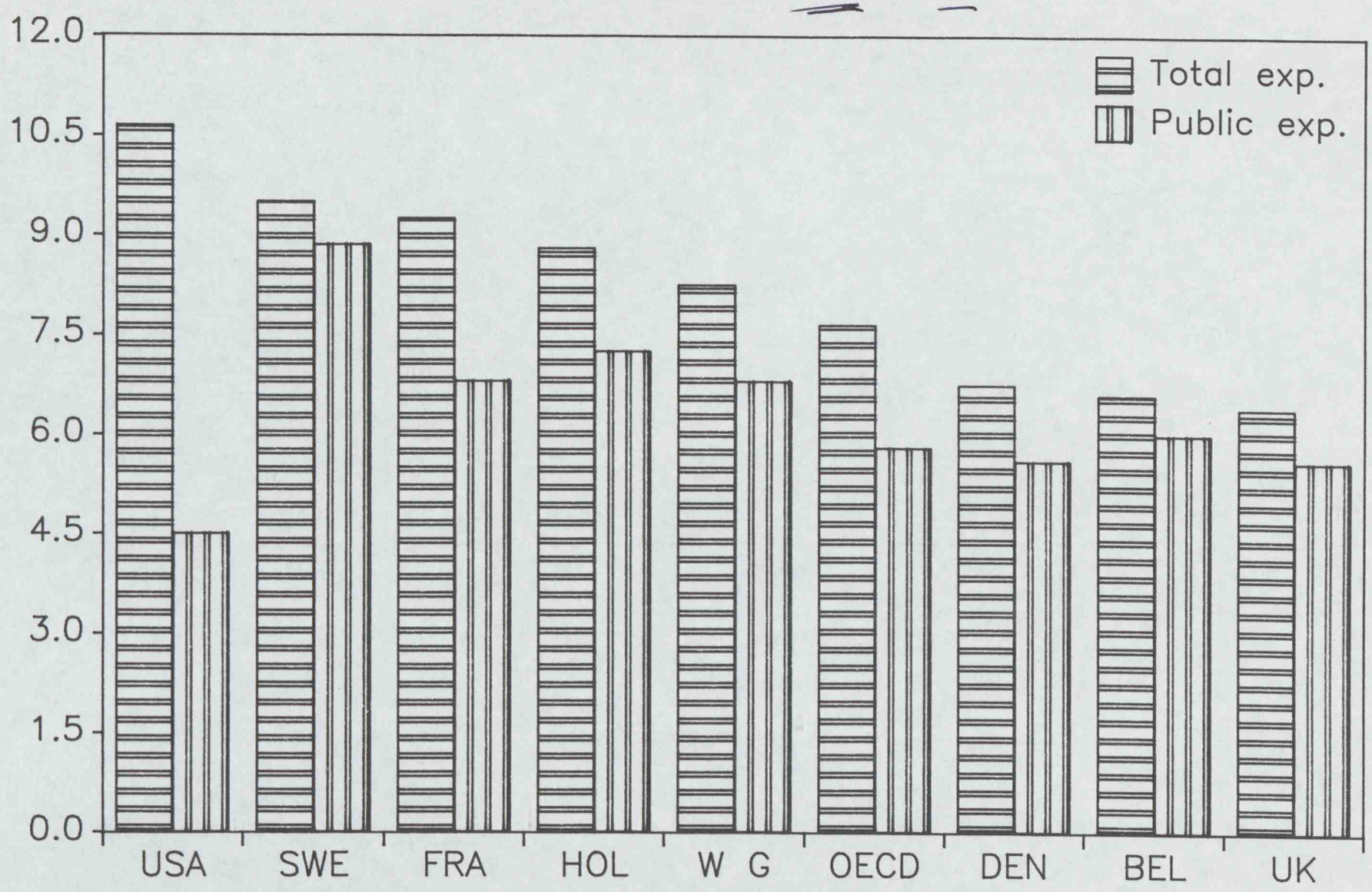

FIGURE 1

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ANNEX

SOME ALTERNATIVE METHODS OF FINANCING HEALTH CARE

1 Introduction

This paper briefly describes some alternative methods for financing health care. These fall into two broad groups.

- a new tax-based strategy aimed at reducing or preventing an increase in the tax burden and increasing consumer choice whilst maintaining the basic structure of the service, and with or without additional resources to be spent on health care. Implementation should be possible within the lifetime of a Parliament;

- an insurance-based strategy which could have the same advantage whilst also lessening Government involvement in the administration of health services. Implementation would be likely to extend over the lifetime of more than one Parliament.

2 An exchequer-financed NHS with additional sources of funds

This could incorporate the following features.

2.1 Greater use of the NI fund

The National Insurance fund is currently extremely buoyant as pay has been rising faster than benefits (which are linked to prices). This situation cannot be guaranteed to last indefinitely but in the meantime it could be used either to allow a reduction in NI contribution rates, or to back a reduction in taxation.

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Alternatively, the buoyancy could be retained and used to finance some or all of the demand-led part of the NHS (i.e., the Family Practitioner Services). This would not affect the level of public expenditure but might reduce the PSBR. NI contributions directly related to the NHS might be more acceptable to the public than general taxation. If NI contribution rates remain unchanged, except for an uprating of the upper limit in line with increases in earnings, the surplus on the NI fund is expected to be as follows:

£ billion

1987/88	1988/89	1989/90	1990/91
0.7	1.8	2.2	2.6

There is already an NHS element in the NI contribution, and this is expected to grow as follows:

2.7	2.9	3.05	3.2

If the expected surplus, plus the NHS element, were available, the total would therefore be

3.4	4.7	5.25	5.8

The net cost of the FPS in these years is projected as:

3.8	4.1	4.3	4.5

In other words, with the exception of the coming financial year (1987/88) when the shortfall would be £0.4 billion (the equivalent of a 0.1 per cent increase in NI contributions), the cost of the FPS could be met from these two elements of the NI fund, with a significant surplus, in each of these forward years.

Contd.....

Another way of increasing the size of the fund would be to abolish, or raise, the upper earnings limit. The proceeds could then be used to increase the funds available to the NHS. Abolishing the limit has been considered, but not proceeded with, on a number of occasions. It would raise £0.9 billion in a full year at 1987/88 prices.

2.2 Raising more revenue through charges

Additional revenue could be raised either by introducing new charges, such as a hotel charge for hospital in-patients (see Appendix A for an assessment), or by reducing exemptions from current charges. Introducing savings vouchers (as for TV licences), or extending the season tickets currently available to cover prescription charges, might reduce the impact of such new charges on those with limited incomes. Other options for extending charges considered in the past, such as a charge for out-patients, a GP consultation fee, or charges for services such as vaccination, could create disincentives to seeking prompt primary care and might therefore entail long-term costs for the hospital service and the general health of the population. However, schemes which created disincentives to hospital care could similarly entail costs for the community services depending upon whether or not individuals were prepared to use their own resources.

2.3 Increased revenue through commercial activity

Promote schemes to maximise health authorities' revenue through commercial ventures (e.g., lotteries, shops, occupational health services for local firms, private clinics). The revenue generated might be only of

E.R.

marginal benefit inrelation to total budgets, but would represent additional resources and have a symbolic community value.

2.4 Introducing greater choice

The introduction of a hotel charge (see above) could be combined with a package of new optional services and amenities designed to make the health service more consumer-oriented. Given that they would have to pay a minimum hotel charge, patients might be more willing to pay a little extra for attractive amenities. If health authorities could retain the income generated in this way as an independent source of revenue, this would create an incentive to maximize revenue by providing the amenities the consumer wanted. A more radical approach would be to allow patients greater choice as to where they obtain health services. For example, individuals could "sign-up" with a particular health authority which would then receive a capitation fee, and those wishing to use private health care could receive vouchers equivalent to the value of the capitation fee. The value of the fee/vouchers would have to be weighted according to the individual's risk category. Health maintenance organisations (see below) might well develop under such arrangements.

2.5 The introduction of private capital to provide facilities and services on a leasing basis.

This would involve the financing of health provision on a similar basis to that used for the new Dartford river crossing. Private capital and management experience could be used to provide and possibly run new facilities, or to redevelop and upgrade older facilities.

3 An insurance-based strategy (i.e. moving away from a solely Exchequer-based system to the generation of independent resources with a continuing Exchequer contribution for disadvantaged groups).

The introduction of such a strategy could be expected to take at least five years for consultation, legislation and implementation, and it would be a considerable time before the benefits would become obvious. The two models are social insurance, as operated in many European countries, and private insurance as operated in the USA.

3.1 Social Insurance

The 1981 report of the working party on alternative means of financing health care considered this. A scheme might have the following features:

(i) A social insurance scheme funded by the working population as a special part of the NI system with both employer and employee contributing.

(ii) Redistributive measures to avoid possible regressive effects, (ie the better off would be asked to pay proportionately more.)

(iii) Voluntary contracting out by employers for the whole (not part) of their workforce on the basis that employers ensure that their employees are adequately covered; those who contract out could join a Health Maintenance Organisation (see Appendix B for details). Contracting out carries the danger of "adverse selection" (i.e. only those least at risk contract-out leading to little reduction in the demand for public health services.) This would be partly countered by

requiring workforces to abide by the majority decision, but some regulation of the insurance industry might be necessary.

(iv) "Top-up" payments for additional services (e.g., amenity beds).

(v) A minimum emergency service for the uninsured, and contributions loaded to provide cover for elderly and unemployed people.

3.2 Such a scheme could only lead to greater responsiveness to consumer demand if accompanied by a move to demand-led budgeting.

A social insurance scheme could be run by an autonomous statutory agency. There is a danger that the contributions might be seen as a new tax. Many EEC countries are looking for ways of switching away from their current heavy reliance on employment based taxes to reduce disincentives to employers taking on extra staff and to reduce knock-on effects on wage demands. Such a system would reduce direct Government involvement in running the health service, but the experience of other countries (e.g. Scandinavian countries, Australia) suggests that considerable involvement would still be required.

3.3 Private Insurance

Introduction of a full-blown private insurance system would be costly in administrative terms. However, a small proportion of the total funds for the service could be raised in this way under either a tax-based or a social insurance strategy. If a new package of charges was introduced, as in 2.2, individuals could be encouraged to insure themselves to cover the increased costs. Existing insurance schemes to cover the costs

of ill-health ("hospital contributory schemes" - see Appendix C for details) could be expanded and adapted. A more radical approach would be to finance health services for the working population from compulsory private insurance, perhaps through employers who could be asked to contribute. The scheme could be flat-rate or risk-related. Individuals above a certain income could contract out and there would be scope for topping up. Employers might be encouraged to offer topping up as a "perk". Services for the non-employed would be funded from taxation. Such an approach has broadly the same advantages and disadvantages as a social insurance system with a stronger emphasis on reducing the role of Government and of public expenditure. It would inevitably be a long term strategy.

4 Resource allocation

For any of the above methods to be effective, cost escalation would have to be prevented. If an insurance-based strategy were to be introduced it would be particularly important to learn lessons from the USA and elsewhere. This might indicate some central control or direction. One approach (the "Enthoven model" see Appendix D for further details) is to allocate resources in accordance with the patient's choice, creating a market with health authorities in competition with each other and the private sector. Information about hospital facilities, waiting lists etc., would have to be provided to facilitate informed choice. A possible disadvantage would be the inefficient use of resources due to over-utilisation of some facilities and under-utilisation of others.

5 Other sources of finances

Other possible sources of funds to the health service include voluntary fund raising and industrial sponsorship. The former already makes a small but significant contribution. It is difficult to see how the latter could "take-off" to any great extent without some benefit accruing to the sponsoring company or its employees (eg advertising, preferential treatment). However, the possibility of exploiting other sources of funding to a greater extent could be explored.

POTENTIAL INCOME FROM CHARGES

A1 Charges might be based on hotel costs (catering, laundry, linen) - some £5 a day in the acute and maternity hospitals, £4 (geriatric) or £3.50 (mental illness, mental handicap) or on all non-treatment costs - £25 (acute), £30 (maternity), £15 geriatric, mental illness, mental handicap.

A2 Assuming that existing low income exceptions apply pro rata in the acute, maternity and geriatric sectors, and (arbitrarily) that 50 per cent of mentally ill and 90 per cent of mental handicap patients would be exempt, income potential is as follows:

(a) Hotel Charge (£5, £4 or£3.50)

	Total	Less Exception	Yield	£ million
Acute	181	- 45	136	
Maternity	20	- 5	15	
Geriatric	74	- 27	47	
M Illness	80	- 40	40	
M Handicap	39	- 35	4	
	394	- 152	242	

(b) All costs (£25, £30, £15)

Acute	905	- 225	680	
Maternity	120	- 30	90	
Geriatric	222	- 81	141	
M Illness	240	- 120	120	
M Handicap	117	- 105	12	
	1604	- 561	1043	

Both yield figures are likely to be considerably overstated, since new charges on such a scale would lead to higher limits for low income exception.

