DEPARTMENT OF HEALTH AND SOCIAL SECURITY
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From the Secretary of State for ~~Social Services~~ Health

CONFIDENTIAL

The Rt Hon John Major MP
Chief Secretary to the Treasury
HM Treasury
Parliament Street
London
SW1P 3AG

25 May 1989

Dear John,

PUBLIC EXPENDITURE SURVEY: HEALTH AND PERSONAL SOCIAL SERVICES AND DEPARTMENTAL ADMINISTRATION

1. I am writing to set out my assessment of the additional resources I shall require for the Health and Personal Social Services and for Departmental Administration over the Survey period. My officials are as usual writing to yours with further details. David Mellor wrote to you on 22 May on the bids for specific revenue grants for Personal Social Services.

2. There are some general points I should make about my bids:-

1. A major part of my bids - £824, £1,208 and £1,933 million - simply reflects the cost of keeping health services running without introducing any new service or other developments or implementing any part of our NHS Review proposals. I cannot emphasise too highly the importance of not diverting funds from patient care to the costs of Review implementation. To that end I attach the highest priority - political and practical - to securing the necessary resources for the maintenance of adequate quality services in line with foreseeable demand.

2. The total of my NHS Review-related bids across programmes is presently estimated at £504, £679 and £676 million, though I expect some refinement of these estimates during the course of the summer. Your officials have already been over much of the ground with mine in the course of discussions on our requirements in 1989-90, and I am grateful for the constructive approach that has been adopted. I recognise the need for further work on some of the bid areas, and this has been put in hand. I shall not hesitate to reduce or withdraw bids that are not substantiated. At the same time we must not lose momentum on, or miss the critical timetable for, our NHS reforms.

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3. We need to emerge from the Survey with a credible overall package. Critics of our White Paper proposals have made play, in a rather ridiculous way, with the fact that it was silent on the overall level of resources for the Health Service. It was obviously absurd to suggest that the White Paper was the place to address this issue, and I have taken my usual robust line since. Nonetheless, we need to have a defensible position at the time of the Autumn Statement when we shall be introducing our legislative proposals, if we are to reassure waverers, including many of our own backbenchers, that the Government's proposals for NHS reform do not in any way undermine our commitment to the National Health Service.

4. There are some changes arising from the NHS reforms that I propose we defer to the next Survey. So far as health authorities are concerned we shall need next time to address the question of external financing limits for self-governing hospitals, while in the FPS field there is the whole question of the changes resulting from the introduction of cash limits on prescribing expenditure. In neither case do I think it would be particularly helpful to try to resolve these issues in the present Survey.

5. I should record that I have not entered any bids in respect of decisions we are likely to have to take in relation to the Griffiths report on community care other than one for the mentally ill (paras 9-10). I reserve the right to enter bids during the Survey as the position develops.

6. Finally, I should like to make a point about inflation. The bids are constructed on the basis of a 4 per cent increase in the gdp deflator next year where relevant, a figure for which external economist support is notably absent. Should this figure become clearly untenable during the course of the Survey it would have major implications for my bids, and I must reserve my right to reconsider each of my bids, if this is warranted.

Hospital and Community Health Services: Current

3. I have structured my bids for this part of the programme under three heads. These are:-

1. The net additional costs of continuing with broadly the present services subject only to foreseeable changes.

2. The costs of implementing our NHS Review proposals.

3. Strictly limited but in my judgement highly necessary service or management developments.

E[redacted].

Maintaining Services

4. So far as 3.1 is concerned I foresee the need for additions of £522, £737 and £999 million in the three Survey years. The bid includes three elements for cost increases incurred or largely committed. The first is provision for carrying through the costs of the 1989 Review Body awards (£119, £122 and £125 million), that is to say simply enabling us to continue to employ the existing medical and nursing workforce. In addition, I propose as we agreed in last year's Survey, to provide within the total for the excess costs of paying Whitley groups above the prevailing inflation rate. My bid includes £81 million in each Survey year for the costs of 1990 pay awards only, sufficient to meet settlements averaging 6.5 per cent. I would expect to target the additions on key areas of recruitment and retention difficulty. There is, as we both recognise, no question of acknowledging this element publicly in the settlement, but it is extremely important that we provide adequately for it. I also need to bid for the cost to health authorities arising from the implementation of the judgement of the European Court of Justice ending zero-rating on fuel and power supplies; this requires additions of £30, £41 and £42 million.

