1,

1. MR. SANDERS MS

2. PRIME MINISTER

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

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

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

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

MAP

We were all amazed to learn that the NHS had increased by 25,000 while we have been in power. Before approving this document, I think we should learn more about how that increase happened. MT

13 February 1981

PERSONAL AND CONFIDENTIAL

Original on Nat Health: Feb 81 NHS Manpower

10 DOWNING STREET

From the Principal Private Secretary

16 February, 1981.

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

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

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

C. A. WHITMORE

David Edmonds, Esq.,
Department of the Environment.

PERSONAL AND CONFIDENTIAL

cc HO
CDL
GWO
CO

HB

NCV
Health

10 DOWNING STREET

From the Private Secretary

19 February 1981

Priorities and policies for health and personal social services

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

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

M. A. PATTISON

12

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

EXTRACT FROM H/C HANSARD VOL 999 NO. 85 WED 25.2.

COL 396

COL 395

Health and Personal Social Services

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

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

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

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

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

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

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

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

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

10 DOWNING STREET

PRIME MINISTER

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

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

18 February, 1981

Original on Nat. Health: Feb 81
NHS Manpower

10 DOWNING STREET

MR. WHITMORE

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

M. A. PATTISON

16 February 1981

Original on Nat. Health: Feb 81
NHS Manpower

file

10 DOWNING STREET

From the Private Secretary

16 February 1981

SF 23.2.81

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

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

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

M. A. PATTISON

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

cjt

010

DEPARTMENT OF HEALTH & SOCIAL SECURITY

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

Telephone 01-407 5522

From the Secretary of State for Social Services

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

12 February 1981

Dear Francis,

PRIORITIES AND POLICIES FOR HEALTH AND PERSONAL SOCIAL SERVICES

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

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

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

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

Yours ever

Patrick

encl

MG

A

DEPARTMENT OF HEALTH & SOCIAL SECURITY

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

Telephone 01-407 5522

From the Secretary of State for Social Services

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

30 January 1981

Dear Willie,

PRIORITIES AND POLICIES FOR HEALTH AND PERSONAL SOCIAL SERVICES

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

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

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

ENC

E.R.

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

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

Yours ever

Patrick

We are still thinking about the best title.

P.

MG

B

To the Chairman and Members of
District Health Authorities

/Date/

/Dear Chairman /facsimile//

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

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

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

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

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

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

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

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

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

/Yours etc

FASCIMILE/

Secretary of State for
Social Services

MG

To the Chairman and Members
of Social Services Committee

/Date/

/Dear Chairman /Fascimile//

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

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

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

/Yours etc
FASCIMILE/

Secretary of State for
Social Services

RESTRICTED

A HANDBOOK OF POLICIES AND PRIORITIES

FOR THE HEALTH AND PERSONAL

SOCIAL SERVICES IN ENGLAND

Department of Health & Social Security

RESTRICTED

CONTENTS

C

CHAPTER 1 - SETTING THE SCENE

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

POPULATION

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

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

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

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

Figure 1:
The percentage of the population in the key age groups: England 1979

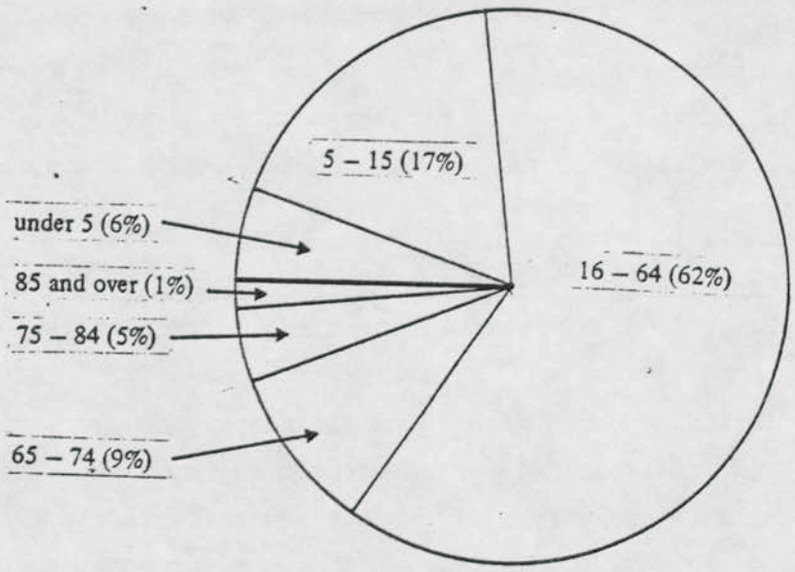
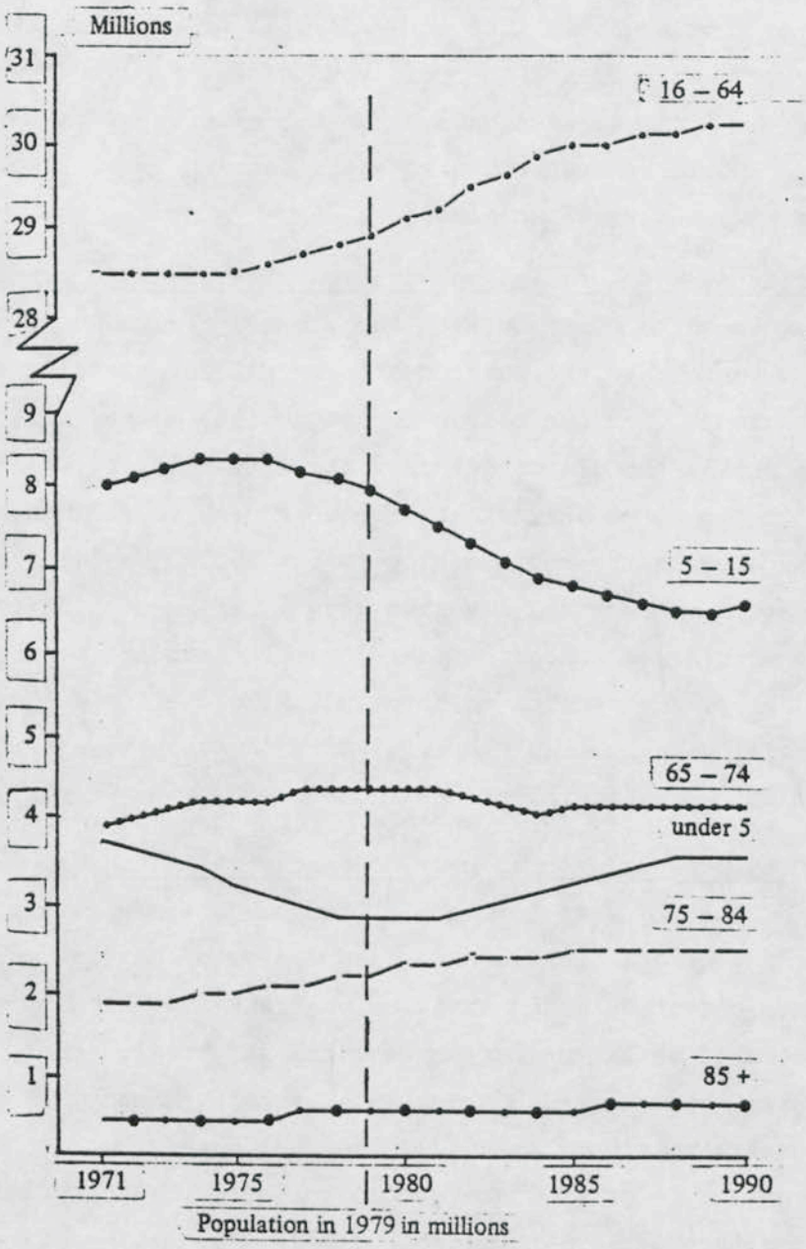