APPENDIX B

HEALTH MAINTENANCE ORGANISATIONS

B.1. Health Maintenance Organisation [HMOs] are systems developed in the USA in which a group of physicians assumes a contractual responsibility to provide a specified range of medical services to subscribers who have agreed to pay a fixed rate independent of the use they make of services. The HMO is primarily accountable to the subscribers both for the adequacy of provision and for the level of the subscription rates. HMOs provide an integrated package of care. One significant recent development in the USA is the piloting of "social HMOs" delivering a wide range of services. The "Seniors Plus" scheme, as the project is called, provides a range of medical and allied services including residential care or support in the home where appropriate.

B.2. A number of studies have found that costs in HMOs are 10-40% lower than in fee-for-service systems, and there is evidence that this saving is partly or wholly due to differences in hospitalisation rates. Clearly however, this finding may not generalise to health care systems outside the USA, where fee-for-service systems do not operate, or where hospitalisation rates are in many cases lower.

B.3. Whether or not the HMO model necessarily produces cost savings it certainly seems to allow greater scope for consumer influence and choice, and could be utilised in the UK, within both a private or social insurance system, as follows:

i) insurance companies and individual DHAs would offer cover on a pre-payment basis;

ii) all insurance carriers would be required to accept all comers and to adopt a community rating (ie charging all subscribers the same premium irrespective of risk for the defined package of health care); and

iii) if premiums were to be the same in all parts of the country a central government equalisation fund would be necessary.

B.4 There may be scope for experimentation, for example, with the introduction of HMOs within one Regional Health Authority.

APPENDIX C

HOSPITAL CONTRIBUTORY SCHEMES

C 1. These schemes provide a cash benefit in the event of a subscriber going into hospital in return for a modest premium. Other benefits (e.g. maternity benefit, and benefits to cover dental and optical treatment) are also available, but the cost of receiving private medical treatment is not covered. A typical example of such a scheme is provided by the Hospital Savings Association. For a contribution of 25p a week a benefit of £21 per week is paid during a stay in hospital and for a contribution of £2 per week a £168 per week benefit is paid. There are about 30 organisations which provide this service and which are members of the British Hospital Contributory Association. Most are locally based, and there are some 3 million subscribers in all. Total income in 1983/84 was £54 million, and total benefits paid amounted to £37 million. In addition, £665,000 was contributed to charities.

C 2. Insurance brokers can arrange similar cover on a commercial basis. Relevant insurance schemes fall into two categories:

a) personal accident and sickness schemes; and

b) permanent health insurance

The advantage of the latter is that the insurance company cannot insert an exclusion or refuse to renew the policy. The cost of personal accident and sickness insurance is similar to that offered by hospital contributory schemes: typically an individual classified as "low-risk" might expect to pay £6 per year for every £10 of weekly sickness benefit with higher rates for higher risk individuals. It may be difficult or impossible for certain high risk individuals (eg elderly people) to obtain a quotation.

APPENDIX D

ANNEX 4. PROFESSOR ENTHOVEN'S PROPOSED STRATEGY FOR THE NHS

D 1. Professor Enthoven is a leading health care economist based at Stanford University, California. In 1985 a Nuffield Occasional Paper "Reflections on improving efficiency in the NHS" reported his findings from a study visit to this country. In essence, Enthoven proposed an internal market within the health service with individual DHAs competing for the custom of patients. His proposed strategy entails:

a) capitation based finance with DHAs operating within a cash limit fixed according to population; and,

b) DHAs to provide or buy comprehensive services, including primary care, for their own population and to sell services to others

In order to create such a system it would be necessary to:

i) tag individual patients and cross-charge for services so that money "moves with the patient".

ii) improve information on costs and performance (although Körner may lay the necessary foundations); and,

iii) give local managers greater freedom to act as entrepreneurs.

The rationale behind the Enthoven model is that it would provide greater incentives to managers and service providers, and create equality of access to care, whilst maintaining centres of excellence. The model also involves the better integration of primary and hospital care thus preventing patients from becoming "locked in" to component parts of the health care system, and improves consumer choice by allowing people on the borders of one DHA to "join" a neighbouring one, creating pressure for better and more responsive services.

D 2. Enthoven sees his strategy as a means of establishing Health Maintenance Organisations financed through private insurance. However, it might be possible to create a more consumer oriented and competitive health service

using the Enthoven approach without moving to a full-blown system of private insurance. In itself his approach does not necessarily increase the funds available for health care, but coupled with initiatives to increase the available funds it could yield a more efficient utilisation of resources if under-utilisation of facilities perceived as "lower quality" did not result.

D 3. Ideally the Enthoven model embraces all health care delivery systems, and this implies the bringing together of HCHS, FPS and LASS budgets under the control of a single body. There is a danger that any less radical approach would result in DHAs attempting to shift costs onto other authorities' budgets (as already happens to some extent), thus negating one of the main purposes of the model.

D 4. The initial report on the "Review of the Resource Allocation Working Party Formula" identified three major areas of difficulty which could rule out full implementation of the Enthoven model:

i) it assumes instant implementation of allocations in line with District RAWP targets;

ii) it involves abrogating the GP's right to refer patients to consultants in other Districts; and,

iii) major investment in financial information systems would be required.

The report therefore recommends a more gradual expansion of cross-charging. It is not entirely clear that points (i) - (iii) are an inevitable consequence of the Enthoven model - but it is important to note that such a recently published report reaches such conclusions. There may be scope for experimentation with a limited version of the model covering certain services only, or confined to one Regional Health Authority.

Copy: No. 2

Personal.

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

23 January

Dear Nigel.

Here is a briefing paper for the PM's meeting with my Secretary of State and me about the future of the NHS and health care.

As you will see, it is political high explosive. It has been prepared by me with the help of a Principal here, Carole Souter. So it is secure. Even so, I fret about the danger.

Grateful for a reaction. I am putting it in to N.F. for discussion here on Monday.

Yours ever
Ken.

CC/BG

16pm

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

The Rt Hon Nicholas Edwards MP
Secretary of State for Wales
Welsh Office
Gwydyr House
Whitehall
LONDON
SW1A 2ER

16 January 1987

Dear Nick.

REVIEW OF COMMUNITY CARE

Thank you for your letter of 19 December regarding the overview of the funding of community care that I have asked Sir Roy Griffiths to undertake.

I certainly recognise that there is a Welsh interest in the outcome, particularly on social security aspects. And I would not expect your efficiency scrutiny to be delayed in any way. Your suggestion of feeding into the study information and views based on Welsh experience seems to be absolutely right and I have asked Sir Roy to ensure that his team of officials make contact with yours to sort out how best that might be done.

I am copying this letter to the Prime Minister, Malcolm Rifkind, Tom King, Nicholas Ridley, John MacGregor and to Sir Robert Armstrong.

Yours Norman.

NORMAN FOWLER

NAT HEALTH: Expenditure PT2

CCBG.

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

The Rt Hon Malcolm Rifkind QC MP
Secretary of State for Scotland
Scottish Office
Dover House
Whitehall
LONDON
SW1A 2AU

16 January 1987

Dear Secretary of State

REVIEW OF COMMUNITY CARE

Your letter of 16 December suggested a need to clarify the implications for Scotland of the overview I have commissioned of Sir Roy Griffiths.

I agree with both the main points you make. Our officials have, I believe, already been discussing arrangements for consultation during the study; and when in due course I receive Sir Roy's proposals I shall indeed want to discuss these with colleagues.

I am copying this letter to the Prime Minister, Nicholas Edwards, Tom King, Nicholas Ridley, John MacGregor and to Sir Robert Armstrong.

Yours sincerely

for NORMAN FOWLER

(Approved by the Secretary of State and signed in his absence)

NAT HEALTH Expenditure PT1

File GA

10 DOWNING STREET

From the Principal Private Secretary 12 January 1987

THE MAUDSLEY HOSPITAL

The Prime Minister has seen Baroness Trumpington's letter of 7 January in which she gives a progress report in dealing with the problems at the Maudsley Hospital.

The Prime Minister has read this letter with interest and looks forward to receiving a further report after Lady Trumpington has visited the Hospital again on 3 February.

(N. L. WICKS)

G. H. Langsdan, Esq.,
Office of Baroness Trumpington,
Department of Health and Social Security.

GA

MS2446p

MEA.
May arise @ questions?

PSV 9/1

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
Private Secretary
10 Downing Street
LONDON
SW1

8 January 1987

Dear Andy

THE HEALTH SERVICE IN ENGLAND: ANNUAL REPORT 1985/86

I enclose three copies of this Report which is the third in a series of annual reports on the health service. I also enclose a copy of our accompanying press release. Copies of the Report have been made available in the Vote Office.

only one received. FILED IN FOLDER AT BACK of FILE.

I am copying this letter and enclosures to Private Secretaries to members of the Cabinet, the Attorney General and the Lord Advocate.

Yours

Jane McKessack

JANE McKESSACK
Private Secretary

Prime Minister
to note.

2

N.L.O
K.I

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

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

Telephone 01-407 5522

From the Joint Parliamentary Under Secretary of State

The Rt Hon Margaret Thatcher MP
Prime Minister
10 Downing Street
LONDON SW1

7 JAN 1987

Dear Prime Minister,

THE MAUDSLEY HOSPITAL

I promised when I wrote to you on 20 October that I would keep you in the picture about our progress in dealing with the problems which I detected at this hospital when I visited it last Summer. I attach a brief note.

I should add that I had a useful meeting with the Chairman and General Manager of this Authority before Christmas when I made it very clear to them that they must maintain the momentum of improvement in the hospital's fabric, cleanliness and where possible staff morale, without exceeding their budgets (not yet allocated for next year) for either capital or revenue spending.

Officials are in close touch with both members and officers of this Authority and will continue to assist them in strengthening management and improving patient care at this hospital, in every way they can.

I have also arranged to visit the hospital again on 3 February when I shall most carefully check on progress. I will let you know the outcome.

Yours sincerely

Trumpington

THE BARONESS TRUMPINGTON

THE MAUDSLEY HOSPITAL, DENMARK HILL - PROGRESS REPORT

Cleaning

The revised contract for domestic cleaning let to a private company from 1 October has been closely monitored and after some initial teething difficulties, is going well. The contract has been varied, at small additional cost, in order to ensure that areas of maximum use have cleaning frequencies adequate to their needs.

Upgrading the wards

In the short term, ward upgradings and refurbishment of entrance and Outpatient Departments are being effected by allocation of a small additional grant this year, and re-ordering of next year's 'small schemes' allocations. Associated re-decoration will do much to improve the hospital's appearance, with consequent effects upon morale. Work on this has already begun.

In the medium term, replacement of the oldest wards will start in May (tenders for construction of a ward block, on which departmental officials have advised, have been let); and plans for approval of a second ward block and for construction of facilities for treatment of older patients are expected. Whilst their construction will be dependent on availability of capital from departmental allocations, we expect to be able to make some contribution this year.

Financial management

With a view to ensuring the best possible value is obtained for money, and that current budgeting and expenditure are kept firmly under control, the Department has insisted that the Authority take on a financial consultant on a part-time basis. He will report within the next three months on financial systems, income and expenditure, and financial relationships with other healh authorities for whom services are provided. (This follows on from the Authority's commitment at its 10 November meeting, to examine further steps

necessary to bring its existing budget into balance (which should also curb excessive media coverage) emanating primarily from lack of sound financial information.

Clinical regimes and training

Informal discussions are taking place between members of the Authority's staff and professional advisers in the Department, about the scope for alleviating temporary overcrowding, etc through changes in professional practice. On a more formal basis, Departmental officials agreed with the Authority's Chairman and Officers at their Annual Accountability Review, held last month, that they would work together over the coming year to define priorities for clinical care, in association with organisations interested in the research and training output of this Authority.

Leadership

Whilst there is evidence that the 'new broom' represented by the General Manager and those he has so far recruited is having a beneficial effect on both planning and management of this hospital, morale is still low and much needs to be done to engage the medical, nursing and other staff, more constructively in management. The Department is actively encouraging and supporting the General Manager in this endeavour.

We shall also use the opportunity of current vacancies on the Authority itself to strengthen it. We are also urgently seeking to identify possible successors to the present Chairman, whose term of office is due to end next year.