5. The second major leg of the requirements for maintaining service standards uses the computer model for making projections from established trends, which we used for the first time in the last Survey. I know that our officials have worked together over the intervening period to enhance the model's capability, and I welcome this because it enables you and me to conduct our discussions with a much clearer view as to the service implications of the options in front of us. The model's projections for the Survey period are that, if there were no change in unit costs and the additional costs in paragraph 4 above were met, additions of £320, £690 and £1,150 million to the baseline would be required to maintain existing and established trends. I propose also additions of £111, £129 and £157 million to provide for explicit new service pressures, targeted expenditure on increased activity and modest exemplary expenditure on improvements in quality notably in outpatient and day clinics. I propose to plan on the basis that there will continue to be decreases in unit costs over the Survey period, and I believe that it is reasonable to look to these to total £180, £420 and £670 million. I should, however, say that I believe that the potential for cash releasing cost improvements is lower than was thought attainable at the time of the last Survey, and the figures included in the above savings estimates are at £100, £250 and £400 million less than you will have been expecting. This reflects a considered judgement here that it will not be possible to apply to the Cost Improvement Programme the increased management effort needed to achieve the earlier figures, while at the same time concentrating on establishment of self-governing hospitals and the new funding and contracts regime for the NHS. Even so, my proposals would mean that by the end of 1992-93 the cumulative value of Cost Improvements would be equivalent to £1.4 billion. The net increase I am seeking under this head is therefore £251, £399 and £637 million.

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6. Finally, I have included the increased costs of treatment and preventive services for patients with AIDS under this broad head. In each of the last two Surveys, we have agreed, because of the difficulties of forecasting, to settle only on the level of expenditure for the first Survey year. I have included bids of £41, £94 and £114 million covering the three Survey years on the basis of last autumn's forecasts of numbers and of continuing with existing preventative programmes. I am not, however, averse to a one year settlement again this year on the same understanding as in previous years.

NHS Review Implementation

7. Turning to the NHS Review proposals these amount in total to gross requirements of £221, £351 and £421 million. Against this, I am able to offer savings of £15 million in each of the first two years in respect of the provision we agreed in the last Survey for increased expenditure in those years in respect of pilot developments. The net addition required is therefore £206, £336 and £421 million. This covers a dozen or more areas most of which have been gone over fairly thoroughly by our officials in relation to 1989-90. The details will be included in the official letter, but broadly the bids fall into three categories:-

1. The 100 additional consultant posts, to which we are already committed, and the introduction of medical audit, which are essential if we are to secure the commitment of the medical profession to our proposals.

2. Measures to strengthen the management of the service to enable health authorities and self-governing hospitals to carry out the roles envisaged for them in the White Paper. Under this heading I put also the cost of introducing capital charges, of meeting the costs of the Audit Commission and of RHA management of FPCs to which the White Paper commits us. The aim of all these changes is of course the better management of resources but it is idle to suppose that we can get there unless we make the necessary investment.

3. The introduction of an appropriate information and information technology underpinning, including the further extension of the resource management initiative, on which again we have a degree of public commitment. Like you, I shall want to be sure that the investment is necessary, pitched at the right level and represents value for money. To that end I have commissioned further work from my officials, and the bid is provisional until this has been concluded.

Management and Service Developments

8. So far as management and service developments not linked to the NHS Review are concerned, I have examined very closely whether these are really necessary, but I have concluded that it would be neither practical nor realistic to call a halt to every development, and I accordingly submit bids totalling £102, £131 and £180 million. A major element in these bids is continuing investment in professional training which is essential to maintain an adequate supply of key staff groups. In this category come extensions to existing programmes for

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implementing Project 2000 and for post-registration training for nurses and midwives. I have also included bids for an expansion in the number of training places for the professions allied to medicine and for extra funding for medical clinical tutors. The other bids are for a small number of service priorities to ensure that particular initiatives get off the ground. These include support for hospices; for supra-regional services; for radiotherapy hyperfractionation; for cochlear implants, and for health education and promotion programmes on a regional basis to take up the opportunities for prevention work outlined by the Review and Primary Care White Papers and the Acheson Report on Public Health.

