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DEPARTMENT OF HEALTH & SOCIAL SECURITY

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Telephone 01-407 5522

From the Secretary of State for Social Services

P A Bearpark Esq
Private Secretary
10 Downing Street
LONDON
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21 December 1987

Dear Andy

HEALTH SERVICE IN ENGLAND: ANNUAL REPORT 1986-87

I thought you might like to have prior notice of the publication of this document which has recently gone to press. The report, which is the fourth of its kind, in non-controversial and contains no new announcements on matters of policy. If past experience is repeated it will not have a particularly high media profile.

We propose to publish the report on Tuesday 12 January unless you have any views to the contrary. I attach a copy of the final draft which has gone to the printers.

Yours ever

Flora

FLORA GOLDHILL
Private Secretary

THE HEALTH SERVICE IN ENGLAND

ANNUAL REPORT 1986-87

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

FOREWORD

PHOTOGRAPH OF THE
SECRETARY OF STATE

The health service is one of our largest, most important and most valued public institutions. It employs nearly a million people, utilises a vast range of equipment and supplies, and operates from a huge estate. In 1986-87 total NHS expenditure in England was nearly £16 billion, an increase of £1 billion on the previous year. The high level of commitment and dedication shown by NHS staff is a major factor in achieving the high standards of treatment and care which patients receive.

In 1986 6 million people were treated as in-patients and nearly 38 million attended out-patient clinics: both these figures are new records. Every working day 1.2 million people use the primary (or non-hospital) health care services. Remarkable though this level of activity is, the health service should not be just a "sickness service". One of the major tasks facing the service is to *promote better health* . "Promoting Better Health" is the title of our recently published White Paper which set out our programme for the future of primary care. The Government is determined that everybody should have the information and help they need to protect their own health. The challenges posed by AIDS, heart disease and many other major diseases can only be tackled effectively by the active promotion and pursuit of good health.

This report highlights some specific themes, such as primary care and health promotion, which are of key importance. Future editions will report progress on these areas as well as covering other key issues as they come to light. The picture which emerges will, I believe, show how well the health service is responding to the challenge of creating a more healthy society.

DECEMBER 1987

JOHN MOORE
SECRETARY OF STATE
FOR SOCIAL SERVICES

CONTENTS

Preface

This is the fourth annual report on the health service in England. Like previous reports it covers key areas of progress and describes what the service has achieved with the public funds it has received. This is first and foremost a report for the user of the health service and will also be of interest to all who work in, or alongside, the health service. The aim is to provide a clear statement of where the health service is and where it is going.

The World Health Organisation's Health for All Strategy to achieve Health for All by the year 2,000, places great emphasis on the vital role of primary health care; the promotion of healthier lifestyle and reduction of preventable diseases; and the development of support measures such as improved management and planning structures. As this report shows the NHS has a good record in all these fields.

HOW TO USE THIS REPORT

This report is organized in a different way from the three previous ones. More detailed information is provided on specific areas where there have been developments of interest and importance. This will be the pattern for future reports. The subjects chosen for detailed treatment this year are :

* Primary Health Care
* The fight against AIDS
* Prevention

These areas have been chosen not because other areas, such as care in the community, are not important, but because there have been specific developments to report during 1986/87.

The report opens with a description of how the health service is organised and financed. This chapter should provide a useful point of reference for readers who are interested in the developments described later in the report, but need a basic introduction to how the service is run.

Following the discussion, of the three vital areas mentioned above, there is a brief account in Chapter Five of health outcome measures which indicate the overall health status of the nation, and may provide some evidence on whether health care policies are effective.

Chapter Six then summarizes recent developments in the hospital and community health services, both in the acute sector and in the services for the priority care groups; and Chapters Seven and Eight deal with the management of the health service, the use of resources, and important issues relating to the staffing of the service.

The final Chapter is a "forward look" which identifies areas likely to be of special interest in 1988/89. Some of these will be dealt with in the next year's report.

Although the report centres on the financial year 1986-87, it is not rigidly confined to the events of that year. To do so would place an artificial restriction on the description of key developments - particularly those in the vital fight against AIDS and in primary health care.

It is hoped that this report will be of use to all who are interested in health services in England.

CHAPTER 1: HOW THE SERVICE IS RUN

The health service is a massive organization of considerable complexity. It is hardly surprising that users of the service are often confused as to who has responsibility for providing what services. This Chapter briefly describes the structure of today's health service, how it is run, and how it is funded.

THE SECRETARY OF STATE

The Secretary of State for Social Services is responsible to Parliament for the provision of health services in England. Services are split into the Family Practitioner Services (FPS) and the Hospital and Community Health Services (HCHS). These services are administered separately from the social services provided by local authorities. Figure 1 sets out the relationship between the Secretary of State and the various branches of the health services. The Secretary of State is advised on the management of the health service by the NHS Management Board. The Board which is chaired by Mr Tony Newton, the Minister for Health, is made up of :

* members with high level management experience within the NHS
* members with similar management experience in the private sector
* senior officials at the DHSS

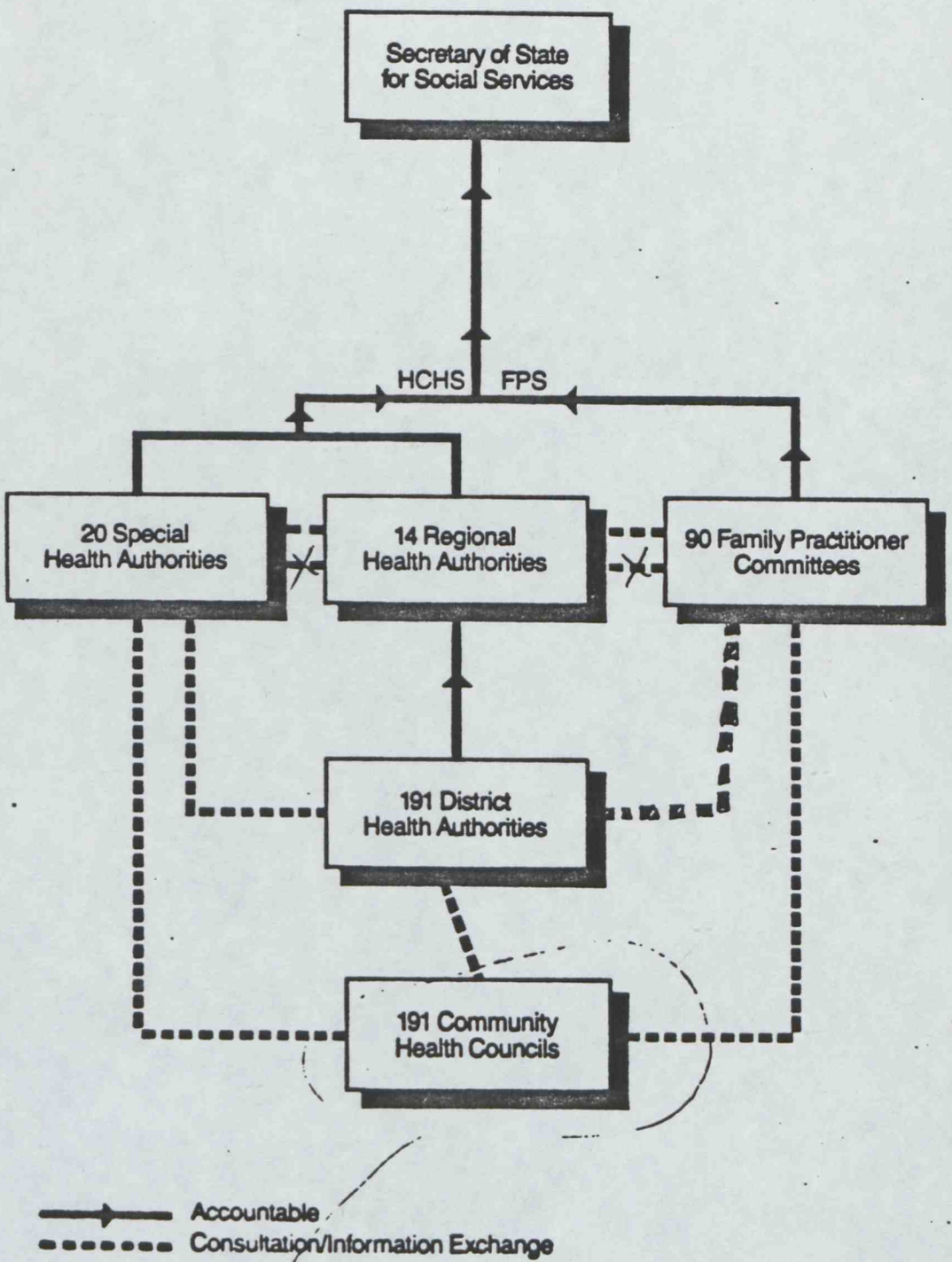
THE FAMILY PRACTITIONER SERVICES

Primary care provided by the Family Practitioner Services accounts for nine-tenths of all consumer contact with the NHS and is the key to an effective health service. On average each working day over one million people visit the family doctor or dentist, call in at the local pharmacy or are seen by a community nurse. The FPS, which includes services such as family doctors, dentists, opticians and pharmacists , costs some £4000 millions per year. They are administered by the Family Practitioner Committees (FPCs). There are 90 FPCs serving England and the geographical areas they cover normally correspond to those covered by local authorities.

THE HOSPITAL AND COMMUNITY HEALTH SERVICES

The HCHS includes the hospital service - both acute and long stay hospitals - and such services as community nursing, child health clinics and the school health services. They are run by the local District Health Authority (DHA). The 191 DHAs in England vary greatly in size - the population covered ranges from 90,000 to 860,000 and annual budgets from £25m to £160m. Each DHA in England reports to a Regional Health Authority (RHA) of which there are 14. RHAs allocate resources to Districts and seek to ensure that services are coherently planned and effectively

Figure 1. The Organization of the Health Service in England



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delivered. Figure 2 shows the location of the 14 RHAs and the amount of money they each spent in 1986-87. RHAs and Special Health Authorities also provide certain special services such as blood transfusion. All health authorities are corporate bodies, each with a chairman and members whose role is to make decisions on the provision of services. Chairmen of DHAs, and chairmen and members of RHAs and SHAs are appointed by the Secretary of State.

In addition to DHAs there are 20 Special Health Authorities (SHAs) some of which are responsible for the provision of certain specialized services, such as disablement services, and for running the 8 Postgraduate Teaching Hospital Groups in London. The latter provide advanced teaching, training and research in certain medical specialities in conjunction with an associated Postgraduate Medical Institute or Medical School of London University. Others, such as the Mental Health Act Commission, have a special role in the oversight of certain services. The work of another important SHA, the Health Education Authority, is discussed in detail in Chapter 4.