Figure 2:

Population estimates 1971 – 1979; 1979 based projections to 1990



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

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

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

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

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

TABLE 1 : HEALTH AND PERSONAL SOCIAL SERVICES: GROSS EXPENDITURE

England. £m at 1980 survey prices

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

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

Discrepancies in totals are due to rounding

BUILDINGS

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

MANPOWER

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

TABLE 2: NHS DIRECTLY EMPLOYED STAFF: ENGLAND

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

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

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

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

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

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

VOLUNTARY SERVICES

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

PRIVATE HEALTH CARE

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

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

(a) 5,500 acute beds in hospitals.

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

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

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

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

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

TEXTUAL REFERENCES

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

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

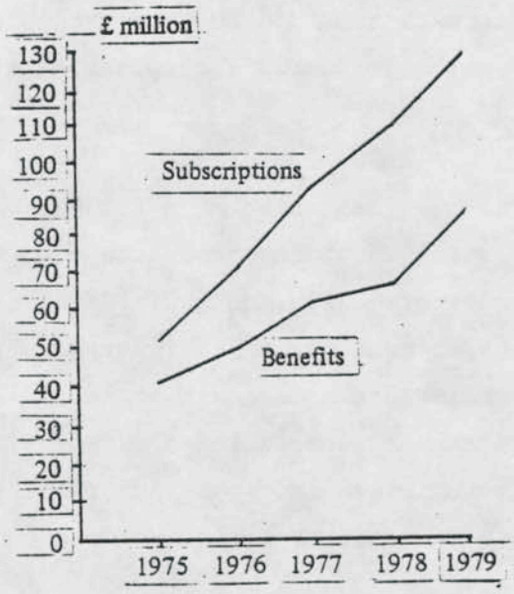
3. Committee on Voluntary Organisations. The Future of Voluntary Organisations: Report of the Wolfenden Committee. Croom Helm. 1977.

OTHER REFERENCES

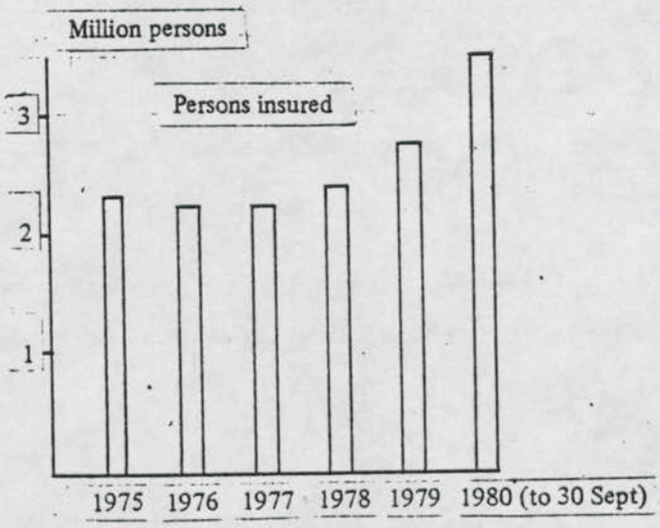
1. Department of Health and Social Security. Health and Personal Social Services Statistics for England, 1978. HMSO. 1980.

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

Figure 3:
UK private medical care; provident associations



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



CHAPTER 2 - PREVENTION

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

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

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

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

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

THE GOVERNMENT'S ROLE

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

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

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

THE ROLE OF HEALTH AUTHORITIES

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

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

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

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

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

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

A LOCAL STRATEGY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

TEXTUAL REFERENCES

1. Department of Health and Social Security. Prevention and Health: Everybody's Business: A Re-assessment of Public and Personal Health: A Consultative Document prepared jointly by the Health Departments of Great Britain and Northern Ireland. HMSO. 1976.