Hospital and Community Health Services: Capital.

9. In recent years Exchequer funding for health authority capital has declined in real terms, and despite the modest increase agreed in last year's Survey this remains the broad picture. Health authorities have the further problems of higher construction prices, undermining the purchasing power of their allocations, while more recently it has become clear that their land sales income is being affected by a marked falling off in the demand for land, that seems principally to be the result of reduced new housing starts following the mortgage rate increases. Taking these factors together, I have no alternative but to bid for additional resources to maintain the existing planned programme. In addition I see a strong need for extra investment for replacement of medical equipment, for a variety of measures to meet safety standards for both staff and patients, to enable more rapid investment in community care facilities in advance of mental hospital closures and for the capital aspects of implementing the NHS Review.

10. In total my bids amount to £518, £624 and £688 million. £100 million in each of the Survey years is to compensate for higher construction costs that have already occurred and for a forecast reduction in land sales income in each of the three years that may in the event prove too optimistic. £116, £93 and £93 million respectively is the cost of very modest additional investment principally in medical equipment and safety standards. So far as community care developments for the mentally ill are concerned, I wrote to you on 24 May suggestion an early announcement that we would encourage further schemes, on the lines of Bromley but this time directed at land values locked up in mental illness hospital sites, for a composite deal whereby a developer would finance and build community care facilities at a fixed price in return for an assured land purchase deal later. I recognise that you will need time to consider and respond to this suggestion. If we were unable to agree on this an alternative way to achieve such a result would be by the sort of capital loan scheme that I proposed last year, and I have therefore included a bid of £100, £200 and £300 million to enable such a fund to be established, with a view to its eventually becoming self-funding as land values are unlocked. My personal preference is to use private sector finance and expertise in this sort of joint development but I suggest that we keep both options on the table at the present time. Should we agree ultimately on a capital loan fund financed in the initial stage by the Exchequer, it is axiomatic in my view that funding should be seen to be additional. Turning finally to my NHS review related bids these are £202, £231 and £195 million, the overwhelming parts being for resource management and enhanced information and computer systems. My remarks about further appraisal (para 7.3 above) apply equally to these capital aspects.

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FAMILY PRACTITIONER SERVICES

11. The 1988 Survey consolidated the fundamental changes in the Family Practitioner Services agreed in 1987 and was geared primarily to matching services to demand. This year, as we seek to complete the programme of reforms in our 1987 White Paper Promoting Better Health and start implementing Working for Patients, our agenda has to be more complex and wide ranging. My bids therefore have four objectives:

(1) to meet the costs of forecast demand;

(2) to support the implementation of Working for Patients;

(3) to continue the implementation of Promoting Better Health;

(4) to allow for other service developments.

12. The first objective, as in previous years, is to reinforce the baseline to allow forecast demand to be met. I foresee additional requirements of £172: £344: £806 million in the Survey years. Of this £48: £50: £52 million is for the forward years' costs of this year's Doctors and Dentists Review Body award. The rest, £124: £294: £754 million, reflects revised forecasts of demand and inflation. These estimates take into account all the savings agreed in previous Surveys, and indeed reflect higher levels of forecast income from patient charges than does the baseline. In addition, though this was not a Survey commitment, the bids reflect savings secured by our abolition of the pharmacists' cost-plus contract, estimated as £48: £52: £55 million.

13. Part of the demand bid (and the baseline) relates to areas of general medical service expenditure - practice premises improvements and directly reimbursed ancillary staff costs - which are to be managed by FPCs within cash limited budgets from 1 April 1990. Our officials are already in touch about the way this cash limit should be established.