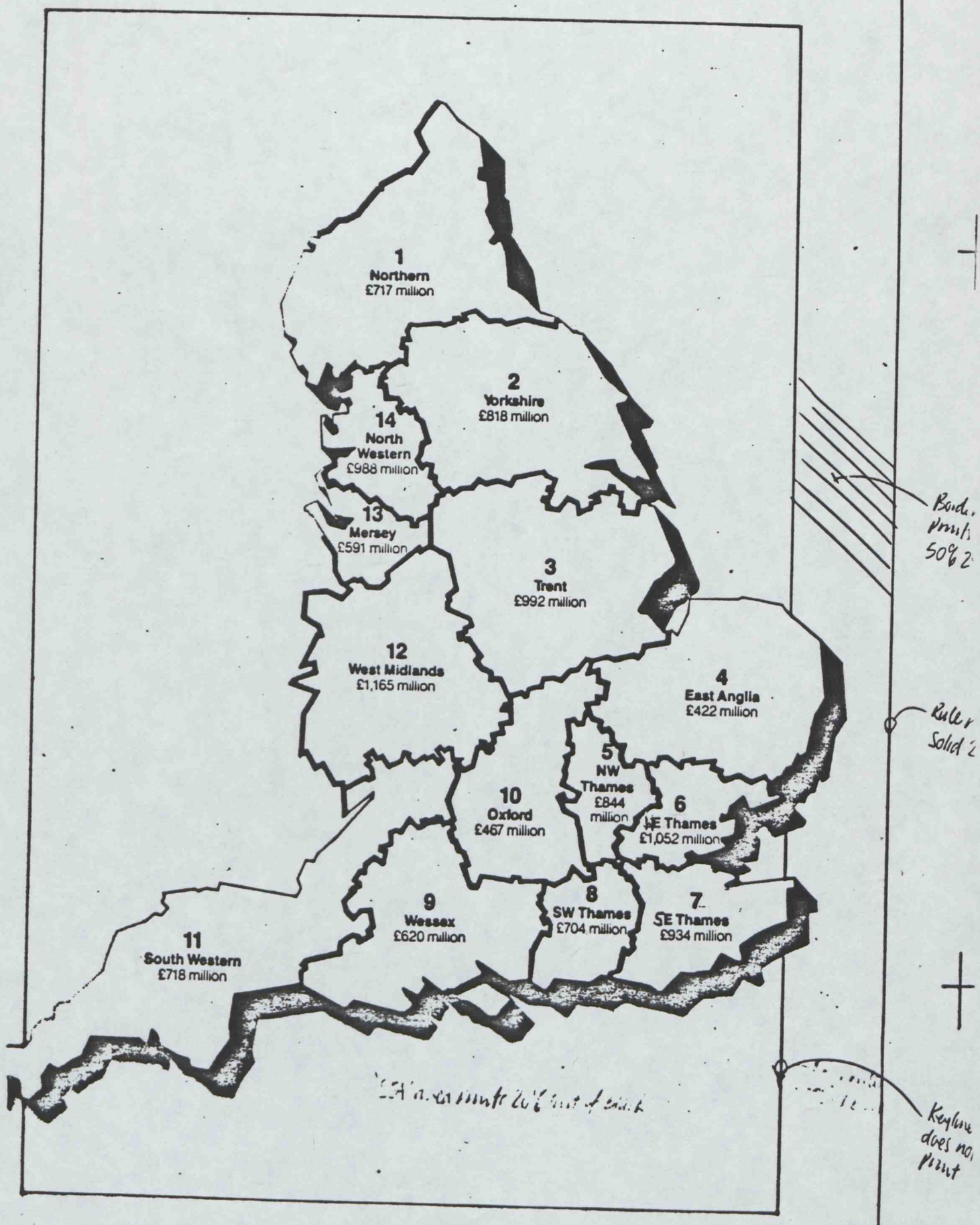
The interests of the public in local health services are represented by Community Health Councils (CHCs). CHCs are independent statutory bodies whose primary role is to represent the consumer's point of view and to offer constructive comment on ways in which services can improved. They also help individual members of the public who may wish to complain or make representations to an authority, and they provide information about local services. DHAs and FPCs must consult the relevant CHC about any major plans for change in services.

HOW THE NHS IS FUNDED

The level of NHS spending is determined by the Government as part of their overall control of public expenditure. In recent years the NHS has continued to enjoy an increasing share of the public expenditure programme.

Of every pound the NHS spent in 1986-87, 85 pence came directly from the taxpayer; 11 pence came from the NHS contributions paid weekly by employers and employees with National Insurance contributions; and the remaining 4 pence comes from miscellaneous income and receipts - mainly patients' charges and the sale of surplus property and land.

Figure 2: NHS Regional Health Authorities showing provisional revenue and capital spending in 1986/87 (to the nearest million)



CHAPTER 2 PRIMARY HEALTH CARE

The primary health care services are the frontline of the health service. They include all those services provided outside hospital by family doctors, dentists, pharmacists and opticians (the Family Practitioner Services) and by community nursing staff and the professions allied to medicine.
These services deal with over *nine - tenths* of the contacts that the public have with the health service in England. Extensive use of them is made not only by those who are ill but also by those apparently in good health who need advice or screening.

The importance of these services to everybody in the community is illustrated by the statistics. On an average working day in England about two thirds of a million people consult their family doctor. About 270,000 go to the dentist, and more than 75,000 are visited by nurses or other health professionals working in the community. In 1986/87 some £4800 million was spent on primary care in England. Figure 3 illustrates the growth which has occurred in the Family Practitioner Services in recent years.

PRIMARY CARE REVIEW

On 25 November 1987 the Government published "Promoting Better Health", a White Paper on primary health care services. Government's objectives for these services were confirmed in the White Paper:

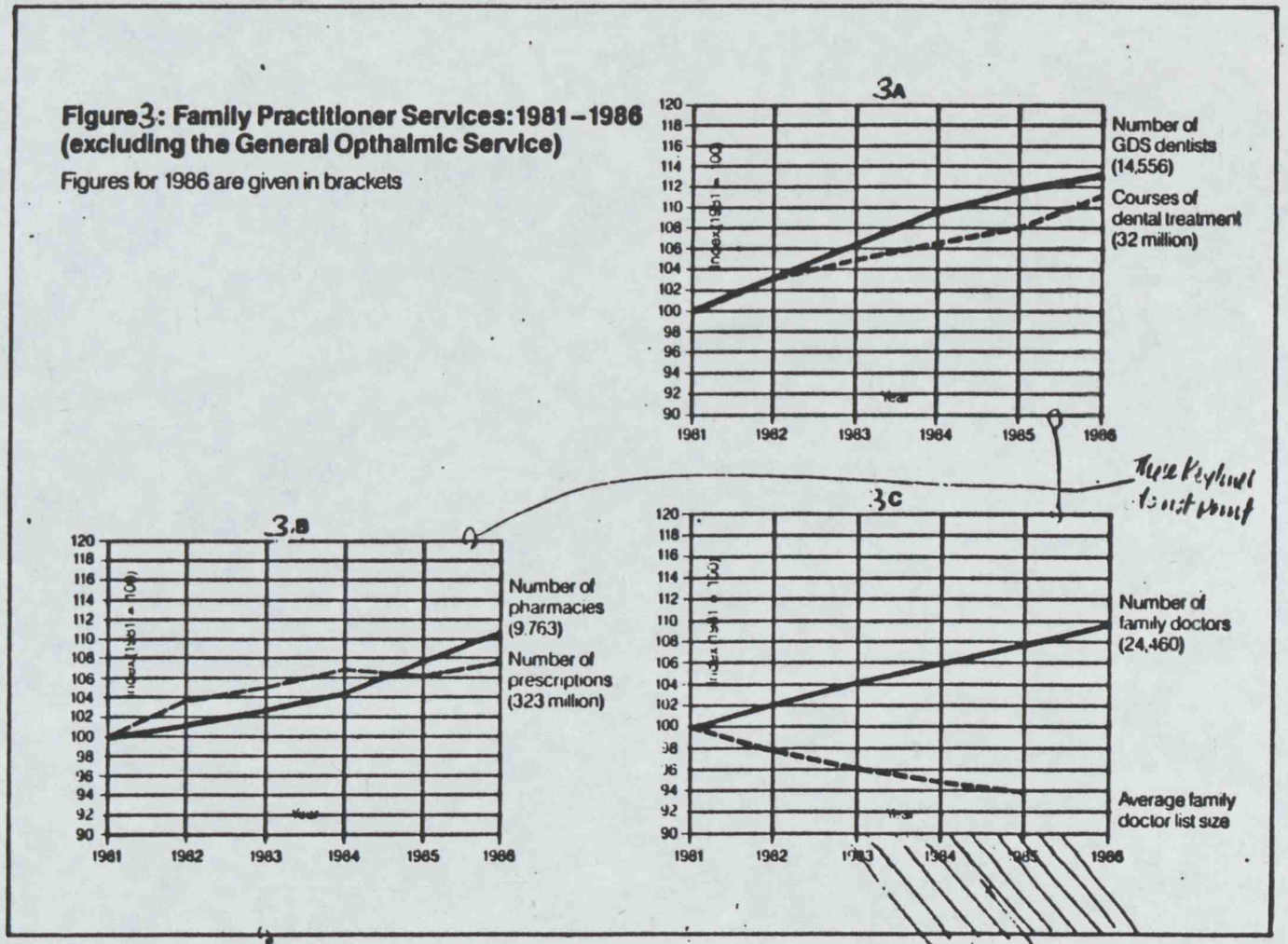
* to make services more responsive to the consumer
* to promote health and prevent illness
* to raise standards of care
* to give patients the widest range of choice in obtaining high quality primary care services
* to improve value for money.

The White Paper describes a range of proposals intended to realize these objectives. The main changes are:
-the setting of targets for family doctors to achieve higher levels of vaccination, immunisation and cervical cytology screening;
-more health promotion sessions in general practice;
-a wider role for pharmacists;
-regular health checks for particular groups, such as the under-5s and elderly people;
-a new contract for dentists which will encourage prevention;
-an extension of the primary care team to include skills such as chiropody, physiotherapy and others;
-action to see the skills of community nurses are better used (see Chapter 7 of this report).

Separate chapters of the White Paper set out the Government's intentions in relation to the community nursing review and the review of family practitioner services complaints procedures. Overall the Government believes the measures, which it will discuss with the professions concerned, will achieve an important

Figure 3: Family Practitioner Services: 1981–1986 (excluding the General Opthalmic Service)

Figures for 1986 are given in brackets



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shift of emphasis towards the active promotion of better health by the family health services.

HEALTH AND MEDICINES BILL

A number of proposals in the White Paper require legislation. The Government introduced on 25 November the Health and Medicines Bill which will enable the Government to introduce charges for dental examination and to remove free sight tests from the National Health Service. By these means the Government will be able to secure additional resources to help meet the cost of the improvements identified in the White Paper.

In addition the Bill will give direct effect to some of the White Paper proposals, for example on retirement age of family doctors and dentists - as well as making other changes to the law in relation to health authorities' powers to generate income, training grants for local authorities' social services departments, local authorities' power to charge for hospital social workers and fees for medicines licences.

GENERAL MEDICAL SERVICES

The number of family doctors in general practice in England increased by 425 to 24,460 in October 1986 - an increase of of 9.7 per cent on 1981. This growth is illustrated in figure 3(c) which shows that as the number of family doctors has risen their average list size has decreased from 2,201 in 1981 to 2042 in 1986. The number of trainees in general practice decreased by 104 to 1654 in 1986, compared with 1758 in 1985 and 1561 in 1981. The number of ancillary staff, particularly practice nurses, working in support of family doctors increased to 29,440 (a rise of 34.4% over 1981.) As a result of the increases in ancillary staff, and of GPs themselves, services are becoming available to more people. Health promotion, screening clinics and care of those with chronic disease are now seen as an increasingly important part of primary care.

During 1986 a further £600,000 was made available under a special temporary scheme to provide a higher rate of improvement grant to general practitioners' premises in the most deprived inner city areas. The aim was to encourage GPs in these areas to improve run down premises.

GENERAL DENTAL SERVICES

The number of courses of dental treatment provided through the general dental services in England during 1986 rose by 2.9 per cent to about 32.3 million. In 1986 about £698 million was paid to dentists in fees (about 10 per cent more than in 1985). 31% of this cost was met from patients' charges. The number of dentists on the UK Dentists Register also continued to rise and by the end of 1986 there were 24,850 - an increase of 258 over 1985. Over the last ten years the number of dentists has grown by about quarter. This growth is illustrated in figure 3(a).

PHARMACEUTICAL SERVICES

The number of pharmacies has continued to increase, to 9,760 in 1986 compared with 8,800 in 1981, and the number of prescriptions dispensed rose to 323 million after a fall in the previous year. This compares with 300 million in 1981. This is illustrated in figure 3(b). The cost of the services in 1986/87 was £1,787 million, over three quarters of which is accounted for by the cost of medicines. This represents a real terms increase of 4.7% over the previous year.

A new contract for pharmacists was introduced on 1 April 1987. This is intended to ensure that the provision of pharmacies is more closely matched to the needs of consumers. The White Paper "Promoting Better Health" makes it clear that the position will need to be reviewed, once the new system has settled down. Meantime the Government will seek to promote a wider role for pharmacists, as advised in the Nuffield Report.

PRESCRIBING

GPs need feedback about their own precribing if they are to precribe more effectively and economically. Agreement has been reached with the medical and other professions for a new system of prescribing information which will provide all doctors with well presented, timely and more frequent data from Autumn 1988.

GENERAL OPHTHALMIC SERVICE

The number of NHS sight tests has continued to grow and there was an increase of 2 per cent between 1985 and 1986 when the number rose from 10.2 million to 10.5 million. The number of ophthalmic opticians (who provide nearly 90 per cent of all sight tests) and ophthalmic medical practitioners (who provide the rest) increased by 2 per cent over the same period. In 1986 nearly 2.25 million children and adults on low incomes benefited from help with the provision of their glasses, either through free NHS glasses or through the NHS optical voucher scheme which replaced these from 1 July 1986. The White Paper "Promoting Better Health " proposed a number of developments to the General Opthalmic service for the future.

COMPLAINTS ABOUT FAMILY PRACTITIONERS

There is a statutory procedure for investigating complaints about doctors, dentists, pharmacists and opticians in the family practitioner services. Complaints are investigated by special committees, known as Service Committees, on behalf of the Family Practitioner Committee. They aim to establish whether the practitioner has complied with his Terms of Service and, if not, to recommend what disciplinary action should be taken. Complaints which are made, should be investigated and resolved as impartially and as quickly as possible. In August 1986, the Government issued the consultative document "FPS Complaints Investigation Procedures". Following

that consultation exercise, the Government announced in the White Paper that it intends to pursue a number of improvements designed to simplify and speed up procedures.