NAT HEALTH. Expenditure
PT7

SWYDDFA GYMREIG
GWYDYR HOUSE
WHITEHALL LONDON SW1A 2ER
Tel. 01-233 3000 (Switsfwrdd)
01-233 6106 (Llinell Union)

Oddi wrth Ysgrifennydd Gwladol Cymru

WELSH OFFICE
GWYDYR HOUSE
WHITEHALL LONDON SW1A 2ER
Tel. 01-233 3000 (Switchboard)
01-233 6106 (Direct Line)

From The Secretary of State for Wales

The Rt Hon Nicholas Edwards MP

19 December 1986

REVIEW OF COMMUNITY CARE

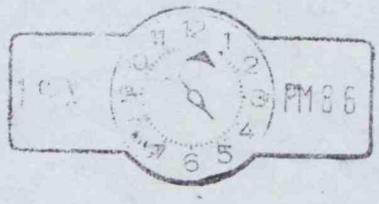
I welcome the proposal outlined in your minute of 2 December that Sir Roy Griffiths should be asked to undertake an overview of the way in which public funds are used to support community care policy. The social security benefit arrangements in particular have major implications for the delivery of community, health and social services and need to be reviewed in the context of our community care policies. Indeed a joint working party led by your Department has for some time been examining social security support for residential care and is due to report shortly. I imagine that the findings will be covered in Sir Roy's remit. Any proposed changes affecting social security would almost certainly have to apply on a Great Britain or United Kingdom basis and I would want my Department to have the opportunity of providing Roy Griffiths with an account of our experience of the effects of the present social security arrangements on the delivery of personal social services.

You referred to variations in the way in which community care funds are managed in different parts of the country. In Wales we have diverged significantly from England in a number of respects and as you know I have launched major initiatives in the field of community care for the mentally handicapped and the elderly; and I am currently considering a further major initiative on mental illness. I would find it more appropriate, therefore, if Roy Griffiths' recommendations in this area were confined to England, though I shall naturally want to assess the implications any proposed changes, in the social security field in particular, may have for the way in which we develop services in Wales. My Department is, for example, in consultation with Sir Robin Ibbs, about to embark upon an efficiency scrutiny of community care central funding in Wales and the potential for providing incentives for more positive co-operation. I would certainly not wish to be inhibited from pressing ahead with this study. Indeed, I would hope that our findings and our experience of recent initiatives in Wales would provide a useful input to Roy Griffiths' review. As with his earlier study, I am sure that there would be no difficulty about settling on arrangements for exchanging information and views as this inquiry proceeds.

I am sending copies of this letter to the Prime Minister and those who received copies of your initial minute.

The Rt Hon Norman Fowler MP
Secretary of State for Social Services
Department of Health and Social Security

NAT. HEALTH: Expenditure: Part 7



LO4AIK CP
a Prof. Griffiths

10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

Private Office rang. say didn't arrive until 8 Jan! 16/1

17 December 1986

NHS MANAGEMENT ACCOUNTS

The Prime Minister, as you know, visited before Christmas the Christie Hospital in Manchester. Her guides on the tour mentioned to her the difficulties faced by the hospital because the hospital was unable to charge an economic price, or in some cases at all, to other districts or regions which sent patients to the hospital. This was a particular difficulty because the Christie Hospital tended to receive only the most serious and difficult cases. (I may say that virtually everyone to whom I spoke in the hospital took the opportunity to mention this grievance to me.)

You will remember that the problem of inter-region and inter-district charging was discussed at the Prime Minister's dinner for Chairmen of Regional Health Authorities. The Prime Minister would be glad to know where matters stand on this.

DAVID NORGROVE

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

CC/B5

SECRETARY OF STATE FOR SCOTLAND

SCOTTISH OFFICE
WHITEHALL, LONDON SW1A 2AU

CONFIDENTIAL

The Rt Hon Norman Fowler MP
Secretary of State for Social Services
Department of Health and Social Security
Alexander Fleming House
Elephant and Castle
London
SE1 6BY

NFBM

16 December 1986

Dear Norman,

REVIEW OF COMMUNITY CARE

I am grateful to you for sending me a copy of your minute of 2 December to the Prime Minister on this subject.

I agree with you as to the importance of studying the way in which public funding is being used in this field with a view to seeing how the available funds could be used to better effect. I would not wish to oppose the idea of a study on the lines you propose which is related to England, though it seems essential to clarify the implications for Scotland at the outset since your announcement is almost certain to give rise to questions north of the border.

As I see it, there are strong arguments on the grounds of simplicity for limiting study to England. At the same time, we must accept that it would be very difficult for me to mount a similar study in Scotland (either now or later on) because the funding which is going into community care in Scotland from the Social Security side of your Department is outwith my control. For this reason, I believe it will be essential that we can say at the outset how we propose to deal with the situation in Scotland.

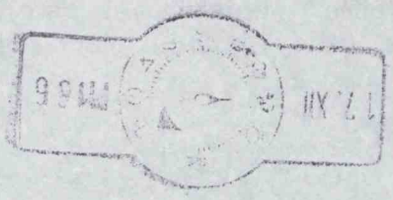
The main points to be made are that there will be close consultation in the course of the study, and that the recommendations emerging from it will be subject to joint consideration by Ministers on a GB, or UK, basis before decisions are reached. I hope you agree that this line should be taken in response to any questions raised on your statement, and in reply to any representations made to me subsequently by Scottish interests.

I am copying this letter to the Prime Minister as well as to Nicholas Edwards, Tom King, Nicholas Ridley, John MacGregor and Sir Robert Armstrong.

Yours ever,

MALCOLM RIFKIND

Nat Health: Esap + Eff PT7



SENIOR STAFF IN CONFIDENCE

fe VK

ABPS - do you wish to keep? So far as the Appt is concerned - yes. Copy to CF to bring forward for Report.

10 DOWNING STREET

From the Principal Private Secretary

SIR ROBERT ARMSTRONG

PERSONNEL DIRECTOR, NHS MANAGEMENT BOARD

I have shown the Prime Minister your minute of 8 December in which you ask her to agree that the Grade 3 post now occupied by Mr. Wormald should not be abolished, if Mr. Wormald is promoted to Grade 2 as Director of Operations for Personnel.

The Prime Minister now agrees, in the light of your explanation, that the Grade 3 post should be maintained. But she has asked that she should be given in, say, six months time a report on what has been achieved in the NHS since the changes in management were made earlier this year. I should be grateful if you could arrrange with the DHSS to provide such a report.

N.L. WICKS

10 December 1986

SENIOR STAFF IN CONFIDENCE

003/2982

CC 86

CONFIDENTIAL

FROM: CHIEF SECRETARY
DATE: 10 December 1986

NBPM -

PRIME MINISTER

COMMUNITY CARE

I have seen Norman Fowler's minute to you of 2 December proposing that Sir Roy Griffiths should undertake an overview of community care policy.

2 This seems an excellent idea. It offers the chance of outside expertise from an experienced manager, while avoiding the pitfalls of arousing expectations for additional public expenditure.

3 I should like Treasury officials to be kept closely in touch with Sir Roy's work.

4 I am sending a copy of this minute to Norman Fowler, Malcolm Rifkind, Nick Edwards, Tom King, Nicholas Ridley and to Sir Robert Armstrong.

JM

JOHN MacGREGOR

NAT HEALTH

EXP + EFF

v67.

CONFIDENTIAL

Rice

R
VSCADK
CeBG

10 DOWNING STREET

LONDON SW1A 2AA

From the Private Secretary

10 December 1986

Dear Tony,

REVIEW OF COMMUNITY CARE

The Prime Minister has seen your Secretary of State's minute of 2 December proposing a review of community care to be carried out by Sir Roy Griffiths.

The Prime Minister is content, subject to the views of colleagues, that this review should go ahead. She would like to be kept in touch with its progress and she would wish to hold a meeting to discuss its interim results in the spring.

The Prime Minister believes there may well be areas where the balance between community care and institutional care will be worth Sir Roy's consideration. Whilst she would not wish to propose a change in the terms of reference, she hopes your Secretary of State will encourage him to consider the balance between institutional care and community care where his enquiry shows that it would be fruitful for him to do so. The Prime Minister also thinks it would be worthwhile for Sir Roy to investigate areas where the private sector, including voluntary organisations, might be encouraged to provide care in the community. It could, for example, be cost-effective for private sector organisations to provide a package of care which in the public sector would be provided by different groups (such as home helps, meals on wheels and basic nursing).

I am copying this letter to Robert Gordon (Scottish Office), Colin Williams (Welsh Office), David Watkins (Northern Ireland Office), Brian Leonard (Department of the Environment), Jill Rutter (Chief Secretary's Office) and Trevor Woolley (Cabinet Office).

Yours,
David.

DAVID NORGROVE

MA

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

CONFIDENTIAL

CONFIDENTIAL

PRIME MINISTER 1

REVIEW OF COMMUNITY CARE

Please read the minutes from David Willetts and Norman Fowler below before reading on.

I wonder whether it is right to seek to change the terms of reference for the review to include the scope of community care? This would tend to reopen the whole debate about how far people should be shifted into the community and would make the inquiry a much more massive and controversial affair. The same result could be achieved by suggesting to Mr. Fowler that he encourages Roy Griffiths to consider the balance between institutional care and community care where he thinks it would be fruitful for him to do so.

With this amendment and the other points suggested by David Willetts, agree the proposed review subject to the views of colleagues? (The Chief Secretary is content that the review should go ahead.)

David Norgrove
9 December 1986

JA2AIB

CONFIDENTIAL

B/F with N Fowler's minute

CONFIDENTIAL

PRIME MINISTER

5 December 1986

REVIEW OF COMMUNITY CARE

press conference tbc in Thursday

The Audit Commission will publish a report before Christmas attacking the way in which the community care policy is being implemented. This has concentrated Norman Fowler's mind: he wants to defuse the growing criticism by announcing that Roy Griffiths is reviewing the whole subject.

The financial arrangements are certainly a shambles with an enormous budget divided up roughly as follows:

NHS	Community Health Services	£0.8 b
NHS	Day Patient Care	£0.1 b
LAs	Residential Homes	£0.6 b
LAs	Domiciliary Services	£1.3 b
Social Security	Disability Benefits	£1.5 b
Social Security	Nursing Homes	£0.2 b
Total (but list is not comprehensive)		£4.6 b

It is a good idea to review the whole subject. I recommend that you warmly welcome Norman Fowler's proposals but you may want to add the following points.

First, Norman Fowler nowhere sets out a timetable. I understand that he is thinking in terms of a report by the Autumn of next year but doesn't wish to announce anything to tie him down if election fever mounts. But Autumn is surely the latest possible ~~debate~~ date for a useful, sharp report. You may therefore want to suggest you will chair a meeting in the Spring to get a progress report. That should keep the work on track.

CONFIDENTIAL

Secondly, the terms of reference are drafted as if community care is obviously the right policy and the only question is how best to implement and finance it. Community care is best for some people. But, as you were pointing out the other day, a well run, modern long stay insititution in the countryside may be a better way of treating some groups (eg severely mentally handicapped) than sticking them in a hostel in a city centre. So the review should also investigate the scope of community care.

Thirdly, the Review will prepare the ground for capping the uncontrolled growth of Supplementary Benefit expenditure on nursing homes, which has zoomed up from £20m in 1979/80 to £240m in 1984/85 and is still growing. But at least this spending is a sort of voucher with which people are buying private care of their own choice. It would be a pity if sensible cash controls also led to a return to public sector provision. The private sector can contribute in other ways apart from nursing homes. For example, rigid job demarcation in the public sector can lead to over-elaborate provision of care by lots of different groups. It might be much more efficient to buy a package of care from one private sector organisation which provided a combined home help/meals on wheels/basic nursing service. The voluntary sector can also provide a lot.

Finally, you may be worried whether Roy Griffiths will be able to take on this extra task. His work as Deputy Chairman of the Management Board is already taking a lot of time as Norman Fowler and Tony Newton are preoccupied with Aids. And of course he still has his work at Sainsburys. But Sir Roy is confident he can take this on. It is very encouraging that, after being suspicious at first, Norman Fowler is now keen to use his abilities as much as possible.

CONFIDENTIAL

Conclusion

I recommend that David Norgrove write to Norman Fowler's office welcoming the review but noting that:

- you will want to hold a meeting to check progress in the Spring;

- it should also investigate whether community care is always the best and most cost-effective option;

- it should investigate innovative ways of using the private and voluntary sectors.

David Willetts

DAVID WILLETTS

CONFIDENTIAL

010

CCBG

BTF Wednesday.