14. The NHS Review bids are to enable General Medical Practitioners (GMPs) to manage practice budgets and indicative drug budgets. Doctors will need skilled technical support if they are to obtain value for their patients (and the tax payer) from the large practice budgets which they will control. Other GMPs will also require support to manage their indicative drug budgets properly and introduce real changes in prescribing practice. They will need information about their prescribing and an ability to make use of the information. I refer below to the resource implications for the Prescription Pricing Authority; we are investigating whether increased investment in GP computing will also be essential. The bids total £39: £77: £78 million, to which I would provisionally add £25: £4: £4 million for computers for family doctors. This would provide those practices not already computerised with micro computers to assist them in monitoring their own prescribing costs, fund the revenue consequences of that and fund software enhancement for existing users.

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15. I have already referred to the cash limit from 1 April 1990 for GMP practice team staff costs and improvements to practice premises. This proposal was very controversial during debate on the Health and Medicines Bill, and my predecessors gave Parliament and the medical profession firm and unambiguous assurances both that all existing commitments for the reimbursement of expenses would be honoured for at least three years, and that FPCs would have new money to target on the most desirable schemes for improving general practice. The PAC report (House of Commons Paper 553) last year emphasised the need for "extra cash resources" (paragraph 28) in this area, and paragraphs 43 and 46 of the Treasury minute in response promised extra resources. We had of course allocated to these budgets some of the additional funds agreed in the 1987 PES settlement for Promoting Better Health. We are concerned however that in the first year of the cash limit FPCs may find their new money exhausted by commitments incurred during 1989-90, as GMPs increase their uptake of these presently non-cash limited funds in order to improve their ability to compete for patients. While the baseline and our demand bid reflect the past pattern of growth in expenditure, which relates to the growth in GMP numbers, the forecast is not able to pick up the most recent expenditure trends. It is essential for our credibility that our pledges on the operation of these budgets are seen to be honoured in these early years, both to underpin the new GMP contract and to preserve our good faith in the crucial period of introducing practice budgets. I am therefore bidding for £12: £23: £36 million to enable targeted improvements to take place within the cash limit.

16. Finally I have five development bids which total £21: £17: £25 million. They include a bid of £5 million in 1990-91 to restore to the baseline a saving scored in our 1987 settlement when we planned to introduce compulsory retirement for GMPs at age 70 from April 1990. There is now a serious risk of a successful legal challenge to that policy through the Court of Human Rights unless we defer its introduction by one year. The other bids are for peak flow meters for asthmatics, an increase in the value of vouchers for spectacles, computers for General Dental Practitioners and information systems: more details will of course be given in correspondence between our officials.

17. I see no scope at present for further savings on these services. Our demand bid already incorporates wide ranging savings from agreed policies such as the introduction of dental examination charges, the linking of dental treatment charges to 75% of the relevant treatment fee, the ending of the universal entitlement to free NHS sight tests, and the introduction of compulsory retirement limits for doctors and dentists. Our forecasts also take into account our agreement last year that prescription charges will be increased in 1990-91 and 1991-92, though I have made no assumption of any increase in the following year.

CENTRALLY FINANCED SERVICES

Demand-led

18. There are two demand-led budgets - EC Medical Costs and Welfare Foods - and I am entering overall changes of -£11: -£9: +£3 million.

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19. For EC Medical Costs there are large estimating reductions of -£10: -£11: -£7 million reflecting the latest information on the numbers needing health care outside their own EC countries and the cost of this care.

20. On welfare foods, I have looked again at the provision of free milk to children under five in nursery schools. LEAs are starting to claim for milk supplied to school children under five and this is likely to escalate rapidly. Assuming full take-up, this would increase the cost from £4: £5: £5 million to £15: £16: £17 million. I have decided to make savings of these latter amounts by discontinuing nursery school milk as soon as practicable. This is subject to the views I am obtaining of the Prime Minister and other interested Ministers.

21. The estimating changes in the welfare food budget without nursery school milk amount to -£1: +£2: +£10 million. These take account of the 10% discount in the cost of liquid milk which it is hoped to secure through current negotiations.