COMPUTERS IN THE FPS

The computerization of all Family Practitioner Committees in England and Wales has
continued as planned. At the end of October 1987 85 of the 98 FPCs had operational computer systems for patient registration, finance and cervical cytology call and recall. The last FPC computer was installed in November 1987 and the programme is on target to achieve full computerisation in all FPCs by 31 March 1988. As well as yielding substantial administrative savings, this will produce improvements in the planning of services and the care of patients; particularly health promotion for elderly people, women and children. In the long run there will be an interlinked computer network between different FPCs administrative bodies.

CHAPTER 3: THE FIGHT AGAINST AIDS

1. The Acquired Immune Deficiency Syndrome (AIDS) is a unique international health problem of extraordinary scope. In the United Kingdom, the first case was recognised at the end of 1981. By the end of November 1987 a total of 1,123 cases had been reported. Globally almost 64,000 cases have been reported to the World Health Organisation. Since the identification in the early 1980s of the cause or agent - the Human Immuno-deficiency Virus (HIV) - most countries have come to realise the potentially devastating implications of AIDS in terms of human suffering, social impact and costs for health services.

THE GOVERNMENT'S STRATEGY

2. To meet the challenge of this new disease, the Government has developed a comprehensive four part strategy, which comprises:

* Public health measures, such as screening blood donations and a system of monitoring the spread of AIDS and HIV;

* Public education, so that people can learn how to avoid HIV infection;

* Research into vaccines against HIV infection and antiviral therapies for those who are infected; and

* Development of services for those who are infected with HIV or who have AIDS itself.

The Government accepts that its strategy must be flexible and recognizes that it must be carried out in partnership with health and local authorities and the voluntary sector.

PUBLIC HEALTH MEASURES

3. Underpinning the Government's efforts to combat AIDS, is the important work done by the Public Health Laboratory Service (PHLS) both in testing for HIV anti-bodies and in monitoring the spread of HIV infection. Since [1982] there has been an effective system of voluntary reporting to the PHLS Communicable Disease Surveillance Centre (CDSC) of all cases of AIDS. The Director of the PHLS is chairing a group of experts reporting to the Department on methods of improving data collection on and surveillance of the spread of HIV infection.

4. Over the past four years the funding of the PHLS has been increased in real terms by about £2 million. Their total budget for 1987/88 of £39.5 million (£4.8 million over last year's allocation) included £3.6 million in recognition of the additional work the service is undertaking related to AIDS and control of HIV infection.

5. Another crucial public health measure has been to protect the blood supply. Leaflets have been issued to blood donors since 1983, warning those at risk from AIDS they must not give blood. Every potential donor receives this information which is regularly updated. Since October 1985 every single blood donation has been screened for evidence of infection. These precautions

have been extremely successful in maintaining the safety of the blood supply. All blood products for haemophiliacs are now made from screened donations and are heat treated to inactivate HIV.

6. To reduce the risk of transmission of the virus through contact with infected body fluids, advice about AIDS and HIV infection has been issued to doctors, other health care workers and other professionals. Although the basic infection control measures advocated by the Advisory Committee on Dangerous Pathogens remain valid, an expert group is nevertheless considering the possible need for any additional material or updating of the various existing guidelines. The Health Departments will continue to monitor developments carefully and to take further action should new information indicate the need for further measures.

[Illustration: "AIDS Iceberg"]

PUBLIC EDUCATION

7. Public health education is the major weapon in the fight to counter the spread of infection. The aim of the Government's AIDS Public Education Campaign has been to raise and maintain public awareness about the disease, how infection is transmitted and how the risk of infection can be reduced. Although there has been little evidence of heterosexual spread of the virus in the United Kingdom, any man or woman could become infected by intimate sexual contact with an infected person. The campaign has, therefore, sought to warn the whole population about the potential dangers and to dispel myths and misconceptions about transmission routes. As with any campaign aimed at changing deep rooted patterns of behaviour, a long sustained effort will be necessary, mobilising all forms of mass communication media and coupled with close, independent monitoring and evaluation.

8. The first stage of the campaign started in 1983, when those in high risk groups were asked not to donate blood. The general campaign started at a cost of £2.5 million in March 1986 with full page advertisements in the national press. By the autumn of 1986 it became clear that the public wanted more information and were then ready to accept a more hard hitting approach. The Government decided therefore, to allocate £20 million in the next year to meet the cost of a campaign in the mass media to get across the basic facts about AIDS and HIV infection and how individuals could act to protect themselves and others.

9. Between November and March 1987 there was extensive advertising in all the main media and a distribution to all households of the leaflet 'AIDS: Don't Die of Ignorance'at a total cost of £7.5 million. In September 1987 the Department launched a campaign focusing on the drug related risks of HIV infection. New educational work will be carried forward by the Health Education Authority established in April 1987, in close cooperation with other health education agencies and relevant Government Departments. An initial allocation of £4.1 million has been made to the Authority to meet the cost of this work in the current financial year.

[Illustration: "AIDS Don't Die of Ignorance"]

RESEARCH

10. The Government attaches high priority to AIDS research, and the United Kingdom is making a full contribution to the international effort. The main Government-funded research, particularly that in the clinical and biomedical

fields, is co-ordinated by the Medical Research Council (MRC). The Government has allocated an additional £17.5 million for this over the 3 years 1987/8 to 1989/90, comprising:

* £14.5 million (an additional £2.5 million in 1987/8, £5 million in 1988/9 and £7 million in 1989/90) to fund a directed research programme aimed at developing a vaccine to prevent infection, and anti-viral drugs to treat people already infected.

* £3 million for general AIDS research outside the directed programme.

11. As part of the European Community's third Medical and Health research programme 1983-1986 the UK contributed to the coordination of research activities on AIDS in member states. Under the fourth programme 1987-1991, which is currently being planned, the part of the programme concerning AIDS research is being considerably enlarged and will include disease control and prevention, as well as viro-immunological and clinical research.

12. The Department is supporting directly a programme of AIDS research related to health care services and provision. Other centrally funded bodies pursuing research include the Public Health Laboratory Service and the National Institute for Biological Standards and Control. Overall, the Department has so far made available £2 million for research into AIDS in 1987/88. The Economic and Social Research Council has also set aside £1.5 million over the next 3 years for research into the social and behavioural aspects of AIDS.

DEVELOPMENT OF SERVICES

13. All health authorities in England have been asked to develop plans of action to combat the spread of HIV infection, concentrating initially on high risk groups. They have been asked to cover in their plans provision for testing and counselling services and for treating clinical cases of AIDS. Greater public awareness and concern about AIDS has already brought additional pressures on those parts of the health service, particularly clinics for sexually transmitted diseases, which offer personal counselling and tests. Health authorities' plans should cover also what they are doing to enable the service to meet those general demands.

14. The Department increased cash allocations to health authorities in 1987/8 by an average 8.8% for hospital and community health services as a whole, including needs arising from AIDS and HIV infection. In addition the Department has made allocations totalling £12.5 million to the 3 Regional Health Authorities on whom demands arising from AIDS have fallen disproportionately. These are N W Thames, N E Thames and S E Thames. The first of these alone had well over half of all AIDS patients in England; the 3 together accounted for over 4 out of every 5.

15. The Department has also allocated in 1987/8 £280,000 for Haemophilia Reference Centres; £1.3 million for initiatives on drugs misuse counselling, and £800,000 for other special AIDS related projects. These include counselling training courses at St Mary's Hospital, London and in Bolton and East Birmingham health authorities; a course in the clinical management of AIDS patients run at St Stephen's Hospital, London; English National Board Nurse Training courses, workshops for senior community nurses in each Region and 13 fellowships for nurses, midwives and health visitors.

16. To complement statutory provision a number of voluntary bodies are providing care and support for those infected with HIV or who have AIDS, and their carers. They are also providing information and educational material for the community at large. The Government allocated almost £500,000 to voluntary bodies concerned with AIDS in 1986/7. For 1987/8 the Department has approved a capital grant of £500,000 and a revenue grant of up to £100,000 towards the cost of London Lighthouse, an experimental training centre, day centre and residential care facility being established in West London. It has also given £300,000 to the Terrence Higgins Trust has made a grant of £150,000 for the establishment of a hospice ward at the Mildmay Mission Hospital in East London. Grants to voluntary organizations in the AIDS field are expected to total over £1.5m in 1987/88. The establishment of the National AIDS Trust, to coordinate and help to fund the activities of those working in the voluntary sector, should enhance the valuable role which voluntary bodies have played right from the beginning.

INTERNATIONAL COORDINATION

17. In view of the world-wide impact of AIDS, international coordination of measures to tackle it is vital. On 2 November 1987, John Moore, in the first speech by a British Secretary of State for Social Services to the United Nations General Assembly, stressed the need for international cooperation in this field during the General Assembly's special debate on AIDS. The United Kingdom is a major contributor to, and supporter of, the World Health Organisation's Special Programme on AIDS which is playing the key role in drawing together international efforts on a world-wide level to combat AIDS. The Government's commitment to international cooperation is further illustrated by its decision to organise jointly with the World Health Organization the World Summit of Ministers of Health on Programmes for AIDS Prevention to be held in London in January 1988. The objective of the Summit Meeting is to provide Ministers of Health from countries throughout the world with a forum for reviewing policy options for the prevention and control of the spread of AIDS, particularly in relation to information and public health education strategies. The Government is also closely involved in the AIDS programmes of the European Communities and the Council of Europe.

FUTURE PROSPECTS

18. £50 million has been earmarked for 1988/9 to help develop preventive, counselling and diagnostic services and to make a contribution towards the costs of care and treatment in hospitals and in the community for those with AIDS or HIV infection. This level of central provision should make an important contribution towards the costs of AIDS-related services enabling health authorities to develop adequate services for patients with AIDS and related conditions, while maintaining other high-priority services.

19. In May 1987, the AIDS (Control) Act received Royal Assent. The Act requires each Health Authority to publish an annual report which will include details of education services and care provided by the Authority, as well as by others in its area, for people with AIDS. These reports should help to contribute to planning future services. The Act requires that the first reports should be made by the end of 1988.

CHAPTER 4: THE PREVENTION OF ILL HEALTH

1. If the NHS did not attempt to prevent ill health, and to detect disease at an early stage, it would be merely an "illness service". The active promotion of good health, a cornerstone also of the WHO Health for All Strategy, has been of key importance throughout the health service - in the Hospital and Community Health Services, in the Family Practitioner Services, and in the newly created Health Education Authority. It was one of the major themes of the White Paper "Promoting Better Health" published in November 1987.

SMOKING

2. Of all the areas where prevention has an important role to play perhaps none is more important than smoking. It is the single largest preventable cause of premature death in the UK. It has been estimated that 100,000 people die prematurely as a result of smoking each year. It has also been estimated that the illnesses caused by smoking lead to some 50 million working days lost each year, and treatment uses up valuable NHS resources. People have been successful in giving up smoking. The number of adults who smoke cigarettes has fallen from 39% in 1980 to 34% in 1984. However, teenagers continue to smoke at a worrying rate, although the latest figures show an encouraging fall in smoking amongst boys aged 11-15. This success has not been repeated amongst girls, who are now almost twice as likely to be regular smokers as boys.

3. The NHS's strategy on smoking is one of prevention and health promotion - to persuade people to give up or better still, not to start - and treatment for people who have developed smoking-related illnesses. While the Hospital and Community Health Services are mainly orientated towards treatment - though with an increasing emphasis on the health education role that doctors and nurses in general, and GPs and the primary care team in particular, can play - most District Health Authorities now have a smoking policy, and through their health education units are promoting the health message on smoking. North Western Regional Health Authority is a good example of this, and with the Health Education Authority have been very successful through their Project Smoke Free in raising awareness; young people in particular became directly involved in the "Smokebusters" club. Increasingly, hospitals are adopting smoking policies with the emphasis on providing limited smoking areas within generally smoke free premises.

4. It is within the context of Family Practitioner Services that the greatest potential lies for passing on advice on smoking at the time likely to be most helpful. Nearly one million people are in contact with their doctor or another health care professional on an average working day in England. This provides valuable opportunities for advice to be given on how to give up smoking and on other aspects of health promotion. On the international front the UK is actively involved in shaping the WHO's anti-smoking programme and in the European Community's programme "Europe against Cancer", in which proposals to reduce smoking and encourage healthier diet play a major part.