PRIME MINISTER

REVIEW OF COMMUNITY CARE

I am concerned that our community care policy should be as effectively delivered and effectively managed as possible. It is a key element in our strategy for the health service, for the personal social services and for social security. And we devote substantial public funds to it. So we need to be sure that we are doing all we can to get it right.

I therefore propose to ask Sir Roy Griffiths, the Government's adviser on the health service, to undertake an overview of community care policy. The review will be in the nature of Sir Roy's very successful review of management in the health service - in other words it will not be a long Royal Commission type investigation but an inquiry leading to action. Sir Roy will be able to take on points raised by other departments.

The terms of reference of his remit would be:

> "To review the way in which public funds are used to support community care policy and to advise me on the options for action that would improve the use of these funds as a contribution to more effective community care".

We have in hand detailed studies of certain aspects of community care, particularly residential care. But we need to complement these studies by the overview I am proposing for three main reasons.

First, the present structure of social security benefits may encourage people to go into residential or nursing care, when they

E.R.

might actually be better off in their own home and prefer to remain there. It is important that the social security system is sensitive to individual requirements. But it is equally important that the system should operate neutrally and not distort individual choice. Given the sharp rise in expenditure on residential and nursing care in recent years, we need to see whether the system is operating sensibly and fairly. One of the main focusses of Sir Roy's work will therefore be to examine the financing of nursing homes, residential care homes and other group accommodation in which social care facilities are provided on a communal basis and compare it to the financing of domiciliary care.

Second, substantial public funds go, quite rightly, into supporting our community care policies. They are provided through social security, through the personal social services run by local authorities and through the health service. Given the scale of funds involved, we need to look at whether they are being used to give best value for money, whether they are properly targeted and whether people who have help are given the help most appropriate to their needs.

Third, there is considerable variation in the way that community care funds are managed in different parts of the country. And indeed it is sensible that the arrangements should be capable of adaption to suit local circumstances. But this does not mean that there is no scope for better budgetary and other financial management arrangements, which would help to improve the use of resources. This, too, is an area which would benefit from an expert outside scrutiny.

I expect the Audit Commission to publish a report on community care shortly before the Recess, which will be critical of the implementation of community care policy. I propose to announce Sir Roy's inquiry before then.

I am copying this minute to the Scottish, Welsh, Northern Ireland and Environment Secretaries, to the Chief Secretary and to Sir Robert Armstrong.

2 December 1986

N F

SECRET AND PERSONAL

LOG A8V 1.

C D Wallis

10 DOWNING STREET

LONDON SW1A 2AA

From the Principal Private Secretary

1 December 1986

THE FUTURE OF THE NATIONAL HEALTH SERVICE

Your Secretary of State, the Minister for Health and Sir Kenneth Stowe are coming to have a further discussion with the Prime Minister on the National Health Service on Monday 12 January at 1500. In my letter of 28 October I set out some of the topics which the Prime Minister would like to discuss. I now write with a further topic which the Prime Minister would like to discuss at this meeting.

It is, I think, common ground that standards in the Health Service, patient choice and the Service's funding are linked. For example, if a patient and his general practitioner are not in a position to make an informed choice, there is little pressure to raise standards of health care. And if funding does not go to the hospital which the patient has chosen, the better hospitals will not have the resources to treat the patient.

The Prime Minister would like to explore this nexus of issues at the meeting on 12 January. She would be grateful if your Secretary of State could submit a short paper on this subject in time for the discussion.

N. L. WICKS.

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

SECRET AND PERSONAL

(F)

Prime Minister
Shall I do this at end?
N. L. W.

PRIME MINISTER 28 November 1986 28.11

Yes please not

THE DARTFORD HOSPITAL CASE

The grim facts of the Dartford Hospital case are clear. Felix Weale, a respected vascular surgeon, refused to leave home to carry out an emergency operation on somebody who had been prepared for surgery at his instructions, saying it was Christmas Eve and his leave had begun. David Skidmore, a colleague at Dartford Hospital, had to rush in to carry out the operation instead.

The General Medical Council decided that Mr Weale had made 'a gross error of clinical judgement' and found him guilty of 'serious professional misconduct' But the "sad incident" was an exceptional lapse so Mr Weale was not struck off the list.

You asked about all this on Monday. I have spoken confidentially to Ian McColl and Arnold Elton - two senior and distinguished medical figures. They have explained some of the murky background to this case.

Dartford was not a happy hospital. Mr Skidmore and Mr Weale had not spoken for at least four years. Moreover, this tense atmosphere had begun to affect the general quality of medical work at that hospital. Surgeons at Guys found themselves having to operate to correct medical mistakes made at Dartford. But there was no management initiative to sort these problems out. Nobody had the authority to knock heads together. This resembles the enquiry into food posoning at Stanley Royd hospital which showed that people on the inside knew there was a problem but nobody had responsibility for sorting it out.

The General Medical Council is not the right body to handle such problems. The only real crimes in their book are to advertise or sleep with a patient. So the GMC case got a lot of publicity without tough measures, whereas we need the opposite - less scandal and tougher action. David Skidmore may well have been driven to go beyond local management because he lacked confidence in their power or decisiveness.

These disciplinary procedures are not just weak, they are also cumbersome. The Dartford episode occurred back in December 1983. Mr Weale was not suspended during the GMC invesitgation, but sometimes doctors are suspended on full pay for years whilst officialdom goes through elaborate procedures.

Where were the patients in all this? The medical establishment may have known that things were wrong at Dartford, but the poor citizens of Dartford did not know until this gruesome episode. They carried on going to a hospital where relations between the surgeons were so bad that the quality of medical service was at risk. If we are to raise professional standards then we need better information which patients can act on. Schools are now obliged to publish their exam results and open enrolment will enable parents to act on the information. Maybe we will eventually oblige hospitals to reveal more about their performance.

This sad case contains two important lessons.

First, we need respected local management with the power to knock heads together. The doctors' own professional bodies aren't much help and their procedures are too cumbersome.

Secondly, standards, choice, and funding all go together. If the patient and his GP can't make an informed choice then there's no pressure to raise standards. And if the funding doesn't go where the patient has chosen, the good hospitals might not have the money to treat him anyway. At Monday's meeting you again urged Mr Fowler to look at ways of making the money go much more closely with the patient. I recommend that you ask the DHSS for a short paper on this subject to be discussed at the review meeting Nigel Wicks* has arranged for next month.

R. Crossman

for **DAVID WILLETTS** with good approval.

FEA

Already sent to PM: NWRHA

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

Nigel Wicks Esq CBE
10 Downing Street
LONDON
SW1

4 November 1986

Dear Nigel.

I enclose the latest Annual Report of the North Western Regional Health Authority. It strikes me as a well presented summary of the Region's activities which the Prime Minister may like to see, if she has not already.

Yours ever.

Ken.

NORTH WESTERN HEALTH SERVICES ANNUAL REPORT AND ACCOUNTS 1985/6

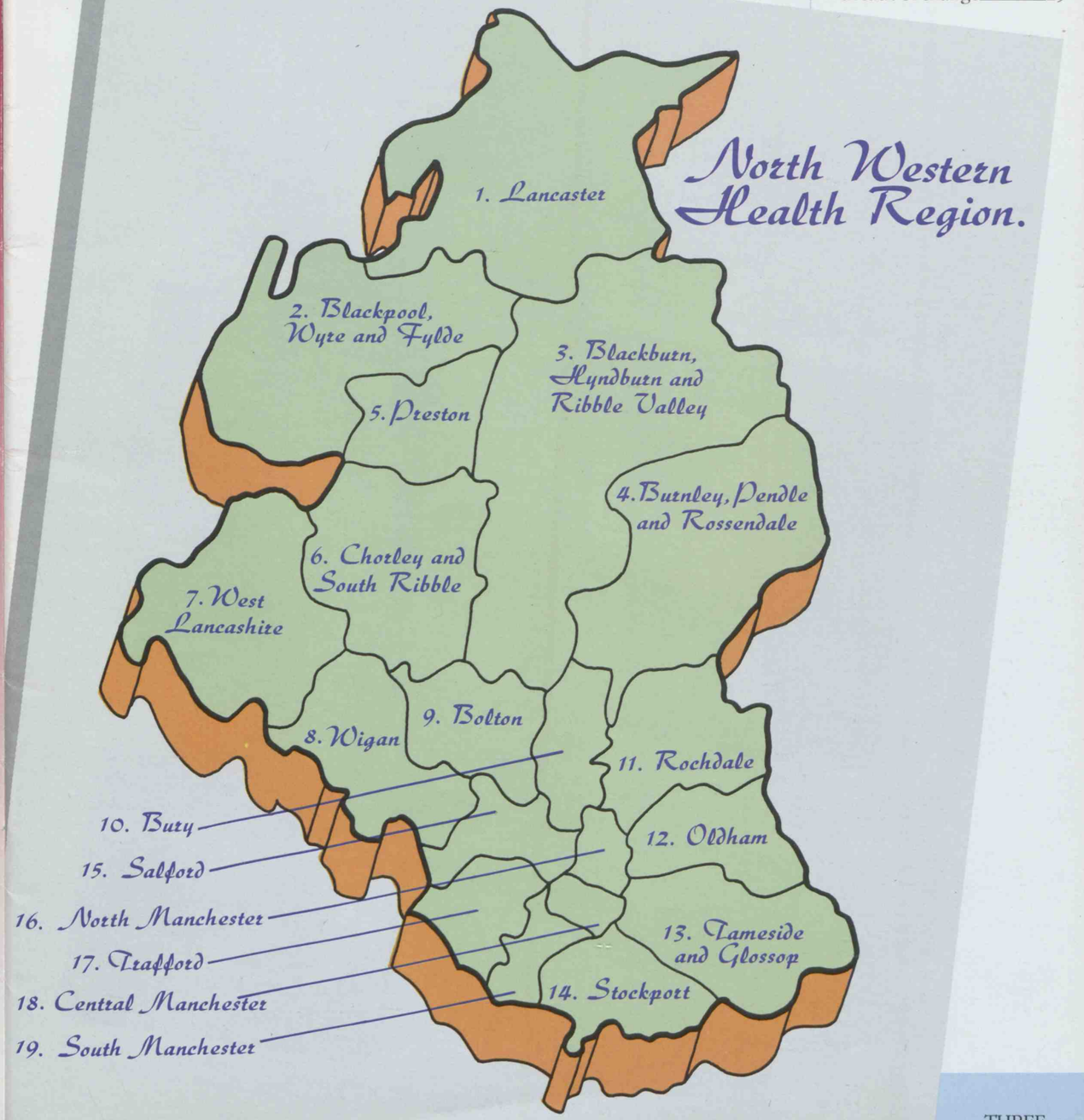
"Another year of progress for North Western Health Services."

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."

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

New maternity unit at Sharoe Green hospital, Preston.

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

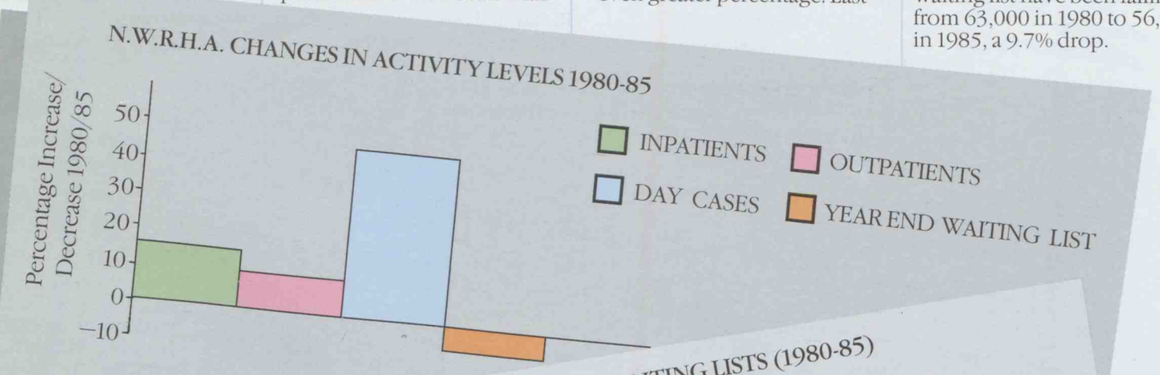
There was also a significant increase in the number of out-patient attendances over the same five-year period. In total they rose by 311,800 (9.5%).

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.