Cash-limited

22. For the CFS cash-limited budgets I am bidding for net additions of £90: £90: £91 million. There are two particular reasons why these are high. First they include costs of implementing the NHS Review of £32: £31: £30 million. Second the CFS running cost settlement in last year's Survey was for one year only and this year's bids include £7: £7: £7 million just to carry forward the increase agreed for 1989-90. If the effect of these two factors is put to one side, the bids are of the same order as those entered last year.

23. You will be pleased to note that the net bids for the cash-limited budgets take account of identified reductions worth £5: £10: £15 million.

24. The bids include increases referred to above for Family Practitioner Committees and the Prescription Pricing Authority to implement the changes proposed and for the next stage of the communications exercise concentrating on specific aspects of the Review. I am also making bids for special hospitals for pay awards and to improve staff/patient ratios; for the Disablement Services Authority for pay and price increases and capital projects; to keep up the momentum on health education and publicity; and to ensure an adequate supply of trained social workers. In the voluntary sector I am bidding to enable a network of counselling services to be set up for alcohol misusers in anticipation of the requirements of the Ministerial Group on Alcohol Misuse.

25. As you know, parts of these services are covered by departmental running costs control and I need to bid for additional cover of £13: £17: £21 million.

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PERSONAL SOCIAL SERVICES: CAPITAL

26. On PSS capital my bids are £30: £40: £50 million. I have not taken account of any shortfall in the spending power from receipts in years 2 and 3 as a result of the new capital control procedures - we have agreed that this needs to be addressed in next years Survey. About half of my bid for 1990-91 is needed to enable the current level of spend to be maintained (£14 million) the rest is to allow for some growth for important service developments (£16 million).

27. Growth of this order may seem high on a baseline of £70 million but it is the minimum that I could claim would enable local authorities to tackle the backlog of maintenance (estimated at £220 million for residential care alone) and improve the quality of their residential care in response to the Wagner report. And other pressures such as AIDS, the elderly mentally ill and general demographic changes also need to be allowed for.

DEPARTMENTAL ADMINISTRATION COSTS

28. My bids for administration requirements are £36, £35 and £42 million. The total increases in Departmental Running Costs cover (including cover for the CFS budgets as set out in paragraph 25) which I am seeking amount to £49: £52 and £63 million. They are at this stage provisional. And they are net of the efficiency savings I plan to make over the Survey period. These are discussed in the attached draft Management Plan which my officials will be refining over the next few weeks. Our officials have discussed and will need to keep in touch on these issues and on the arrangements following the split of the Departments which have a bearing on the bids for the two Departments.

29. This is a time of great change for my Department. We have still to absorb fully the effects of the split from Social Security and are in the process of clarifying the split of responsibilities between the NHS Management Executive and the rest of the Department. At the same time we are engaged on an exacting new programme of work resulting from the NHS Review whilst responding to increased pressures in other areas and maintaining a high level of 'baseline' activities. These are the general factors that lie behind my bids, and, together with the costs flowing from the accommodation strategy and from the Department's information and IT needs, account for the large increase in this programme in the first year of the Survey. Thereafter the increases I am seeking are very modest in real terms.

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30. There are a few points I need to highlight :

1. NHS Review: You know the priorities here. And our Officials have discussed in detail the work programme and resources which are required for successful implementation in the time-scale the Government has set. That work programme will be at its most intense this year and next, after which the lead will gradually shift to Health Authorities; but I will need some additional resources to deal with post-implementation changes.

2. NHS Audit: My officials have discussed with yours the need for increased resources to facilitate the smooth and successful transfer of the NHS Audit Branch of my Department to the Audit Commission. I attach great importance to this move which goes hand in hand with the Review changes.

3. NHS Management Executive: We are still working through the implications for the Department and the Management Executive of the meeting with the Prime Minister of 25 April and may need to revise bids nearer the time of the review in July. For the moment I have included a bid of £1 million in each Survey year to provide Duncan Nichol with the flexibility he will need to appoint key staff, purchase outside advice etc.