5. Smoking is a wide-spread cultural phenomenon still ingrained in society. Action at national level beyond purely health settings is therefore needed. Much has been done by the Health Education Authority through mass media campaigns and through school-based health education activity. The DHSS has also been working with the Health Education Authority on tackling the problem of dissuading teenagers, especially girls, from smoking. The Government has continued the tradition of negotiating voluntary agreements with the tobacco industry on restricting advertising and sports sponsorship, especially where it might have disproportionate appeal to young people.

[Illustration: HEA poster]

DIET

6. The Committee on Medical Aspects of Food Policy (COMA) has set up a panel which is now conducting a review of the developing scientific evidence about diet and cardiovascular disease. COMA has also set up a panel to consider the effects of dietary sugars, which is expected to report by the end of 1988. A third panel, charged with reviewing the Recommended Daily Amounts (RDAs) of food energy and nutrients for groups of people in the United Kingdom, has started work and is expected to issue a series of interim reports on specific nutrients.

7. In the course of 1987 COMA completed reviews of the use of very low calorie diets and present-day practice in infant feeding, resulting in the publication of the 1987 COMA reports "Present-Day Practice in Infant Feeding: Third Report" and "The Use of Very Low Calorie Diets in Obesity".

8. The Department continued to maintain close co-operation with the Ministry of Agriculture in all matters relating to food and health. The fieldwork for the joint Ministry of Agriculture/DHSS national survey of adult diets was completed in September and processing the data has begun. The survey achieved a notably high response rate and will provide information about what foods people eat, and in what quantities, and about the nutritional status of the population.

9. In July, following consultation with consumer and health interests, the Ministry of Agriculture issued guidelines for voluntary nutrition labelling and are considering a statutory standard nutrition labelling format to which manufacturers, and retailers who wish to provide nutrition labelling, would be required to adhere.

HEART DISEASE AND HEALTHY LIFESTYLES

10. A major campaign aimed at reducing coronary heart disease in particular and promoting a healthier way of life in general, was launched in April 1987. This campaign - "Look After Your Heart" - is being run jointly by the Department and the Health Education Authority. It is intended to serve as an 'umbrella' under which a wide range of national and local activity can be taken forward.

11. Nationally, the main emphasis in the first phase of the campaign has been on raising public awareness of the main risk factors of heart disease - smoking, lack of exercise, an unhealthy diet and obesity - and encouraging individuals to avoid them. TV and poster advertising campaigns have been mounted and well over 6 million leaflets and other publications have been distributed. In addition, major industrial and public sector organisations have joined the campaign and are taking action to improve the health of their employees. Several food manufacturers are using 'pack-side' promotions in support of the campaign and various sections of the food industry, notably the dairy and meat trades, are encouraging the wider availability of healthier products.

12. At local level, a community development programme is acting as a catalyst in bringing together health authorities, local authorities, voluntary organisations and others in "Look After Your Heart!" initiatives, and a 'small grants' scheme for the development of these projects has been set up. More

than 75 projects will have taken place during 1987, largely due to efforts by District health education units. Inner city areas are also being targeted. A "Heartbeat Award" Scheme for restaurants is also an important part of the campaign. To qualify, catering establishments must fulfil certain criteria relating to standards of hygiene, provision of non-smoking areas and the provision of healthy food choices. The Government together with the Health Education Authority is firmly committed to taking forward this campaign into the 1990s.

MISUSE OF ALCOHOL

13. The Government is very concerned about the misuse of alcohol and its effects on individuals, the family and society. The Government has set up the Ministerial Group on Alcohol Misuse to consider the many aspects of the misuse of alcohol. This group has been established at the joint instigation of the Home Secretary, the Rt Hon Douglas Hurd, CBE, MP and the Secretary of State for Social Services, the Rt Hon John Moore, MP. The Group is chaired by John Wakeham MP, Lord Privy Seal and Leader of the House. This forum, which first met on 3 November 1987, provides an important opportunity to review and co-ordinate preventive efforts and identify goals which everyone in the country can work towards. It will look at new approaches which both the Government and other organisations might take to specific problems both nationally and locally. It will take account of surveys and research about drinking in the UK and consider the many initiatives which are already being taken by Departments, statutory and voluntary organisations and the private sector including the drinks industry.

HEALTH EDUCATION AUTHORITY

14. The Government is convinced that a vital key to improving the nation's health is in shifting the balance in the NHS more in favour of disease prevention and health promotion.

15. In order to assist the better integration of health promotion into NHS planning, the Health Education Council was reconstituted in April 1987 as a special health authority - the Health Education Authority - and made an integral part of the NHS. While retaining its status as a source of independent advice on all matters relating to health education, the new Authority is being directly involved in the process of planning disease prevention and health promotion policies within the NHS.

16. An important part of the Authority's task has been to take over from 26 October responsibility for new work on the public education campaign on AIDS. It has also assumed responsibility for, and is carrying forward and developing, the important health education programmes which the former Health Education Council had in hand. These cover a wide spectrum and include smoking, coronary heart disease, health in old age, family health, womens' health issues, alcohol misuse and dental care. The HEA's programmes are promoted by way of resources supplied to health education officers employed by the health authorities, mass-media campaigns and teaching materials provided for use in schools, colleges and further education establishments.

SCREENING: NEW DEVELOPMENTS

17. Prevention is better than a cure. However, more effective treatment can often be offered if a disease is detected as early as possible. Important developments in screening for women should help to achieve this.

BREAST CANCER SCREENING

18. On 25 February 1987 the Government announced that the first nationwide breast cancer screening service in the world would be set up in the United Kingdom. The decision had been taken in the light of the Forrest Report's conclusion that deaths from breast cancer in women aged 50-64 offered screening by mammography (breast x-rays) could be reduced by at least a third.

19. The service will include a computerised call and recall system to invite women between 50 and 64 for screening by mammography every three years, with optional screening for women of 65 and over. There is insufficient evidence so far to show that mass screening for women under 50 is effective in significantly reducing the death rate; however younger women at special risk may be offered mammography if referred by their general practitioner.

20. An additional £6 million was provided in 1987/88 to set up at least one screening centre in each of the 14 English Regions, each centre covering a population of about half a million people. Each Region has been funded to provide not only screening by mammography at mobile or static units, but also facilities for the assessment of any abnormalities detected by screening and for diagnosis, treatment, counselling and after-care. Four of these centres (at Guildford, Nottingham, Manchester and Camberwell (King's College)) will provide training for staff for the whole programme in England. The remaining English centres (to give a total of about 100) will be set up during 1988/89 and 1989/90. The programme is being implemented over three years in order that staff may be trained and back-up services developed.

21. An Advisory Committee, chaired by Professor Martin Vessey, has been set up to advise on the development of the service, to monitor its effectiveness and efficiency and advise on research concerned with the service.

22. A new committee, chaired by Professor Sir Patrick Forrest and including representatives from the Medical Research Council and the major cancer charities has also been set up to co-ordinate further research.

23. To facilitate implementation of the screening programme and obtain benefits of NHS purchasing "muscle" a nationally co-ordinated initiative has been undertaken to evaluate available equipment and to set up a 'best-buy' facility offering good value-for-money for NHS Authorities.

CERVICAL CANCER SCREENING

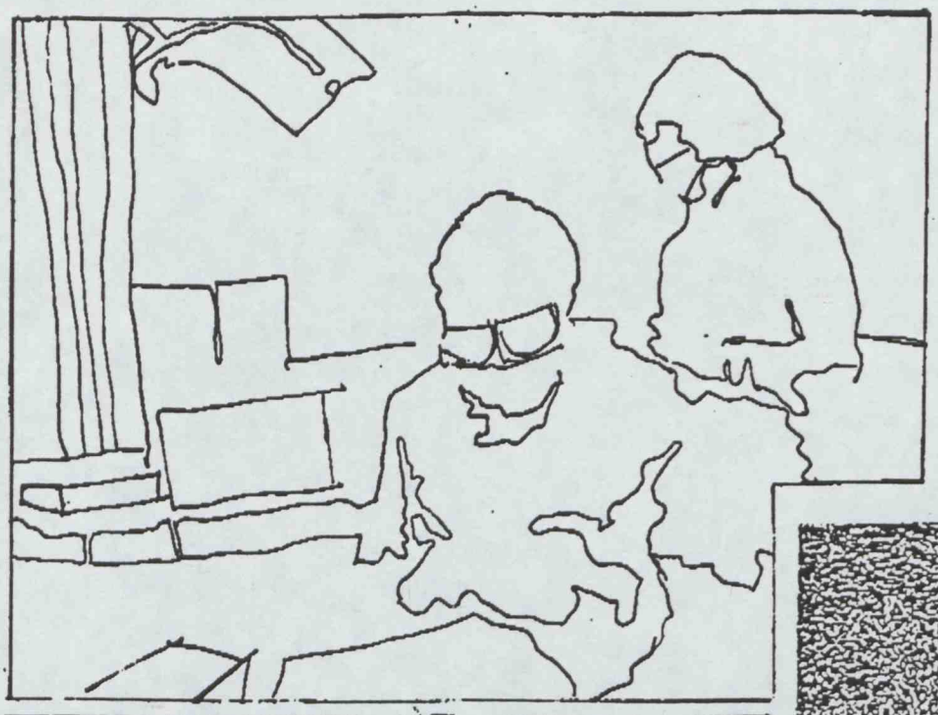
24. Screening for cervical pre-cancers has been available through the NHS for more than 20 years. Since 1981 deaths from cervical cancer have fallen by only one per cent to 2,004 in England and Wales; the number of smear-tests rose by 30 per cent to 3.9 million. There was increasing evidence that the screening programme was not as effective as it might be. Accordingly, in January 1986, improvements to cervical cytology screening programmes were made a service development priority for all Health Authorities. Most Health Authorities are now operating computerised call and recall systems, and the remainder are expected to be doing so by Spring 1988. In February 1987 they

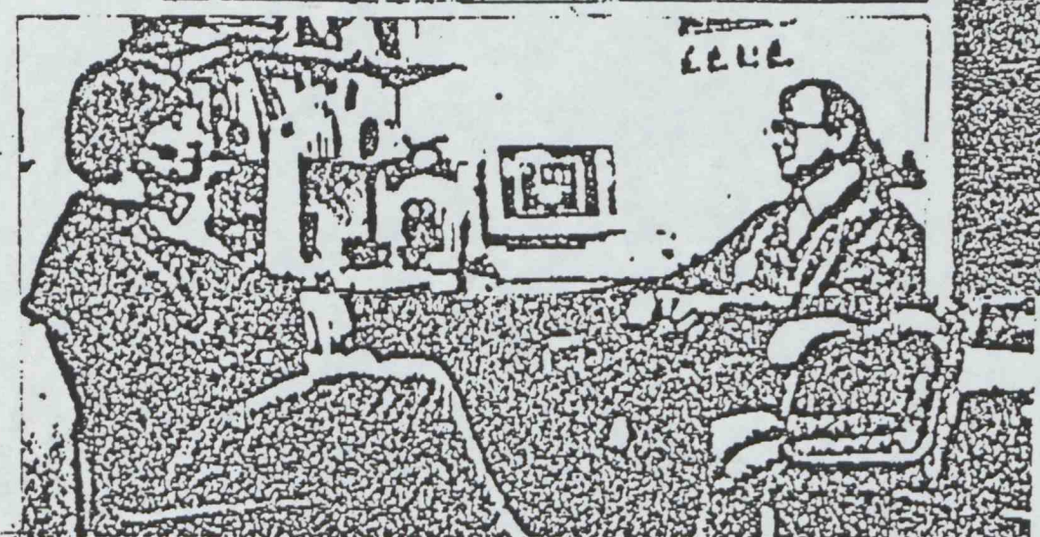
were asked to ensure that these systems covered all women aged 20 to 64; and to make a named individual responsible for the organisation and effectiveness of each authority's screening programme. Health authorities have also been required to ensure that laboratories can meet demand and have adequate arrangements for quality control and that there are fail-safe mechanisms for the follow-up of abnormal smears, and adequate facilities for the prompt investigation and treatment of women who need it.