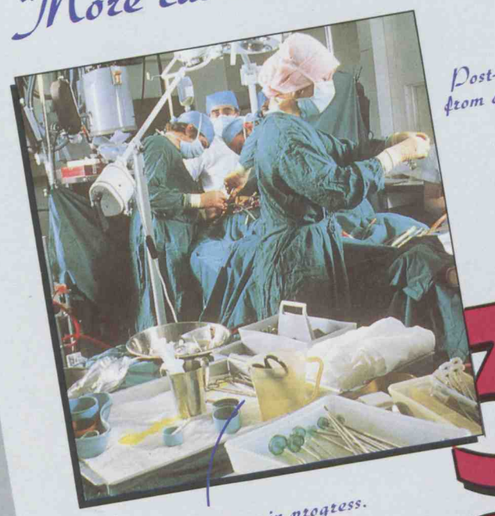
Renal dialysis

- 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 another 60 places.

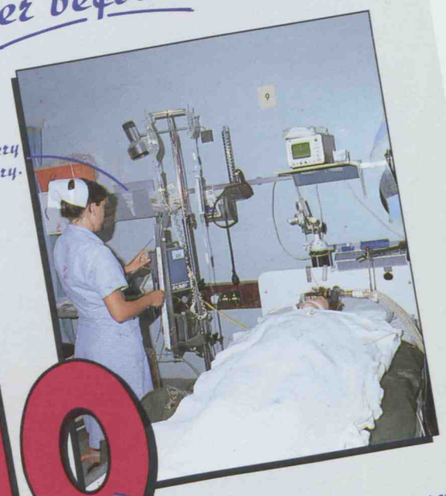
Kidney transplants

- 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.



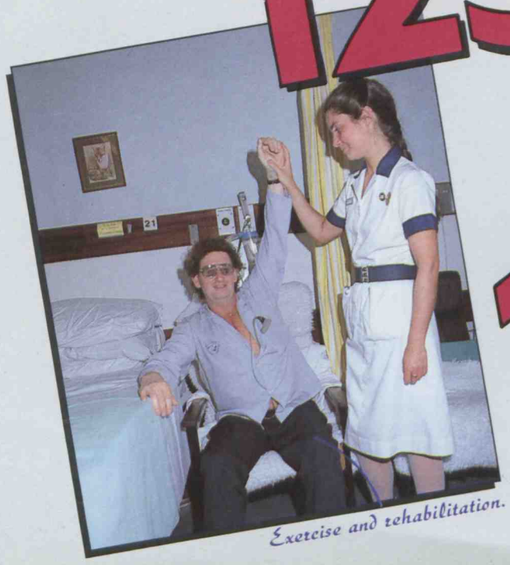
Post-operative recovery from open heart surgery.

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 – Leukaemia 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:

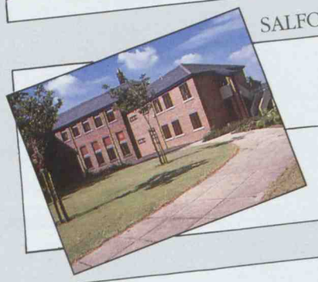
WIGAN		Date completed
*Royal Albert Edward Infirmary – Ward Block Phase I providing 112 acute beds; 3 operating theatres and one minor theatre	£6.64m	May 1986
*Leigh Infirmary Second Mental Illness Unit providing 60 in-patient beds and 80 day places	£2.69m	May 1985

*Leigh Infirmary HSDU, sub-station and roadworks	£1.85m	December 1985

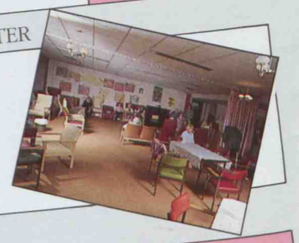
BOLTON		Date completed
*Fall Birch Elderly Severely Mentally Infirm Day Unit with 40 day places and support places	£1.14m	December 1985

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

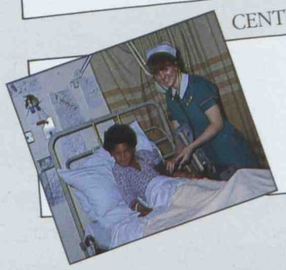
BURY		Date completed
*Fairfield General Hospital – Boiler House	£1.47m	November 1985
*Fairfield General Hospital – Mental Illness Day Unit with 80 places	£1.32m	April 1986
*Fairfield General Hospital – Communications Complex	£0.46m	July 1985



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

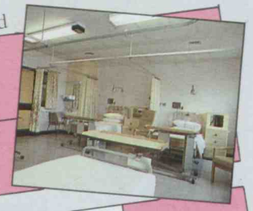
OLDHAM		Scheduled completion
*Oldham District General Hospital – Phase I Redevelopment providing 300 beds; seven operating theatres; an accident and emergency department; a pharmacy and new out-patient and X-ray departments	£17.74m	February 1988

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

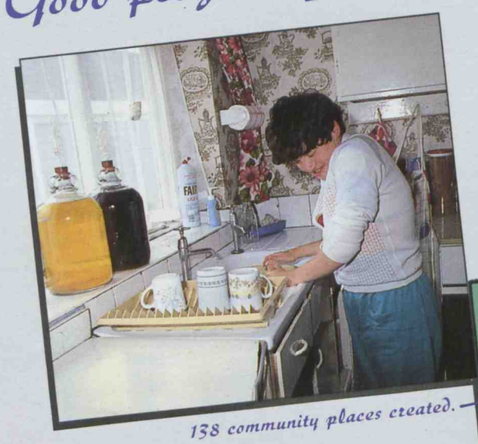
Sixty-four new 'direct care' community staff for mental handicap were appointed, including nurses, health visitors, team leaders, speech therapists and others who have been specifically trained to support individuals at home and their families.

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:

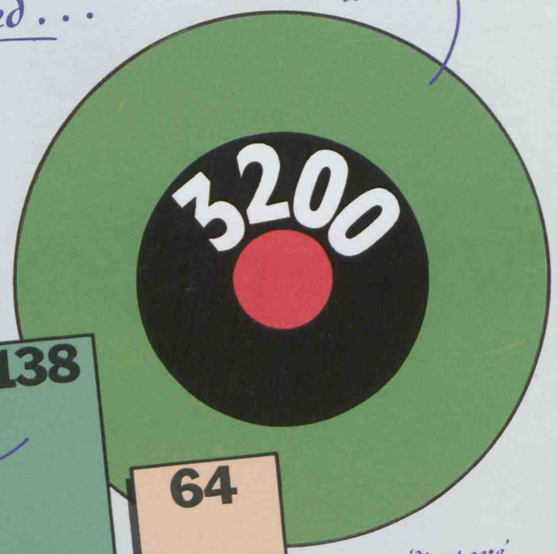
- A video entitled "A Home of Their Own" was produced and launched by the RHA in October, 1985. Telling the story of four young mentally handicapped women on their journey from life in Calderstones Hospital, Burnley, to an ordinary house in Rochdale, it demonstrates through a documentary format that, 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.



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)

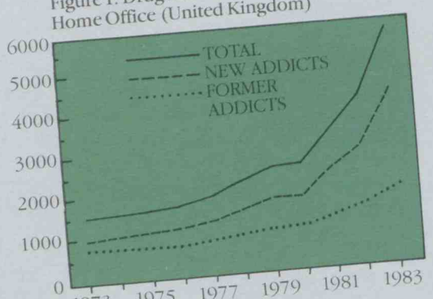
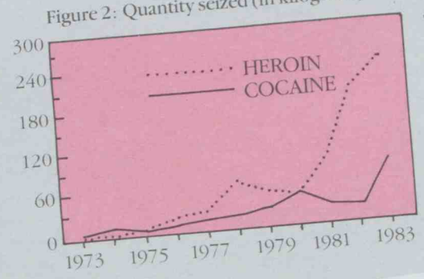
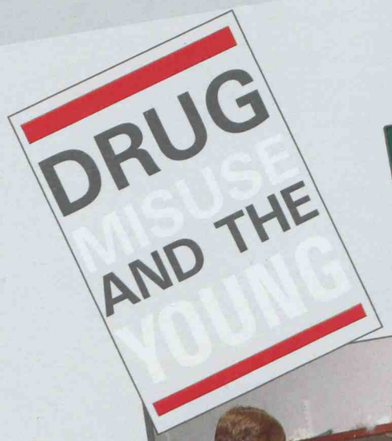


Figure 2: Quantity seized (in kilograms)



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..."

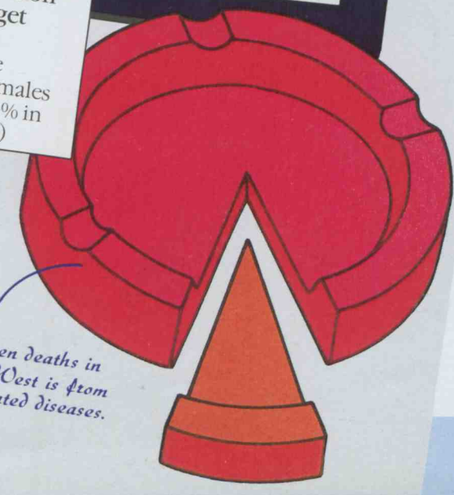
Already 9000 children have been recruited to the Smokebusters Club.

Newspaper advertising to help smokers give up.

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

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 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 June 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.

Prevention of alcohol misuse
Strategic target (1983-93)
*to reduce to 4% of males aged 18 and over those who consume an average of eight or more units of alcohol a day;
*to reduce to 1% of females aged 18 and over those who consume an average of six or more units of alcohol a day.

Dental Health
Strategic target (1983-1993)
*to increase to over 90% those receiving public water supplies containing approximately 1mg/litre (one part per million) of fluoride.

Nutrition and Healthy Eating
Strategic Target (1983-93)
* to increase to 70% those aged 14-70 years who can identify the major foods which are high/low in fat, sugar, salt, fibre, vitamins and calories.

Adjusting the fluoride level of water supplies will help prevent tooth decay.

Average of £7.20 per week per household is spent in the Region on alcoholic drinks.

Sensible drinking, with a daily limit on the amount to be consumed, is the key to the future alcohol education campaigns in the region.

Eating for health: part of the strategy to beat coronary heart diseases.

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.

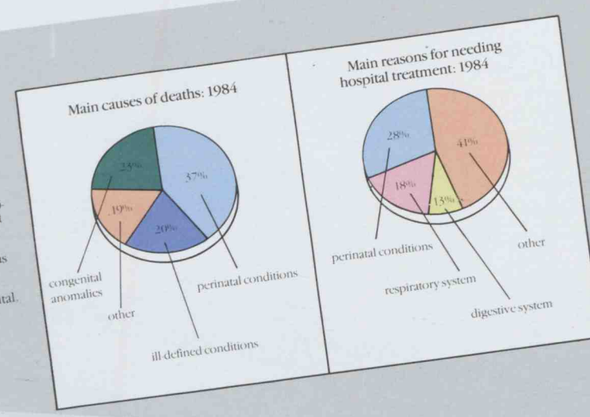
HEALTH IN THE NORTH WEST
Scope for action

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?

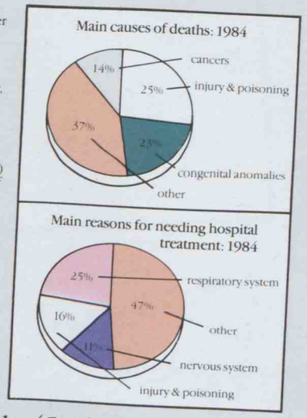
Infants aged under one year

- 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.



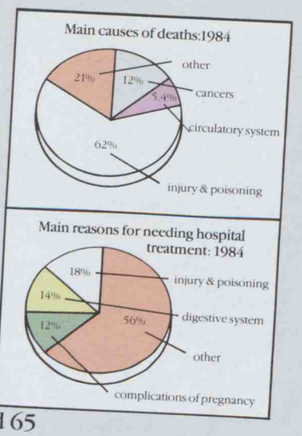
Young children aged 1-4

- 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.



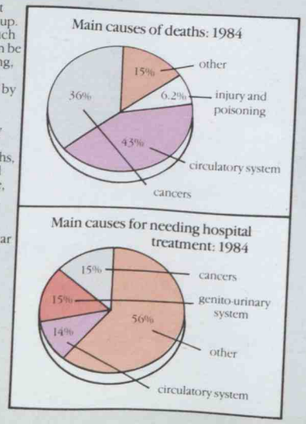
Young adults aged 15-24

- 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.



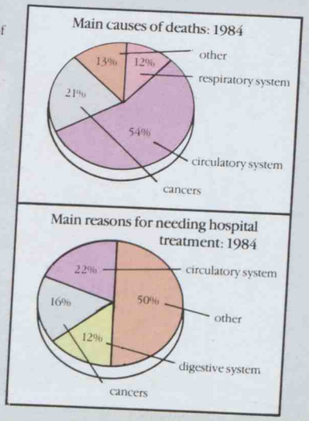
Middle-aged adults 45-54

- 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.