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

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

D

OTHER REFERENCES

RESTRICTED

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

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

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

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

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

RESTRICTED

CHAPTER 3 - THE VOLUNTARY SECTOR

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

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

LINKS WITH STATUTORY SERVICES

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

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

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

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

FINANCE

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

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

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

TEXTUAL REFERENCES

1. Hadley R and McGrath M Going Local - Neighbourhood Social Services, Bedford Square Press, February 1980

2. Health Services Act 1980. HMSO

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

4. Finance Act 1980. HMSO.

OTHER REFERENCES

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

CHAPTER 4 - THE STATUTORY SERVICES

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

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

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

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

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

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

PRIORITIES

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

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

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

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

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

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

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

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

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

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

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

COMMUNITY CARE

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

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

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

PRIMARY AND DOMICILIARY CARE

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

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

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

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

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

PLANNING AND COLLABORATION

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

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

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

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

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

FINANCE

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

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

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

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

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

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

MANPOWER

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

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

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

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

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

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

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

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

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

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

QUALITY AND EFFICIENCY OF SERVICES

District Health Authorities

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

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

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

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

the service would be the more fruitful approach.

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

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

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

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

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

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

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

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

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

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

Personal Social Services

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

TEXTUAL REFERENCES

1. Department of Health and Social Security. Priorities in the Health and Social Services: The Way Forward. HMSO 1977.

2. Department of Health and Social Security. Health Services in England: DHSS Planning Guidelines for 1980-81. HC(80)9. DHSS 1980.

3. Royal Commission on the National Health Service. Report. Cmnd 7615. HMSO 1979.

4. Reply by the Government to the Third Report from the Social Services Committee 1979-80. Cmnd 8086. HMSO 1980.

5. House of Commons. Third Report from the Social Services Committee, Session 1979-80: The Government's White Paper on Public Expenditure. The Social Services. HMSO 1980.

6. Department of Health and Social Security. The Respective Roles of the General Acute and Geriatric Sectors in the Care of the Elderly Hospital Patient. DHSS 1981.

7. Department of Health and Social Security. Report on a Study of the Acute Hospital Sector. DHSS 1981.

8. Department of Health and Social Security. Community Care. DHSS 1981.

9. Collins E and Klein R. Equity and the NHS: Self-Reported Morbidity, Access and Primary Care. British Medical Journal, vol 261, pp 1111-1115. 25 October 1980.

10. Department of Health and Social Security. Health Centre Policy HC(80)6. DHSS. 1980.

/11. London Health Planning Consortium - Primary Care Study Group. A Review of Primary Care. DHSS. 1981./

/12. Standing Medical Advisory Committee/Standing Nursing and Midwifery Advisory Committee. The Work of the Primary Health Care Team. DHSS. 1981./

/13. Office of Population Censuses and Surveys. Access to Primary Health Care. HMSO. 1981./

14. National Health Service Act 1977. HMSO.

/15. Department of Health and Social Security. HN(81). DHSS. 1981./

16. Department of Health and Social Security. Health Service Development: Medical Teaching in the NHS - a Discussion Paper. HM(80)40. DHSS 1980.

17. Department of Health and Social Security. Sharing Resources for Health in England: Report of the Resource Allocation Working Party. HMSO 1976.

18. Department of Health and Social Security, Scottish Home and Health Department, Welsh Office, Medical Manpower - The Next Twenty Years: A Discussion Paper/HMSO 1978.

19. Department of Health and Social Security. Structure and Management. HC(80)8/LAC(80)3. DHSS 1980.

20. Hospital Costing and the Clinician -

21. National Development Group for the Mentally Handicapped. Improving the Quality of Services for Mentally Handicapped People - A Checklist of Standards. DHSS. 1980.

22. HN(78)53 -

OTHER REFERENCES

1. Department of Health and Social Security. Priorities for Health and Personal Social Services in England: A Consultative Document. HMSO 1976.

2. Working Group on Inequalities in Health. Inequalities in Health: Report of a Research Working Group. DHSS 1980.

3. Department of Health and Social Security. Joint Care Planning: Health and Local Authorities. HC(77)17/LAC(77)10. DHSS 1977.

4. Department of Health and Social Security. Joint Finance: (a) Revision of Agreed Arrangements for Revenue Support (b) Delegation of Authority to Use Joint Finance for Approved Health Purposes. HC(79)18/LAC(79)11. DHSS 1979.

5. Health Advisory Service:

(a) National Health Service: Annual Report of the Health Advisory Service to the Secretary of State for Social Services and the Secretary of State for Wales for the Year 1976. HMSO. 1977.

(b) Annual Report of the Health Advisory Service 1977/78. (Report not published but copies available on loan for fortnightly periods from DHSS (RL1B), Room 1523, Euston Tower, 286 Euston Road, London NW1 3DN).

6. Development Team for the Mentally Handicapped.

(a) First Report 1976-77. HMSO 1978.

(b) Second Report 1978-79. HMSO 1980.

7. Department of Health and Social Security. The Social Work Service of the DHSS. DSWS(79)1. DHSS 1979.

CHAPTER 5 - PRIORITY GROUPS AND SERVICES

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

ELDERLY PEOPLE

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

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

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

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

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

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

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

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

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

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

SERVICES FOR THE MENTALLY ILL

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

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

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

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

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

(c) Make arrangements satisfactory to patients and staff locally for the closure over the next 10 years or so of those mental illness hospitals which are not well placed to provide a service reaching out into the community and are already near the end of their useful life. Such closures should provide a source of staff, capital and revenue to support the development of the new pattern of health services for the mentally ill; including community psychiatric nursing and perhaps help to support the development of services provided by local authorities.