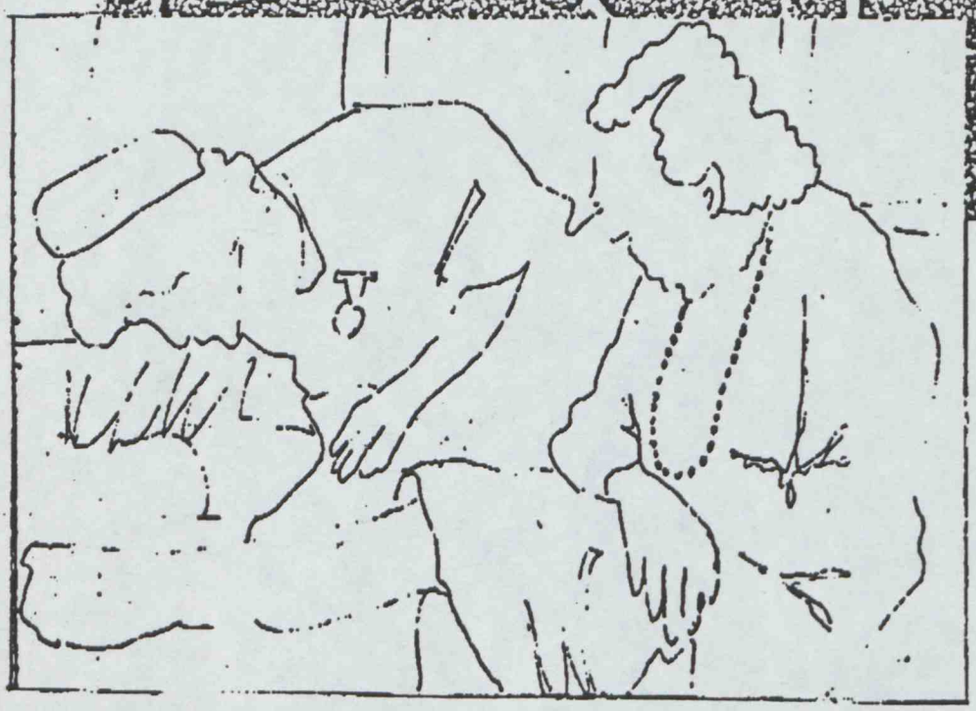
25. In April the Secretary of State asked Sir Roy Griffiths, Deputy Chairman of the NHS Management Board, to lead a small team to oversee the implementation of the Government's policies on breast and cervical cancer screening. The team is working with health authorities and family practitioner committees to ensure that they have viable plans, not only for installing computerised call and recall systems, but also for improving of screening and follow-up of women who do not respond to screening invitations.

Primary Health Care - A Service for All

HP.



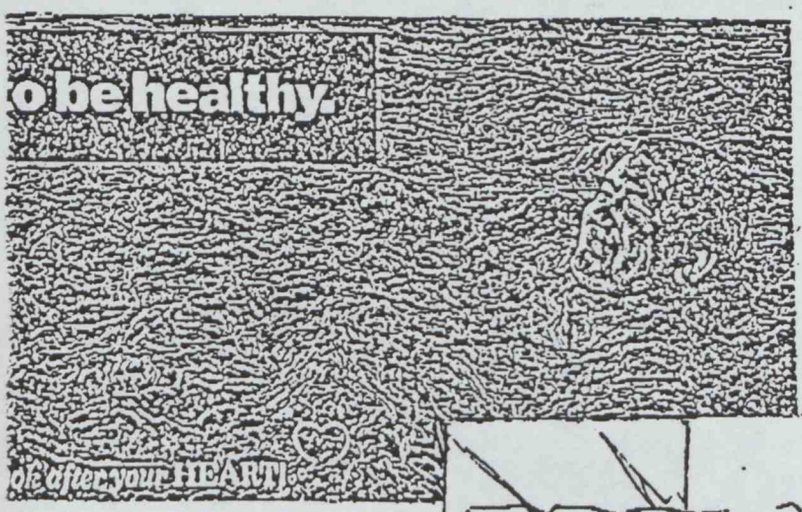


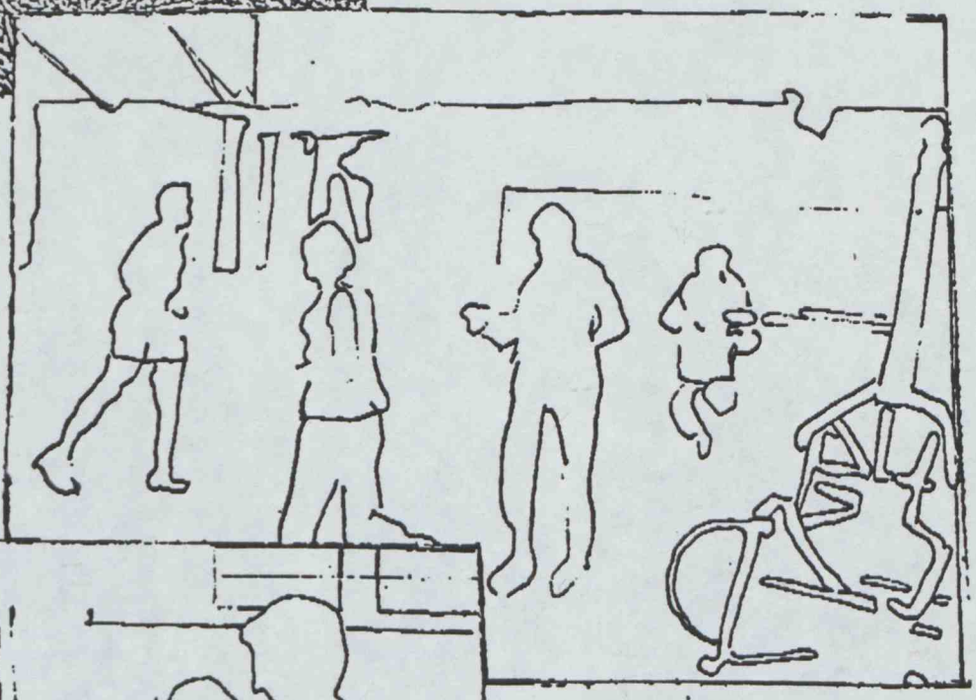


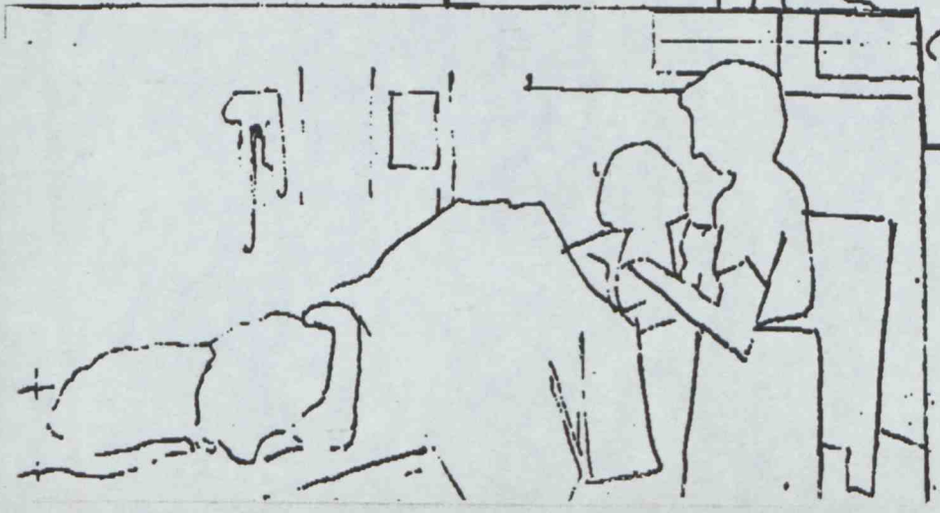
Centre page

Prevention- Better than a cure

RHP







Celebrate page

CHAPTER 5: HEALTH OUTCOME MEASURES

If the Health Service is delivering services of the right quality and quantity, and is placing the right emphasis on the prevention of ill health, this should be seen to have a positive effect on the health of the nation. This chapter reports, very briefly, on measures which are used to monitor the health of the population as a whole.

Improvements in life expectancy have gone hand in hand with the increases in health service activity seen in the last few years. Although the causes of changes in mortality are complex, and include past changes in the standard of living and in lifestyle such as a decrease in smoking and better diet, improvements in health care have also played a significant role in these trends. Since 1981 the standardised mortality ratio (SMR)(a measure of the death rate which takes account of changes in the age structure of the population) has declined slightly by 0.3 per cent. The latest figures also show improved prospects for life expectancy throughout the age range. Children born in the years 1982-84 can expect on average to live two years longer than those born ten years before. The same ten-year period has seen life expectancy gains of more than a year for ages up to 70, with smaller gains up to 85.

For a small number of disorders mortality rates can be used as indicators of the success of the health service in curing disease. These are the potentially 'avoidable causes of mortality' where clinical treatment is most likely to save life and normally does so in younger patients under 65. Figure 4 and Table 1 below show the record over the past 5 years. The improvements in potentially 'avoidable deaths' occurred during a period when the levels of deaths from other causes showed little change. 'Avoidable deaths' account for just under 3% of all deaths, but one in every eight deaths before the age of 65.

Clinical treatment has less chance of saving life amongst elderly people, but here too the past few years have seen the death rate falling by 6%, over a period which also saw an increase in hospital treatment among this group. Elderly people account for a large proportion of the increase in hospital treatment over the last five years.

Figure 4: Avoidable causes of mortality 1981–86 England and Wales

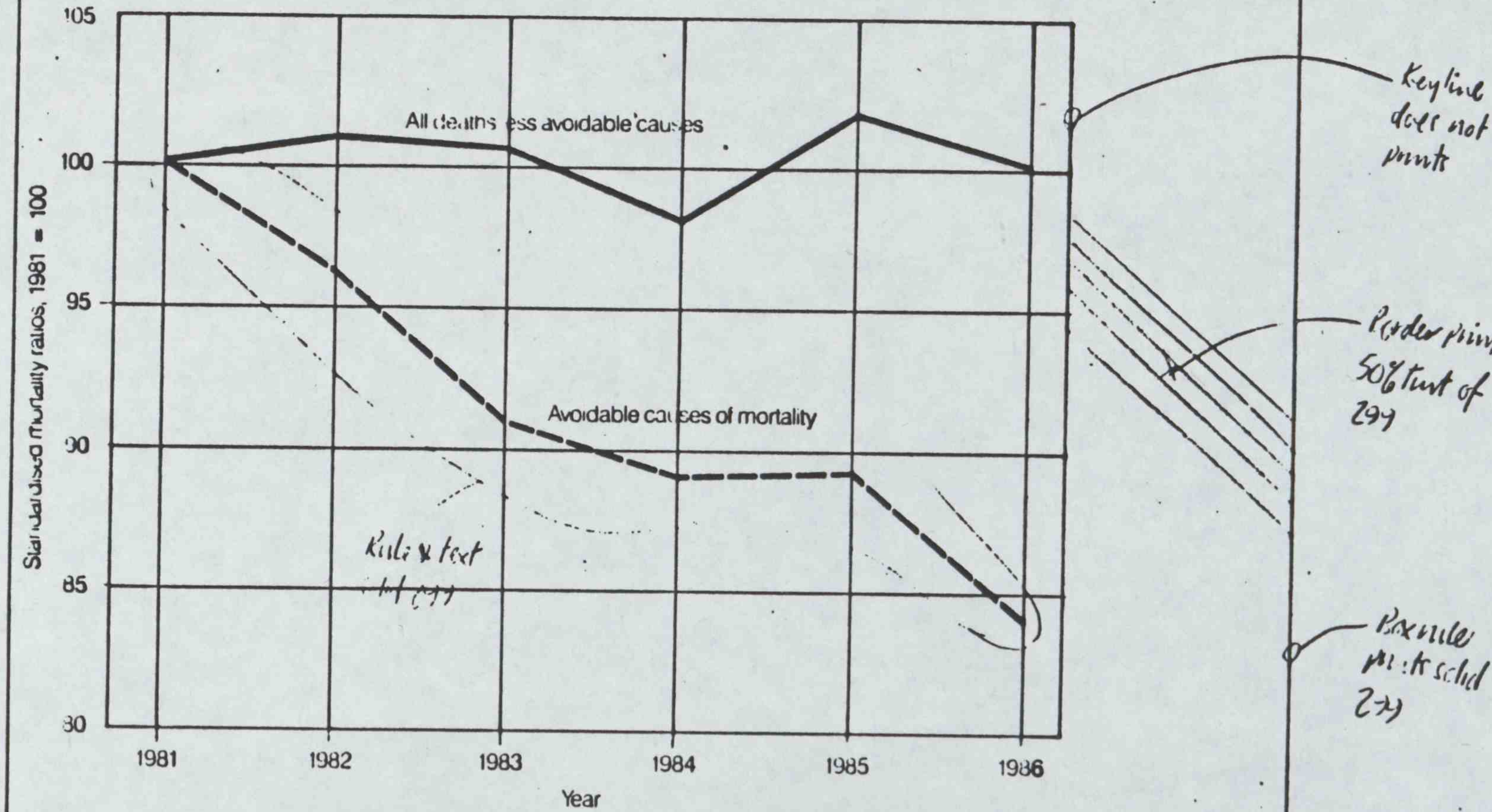


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Table 1
'Avoidable Causes of Mortality'†
Percentage Changes in SMRs 1981-86[3], England and Wales

Cause	Age group	Percentage Change 1981-86
Perinatal deaths	-	-19
Tuberculosis[1]	5-64	-36
Cancer of the cervix	15-64	-1
Hodgkin's Disease	5-64	-22
Chronic Rheumatic Heart Disease	5-44	-47
Hypertension/cerebrovascular Disease	35-64	-18
Surgical deaths[2]	5-64	-11
Respiratory Diseases	1-14	-56
Asthma	5-44	0
Total of above	as above	-16
All causes except those shown above	all	0
All causes	all	0

[1] Omits late effects of tuberculosis
[2] Appendicitis, choleolithiasis, cholecystitis and hernias
[3] SMR for 1981 equals 100. SMR = Standardised mortality ratio; a measure of the death rate which takes account of changes in the age structure of the population.