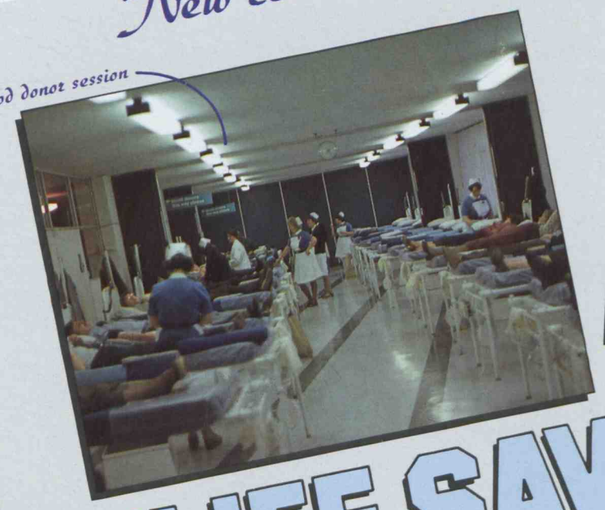
Campaign for new donors

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

RED ALERT

DON'T LET US RUN OUT OF BLOOD

THE NATIONAL BLOOD TRANS

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 . . ."

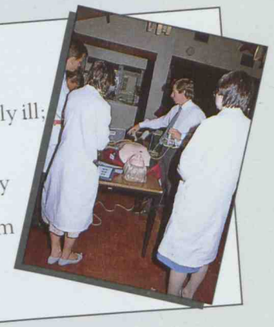
New technology is helping to improve the control of drug usage.

Computerised medical records system at Rochdale Infirmary

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

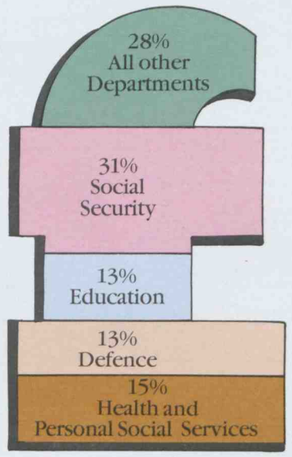
SALFORD
- Kendal day unit opened at Prestwich Hospital, providing 50 places for elderly patients with mental infirmities;
- an additional 16 community places established for mentally ill residents in long-stay institutions;
- completion of £¾ million scheme to upgrade kitchen and restaurant at Ladywell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

% allocation of funds to Government Departments, 1985/6



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:

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

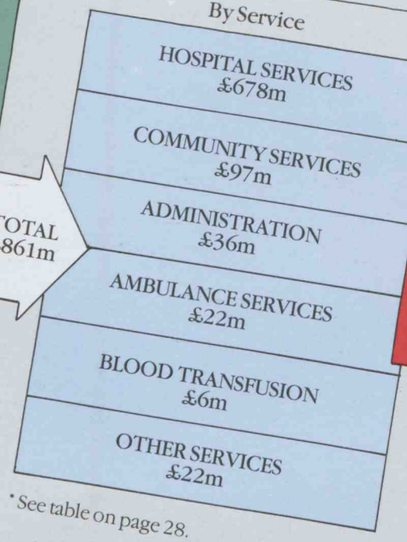
£861 million was spent on running health services in the North Western Region in 1985/86 compared with £814 million in the previous year, an increase of 5.7%.

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

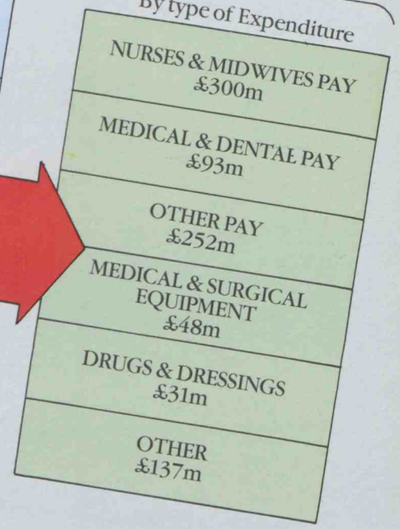
Where the Money came from

Where the money was spent

By Service

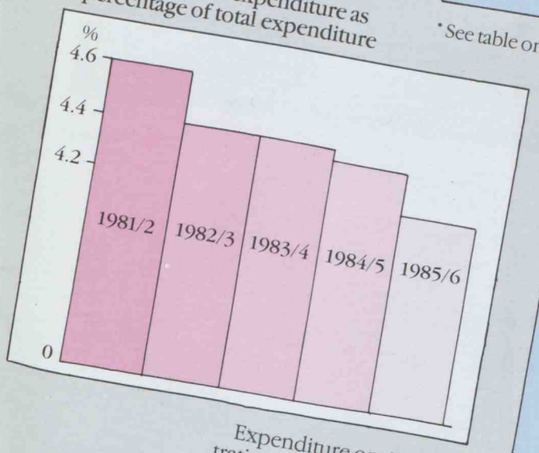


By type of Expenditure



*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:

Health Authority	Total spending by health authorities in the North West				Total 1985/86 £m	Total 1984/85 £m
	Hospitals £m	Community Health £m	Administration & Support Services £m	Other £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		OUT PAT'S	A & E
	COST PER DAY £	COST PER CASE £	COST PER ATT. £	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 Stocks	23,007	11,215	+11,792
Debtors	18,622	19,911	−1,289
	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	
Other	2.7
	0.1
Total Income	2.8
	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	Income and Expenditure 1985/86 £000's	1984/85 £000's
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

Accumulated Fund	Balance Sheet March 86 £000's	March 85 £000's
Capital in Perpetuity	1,151	739
Other Funds	19,600	16,989
	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

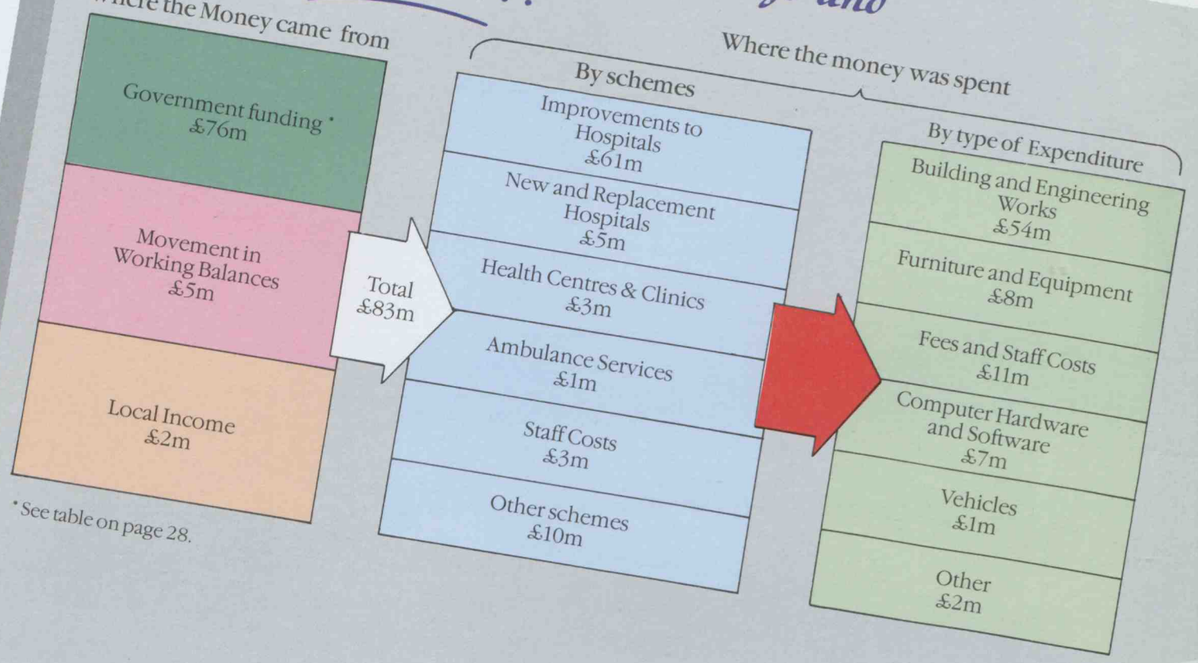
CAPITAL EXPENDITURE 1985/86

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

Published by North Western Regional Health Authority
Gateway House, Piccadilly South, Manchester M60 7LP. Tel: 061-236 9456.

Published by North Western Regional Health Authority
Gateway House, Piccadilly South, Manchester M60 7LP. Tel: 061-236 9456.

10 DOWNING STREET

Prime Minister

Norman Fowler has agreed to the change in the NI contribution to the NHS.

DCV
5/11

Good work

CF

MR. WICKS

NHS DISCUSSION

I have fixed this meeting for Tuesday, 16 December at 11 a.m. for one hour. DHSS will let us know who the Secretary of State will be bringing with him.

CR

29 October, 1986.

10 DOWNING STREET

MRS. RYDER

Please could you speak to me about the timing of the meeting with Mr. Fowler referred to in the letter attached.

DSG.

N. L. Wicks

28 October 1986

AM
P/HH
K. Stowe
Newton-
Nov. 1 Nov.
2 ~ 14 Dec.
KT for Nov.

CONFIDENTIAL AND PERSONAL

FILE

10 DOWNING STREET

From the Principal Private Secretary

28 October 1986

Dear Tony,

THE NEXT MOVES FORWARD ON THE NATIONAL HEALTH SERVICE

I mentioned to you on the telephone last week that the Prime Minister would welcome a meeting with your Secretary of State some time in December to carry forward the discussions of July and September on the National Health Service. This would be in addition to the discussion which I understand is planned in the Strategy Group.

An agenda for the December discussion might include:

- progress with improving presentation
- action to reduce waiting lists
- the future of RAWP
- guidance on priorities to be given to the Regional Health Authorities in spending the NHS allocation which comes out of the 1986 PES
- progress on initiatives on breast cancer and cervical cancer screening
- longer term reorganisation.

No doubt your Secretary of State will have further items for the discussion. Could I suggest that your Department should produce a paper for the meeting covering the various points on the agenda. Your Secretary of State can bring Mr. Newton and Sir Kenneth Stowe to the discussion if he wishes to.

Yours ever,
Nigel Wicks

N. L. Wicks

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

CONFIDENTIAL AND PERSONAL

Prime Minister
To note that employers also contribute 0·6% for the NHS.
DRV
24/10

MR NORGROVE

24 October 1986

NATIONAL INSURANCE AND THE NHS

Here, for the record, are the figures for the breakdown of national insurance rates which we discussed this morning.

The contribution rates are:-

	employee	employer
Employment Protection	0.25	0.2
NHS	0.75	0.6
National Insurance Fund	8.0	9.65
Total	9.00	10.45

The total NHS contribution from employers and employees raises £2.19b. The Treasury believe they can vary the NHS contribution by 0.1% of earnings for both employers and employees, without legislation. That would raise a further £340 million. They can also trim the Treasury supplement without legislation. The Treasury believe these measures should enable us to avoid any reduction in national insurance rates in the next two years.

David Willetts

DAVID WILLETTS

PRIME MINISTER

As you know, Panorama have done two programmes on the NHS. The first one went out on Monday 13 October. As just one example of the way in which the record on the health service is misrepresented, you may care to note the part of the transcript which I have highlighted. Panorama note that 200 babies are born at the 22 bed Bramley Mead Maternity Home near Blackburn. They note that new plans have threatened to close "this cosy maternity home".

The truth is this:

- there are no plans to close Bramley Mead

- the Home may close in 1996 when a new £5 million maternity unit at the main hospital in Blackburn, Queen's Park, is opened in 1996

- the beds at Bramley Mead are grossly under-utilised. Last year there were 9 births per bed compared to 49 at Queen's Park Hospital. That constitutes a massively wasteful use of resources.

- the Maternity Services Advisory Group have recommended that maternity beds should be sited with consultant units. There is at present no consultant cover at Bramley Mead.

David Wolfson spotted that the figures for Bramley Mead looked very inefficient when he saw the programme.

MARK ADDISON

24 October 1986

VC2ANI

SMD

NHS: LONDON

Points to make

- Since 1978 the number of patients being treated has increased; 70,000 more inpatient cases a year, 75,000 more day cases.

- Spending has increased in real terms (by about 5%).

- In 1986/87 the four Thames regions will have cash increases of 5.7% - double the current rate of inflation.