5.10 The care of patients who are difficult to manage, including those who have committed an offence, is part of the responsibility of NHS psychiatric and mental handicap services. These patients fit less easily into the new pattern of services. Many psychiatric hospitals and units and mental handicap hospitals provide an adequate service for them but it is important that others should develop such facilities. It remains Government policy for each region, using central funds, to establish in addition a regional secure unit (and secure facilities in the interim) to accommodate those who, while not requiring treatment under conditions of security such as are only to be found in special hospitals, cannot be managed satisfactorily in an ordinary NHS hospital or unit. These secure facilities should be seen as part of a continuum of care in local psychiatric services, but experience has shown that without a strong lead from the authority, they are difficult to establish. The Royal College of Psychiatrists has recently published a report 'Secure Facilities For Psychiatric Patients - A Comprehensive Policy'[5].

SERVICES FOR THE MENTALLY HANDICAPPED

5.11 The path of development of services for mentally handicapped people remains broadly as set out in the 1971 White Paper 'Better Services for the Mentally Handicapped'.[6] A recent Departmental review of mental handicap policy 'Progress, Problems and Priorities'[7] shows that there has been an encouraging increase in day services but that too many resources are still concentrated in large, badly located buildings and in services that do not best meet the needs of the people they are intended to serve. The Government has accepted in principle the model of care set out in the Report of the Committee on Mental Handicap Nursing and Care[8] (Jay Committee) but has indicated the need for further consideration of the best way of providing

for the special needs of the relatively small numbers of the most severely multiply handicapped people. The main aims for authorities should be to:

(a) Provide a locally based service that enables mentally handicapped people to live with their families where possible, or failing that in a local community setting.

(b) Help develop the capabilities of each individual so that he or she can live as independent a life as possible.

(c) Support those looking after mentally handicapped people at home by providing day services, and short-term residential care for training, relief and holiday purposes.

5.12 The 1971 White Paper[6] set as a target the introduction of necessary changes within 20 years. Resource constraints will make this more difficult to achieve, and developing joint planning between health and social services authorities, and close involvement of voluntary bodies and other agencies such as education and housing authorities will be essential. Joint funding, referred to in Chapter 4, facilitates joint co-operation between health and local authorities on important projects. Funds may also become available from disposal of redundant hospitals.

5.13 Some mentally handicapped children and adults, will require residential care in a health setting, but the aim must be to limit this to those who have clear medical and nursing needs, and any new provision should be in smaller and more local units than envisaged in the 1971 White Paper.[6] Large hospitals do not provide a favourable environment for children to grow up in, and it is clear that the White Paper considerably over-estimated the numbers of children who would require this care. A range of alternatives to care in mental handicap hospitals is being developed and should be taken into account in planning children's services.

SERVICES FOR PHYSICALLY DISABLED AND SENSORILY IMPAIRED PEOPLE

5.14 Chapter 2 referred to the screening and other methods which will help prevent disability. Services for people who are physically disabled or sensorily impaired should have the general aim of enabling them to lead full and purposeful lives if possible in the community, and preventing or

reducing the effects of their conditions. Social services departments will need to provide social work, home helps, meals on wheels, aids to daily living etc; and, in co-operation with housing departments, home adaptations. Health authorities will need to provide district nursing and incontinence services, remedial therapy, speech therapy services and chiropody. Voluntary bodies, often acting as agents of local authorities, can provide such services as care attendant schemes, holiday homes, counselling and information.

5.15 Health and local authorities should aim to:

(a) Relieve pressures on caring relatives through more short-term care and treatment (including day care), development of services for the incontinent, care attendant schemes and perhaps through the development by voluntary bodies and community groups of other supporting services for disabled people and their families;

(b) Further improve arrangements for caring for younger disabled people separately from the elderly;

(c) Help those with hearing impairments to make the best use of the improved range of aids, in particular by the recruitment and training of additional hearing therapists;

(d) Improve co-operation between authorities to ensure that visually handicapped people, particularly the elderly, are aware of and can benefit from the services and advice which should be available to them. Services for newly blind people should be improved. They should be able to receive teaching in daily living skills and the support necessary to achieve independence in the community.

5.16 Good rehabilitation services minimise the impact of disabling accident and illness; they should be fostered. Referral arrangements between health and employment services need particular attention: a recent report of the National Advisory Council on Employment of Disabled People is being issued for consultation.[9]

National Health Service

5.17 A Paper entitled 'Prevention in the Child Health Services'[10] was made available in March 1980 outlining the main objectives and content of the preventive child health services. It also suggested a basic programme of surveillance and stressed the importance of health education. A crucial need is to improve take-up of child health services since it is often those who need these services most who use them least; but as the scope for the expansion of these services is limited, any additional resources should be directed towards areas of high social stress, high infant mortality or low take-up of preventive services.

5.18 The Government has endorsed the overall philosophy of the Court Committee Report,[11] has reaffirmed the principles set out in HC(78)5,[12] and has stated it's concern that health authorities should develop plans for an integrated child health services as soon as resources permit. It has also been reaffirmed that all acutely ill children in hospital should be treated in comprehensive children's departments under the general oversight of a consultant paediatrician and that those departments should be staffed by suitably qualified nurses. The Consumers Association's excellent report on 'Children in Hospital',[13] published in June 1980, was recently commended to health authorities.

5.19 In August 1980 the Government published the White Paper 'Special Needs in Education' (Cmnd 7996) announcing its intention to introduce legislation to reform the statutory framework of special education in line with the recommendations of the Warnock Report. The concept of special educational treatment appropriate to certain defined categories of handicap will be replaced by a new concept of provision to meet special educational needs. The Government's approach envisages a substantial contribution from the health and personal social services, and medical and other staff will play an important role inthe assessment of children's needs.