†J Charlton et al. How have 'avoidable death' indices for England and Wales changed? 1974-78 compared with 1979-83. Community Medicine. Vol. 8. pp. 304-314,

Table 2
Death rates among Elderly People
Percentage Changes 1981-86, England and Wales

Age group		
65-74	M	-5.9
	F	-2.9
75-84	M	-3.9
	F	-3.6
85 and over	M	-3.2
	F	-4.0

CHAPTER 6: DEVELOPMENTS IN THE HOSPITAL AND COMMUNITY HEALTH SERVICES

The Hospital and Community Health Services are made up primarily of

* short stay provision in hospitals. Each district health authority has at least one general hospital providing a range of acute care for physical illnesses.
  Such hospitals often also provide short stay care for people suffering from the diseases associated with old age or from mental illness. Care is provided on in-patient, day or out-patient basis.

* long stay provision in psychiatric, mental handicap and geriatric hospitals. Such hospitals may have associated day hospitals for provision of day care.

* The community health services primarily consisting of District Nurses, Health Visitors, Midwives and Community Psychiatric Nurses.

ACTIVITY IN THE HOSPITAL AND COMMUNITY HEALTH SERVICES

With changes in clinical practice and tauter management, the service has again been able to increase activity levels on the previous year. For example

In patient cases	up 60,000 (0.9%) to 6.41 million
Day cases	up 87,000 (9.1%) to 1.05 million
Total out patient attendances	up 287,000 (0.8%) to 37.7 million

The growth in day cases has been particularly dramatic and this reflects advances in diagnostic techniques and methods of surgery and treatment. These have made it possible for patients who formerly had to spend several days in hospital, to return home the same day. This is better for them, and of course frees beds in the hospital.

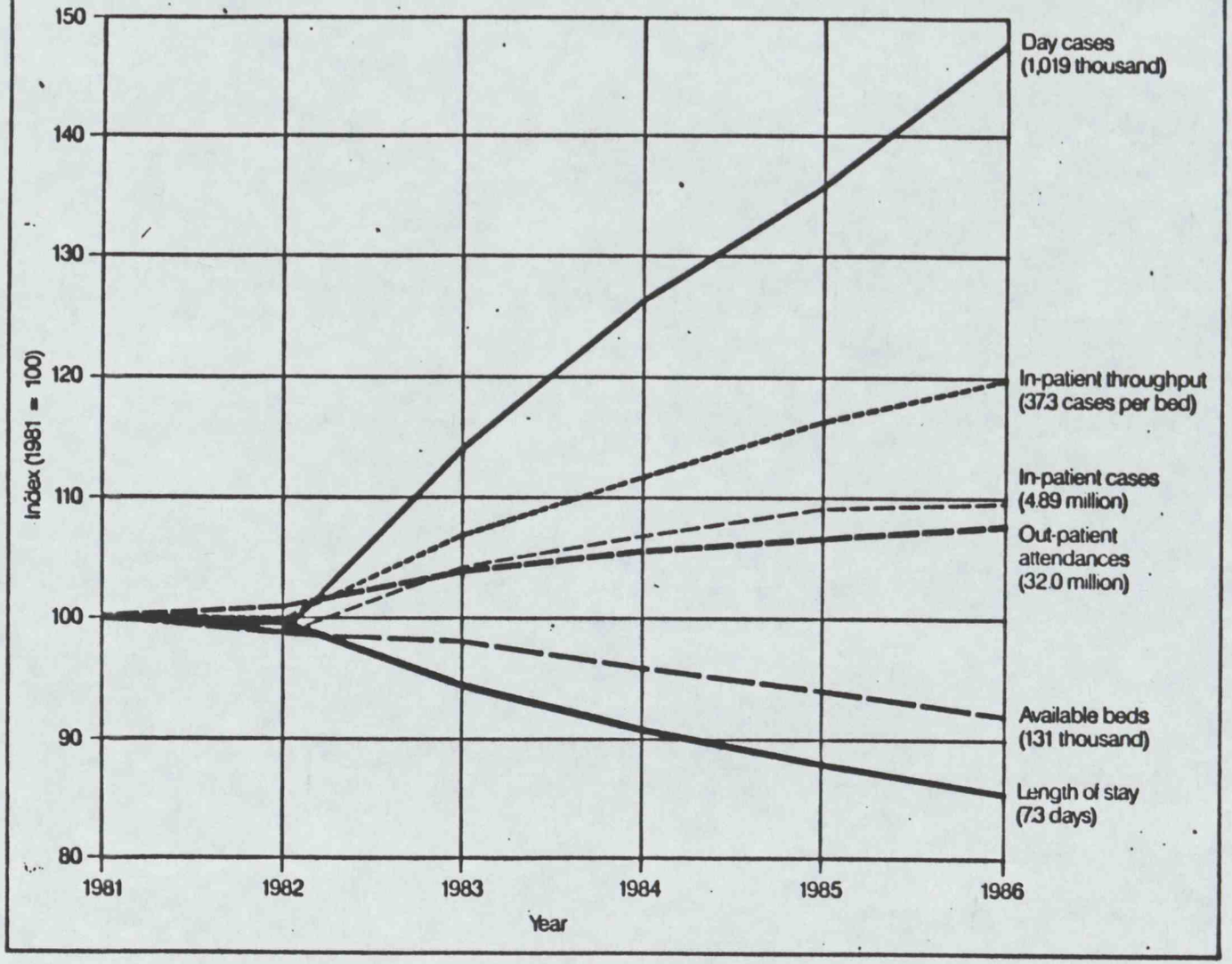
ACUTE HOSPITAL SERVICES

Figure 5 illustrates recent trends in the acute sector. It can be seen that progress has continued to be made towards a more efficient use of facilities. The number of cases treated has continued to grow, but the average length of stay has dropped markedly, particularly since 1982, allowing more patients to be treated per bed during the year.

WAITING LISTS

Figure 5: Acute Hospital Services 1981 – 86

Figures for 1986 are given in brackets



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Despite the growth in activity, the number of patients waiting for hospital in-patient treatment rose slightly between March 1986 and March 1987. However, the proportion of patients waiting for over 12 months has reached its lowest level for over a decade.
The drive to achieve further improvements in waiting lists and times, which was announced in July 1986, received a further impetus in November 1986, when a special waiting list fund was established.
The first year's allocation of £25 million will enable Health Authorities to treat over 100,000 extra patients from in-patient waiting lists during 1987-88. The schemes supported are intended to make a impact on many of the longest waiting lists throughout the country.

SUPRA REGIONAL SERVICES

Supra-Regional Services are specialised clinical services which in order to be clinically effective and economically viable, need to be provided by centres serving a population significantly larger than that of a single health service region. A total of £31 million revenue funding was allocated in 1986/87 for the nine supra-Regional services.

Psychiatric Services for Deaf People will be designated as a supra-regional service in 1987/88. Capital funding for these services will be introduced for the first time in this year. £1.1 million will be allocated between the neonatal and infant cardiac, specialised liver and heart transplant services and endoprosthetic services for primary bone tumours.

Heart Transplants

Heart transplantation was designated as a supra-regional service in 1986. In 1986 227 transplants were performed, 51 of which were combined heart and lung operations. A total of 669 transplants have been carried out since the start of the programme in 1979.

Liver Transplants

127 liver transplants were performed in 1986, bringing the total number of operations carried out since the beginning of the programme to 307. Leeds will be designated as an additional supra-regional centre from 1988.

Kidney Transplants

Kidney transplants are the preferred method of treatment for most renal patients with end-stage renal failure. The number of transplants performed in 1986 was 1,493. This surpassed the previous record total set in 1984 by 50 transplants.
6,638 patients were alive with a functioning transplanted kidney in 1986, almost half the number of patients

being treated for end-stage kidney failure that year.

MATERNITY AND CHILD HEALTH

Maternity Services

In 1981 the Government established a Maternity Services Advisory Committee to advise on matter relating to the maternity and neonatal services. This Committee has published three reports covering antenatal care, care during child birth and care of the mother and baby. The reports contain detailed advice on the provision of high quality services in these areas. Over the last year health authorities have been reporting on the success they have had in implementing this advice.

Ten years ago only two in ten babies born weighing less than 1,000 grammes survived the critical first month of life. In 1985 about five in ten survived. There have also been rapid development in neonatal care. The proportion of very low weight babies born alive has increased by 33% in the last five years. These very small babies make up about 1% of all births. The long-term intensive care facilities required when a baby is likely to be in hospital for some time have been concentrated in selected regional centres, although all maternity units are expected to be able to meet the immediate needs of babies born there. The quality of this service is reflected in a reduction in the perinatal mortality rate from 11.7 per 1,000 births in 1981 to 9.3 per 1,000 in 1986.

Child Health Services

The child health services, consisting of specialist hospital-based services, and community health services including the school health service and those provided by family doctor, have a strong preventive role. Virtually all new babies and their parents are seen in their homes in the first year of life by a health visitor, and over 80% of these babies also attend health clinics. As the child grow older, contact with health services is normally maintained - in 1985 over 70% of all children between the ages of 1 and 5 were seen by health visitors, and over three quarters of children between 4 and 14 years were seen in school by nurses as part of child health surveillance programmes. With older children, the focus moves to health education: the aim is to encourage children to adopt positive attitudes to health and healthy life-styles

MENTAL ILLNESS SERVICES

For mental illness services the aim is to provide a comprehensive local service in each District, consisting of

* short-stay and continuing in-patient care
* community services such as day hospitals
* support at home which can often offer an alternative to in-patient care.

At the same time there are now only 8 out of 191

Districts which have no psychiatric in-patient services. All except 8 Districts now have a community psychiatric nursing service, and the number of nurses in them has more than doubled between 1982 and 1986. The number of psychiatric day hospitals has risen from 300 in 1981 to just over 500 in 1987.

MENTAL HANDICAP SERVICES

Children

Progress continued to be made in meeting the target set for the NHS "that by the end of 1988 alternative provision should have been made so that no mentally handicapped child receiving long term care should need to live in a large mental handicap hospital". By the end of 1986 some 392 mentally handicapped children in NHS residential care (including short-term care) were in hospital. This compared with a total of 585 at the end of 1985.

Adults

The number of adult residents in mental handicap hospitals also continued to drop from 33,674 at the end of 1985 to 31,069 at the end of 1986. This drop was possible because alternative provision in the community is being developed by health and local authorities working together with the voluntary and private sector. Run-down and possible closure of the hospitals will follow as residents move out or cease to be admitted, but residential care in smaller health settings will continue to be necessary for some mentally handicapped people with special needs.

SPECIAL HOSPITALS

The four special hospitals, Broadmoor, Moss Side, Park Lane and Rampton, provide treatment in conditions of special security for patients with dangerous, violent or criminal propensities who are detained under the Mental Health Act. Following the establishment of the Rampton Hospital Board in July 1986 (which replaced the Rampton Hospital Review Board established in June 1981) local management boards for the other hospitals were established in January 1987. There is a board for Broadmoor hospital, and a joint board for Moss Side and Park Lane hospitals. The local management boards are Special Health Authorities and are responsible for the management of all services in the hospitals. They will provide locally-based leadership for the Hospital Management Teams and will work with them to provide strengthened leadership for the hospitals and improved management and patient care.

SERVICES FOR ELDERLY PEOPLE

The number of elderly people treated in geriatric departments continued to rise. 396,000 inpatient cases were treated in 1986, a 3.7% increase on 1985. The number of outpatient attendances rose by 8.1% between 1985 and 1986, to 364,000. The number of doctors working in geriatric departments also continued to rise - the number of consultant geriatricians rose to 478 (whole time

equivalent) a 8.1% increase over 1985, and the number of other doctors working in geriatric departments rose to 1352 (whole time equivalent), an increase of 1.2%.