- Capital spending has increased after Labour's cuts. Nearly £700 million has been spent on new health care facilities in London since 1979.

- The number of doctors and dentists has increased.

- The number of nurses has increased.

- London continues to have about 20% of expenditure on the hospital services for about 15% of the population.

SRWALA

PRIME MINISTER

THE NEXT MOVES FORWARD ON THE NATIONAL HEALTH SERVICE

You had some useful discussions with Mr. Fowler in July and September on the NHS. These discussions covered presentation of the Service, some specific initiatives such as waiting lists, and the possibilities of longer term reorganisation in the next Parliament. Mr. Fowler was sent away to improve presentation (which I think he is doing) and to pursue the other matters.

In order to sustain his momentum, I think (and Ken Stowe agrees) that it would be helpful for you to have a further discussion with Mr. Fowler (and Mr. Newton and Ken Stowe) in late November/early December. The agenda might be:

- progress with improving presentation
- action to reduce waiting lists
- future of RAWP
- guidance on priorities to be given to the Regional Health Authorities in spending the NHS allocations which come out of the 1986 PES
- progress on the initiatives on breast cancer and cervical cancer screening (two politically important initiatives which Mr. Fowler is progressing)
- longer term reorganisation.

Do you agree to a meeting on these lines at a convenient time six weeks or so hence? If so, I should like to tell Mr. Fowler's office now because knowledge of the meeting will concentrate minds in the Department and help push forward progress.

N.L.W.

(N. L. WICKS)
20 October 1986

MG

Prime Minister

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

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

Telephone 01-407 5522

From the Joint Parliamentary Under Secretary of State

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

Dear Prime Minister,

THE MAUDSLEY HOSPITAL

20 OCT 1986

You asked for a report on progress in dealing with the problems which I detected at this hospital when I visited it in July. This is attached.

You may be assured that I shall be keeping the situation at the Maudsley Hospital under scrutiny and I will not hesitate to take further action if necessary. I am seeing the Chairman of the Authority shortly. I shall then satisfy myself personally that he understands that the momentum of improvements must be maintained. I shall visit the hospital again in about three months' time to check on progress.

I shall, if I may, keep you in the picture.

Yours ever

Jean

THE BARONESS TRUMPINGTON

ENC

THE MAUDSLEY HOSPITAL

BACKGROUND

The Maudsley Hospital is administered by the Bethlem Royal Hospital and Maudsley Hospital Special Health Authority. It is linked with the Institute of Psychiatry of London University. The Maudsley Hospital provides a wide range of general psychiatric and specialized services (eg alcoholism, neurosurgery, anorexics, children).

2. The main ward block at the Maudsley is 70 years old and is unsuitable for modern psychiatric care.

3. The Special Health Authority has had difficulty in living within its means. The problem stems partly from the ambitions of the clinical staff to expand services, and partly from indifferent management in the past. Earlier this year the authority were given until the end of 1987/8 to bring their spending into balance.

4. In October 1985 the SHA appointed a new General Manager who has made a good start on tackling the many problems. His attempts to enforce financial realism on the clinical staff have however led to accusations of "cuts" which have received much coverage in the media. He is making some progress and deserves to be supported. He himself fully accepts the criticisms made by Lady Trumpington, has made a start in tackling them and is determined to carry the task through.

FOLLOW-UP TO LADY TRUMPINGTON'S VISIT IN JULY

5. The contract for cleaning the Maudsley Hospital has been revised and relet from 1 October to Initial Health Care Services, a private contractor. The new contract incorporates higher specifications in some respects. The NHS Management Board's Director of Operations visited the Hospital on 3 October, with a domestic services adviser, who found the cleaning in the areas visited was now generally of a more than acceptable standard. A few points of criticism were detected and have been or are being put right.

6. As noted above the main ward block needs replacement. Phase I of the redevelopment scheme is planned to start building in mid-1987; it is to be funded wholly by the Hospital's Trustees. Phase II, to be funded by the Exchequer, will follow. Unsatisfactory wards should be replaced by the end of 1990.

7. In the meantime, the new general manager has already instituted a programme of short-term upgrading to raise standards, within sensible economic limits. This programme will now be extended so as to bring all the old wards up to a reasonable standard within 12 months. The work will ensure better standards of space and privacy in the dormitory areas, will complete the upgrading of ward kitchens and sanitary areas, and will include redecoration and furnishing where necessary.

8. Some of the problems identified during Lady Trumpington's visit raise questions of professional (ie medical and nursing) judgment. Some of the wards seem overcrowded during the day time because large numbers of day patients are encouraged to attend, in addition to in-patients. Most patients are expected, as part of their treatment, to keep their own bed areas tidy and to make their own beds, but some do not do so. Senior medical and nursing advisers from the Department will assist the general manager in pursuing these points with the senior professional staff at the Maudsley.

FURTHER ACTION BY THE DEPARTMENT

9. The problems identified at Lady Trumpington's visit have been or are now being dealt with by the Hospital, along with many other problems. (The health authority is due to discuss, on 10 November, proposals for financial savings in clinical areas that may be controversial).

10. Lady Trumpington proposes to go over all the relevant ground with the Chairman of the Authority shortly, in order to reinforce the messages already given. She will also visit the Hospital again in January, to check on progress. The pressure will be maintained.

LINE TO TAKE

11. Any public criticism concerning the Maudsley is more likely to centre on stories of insufficient funding and the alleged impact of that (and possibly of private contractors doing the cleaning) on environmental standards in the hospital. The general line to take is:

"The Bethlem and Maudsley Health Authority are doing important work in training, research and service, but, like other health authorities, must live within their means. They have been given until March 1988 to bring their spending into balance, and should be able to do so without damaging cuts in services. [As regards cleaning, a new contract has been in operation since October 1 and standards are now satisfactory.]"

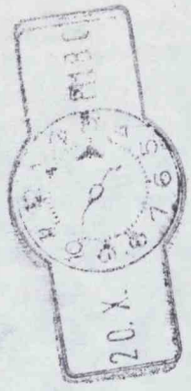
We well get a better line to take than this, drawing on some of the positive steps which are being taken to improve matters.

N.C.W.

NAT HEALTH

EXPENDITURE

PTY



file 4 6

MR. BEARPARK

cc: Mr. Sherbourne
Mr. Willetts
Mrs. Goodchild

HEALTH

Following a minute from Mr. Willetts, the Prime Minister has agreed that it would be worthwhile to include drug company representatives at some events here or at Chequers. The intention would be to help to restore relations with the drug industry after the squalls over the limited list proposals. I should be grateful if people receiving this minute could keep this in mind.

The Prime Minister has also agreed that it would be worthwhile for her to follow her programme of hospital visits by inspecting a modern family practitioner clinic. You might like to discuss this with Mr. Willetts and DHSS.

DAVID NORGROVE

13 October 1986

Prime Minister 2

Some suggestions marked in the margin.

DRV 10/10

PRIME MINISTER 10 October 1986

THE POLITICS OF HEALTH AFTER THE CONFERENCE

The Party Conference suggests that all the work that has been put into improving NHS presentation especially since your meeting in July is beginning to bear fruit:

- The Conservative Medical Society used to be dominated by fuddy-duddies. It is becoming much more purposeful and positive under the leadership of Arnold Elton. Their newsletter has just been revamped and they are now trying to combat the hostile propaganda which appears on hospital noticeboards.

- Your frequent visits to hospitals, your dinner with the Regional Chairmen and your visit to the CMS meeting all combine to give an impression of strong Prime Ministerial interest in the subject. This boosts the morale of our supporters in the Health Service and helps win over the sceptics.

- The discussion at the Conservative Medical Society and in the main Conference debate was level-headed and thoughtful.

- And of course Norman Fowler's fine speech went down very well with the delegates. He set out clearly the themes for the Government's offensive - the record of hospital building, the need to cut waiting lists, building on existing achievements in high-profile clinical specialities such as hip replacement operations.

I list below some politically tricky issues which may need particular attention over the coming months.

RAWP

RAWP is one of those contentious issues which causes divisions within parties as much as between them. The CMS meeting on Tuesday included polite but tense arguments between Londoners and representatives from Oxfordshire, the Midlands and Yorkshire. I recommend a double strategy:

i. The London teaching hospitals claim they still get the complicated cases from other districts whilst losing funding at the same time. I am sure there is something in this although it is very difficult to measure. We should put them to the test by tying funds more closely to individual patients. This is something to press for when Norman Fowler reports on his review of RAWP later in the year.

ii. You could bring out publicly how you personally are torn on this issue. Why not say 'I represent a London constituency and come from Lincolnshire'? That way Conservatives from all parts of the country see that you understand both sides of the issue.

The Drug Companies

We have had a tricky couple of years with the drug companies. They didn't like the limited list proposals and produced some really offensive advertising attacking the Government. They were also worried about the renegotiation of the Pharmaceutical Price Regulation scheme. But both those issues are now settled. And meanwhile the Labour Party has come up with a new threat to nationalise at least one major drug company. This provides an opportunity to restore relations with the drug industry. Their advertising budgets should be turned to attacking Labour's nationalisation plans and, more generally, spreading the good news of medical advances.

Agree?

I recommend that, if your diary permits, it would be worth while including drug company representatives at some informal social events here or at Chequers.

Yes pse

Scares About Cuts

One District Health Authority member made a very good point to me at the Conference. As part of its planning exercise for next year, his Regional Health Authority had asked all districts to submit plans showing the implications of 5% budget cuts. The district would have had to identify unpopular ward closures which local politicians could then exploit, even though such cuts were most unlikely to occur. This is the NHS equivalent of the departmental 'parade of bleeding stumps' which marches past the Treasury every Autumn. I recommend encouraging Regional Health Authorities to conduct their planning exercises diplomatically so as to avoid awakening unjustified local scares about cuts.

David could take this up with DHSS?

Yes

Mrs Edwina Currie

Mrs Currie has become a media character. Every remark (and every meal) gets intense publicity, so what she says is very important. If it is good and vivid, she will be an enormous asset in health campaigning. If it is crass, she can do a lot of damage. So the challenge is to target this powerful weapon as well as possible. If the diet issue rumbles on, could she visit a hospital where catering has been contracted out to enjoy the fine food offered to patients?

I really think No 10 should stay out of this. It's for N Fowler to sort out.

The Waiting List

The waiting list campaign has successfully caught the media's attention. It is good ground to fight on as:

- the waiting list is one of people's main worries about the NHS;

- Labour's record was so bad;

- the solution lies in better management.

Norman Fowler is due to receive reports from the regions by the end of this month setting out proposals for cutting waiting lists. He will then come back to you to discuss possible next steps.

Meanwhile, the waiting list remains stuck at about 660,000 and may even be creeping up slightly. 130,000 have been waiting more than a year, and of these one third are concentrated in the 20 worst districts. The people waiting more than a year are the real scandal, where there is the greatest scope for dramatic improvement. We should focus on them just as Restart focuses on those who have been unemployed for more than a year. Close analysis of the sufferers reveals two main themes:

(i) People with irritating complaints like hernias or varicose veins, who have been left out in the cold as the more dramatic life-saving operations receive priority. Often the problem is that one consultant is not carrying out enough operating sessions, or a hospital is slow to discharge its patients and cases are backing up. That points to management action and possibly some marginal extra funds which the districts should be able to find within their own budgets.

(ii) Sometimes, the figures prove to be fictitious. One Birmingham hospital had 4,000 people on its waiting list and sent out a letter to find out whether they all still needed treatment; 3,000 replied. The 1,000 who failed to reply remained on the waiting list, when they should have been taken off.

Jim Ackers, the West Midlands Chairman, is doing a particularly good job on waiting lists. His region is developing a computerised system for referring people to the districts where the list is shortest. He estimates that it should be possible to halve the number of people waiting over a year within the next 2 years at a cost of about £7 million out of a total budget of £1 billion. If every region implemented such a programme, we could soon point to great progress. When Norman Fowler reports back on waiting lists, you may want to invite Jim Ackers to the meeting so that he can talk about the practical lessons from the West Midlands.

General Practitioners

It is so easy when talking about the Health Service to focus exclusively on hospitals. But many people never see a hospital from one year to the next, whereas, on average, we visit a GP 5 times a year. They have a big influence on people's perceptions of the Health Service. Norman Fowler is publicising the proposals in his consultation document on primary care. That might provide the basis for direct mail shots to GPs to emphasise the Government's commitment to them. Another possibility would be for you to follow up on your programme of hospital visits by inspecting a modern Family Practitioner Clinic.

Agree?
Yes

David Willetts

DAVID WILLETTS

CCBG

NORTHERN IRELAND OFFICE
WHITEHALL
LONDON SW1A 2AZ

SECRETARY OF STATE
FOR
NORTHERN IRELAND

DN to all
PAB

CBM
9/K.