Personal Social Services

5.20 A prime objective of both statutory and voluntary services should be to encourage the development of self-help and community activities involving children, and through these to help parents look after their children better. The development of play groups, family centres and home visiting schemes can all make a significant contribution. There are, nevertheless, 100,000 children in the care

of local authorities. While some of these children are best cared for in residential homes, far more of them could benefit from living in a family environment with foster parents. More, too, could be adopted by suitable families. Fostering and adoption not only benefit the child; they are also an economic use of resources when compared to high-cost residential homes. Voluntary agencies have always played an important role in services for children, and local authorities should build on this in the development of their own services.

5.21 Local authorities have a statutory responsibility to provide adequate care and protection for youngsters in trouble or at risk of getting into trouble with the courts or police. Detailed plans were announced in the White Paper on Young Offenders[14] for strengthening magistrates courts by giving them powers to make 2 new orders. The Residential Care Order will enable them to require that a youngster who offends while already in local authority care as a result of an earlier offence shall not live at home for a defined period. This will provide magistrates with a real alternative to a custodial sentence in certain circumstances. The Supervision Order will be strengthened to enable them to require a young offender to participate in an agreed programme of supervised activities such as intermediate treatment (IT) and is part of the current commitment to promoting community-based ways of dealing with disadvantaged young people so as to keep them in contact with their families, friends and home environment. Local authorities have been asked to protect their IT expenditure, while the Department is encouraging voluntary organisations to participate in IT by giving grant aid.

MATERNITY SERVICES

5.22 Notable achievements have been made over recent years in reducing perinatal and neonatal mortality and associated handicaps. The Government's Reply, Cmnd 8084,[15] to the Second Report from the Social Services Committee for the 1979-80 session[16] reaffirmed the priority they attach to further reduction through the improvement of maternity and neonatal services. They believe that the best way of effecting this is for health authorities to consider the great majority of the Committee's recommendations which concern the National Health Service. Authorities have been sent copies of the Committee's Report and the Government's reply and have been asked to study them in the light of local circumstances and needs to give priority to implementing those recommendations which they judge most urgent as part of a sustained campaign to improve services in each area.

5.23 The Committee recommended the introduction of national standards and norms, for staffing and equipment in the maternity and neonatal services. The Secretary of State intends to establish minimum standards which are

attainable within a reasonable time and with reasonable staffing and finance: discussions are being held with the relevant professional bodies about the fields in which standards should apply and how they should be defined.

TEXTUAL REFERENCES

/1. Department of Health and Social Security, Welsh Office, Scottish Home and Health Department, Department of Health and Social Services (Northern Ireland) Growing Older. Cmnd HMSO. 1981./

2. Department of Health and Social Security. Report on a Study of the Acute Hospital Sector. DHSS. 1981.

3. Department of Health and Social Security. Better Services for the Mentally Ill. Cmnd 6233. HMSO. 1975.

4. Department of Health and Social Security. Report on the Working Group on Organisational and Management Problems of Mental Illness Hospitals. DHSS. 1980.

5. Secure Facilities For Psychiatric Patients - A Comprehensive Policy. /London/ Royal College of Psychiatrists /1980/.

6. Department of Health and Social Security, Welsh Office. Better Services for the Mentally Handicapped. Cmnd 4683. 1971.

7. Department of Health and Social Security. Mental Handicap: Progress, Problems and Priorities - A Review of Mental Handicap Services in England Since the 1971 White Paper 'Better Services for the Mentally Handicapped'. DHSS. 1980.

8. Committee of Enquiry into Mental Handicap Nursing and Care. Report. HMSO. 1979.

9. National Advisory Council on Employment of Disabled People: Working Party Report to Council. Current arrangements for liaison between health social and employment services for the rehabilitation and resettlement of disabled people. DHSS. 1981.

10. Department of Health and Social Security. Prevention in the Child Health Services. DHSS. 1980.

11. Committee on Child Health Services. Fit for the Future. HMSO. 1976.

12. Department of Health and Social Security. Health Services Development: Court Report on Child Health Services. HC(78)5. DHSS. 1978.

13. Consumers Association. Children in Hospital. Consumers Association. 1980. /and HN or HC reference/

14. Home Office, Department of Health and Social Security, Welsh Office, Young Offenders. Cmnd 8045. HMSO. 1980.

15. Reply by the Government to the Second Report of the Select Committee on Social Services. Cmnd 8084. HMSO. 1980.

/16. House of Commons. Second Report from the Social Services Committee, Session 1979-80: Perinatal and Neonatal Mortality. HMSO. 1980./

OTHER REFERENCES

1. National Development Group for the Mentally Handicapped.

(a) Pamphlet 1. Mental Handicap: Planning Together. DHSS. 1976.

(b) Pamphlet 2. Mentally Handicapped Children: A Plan for Action. DHSS. 1977.

(c) Pamphlet 3. Helping Mentally Handicapped School Leavers. DHSS. 1977.

(d) Pamphlet 4. Residential Short-Term Care for Mentally Handicapped People: 'Suggestions for Action'. DHSS. 1977.

(e) Pamphlet 5. Day Services for Mentally Handicapped Adults. DHSS. 1977.

(f) Helping Mentally Handicapped People in Hospital: Report to the Secretary of State for Social Services. DHSS. 1978.

(g) Creating a Learning Environment: Chapters 5 and 6 of 'Helping Mentally Handicapped People in Hospital'. DHSS. 1979.

CHAPTER 6 - PARTNERSHIP WITH THE PRIVATE SECTOR

6.1 Part of the health care of this country has always been provided by the private sector - private hospitals and nursing homes, private care in general practice, and health schemes related to employment. The size and scope of the private sector were briefly described in Chapter 1. Public and private medicine are closely inter-related. Those who use private medicine usually continue to use the NHS for certain services, and many doctors work in both sectors. In the past Governments have too often neglected or ignored the opportunities for co-operation between the private and public sectors.