4. Manpower and Salaries: I have identified increased requirements in connection with the NHS Review and the split of the Departments; and for the meeting of other commitments, some of which have had to be deferred because of other pressures and priorities. In particular, the cost of paying staff has increased substantially in the last two years and has far exceeded the levels assumed in earlier Survey settlements, with the result that the flexibility for DH which last year's arrangements for the split were intended to provide has been absorbed by the underfunding on pay. We have had no alternative but to discharge the necessary functions and tasks arising from the split at the expense of leaving vacancies and deferring tasks elsewhere in our business. And we need to ensure - see my comments at 2.6 above - that a realistic allowance is made this time round.

6. Information System and Technology: I am submitting marker bids only at present. My officials will be discussing with yours the uncertainties facing us at present in this area until major decisions have been taken on the Department's future information systems in the light of the NHS Review and on-going studies.

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7. Accommodation: My bids reflect the combined headquarters accommodation strategy for the two Departments which will ultimately see the headquarters staff located in some 4 or so buildings (as opposed to the present dozen or so poor quality buildings) resulting in greater efficiency; improved communications and better staff morale.

8. Relocation: Final decisions on this have yet to be made and I have not as yet included any bids for this. But there will be transitional costs arising in the Survey years. Officials are working on these and I will be submitting a bid for relocation costs in due course.

CIRCULATION

31. I am sending copies of this letter to the Prime Minister, Peter Walker, Malcolm Rifkind, Tom King and Sir Robin Butler.

Kenneth Clarke

DRAFT 25 MAY 1989

DEPARTMENT OF HEALTH

PUBLIC EXPENDITURE SURVEY 1989: MANAGEMENT PLAN

1. INTRODUCTION

1.1 The Department of Health has service responsibility for the Health and Personal Social Services programme covering

- Hospital and Community Health Services, the largest employer in the country, with a workforce of about 800,000 staff and a total annual spend of over £15 billion;

- Family Practitioner Services provided by some 55,000 self-employed contractors who deal with nearly 60,000 patient contacts a day at a gross annual cost of £5 billion;

- Central Health and Miscellaneous Services with programme expenditure of about £650 million a year, comprising some 200 budgets ranging from running the four Special Hospitals to financing Health Services Research and Development;

- Personal Social Services provided by Local Authorities and involving gross annual expenditure of £4 billion and a workforce of around 300,000 staff.

1.2 Some 63% of the Department's running costs go towards the administration, management and policy development of these programmes. The rest is made up of four running costs budgets in the Centrally Financed Services (CFS): the Special Hospitals (28%); the Disablement Services Authority (6%); the Youth Treatment Centres (2%); and the Artificial Eye Service (less than 1%).

1.3 The Department facilitates the direct line of responsibility between Ministers and Health Authorities, Family Practitioner Committees and other bodies involved in the running and management of the NHS. DH Ministers' service responsibilities for Local Authority Personal Social Services require on-going dialogue with Local Authorities and with the Department of Environment and other Government Departments.

1.4 In serving the Secretary of State, the Department of Health:

a. advises the Secretary of State on policy;

b. acts as the Headquarters of the NHS; and

c. manages other Authorities and Groups accountable to the Secretary of State.

The total size of the Department is about 8,600 staff of which about 4000 are based in London (including 1000 staff employed in professional grades). Of the total, about 5900 staff belong to Authorities/Groups accountable to the Secretary of State for carrying out executive functions, including direct services to client groups: these include the Special Hospitals (employing some 3200 staff), the Disablement Services Authority (some 1000 staff) and the NHS Superannuation Branch (some 500 staff based in North Fylde). A further 600 or so staff work in the support divisions (Departmental Personnel, Office Services, Central Resource Management etc). Of the remaining 2100 staff about half can be attributed to NHS Management Executive functions; and half to the remaining functions of the Department.

1.5 By far the larger proportion of the Department's running costs are thus incurred on executive functions associated with the proper delivery of care by statutory authorities such as Health and Local Authorities; and with the management of the NHS from whom high efficiency and productivity increases are demanded each year.

1.6 The rest of the Department performs a much wider range of functions. These can be classified as;

- Preparation, passage and implementation of legislation;

- NHS policy work;

- The central finance function, including Survey negotiations on HPSS and DH Administration; and the associated monitoring, control and accounting processes;

- Public Health policy work (including public health education) as well as NHS public health activities; this covers Local Authority public health functions and advice to other Government Departments, for instance on food safety and radiation;

- The licensing and regulation of drugs through the Medicines Control Agency; and of private hospitals.