The Rt Hon Norman Fowler MP
Secretary of State for Social Services
Department of Health and Social Security
Alexander Fleming House
Elephant and Castle
LONDON
SE1 6BY

8th October 1986

Dear Secretary of State,

NHS MANAGEMENT BOARD APPOINTMENTS

Thank you for copying to me your letter of 1 October to Malcolm Rifkind.

In Northern Ireland, Richard Needham chairs the Supervisory Board for Health and Personal Social Services, with three outside members. What you have announced does not cause us any difficulty, and I welcome the availability to me of Roy Griffiths' advice. He made a most helpful visit here recently to contribute to a management development programme, and informally offered his assistance as required. I am sure we can make good use of his services.

I am copying this letter to the Prime Minister, the Secretaries of State for Scotland and Wales, the Chancellor of the Exchequer and to the Secretary of the Cabinet.

Yours Sincerely
D Wand
(Private Secretary)
for TK

(Approved by the Secretary of State
and signed in his absence in Northern Ireland)

NAT HEALTH

EXPENDITURE

PT 7

6

10 DOWNING STREET

From the Principal Private Secretary

6 October 1986

Thank you for your letter of 29 September enclosing the video film prepared by Brian Redhead about the Authority's story of its plans and developments within Merseyside.

I will certainly find an opportunity to look through this myself and to draw it to the Prime Minister's attention. Thank you again for sending it to me.

With best wishes,

N.L. Wicks

R.D. Wilson, Esq.

G

FILE SLH
cc Jim Coe

C/F Have you the other copies? 6/10

10 DOWNING STREET
LONDON SW1A 2AA

THE PRIME MINISTER

6 October 1986

Dear R. Wilson,

I have seen Mr Lamont's letter of 2 October with which he enclosed some of the Mersey Regional Health Authority press and publicity material.

I read this material with great interest. It provides good evidence that the Mersey Authority is in the vanguard of the publicity efforts to publicise the achievements of the National Health Service. I was particularly struck by the ingenious logo which you carry through from your leaflets to press notice headings and into the other material. I was impressed too by the content and the writing style of the material. Short, snappy, newsy paragraphs which ought to attract media attention and the photographic montage of the press cuttings confirms this. I was glad to see the advertising features in the Liverpool Echo, paid for, I note, by your main contractors and suppliers.

Please keep up the efforts to publicise the good work which the Mersey Regional Health Authority is doing for the people of the area.

Kind regards.

Yours sincerely

Margaret Thatcher

R. D. Wilson, Esq.

CAJ

Life 88

10 DOWNING STREET

From the Principal Private Secretary 3 October 1986

Thank you for your letter of 2 October with which you enclosed some of the Merseyside Regional Health Authority's public relations and publicity material.

I will certainly draw this to the Prime Minister's attention.

N L WICKS

Hugh Lamont, Esq.

OA

PRIME MINISTER

cc Mr Coe

MERSEY REGIONAL HEALTH AUTHORITY PUBLICITY MATERIALS

The public relations officer of the Mersey Regional Health Authority says in his letter at Flag A that you asked his Chairman, Mr Don Wilson to arrange for some of his Authority's publicity material to be sent to you so that you can see what it is like. This is attached to the letter. Jim Coe's assessment of the material is immediately below it at Flag B.

Mr Lamont suggests that you might let his Chairman have your comments on the material. I attach a draft letter below.

N.L.W.

Please file. We must hold up a record

NLW

N.L. Wicks

3 October 1986

SL3ASW

B

MR WICKS

MERSEY REGIONAL HEALTH AUTHORITY PUBLICITY MATERIAL

You asked for an assessment of publicity material sent to the Prime Minister from Mersey Regional Health Authority.

The colour leaflets are reasonably good. Although they are certainly not in the top rank as far as design goes, given that they have been produced locally and, presumably to quite a tight budget, there is little to complain about.

It is interesting to see that their logo, which resembles forked lightning (!) is carried through from leaflets to press notice headings. This shows that they have given some thought to the need for a common design theme.

The press notices do not compare with the best from government departments - but they are not as bad as the worst!

Mistakes have been made in:

- using single, instead of double, spacing;
- leaving too narrow a left-hand margin;
- typing on the back of some sheets;
- forgetting to date some of the releases.

As far as content and writing style are concerned, I think the press officers has done quite a good job; short,

newsy paragraphs which are likely to get him the media coverage he wants. Indeed, the photographic montage of press cuttings confirm this.

The advertising features are par for the course. Personally, I don't rate them very highly! I have yet to meet anyone who reads them. But if it is not costing the Health Authority anything....

The two copies of "house" newspapers are a bit flat. They need a greater variety of pictures, better layout and more sub-heads to break up the print mass.

I understand from DHSS information division that the Mersey Authority is in the forefront in publicity terms. All Authorities have PROs and most (I think there are two exceptions) are reasonably active.

JIM COE
Deputy Press Secretary

3 October 1986

A

Mersey Regional Health Authority

Hamilton House,
24, Pall Mall,
Liverpool L3 6AL.
Tel: 051-236 4620

Our Ref. HJL/PO

Your Ref.

When telephoning or calling please ask for:

Mr H J Lamont
Ext 2009

2 October 1986

Nigel Wicks Esq
Principal Secretary to the Prime Minister
10 Downing Street
LONDON
SW1A 2AA

Dear Mr Wicks

The Prime Minister was kind enough recently to ask our Chairman, Don Wilson, to arrange for some of our public relations and publicity material to be sent to you for her attention so that she might study them over a weekend at Chequers. I therefore have great pleasure in enclosing the following publications which represent the range of our work:

On Course with Care - this Authority's annual report for 1984-85
Towards the 21st Century - a summary of our long-term strategy
A Brighter, More Caring Future - a brochure which supports a promotional video on care in the community

Some examples of recent press releases:

A series of advertising features which have appeared in the Liverpool Echo
WHAM - a newspaper for health workers in Warrington
Health with Care - Halton Health Authority's annual report
Two brochures which provide information on hospitals
Details of "Person to Person" - a customer relations training package
A photographic montage which shows that our "good news" stores are getting into print.

Mrs Thatcher may find the advertising features in the Liverpool Echo to be of particular interest. The advertising space is paid for by our main contractors and suppliers and, as the Echo claims a readership of 1,000,000 each evening, the series has given us an opportunity to bring our message to more than half the population of our region.

The Prime Minister will notice that so far we have had published a five-page supplement on our ten-year strategy and features on energy saving, our new Regional Central Store and on new linear accelerators which have cost £2 million. A feature on three major hospital developments in Liverpool is to be published on Wednesday, 8 October.

I appreciate that the Prime Minister always has a busy schedule and that she will be particularly occupied at present with the party conference, not to mention important affairs of state, but if she could find a few minutes to pass on her thoughts and comments on the material to Don Wilson it would be greatly appreciated.

Yours sincerely

Hugh Lamont.

HUGH J LAMONT
Public Relations Officer

Enc

CCBG

NBPM

SECRETARY OF STATE FOR SCOTLAND

SCOTTISH OFFICE
WHITEHALL, LONDON SW1A 2AU

The Rt Hon Norman Fowler MP
Secretary of State for Social Services
Department of Health and Social Security
Alexander Fleming House
Elephant and Castle
LONDON
SE1 6BY

2 October 1986

Dear Norman,

NHS MANAGEMENT BOARD APPOINTMENTS

Thank you for your letter of 1 October telling me about the review you have undertaken in close consultation with the Prime Minister to alter the arrangements for the NHS Management Board.

In Scotland the Health Service Policy Board is already under Ministerial chairmanship. Following the Ministerial changes here John MacKay will be succeeded by Simon Glenarthur. What you have in mind to propose therefore causes me no difficulty whatsoever and I endorse what you say about the status of the Management Board under Ministerial direction. I note your appointment of Roy Griffiths as Deputy Chairman; and I shall bear in mind that he will be willing, as the Government's adviser on NHS management, to make his advice available to me and the other Secretaries of State with Health responsibilities.

I am copying this reply to the Prime Minister, the Secretaries of State for Wales and Northern Ireland, the Chancellor of the Exchequer and to the Secretary of the Cabinet.

Yours ever,

Malcolm

MALCOLM RIFKIND

HMP27501

NAT HEALTH

EXPENDITURE

PT 6

CONFIDENTIAL

Pre Minister 1 to note. N.L.W 1.10

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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

The Rt Hon Malcolm Rifkind MP
Secretary of State for Scotland
Scottish Office
Dover House
Whitehall
LONDON
SW1A 2AU

1 October 1986

Dear Malcolm.

NHS MANAGEMENT BOARD APPOINTMENTS

As you know, Mr Victor Paige resigned in June from the position of Chairman of the NHS Management Board within my Department. Mr Len Peach, the Board's Personnel Director, has been acting as Chairman while I have carried out a careful review of the position. I have done this in close consultation with the Prime Minister who strongly endorses the action I am now taking.

The Minister for Health, Tony Newton, will take over the Chairmanship of the Board. This will I am sure strengthen the authority of the Board and should dispel any doubts that may remain in people's minds about its status as part of my Department under Ministerial direction.

Secondly, the standing of the Board will be further strengthened by my appointing Sir Roy Griffiths as Deputy Chairman and the Government's Adviser on NHS Management; Sir Roy - like Robin Ibbs - will have direct access to the Prime Minister. His appointment will be part-time and unpaid. Sir Roy will, of course, be willing to make his advice available to you and the Secretaries of State for Wales and Northern Ireland.

Thirdly, Mr Len Peach will be appointed Chief Executive Officer of the NHS Management Board; he will be (as Mr Victor Paige was) the Accounting Officer for the Hospital and Community Health Services and will have the rank of Second Permanent Secretary.

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I attach a copy of the draft press notice which I propose to issue at 4.30 pm on Thursday 2 October.

I also propose to announce at the same time that John Major, having succeeded Tony Newton as Minister of State with responsibility for Social Security, will also succeed Tony as Minister for the Disabled.

I am copying this letter to the Prime Minister, the Secretaries of State for Wales and Northern Ireland, the Chancellor of the Exchequer and to the Secretary of the Cabinet.

Yours ever.

NORMAN FOWLER

E.R.

October 1986

NHS MANAGEMENT BOARD APPOINTMENTS

Norman Fowler, Secretary of State for Social Services today announced that, with the approval of the Prime Minister, the following appointments have been made in the Department of Health and Social Security.

1. Mr. Tony Newton OBE MP, Minister for Health, to be also Chairman of the NHS Management Board.

2. Sir Roy Griffiths, Deputy Chairman and Managing Director of J. Sainsbury PLC, to be Deputy Chairman of the NHS Management Board and the Government's Adviser on NHS Management, with direct access to the Prime Minister. Sir Roy Griffiths' appointment will be part-time and unpaid.

3. Mr. Len Peach, currently Personnel Director of the NHS Management Board, to be Chief Executive Officer of the Board and Accounting Officer in the rank of Second Permanent Secretary. Mr. Peach is already on secondment to the Civil Service from IBM. A new Personnel Director will be appointed in due course.

NOTE FOR EDITORS

1. The NHS Management Board was set up within the Department of Health and Social Security on the recommendation of the NHS Management Inquiry, chaired by Sir Roy Griffiths, which was asked by the Secretary of State for Social Services in 1983 to review management arrangements for the NHS. The Government accepted the Inquriy's recommendation that the Departmental functions concerned

E.R.

with the management of Health Authorities should be carrried out, within the Department and under the existing statutory framework, by a Board constituted from the health service, the private sector and the Civil Service.

2. Mr. Peach, the Board's Personnel Director, has been acting as Chairman since Mr. Victor Paige, CBE, resigned on 3 June 1986.

3. The other members of the Board are:

Sir Donald Acheson	-	Chief Medical Officer
Mr. G.A. Hart	-	Director of Operations
Mr. M.J. Fairey	-	Director of Planning and Information Technology
Mrs. G.T. Banks	-	Director of Health Authority Finance
Mr. A. Merifield	-	Director of Health Authority Liaison
Mr. I. Mills	-	Director of Financial Management
Mrs. A.A.B. Poole	-	Chief Nursing Officer
Mr. D. Nichol	-	Non-Executive Director

In addition, Mr. D.N.I. Pearce is Property Adviser to the Board and Mr. T. Critchley is the Board's Director of Procurement and Distribution.

PART 6 ends:-

NCW TO PM 30.9.86

PART 7 begins:-

SS/DHSS TO SS/SCOT 1.10.86


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