PRIVATE PATIENT USE OF NHS FACILITIES

6.2 The Health Services Act 1980[1] dissolved the Health Services Board and halted the enforced withdrawal of private facilities from NHS hospitals. Where there is local demand new facilities will be authorised, subject to the statutory requirement that NHS patients should not be significantly disadvantaged as a result. The arrangements are set out in HC(80)10.[2] Provided that arrangements for admission and treatment are fair to all concerned, private practice and the income it generates should be to the benefit of NHS hospitals. In addition to the statutory safeguard, principles of good practice have been agreed with the medical profession which cover such matters as common standards of care and services, the prevention of out-patient queue jumping, and common waiting lists for urgent admissions and the seriously ill and for highly specialised diagnosis and treatment. If the present trend towards treatment of private patients suffering from routine surgical conditions in independent hospitals continues, the importance of equal access to specialised facilities will increase. Revised consultants' contracts permit highly skilled medical staff to use their time efficiently and flexibly both in the public and private sectors.

PRIVATE HOSPITALS

6.3 The Government have retained powers to check that the NHS is not harmed by large new private sector developments. Health authorities are responsible

for ensuring that adequate standards are maintained in private hospitals. Apart from these controls the private sector is free to find its own level. The growth of independent hospitals shows the demand for their services. As the Royal Commission on the National Health Service[3] noted, they can respond more directly to patients' needs, and provide pointers to areas where the NHS is deficient. For example, lengthy NHS waiting times for minor surgery have led to development of facilities in the private sector. A close working relationship between health authority and private developer from the planning stage onwards will help to ensure that private facilities complement those provided by the NHS. In much the same way planning of new NHS hospitals should take account of private institutions.

6.4 The expansion of the private sector should not be confined to acute facilities in hospitals. The growing importance of prevention and of the provision of nursing care for elderly people has been made clear elsewhere in this Document, and most of it will be outside hospital. There is plenty of room for growth in this area.

THE NHS AND THE PRIVATE SECTOR

6.5 The present constraints on the resources available to the NHS should encourage a more imaginative approach to the possibilities of planning and providing services in partnership with the private sector where it is economical to do so. Interchange or sharing of private sector and NHS staffing may eventually be possible. In some places contractual arrangements for the use of independent hospitals and nursing homes to provide services for NHS patients are in integral part of NHS services.[4] They provide flexibility by adding to the options open to health authorities. Where there is a bottleneck in the provision of health services, the possibility of temporary or longer term contractual arrangements may be worth considering. For example, a long waiting list caused by a shortage of theatre facilities may be helped by a short term contract to reduce the backlog. A shortage of capital to provide an expensive item of equipment might be met by encouraging a private developer to provide the equipment under contract. In certain circumstances either party could benefit from the use of facilities at full capacity, whereas facilities provided separately might be under-used.

PRIVATE CARE IN THE PSS

6.6 Outside hospital the contribution of the private sector to the care of our growing number of elderly people is becoming steadily more important, particularly in areas with high proportions of retired and elderly people, where the statutory services are already hard pressed. The private and voluntary sectors provide about 30% of residential care available for elderly people. Local authorities may make arrangements with registered private homes for the care of elderly or infirm people, and many do so. Charges for such 'sponsored' residents are assessed on the same basis as for residents in an authority's own homes.

6.7 Local authorities may make arrangements with private concerns and individuals for provision of holidays, for fostering children and for the periodic relief of families caring for elderly people; and some individuals make private arrangements for domiciliary support (such as domestic cleaning and nursing care). But there is so far little interest in the private sector in providing a basic range of support services for people living in their own homes who could afford to pay for it; and only a few private firms have shown an interest in sheltered housing arrangements.

6.8 Private enterprise plays a useful part in providing children's homes and here too there is room for development. There are about 170 private children's homes in England and Wales which, in return for a fee, accommodate children in the care of local authorities. Many specialise in taking family groups or the older or more difficult children. /The Government favours the idea, when opportunity permits of private children's homes being brought into line with other accommodation for children in care, by requiring them to register and conform to adequate standards./

TEXTUAL REFERENCES

1. Health Services Act 1980. HMSO.

2. Department of Health and Social Security. Health Services Act 1980; Private Medical Practice in Health Service Hospitals and Control of Private Hospital Developments; Amenity Beds. HC(80)10. DHSS. 1980.

3. Royal Commission on the National Health Service. Report. Cmnd 7615. HMSO. 1979.

4. Department of Health and Social Security. Contractual Arrangements. HC(81)1 - DHSS. 1981.

NEXT STEPS

Neither at region nor district in the NHS, nor in social services departments, will it be necessary to engage in a fresh round of planning, as a result of these guidelines. Their message will be best reflected in the continuing re-assessment of services and opportune decision-taking by members and their senior officers. It is intended that they, and professional groups, should study the document and consider how its message can best be developed and implemented for their local circumstances. There is not be be a formal consultation process for this document but the Department will be pleased to receive any comments, general or particular, from national or local bodies.

As authorities proceed with assessment and self-audit, and whether in reports of progress or in drafting and publishing plans, convey to their own community and staff their assessments and their proposals for action, the Department will seek to review the overall pattern. It will be able to discuss with national bodies and representative groups, including the voluntary organisations, and learn their views of progress. The NHS planning system is being simplified and its requirements reduced (consultation is going on about this), and in its modified form this will provide an important means of assessing how the strategy is generally being applied within the new DHAs. Regular statistical returns

to the Department, which are to be substantially cut, will provide a quantified account of some objectively measurable items.