- Personal Social Services policy, finance and inspection;

- Making, and monitoring the use of, grants to voluntary bodies;

- Representing UK Health and Personal Social Services interests abroad, particularly in the European Community;

- Common services (including statistics, economic advice and the management of the Department's own research programme).

2. WORKLOAD OVER THE SURVEY PERIOD

2.1 The work of the Department covers a wide and varied field. It is of necessity undergoing significant changes following the publication in November 1987 of the Primary Care White Paper "Promoting Better Health"; the split of the Departments of Health and Social Security in July 1988; and the publication in January 1989 of the White Paper "Working for Patients" which set out the outcome of the Government's Review of the NHS.

2.2 The first and last of these involve the Department in a sizeable, and complex, programme of new work within very tight timetables in order to implement the new arrangements swiftly and credibly. All three, but especially the last two, require major changes to the organisation of work within the Department.

2.3 In particular the setting up of the NHS Management Executive as an organisation within the Department but with a separate and defined status under the Secretary of State, and having responsibility for all central operational and management work on the NHS (including the FPS), requires

- a range of changes in practice and procedures to strengthen the line management authority of the Chief Executive;

- a central organisation which encompasses a more clear-cut division of staff and responsibilities as between the Management Executive and the rest of the Department.

2.4 The split of the two Departments has resulted in this Department having to take on additional functions in the field of personnel, finance and central resource management. 1989-90 will be

the first full year of the Department operating as a separate entity and it is likely that the procedures and systems necessary for its successful operation and management will continue to be refined into the Survey period.

2.5 The workload and resource requirements arising from these developments cannot be forecast with full confidence at present. Ministers attach the highest priority to the implementation of the Primary Care and NHS Review White papers. The changes require extensive consultation and discussions with those involved; those on primary care developments so far have proved to be time-consuming and difficult. And the impact on work should not be underestimated. The workload consequences of the split of the two Departments are unavoidable and yet to settle down. Some services are for the present being provided by one Department on behalf of the other on a repayment basis. In other areas one or the other Department is providing common services with the intention of identifying and dividing the respective responsibilities at a later date. All these factors will need to be reassessed as time progresses.

2.6 Additionally, Ministers are about to announce far-reaching decisions in response to Sir Roy Griffiths' report on Community Care. The full consequences flowing from these changes will not be known for some considerable time yet and cannot perforce be reflected in the Management Plan at present.

2.7 Moreover, the Department can expect to face major location changes during the Survey years from the implementation of its accommodation and relocation strategies. And the Department is presently in the throes of formulating Information Strategies for its different businesses which in turn will have major implications for the Department's IT requirements. Forecasts of the associated costs and savings from all those factors can only be tentative at this early stage and will need to be refined as the situation develops. [Nor is it possible at present to assess the likely effect on costs of the changes linked to PSA and Crown Suppliers.]

2.8 Major management changes are coming on stream also for the CFS running costs budgets. In particular:

(a) the introduction of a Special Health Authority and appointment of General Managers for the special hospitals, announced in November 1988;

(b) the transfer of the Disablement Services to NHS Health Authorities from April 1991.

3. AIMS AND OBJECTIVES

3.1 The main aims and objectives of the Department for 1989/90 reflecting Ministerial priorities are set out in Annex A*. An objective common to all running costs budgets is to keep expenditure to the minimum compatible with meeting Ministerial and service aims, and achieving value for money. The changes flowing from the NHS Review require a clearer distinction between the functions of the Department and the functions of the NHS Management Executive. And the major aims and objectives attached at Annex A* recognise this division of responsibilities.

3.2 For the CFS, the main priorities are the introduction of the new Special Health Authority in 1989-90 for the Special Hospitals, and the smooth integration of disablement services within the NHS in April 1991. The objectives and plans for CFS running costs budgets are set out in more detail in Annex B.