COMMUNITY NURSING SERVICES

Each year increasing emphasis is placed on creating a health system which is community based. This emphasis has major implications for both the provision of community nursing services, provided by nurses, midwives and health visitors, and the demand made on these services.

Consultations on the report of the Community Nursing Review ("Neighbourhood Nursing: A Focus for Care") ended on 31 December 1986. Over 1,200 written comments were received on the Community Nursing Report alone. During the year, these comments, and those made during the public consultation meeting were considered, and a circular was issued in November 1987. This invites health authorities to review the organisation of their community nursing services in the light of the recommendations of the Report, but recognises that the final decision on how this should be done must rest with the Authority. It outlines the Government's views on possible developments in the range of activities carried out by nurses working in the community.

QUALITY ASSURANCE

In recent years there has been a growing awareness, both within the Service and amongst patients and other organisations that the NHS can and should be more sensitive to the needs and views of the consumer. As a result many initiatives to improve quality have been started by health authorities, and few authorities are without some quality project.

Ensuring high quality, and maintaining and enhancing standards of care, are now firmly recognised as a vital part of general management - (see chapter 7). Professional bodies and individual professionals in the health service, also play a key part in the drive to improve quality. The aim is to develop a service which takes account of what the consumer wants. That means listening to what the consumer says and taking full account of the consumer's views in planning and delivering services.

Emphasis is also being given to the quality of service in the Family Practitioner Services, particularly as part of the recent review of Primary Care. These developments are described in chapter 2.

CHAPTER 7 IMPROVEMENTS IN MANAGEMENT AND THE USE OF RESOURCES.

MANAGEMENT

It is too early to attempt to assess the full benefits of the appointment by health authorities of Regional, District and Unit General Managers. However, these managers are already bringing a more energetic and creative leadership to the service, and making more effective use of resources. This keen interest has been demonstrated by achievements in

* the sale of surplus land which contributed £280 million towards the NHS building programme from 1984/85 to 1986/87
* cash-releasing cost improvements which up to 1986/87 have released £400 million to help fund service costs and developments with a further £152 million planned in 1987/88.

The tauter management approach is one reason why the Service has been able to increase activity levels, with a falling length of stay for patients.

Following the introduction of new long term pay arrangments for general managers in 1986, arrangements were announced at the end of (1987) for a new pay and grading structure for senior managers in regional and district health authorities. These reflect the additional responsibities senior managers have taken following changes in the way authorities are now managed. This represents further progress towards performance related pay for senior management following the changes recommended by Sir Roy Griffiths and his colleagues in 1983.

INFORMATION STRATEGY

Every health authority will have implemented the bulk of the wide-ranging recommendations of the Steering Group on Health Services Information (the Korner Steering Group) in 1987; all but a few had done so by April 1987. The information will provide District Health Authorities with a much firmer basis for soundly informed management. The next steps have now been taken by the newly formed Information Advisory Group which played a major role in drawing up the document "A National Strategic framework for Information Management in the Hospital and Community Health Services", published in October 1986. The framework is based on the idea that health authorities need to manage and use information in order to improve services to patients. Complementary courses of action for health authorities and central bodies are proposed and most of the tasks for central action will be completed during 1987.

RESOURCES

Spending on the NHS continued to rise in 1986-87 to a total of nearly £16 billion. That is equivalent to £43 million every day - or just over £1,300 a year for a family of four people. The greater part of this total, some £10 billion, was spent on the

hospital and community health services.

Nearly three quarters of all expenditure in the hospital and community health services is on pay. Pay rises, therefore, account for much of the increase in overall spending. It also costs more each year to treat the increasing number of elderly people.

To keep pace with these demands and to help provide for the development of services, health authorities continued to ensure that they made the best use of resources. In 1986-87 £153 million was generated from cash releasing cost improvements which was available to help meet increased service costs and developments. Further increases in levels of activity were made possible by other improvements in efficiency. Nevertheless, demand on the service continue to rise and difficult choices have to be made between conflicting priorities.

Between 1981/82 and 1986/87 spending in real terms on the Family Practitioner Services increased by 21%. In 1986/87 expenditure was £3883 million which represented an increase of 4.4% in real terms over 1985/86. At constant prices this amounted to £82 per person in England, compared with £69 in 1981/82, of which some 35% respectively was spent on prescribed medicines.

This increased expenditure on the FPS has gone to pay for more doctors, to meet the needs of a growing proportion of elderly people, and to keep pace with advances in clinical practice. It has been accompanied by a number of measures intended to produce better value for money, including the continued operation of the selected list scheme for medicines, initiatives to develop more effective and economical prescribing, and the introduction of computers into the administration of the services.

[Note: Changes quoted in real terms have been calculated after allowing for general inflation as measured by the Gross Domestic Product deflator.]

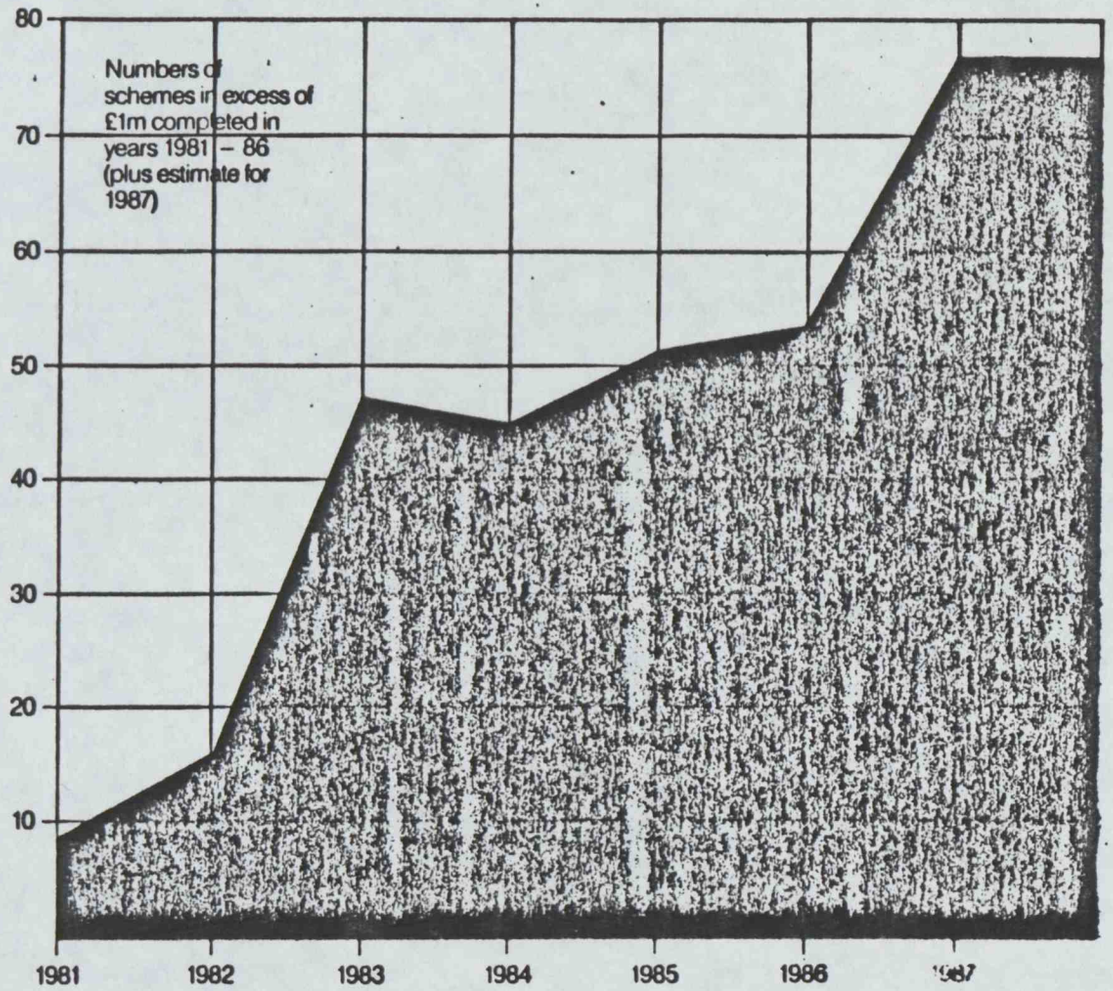
COMPETITIVE TENDERING

Health Authorities continued to make good progress in putting their domestic cleaning, catering and laundry services out to tender. At 30 September 1987 84 per cent by value of the three services had been tested and the saving generated from the contracts awarded at that date totalled almost £103 million. Savings which form part of the Cost Improvement Programme are expected to continue to increase and are available to Health Authorities to develop patient-care services.

CAPITAL EXPENDITURE AND BUILDING

Investment in new and improved accommodation and facilities increased between 1981-82 and 1986-87 by almost 25%

Figure 5: Health Building Programme 1981 – 86



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more than the rise in general construction industry prices. Total capital spending has increased from £568 million to some £960 million. As mentioned above, the sale of surplus land contributed to the capital spending programme. This growth is illustrated in figure 6 which shows the numbers of schemes costing more than £1 million completed in the years 1981 to 1986.

High priority is attached to the improvement and modernisation of NHS buildings. Increased investment and continuing improvements in the planning and design of hospitals including the growing use of the Department's standard design , known as "Nucleus", are helping to ensure the success of the largest ever sustained building programme.

In 1986-87 plans for 14 building schemes each costing over £5 million received approval from the Department. Overall there are in excess of 480 schemes each costing over £1 million, with a total value in excess of £3 billion, at various stages of planning, design and construction. In the five years 1981-86, 210 new hospital schemes each costing over £1 million were completed and it is expected that a further 77 such schemes will be completed in 1987. These developments have provided new beds and many other facilities such as operating theatres, X-ray Departments, Accident and Emergency Departments and Out-patient Departments.

In the drive to make England and Wales self-sufficient in all blood products, the year saw the substantial completion of the new £60m Blood Products Laboratory at Elstree. This major new manufacturing unit was officially opened by HRH The Duchess of Gloucester on 29 April 1987.

NHS PROCUREMENT

An improved plan for NHS procurement and an 'Action Plan' for NHS support of industry competitiveness were developed and implementation started. Though some aspects of these initiatives are essentially of a long-term nature the benefits of a more professional purchasing and supplies service were already being realised by the end of the year - eg.

* Inventory Reductions
* Further Progress in a Programme to rationalize stores
* Development stategies for Centres of Responsibility for particular products

Studies were also carried out on the direction of developments to secure the best overall value-for-money and saving on the total costs of the supply chain in the years ahead.

CHAPTER 8 NHS STAFF

Figure 7 illustrates the number of directly employed NHS staff in the main staff groups in September 1986. At that time there were about 801,600 (including agency,locum and Family Practitioner Committee staff) whole-time equivalent directly employed staff in England, and about a further 41,000 general medical and dental practitioners contracted to the NHS. In addition there were about 5,100 and 9,800 opticians and retail pharmacist outlets respectively.

The total number of directly-employed WTE staff shows an overall reduction of about 11,300 staff in post on the position 12 months earlier but within this overall figure there were small increases in

* nursing and midwifery staff
* medical and dental staff
* professional and technical staff
* administrative staff
* ambulancemen (including officers)

There were small reductions in works and maintenance staff and a substantial reduction in ancillary staff (down 10.8%). This has meant that the service as a whole has been able to deliver more care of a greater complexity. The decrease in the numbers of ancillary staff has been partly due to the introduction of competitive tendering.