It will be important that those who are responsible for local services, and those who represent the users, should make sure that local standards are maintained, especially for the vulnerable groups. Pilot studies of the best means of monitoring quality and efficiency are being launched. However, much of the desirable improvement proposed by the present document, such as developments in the voluntary sector, and in the balance of health and social services, can only be subjectively and qualitatively assessed. Thus, responsibility lies especially on chairmen and members of authorities to see that they carry the strategy into effect. Ministers are conficent that they will give a good account of their stewardship.

APPENDIX I

ROLE OF CHAIRMEN AND MEMBERS OF HEALTH AND LOCAL AUTHORITIES

1. The Chairmen and members of each DHA will corporately be responsible for the provision, planning, and management of the health care services in their district within national and regional guidelines. They will employ full-time staff to carry out these functions on behalf of the Authority, to whom the officers are accountable. The Authority's Chairman and members will, in turn, be accountable for their decisions through Regional Health Authorities to the Secretary of State.

2. Advice on the role and functions of health authority members was given in Circular HRC(73)22. This will be restated and amplified in a new circular on appointments to District Health Authorities to be issued in the Spring of 1981. There is also a useful chapter on the member's role in NAHA's "NHS Handbook" (published in May 1980).

3. The Local Government Act 1972, sets out in general terms the roles and function of chairmen and members of local authorities. Other legislation relates to specific functions of local authorities including their social services departments.

Appendix 2

REPORT ON A STUDY OF COMMUNITY CARE

SUMMARY

1. The terms of reference of the study were

"To clarify policies for the development of community care for the HPSS in terms of the resources now expected to be available, including self-help, the contribution of the voluntary sector, and the contribution of the private sector, and focusing on the patterns of service and interactions between the NHS and the PSS".

In the time available, it was necessary to limit the scope of the study to a number of specific areas. In view of the emphasis in the terms of reference on the interaction between NHS and PSS provision, one main focus of the study is an assessment of the shift in the balance of care away from long-term hospital or residential provision for certain people whose needs put them on the boundary between long-term institutional and other modes of care. The Study looks particularly at those relatively small groups of elderly, mentally ill and mentally handicapped people whose level of dependency, circumstances or frailty require especially intensive care. These groups are referred to throughout the report as 'boundary groups'. Consideration of much of the work which is carried out in the community by health and social services staff has been deliberately excluded - for example, much of the preventive work carried out by general practitioners, health visitors and district nurses and the episodic type of intervention undertaken by these staff as well as by social workers.

2. The other main area highlighted in the report is the contribution of the voluntary sector. The vital role of the voluntary and informal sectors to the network of community based support available is striking. The option of home based care is often only available where voluntary and informal effort provide the major contribution to caring for people. Given the paucity of data available on the extent of the private (as opposed to the voluntary) contribution to community based packages of care, it was decided to exclude consideration of this area.

3. Community care in relation to specific client groups has been the subject of considerable attention but much less effort has been devoted to an overall analysis of the development of community care. Even within the specific areas chosen for particular attention in this study, much of the ground was uncharted and it has not been possible to draw firm conclusions. The report concentrates on identifying those questions which would seem to require further consideration either by the Department or by key people in the field. It should be emphasised that it was not the purpose of the study to question the philosophy of community-based care. There is little doubt about the benefits to be gained from providing for people's needs in a flexible way which

maintains their links with ordinary life, family and friends, wherever possible, and offers greater choice. The intention of the study was to document progress so far in the specific areas chosen for detailed examination and to indicate possible problem areas in the implementation of policy which require attention in order to maximise the potential of community care.

4. The main points which have emerged and the questions raised are:

(a) The concept

The term 'community care' is used in a variety of ways and may be misinterpreted. It may describe the services and resources which are involved (eg community care is those services provided outside of institutions ...) or an objective of service delivery (eg community care in minimising the disruption of ordinary living...) Although it would not seem fruitful to offer one all-purpose definition it is important to specify what is meant wherever the term is used.

(b) Cost-effectiveness of community care

i. community based packages of care may not always be a less expensive or more effective alternative to hospital or residential provision, particularly for those living alone;

ii. their 'cost-effectiveness' often depends on the contribution of informal carers (relatives, friends and neighbours) who may shoulder considerable financial, social and emotional burdens as a result;

iii. health and social services authorities need to consider <u>all</u> the public expenditure costs involved in determining patterns of service for particular groups although their decisions are likely to be particularly influenced by consideration of those resources for which they are themselves responsible; and

iv. few studies have compared <u>both</u> the cost <u>and</u> the effectiveness of different packages of care. More research is needed in this area but it would be a mistake to underestimate the methodological difficulties.

(c) Developments in community care: the boundary groups

(i) there seems to have been little identifiable shift away from hospital and residential care for elderly people on the margins of institutional and community based care although increased community services such as home helps, meals on wheels and district nursing have clearly benefited those whose needs are not yet such as to put them into this group;

(ii) there may have been a tendency to underestimate the core of elderly people who will always require long-term residential care and reviews by authorities of their need for residential home places may be appropriate;

(iii) the average age of admission to residential homes, and possibly the level of dependency of new residents, has risen. No firm conclusion on reasons for these changes is drawn but one possibility is that they are a consequence of increasing pressure on residential homes resulting from demographic and social factors;

(iv) in relation to the mentally handicapped, there has been a shift away from long-term hospital care to residential home provision but resource constraints seem to have hampered the development at the rate envisaged of other alternatives;

(v) for the mentally ill, progress towards the White Paper targets for the run-down of large, isolated psychiatric hospitals and the provision of community-based packages of care has been considerable but there are bottlenecks eg the lack of day centres; and

(vi) For all these groups, community based alternatives to long-term institutional care require a package of provision with input from health and social services staff as well as from the voluntary sector. This reinforces the importance of close collaboration between health and social services authorities and between these and the different parts of the voluntary sector.

(d) The role of the voluntary sector

(i) It is important to distinguish between the different components of the voluntary sector. A broad classification runs from informal covers (family, friends and neighbours) through mutual aid groups, neighbourhood care groups and volunteers to formally constituted voluntary organisations;

(ii) the informal sector is vital to community based care and needs to be sustained and strengthened;

(iii) however, it is important not to assume that the amount of informal care can be limitlessly increased. The organised voluntary sector and statutory agencies must aim to supplement natural networks where these are absent or deficient;

(iv) further work is required to identify constraints on the development of community based services which could be eased by concentrated action by volunteers and voluntary organisations;

(v) different ways in which social services departments might organise themselves and deploy their staff in order to work most effectively with both the organised voluntary and informal sectors should be explored; and

(vi) voluntary service co-ordinators in the health service might be encouraged to give greater priority to voluntary effort in support of community health services.

(e) Early discharge schemes, day surgery and other developments

A number of issues which are not directly related to the Study's main themes are noted:

i. Early discharge and day surgery schemes require adequate district nursing support and such schemes should not be introduced without full consideration of their impact on the workload of district nurse teams. One of the most important factors in the success of such schemes is the availability of informal care. In most schemes informal care has been the sine qua non of a patient's inclusion.

ii. There is some evidence that some district nurse functions might be performed by other less highly qualified members of the team and that there may be some overlap between the services provided by the district nurse team (particularly nursing auxiliaries) and home helps. Both these issues raise questions for the organisation and operation of district nurse teams and the latter for the relationship between these teams and home help services. It is suggested that tney merit further study.

iii. The respective roles of day hospitals and day centres need clarification in order to ensure that the best possible use is being made of available facilities. The overall level of day hospital and day centre provision may need to be reviewed.

(f) Prospects for future developments

(i) If Departmental policies are to continue to seek a move away from long-term hospital care wherever this is appropriate to people's needs and wishes, ways must be found to ensure that the balance of resources between the NHS and PSS reflects the desired rate of change in responsibilities. There would of course be other factors - outside the remit of this study - which would need to be considered, not all of which would point in the direction of changes as between the NHS and PSS. In some cases, for example, it may be more important to achieve a shift within NHS expenditure from hospital in-patient to community health services.

(ii) manpower constraints on the development of community based packages of care may become as important as financial constraints. There may be particular problems in relation to trained community nurses and in recruiting for those groups eg nursing auxiliaries and home helps which draw on the same pool of manpower, particularly female manpower;

(iii) the indications are that demand for all community-based care will continue to increase over the next decade. The growing number of elderly people, particularly the very elderly, will present the main challenge to all those engaged, directly and indirectly in providing care.

More generally, there would seem to be a case for authorities to review the priority they attach to different aspects of community-based services. It appears that increases in provision since 1975 have not been geared directly to providing a genuine alternative to those on the margins of institutional care. It may be that other objectives of community services are considered more important eg improving the quality of life for people for whom there is no need for institutional care or dealing with episodic illness in the community. However, given current and foreseeable resource constraints, the ability of the statutory authorities to pursue all these objectives simultaneously must be in doubt. In these circumstances it is particularly important for authorities to be clear about their priorities.

EFFICIENCY IN THE NHS APPENDIX 3

1. Paragraphs 4.30 to 4.35 of the handbook consider some of the existing arrangements and changes in hand to enable Authorities to achieve a better use of resources. Those paragraphs do not cover in any detail what an Authority might or should do to improve efficiency.

2. The purpose of this Appendix is to suggest some specific areas where Authorities might take action. In the main, it is a matter of continuing and developing existing approaches and extending to other Districts ideas which have already worked well in particular places. For example:

(a) plain good housekeeping - more efficient cleaning programmes, review of transport arrangements etc (A handbook for NHS transport managers will be issued shortly);

(b) reduced catering costs - introduction of continental breakfasts, reductions in choice of menus, use of vending machines, elimination of waitress service;

(c) administrative savings - reduced use of agency staff, *economies in advertising, postal, telephone and photocopying* expenditure;

(d) *purchase of supplies including renegotiation of bulk supply contracts;*

(e) stock control, including the possible use of computers in pharmaceutical stock control;

(f) equipment savings - strict control over replacement and maintenance;

(g) energy savings - use of lower grade fuel, stricter control of room and ward temperatures;

(h) review of drugs usage and costs, including establishing lists of generic drugs; and

(i) seizing those opportunities which happen to present themselves for releasing resources e.g. by the sale of surplus assets such as hospital land.

3. As suggested above, many authorities have already taken measures to eliminate inefficiency. One authority, for example, introduced a scheme designed to encourage

both staff and patients to make proposals for saving £1 a day. Another launched a 'War on Waste' which included, in addition to measures mentioned in paragraph 2 above:

(a) an automatic one month delay (except in exceptional circumstances) in filling permanent vacancies;

(b) the employment of temporary staff only in exceptional circumstances; and

(c) a critical examination of overtime and bonus schemes. The study, undertaken largely in relation to ambulance staff, has now merged into work on the areas for savings highlighted by the Clegg Commission.

4. It is important for authorities who have been successful in improving efficiency to share their ideas and techniques with others. The National Association of Health Authorities (NAHA) is planning to produce an Index of measures to reduce waste. Pilot studies have been completed, and the Index will be available later this year. The NAHA Index is intended to help people in the NHS to become more aware of what is going on in different parts of the country and of different methods for tackling common problems. All member authorities will be asked to inform NAHA of methods for reducing waste which have been tried, tested and found successful. NAHA will then circulate the details with the names, in each case, of the officer and the authority who initiated the study. It is hoped that authorities will make the most of this opportunity both to contribute to, and draw from, this pool of experience.