FUTURE STAFFING PROSPECTS

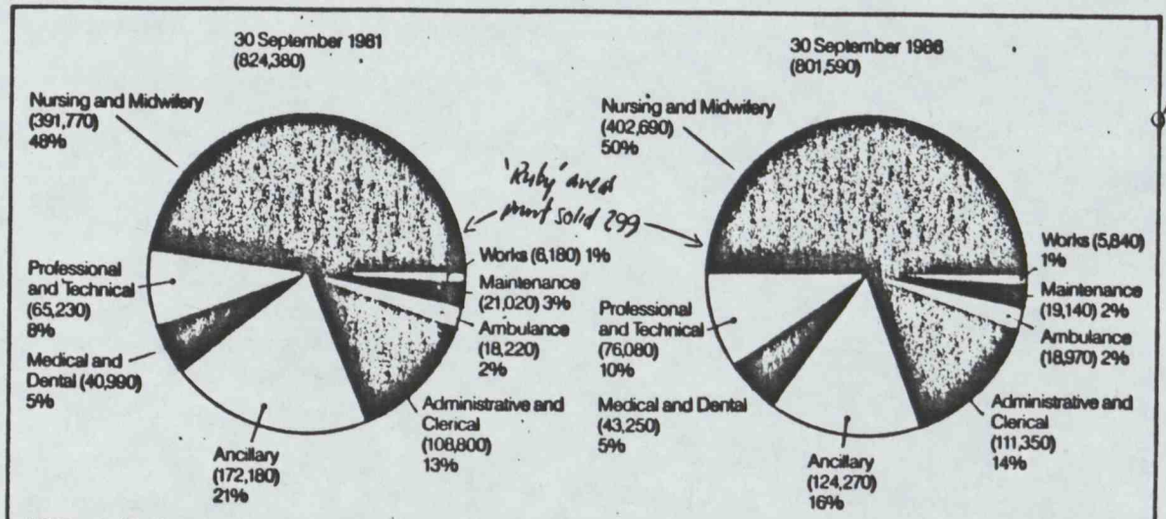
The composition of the NHS workforce and the skills which it deploys must constantly respond to the changing demands of scientific or technological advance, and the changing circumstances within the society which it serves. The personnel function in the NHS is operating against a background of intensified competition for the available workforce, resulting in pay and other pressures that are being particularly felt in some occupations, and by some but not all health authorities. It is clear that the NHS response requires close cooperation between DHSS at the centre - particularly in terms of pay and conditions of service, manpower and strategic planning - and health authorities on whom staff depend for their working environment.

MANPOWER PLANNING

A number of major initiatives have been pushed forward in 1986/87. Manpower planning is the basis for personnel strategy and a check against the feasibility and affordability of service planning. At the national level the work of the Manpower Planning Advisory Group made an important advance in focusing its immediate studies upon the future manpower needs of the professions allied to medicine. Accordingly it has considered staffing in

Figure 7: NHS Directly Employed Staff Comparison of main staff groups England, 1981 – 1986

Whole time equivalent (WTE)



NOTE: 1. The figures used to compile this graph have not been adjusted to take account of the transfer of 2,600 (WTE) Operating Department Assistants from Ancillary to Professional and Technical Staff on 1 April 1984.

2. Figures (WTES) have been independently rounded to the nearest 10. Percentages have been rounded to the nearest whole number.

Keyline does not print

'Ruby' areas print solid 299

Cyanide prints solid 299

Border prints 50% tint of 299 (rainbow)

Reduce to 171mm

physiotherapy, pathology, and occupational therapy.
Revised data flowing from the implementation of the Korner Report from April 1987 will provide an improved manpower data base. There is now a Group considering data needs over and above the baseline set by Korner [see Chapter 7 for more details.]

MEDICAL STAFFING : "ACHIEVING A BALANCE"

1987 saw the publication of new arrangements for hospital medical staffing under the title "Achieving a Balance: A Plan for Action". The new arrangements flow from nearly two years of discussions between UK health departments, the medical profession, and Regional Health Authorities, chaired first by Sir Barney Hayhoe and then by Tony Newton. The package of new measures are intended to :

* increase the number of consultants, to provide both the leadership and the career opportunities a growing service needs.

* ensure sensible planning of the numbers of doctors in training grades, taking account of career prospects

* deliver the right levels of support for consultants, especially in the acute specialties.

The purpose of the reform is to improve the quality of care doctors will be giving to their patients, by increasing the extent to which fully trained doctors are involved in direct patient care and in the supervision of their junior staff. They should also make a career in the hospital service more secure and therefore more attractive.

NON-MEDICAL STAFFING: RECRUITMENT

As noted above, demographic change and a more competitive labour market are making it more difficult to get the right staff in the places they are needed .
For example, the nursing profession in the NHS currently recruits a quarter of all girls leaving school with between five GCE 'O' levels and 2 'A' levels but it is apparent that by [1992] there will be 25% fewer of these qualified female school leavers . However, many employers depend upon attracting large numbers of well - educated and motivated young people. So a major recruitment problem is looming for the NHS. The UKCC's proposals for the reform of nurse education and training, Project 2000, seeks to respond to these imminent recruitment problems (see below). There are many initiatives in the field of nurse recruitment. For example, a feasibility study was commissioned into the use of the YTS scheme as a means recruiting to nurse training and to the support worker grade. Furthermore, RHA Chairmen commissioned management consultants to examine the factors influencing recruitment and retention in nursing.

Similarly, recent years have seen increasing problems of

recruiting and retaining other qualified staff in, for instance, information technology, finance and other professional fields. These problems are not found uniformly across the country, and not among all staff groups, but they are becoming increasingly sharply felt especially in the South East corner of the country. In that context a study was commissioned in 1986 and is well advanced into the difficulties of nurse recruitment in London .

Jobs will have to be made more attractive, especially to women who leave for family reasons, and who through better management of the "career break" can be won back to the NHS. Local initiatives include recruitment drives using video recordings, 'image' advertising and production of material for local recruitment drives, and " re-entry" schemes for staff who have left the Service.

Project 2000

The UK Central Council for Nursing Midwifery and Health Visiting's recommendations on the reform of nurse education have been received by the NHS Management Board. The proposals aim to ensure the nurse of the future is prepared to work both in hospital and the community, to respond to the changing demands of the service and to attract recruits and reduce wastage. The proposals include recommendations to train one level of nurse and thus to cease Enrolled Nurse training, to reduce the contribution of students to the service and to provide a common foundation course for initial nurse training. The Management Board undertook extensive consultation on all aspects of the proposals, and this consultation is now complete. Additional work is being undertaken on the cost and manpower implications, the future of the Enrolled Nurse and on widening the entry gate to nurse training. Decisions concerning the future of nurse education and training are likely during 1988.

STAFF DEVELOPMENT

This embraces training courses and cumulative job experience, and it is an important starting point for planning staff development to introduce individual performance review (IPR). Health authorities are actively seeking to introduce IPR at lower levels, having successfully introduced it for general and senior managers in recent years. For nurses, a joint examination with the staff side has been undertaken of clinical grading structures and a Career Development Project Group has been established. At a national level, the NHS Training Authority (A Special Health Authority)is responsible for identifying training needs, developing plans and standards and supporting authorities in the provision of training.

PAY AND CONDITIONS OF SERVICE

It has become increasingly evident that the rigid application of a national pay and grading structure has led to lack of flexibility and difficulty in competing in local markets.

Competition for staff has intensified , particularly in the South East of the country, and in other areas (and for some groups of staff) there have been similar difficulties in both recruiting and keeping able staff.

The National Health Service Management Board is aware of the need to introduce more flexibility into pay and grading. A regional premium was introduced for information technology staff. The Management Side proposed a new grading structure for Administrative and Clerical staff, but in the event it was not possible to make progress in the negotiations for the 1987 pay settlement. Reviews of grading structures were put in train for speech therapists and some other groups of staff. Following new pay and grading arrangements (including performance-related pay) introduced for general managers in 1986, work was undertaken by joint
NHS/DHSS Working Group leading to an announcement of new pay and grading for senior managers at the end of 1987. (More is said about this in Chapter 7).

In addition to pay, staff in the NHS are of course, interested in all the conditions of service that affect their daily working lives - eg holiday entitlements, protection from violence, pension provision, access to personal data, and equal opportunities. All these issues have been examined in the course of 1986/87 for at least some part of the NHS work force. Furthermore a review has begun of the procedures for staff appointments etc, and conditions of service, to identify areas, where change could lead to more cost effective staff management - an initiative that springs directly from the Griffiths report on the management of the NHS. A Working Group has considered what needs to be done to secure real equality of opportunity for women and people from ethnic minorities in gaining access to employment in the NHS.

PERSONNEL MANAGEMENT

Following the publication of the Griffiths report it has been evident that personnel has to be integrated with other directorates to ensure effective management, under the general manager, of health authorities. There is an increasing need for professionalism in the personnel management, and an NHS Working Party was established in 1986 to study future needs and the means of achieving through career development a fully professional personnel and training capacity in the NHS.

CHAPTER 9: FORWARD LOOK

This Chapter looks to the future. It describes a number of issues which are likely to be of importance in 1988/89. Progress on many of these items will be described in next year's annual report.

THE HEALTH OF PEOPLE FROM ETHNIC MINORITIES

The multi-cultural nature of society poses its own challenge to the NHS. In line with the growing determination of health authorities that services should meet the needs of people from minorities as well as the majority culture, the Minister for Health, Tony Newton, chaired a one day seminar "The Management Challenge of Ethnic Minority Health" in London in November 1987. All regional and some 35 district health authority chairmen and general managers or their senior representatives were invited together with the chairman and Chief Executive of the Health Education Authority. A report of the seminar is being sent to all health authorities, which will be considering its implications for their services. Enabling the health service to meet the needs of people from ethnic minorities is one important plank in creating a service which puts the consumer first.

QUALITY OF SERVICE

This has been discussed in Chapter 6. It will continue to be a key issue in both the hospital and community health services, and the Family Practitioner Services, where implementation of the recently published White Paper will result in major new developments.

WARNOCK

The 1984 Report of the Warnock Committee on Human Fertilisation and Embryology recommended that certain infertility services, including IVF (in-vitro fertilisation), as well as research involving human embryos should be permitted under the control of a statutory licensing authority.
In December 1986 the Government issued a consultation document ['Legislation on Human Infertility Services and Embryo Research'] canvassing options for legislation on these complex issues, and promising to introduce a Bill in the current Parliament. It proposed that, on the particularly controversial issue of embryo research, Parliament should be offered alternative draft clauses and decide the matter on a free vote.

A White Paper was published in November setting out he Government's conclusions on form such legislation should take and it is hoped to debate proposals in Parliament early in 1988.

CHILD ABUSE

The Minister for Health, Mr Tony Newton, announced on 9 July the setting up of an inquiry to look into the arrangements for dealing with suspected cases of child abuse in Cleveland in recent months. In addition, the Standing Medical Advisory Committee has been asked to prepare guidance for doctors on the clinical diagnosis of child sexual abuse and the Standing Nursing and Midwifery Committee has set up a working group to prepare guidance for senior nurses on child abuse. Practice guidelines are also being prepared for social workers and nurses, including health visitors. The professional groups concerned will want to take account of any lessons to be learnt both from Cleveland inquiry and from the Kimberly Carlile inquiry which reported in December 1987.

COMMUNITY CARE

During 1986-87 Health authorities generally continued to play an active part in promoting the shift from hospital - based care to community - based care. Joint finance was widely used in developing community services and, where beneficial to the individual concerned, funding and other arrangements were made with local authorities and the voluntary and private sectors so that people no longer needing to live in long stay hospital could move back to their local community. Community care represents a complex spectrum of care provided by a variety of agents and it is not an easy policy to achieve. It has been necessary for health authorities to plan the transition very carefully and rates of progress will be different in different places.

In December 1986 the then Secretary of State announced that he had asked Sir Roy Griffiths, the Government's adviser on the health service, to carry out an overview of community care policy and advise on options for improving the use of public funds as an aid to more effective community care. Sir Roy's overview will take account of recent Audit Commission and National Audit Office reports. His own report, due around the beginning of 1988, will also provide the context for the Government's consideration of other related work, including a joint central and local Government working party report on "Public Support for Residential Care", published in July 1987, and a review of the role of residential care chaired by Lady Wagner which will report early in 1988.

PUBLIC HEALTH INQUIRY

The Public Health Inquiry Committee, chaired by the Government Chief Medical Officer, Sir Donald Acheson, is due to report to Ministers. The Committee has adopted a broad definition of public health, as follows:

> " the science and art of preventing disease, prolonging life and promoting health through the organised efforts of society."

It has examined the current organisation of the public health services and will be making recommendations designed to produce improvements in the current arrangements. The Inquiry was asked to focus specifically on two areas:

* the control of communicable disease and infection (following the outbreaks at Stanley Royd and Stafford hospitals)
* the organisation of the specialty of community medicine (in the light of the implementation of general management in the NHS).

The majority of its recommendations are directed to these two areas, and are intended to create a sound base for the development of public health. The aim is to obtain a steady improvement in the health of the nation into the next century. The Inquiry's Report will be published shortly as a command paper.

RESOURCE PROSPECTS

Public expenditure on the NHS in England is planned to rise to over £19 billion by 1990-91. Cash increases for the hospital and community health services will continue to be supplemented by health authorities' cost improvement programmes. Gross spending, including various receipts and income from the sale of surplus property and land, will be even higher. In some areas the pace of change and rate of growth in activity levels is already putting pressure on resources. Health authorities must ensure therefore that they continue to manage their resources prudently and that planned changes are affordable.

APPENDIX A Index to Statistical Information and Figures