4. TARGETS AND CONTEXT

4.1 As agreed with Treasury, VFM-related information on outputs/performance/targets for all running costs budgets is being provided separately in support of Ministerial bids.

4.2 At Annex C(1) is a list of the baseline activities routinely undertaken in supporting Ministers in their informing and accounting duties. Additionally there are other inescapable duties, such as those required to be undertaken in the preparation of Vote and Supply Estimates.

4.3 Given the nature of the work and the heavy burden of baseline activities which the Department is required to undertake, there are very few indicators of throughput as such. Annex C(2) lists those areas of the Department's work which are amenable to quantified measurement of workload. And the Department has undertaken to carry out policy evaluations in areas like the resource management initiative, breast cancer screening programme, extension of cervical cancer screening programme, improvements in primary care (Primary Care White Paper) and reductions in waiting lists. Paras 5.1 to 5.3 of this paper discuss the current Management Information Systems of the Department and outline proposals for improving the system itself and for integrating it with budgetary and staff performance appraisal cycles. The aim of these proposals is to ensure that economic decisions are made in the most sensible way.

* In preparation

5. MANAGEMENT INFORMATION SYSTEMS

5.1 The DH now has a well-developed management accounting system. This is a tool used to help managers at all levels set clear objectives, monitor progress against them and re-assess them as conditions change. This is also used to link the annual allocation process with departmental aims and objectives. Divisions are required in their Management Accounts to state their own aims and objectives commensurate with the strategic aims and objectives of the Department; and to demonstrate the resources deployed on each major area of work. This enables priorities to be determined and resources allocated accordingly. Divisions are required to keep their priorities under review during the course of the year; and to amend them as necessary in the light of changed circumstances. As well as regular reviews for management purposes of the achievement of plans set out in Management Accounts, this is also linked to the annual review of personal performance through a stewardship exercise.

5.2 The budgeting, PES and annual staff reporting processes of the Department are now synchronised so as to provide a link between forward budgets, PES bids and personal responsibility plans; and to enable budget stewardship reports and annual performance appraisals to be closely aligned. With the aim of getting nearer the ideal of a single management cycle that avoids duplication of effort, the Department proposes to carry out a study of the various components of the management cycle, including the links with the DH Management Plan and with central initiatives like value for money and efficiency programmes. The study will look at the purpose, information needs, timing and inter-dependencies of the various strands. It will commence by June and is intended to be carried forward swiftly. In the light of its findings, changes will be introduced in the 1989-90 HQMA round for the 1990-91 financial year.

5.3 For the CFS, detailed guidance is issued to budget holders on budget management and accounting, including specific guidance on achieving value for money. This has been reviewed recently and revised guidance was issued in February 1989. The responsibility for exercising control over expenditure on individual CFS budgets and for monitoring the delivery of the planned efficiency savings rests with the budget holders assisted as necessary by finance liaison sections. Information on running costs expenditure by the Special Hospitals and Youth Treatment Centres is received from local budget managers and analysed on a monthly basis, and equivalent management information systems are being developed by the Disablement Services Authority.

6. RESOURCES

(Note: Figures are provisional. Pay and price assumptions are subject to review).

6.1 The running costs resource requirements and implied bids over the Survey period together with the assumptions about pay and prices which underpin them are given below for each running costs budget. The Survey bids are given net of efficiency savings.

Administration Costs

6.2 The Department is carrying out further work on its pay and price assumptions for the Survey period and these are thus subject to review.

6.3 The resource requirements over the Survey period are:

	£ million		
	1990-91	1991-92	1992-93
Net requirement	194.4	200.8	212.0
PES Baseline	158.8	165.8	169.9
Survey Bid (Net) : TOTAL	35.6	35.0	42.1
NHS Review	6.7	4.3	3.5
NHS Audit	4.1	-	-
NHSME (marker bid)	1.0	1.0	1.0
Manpower (excluding NHS Review)	7.1	9.3	12.8
Non-Manpower (excluding NHS Reveiw)	16.7	20.4	24.8

6.4 The manpower costs are underpinned by assumptions on pay increases in the Survey years of 7.5%; 6.5% and 6%. For non-manpower the price increases are based on budget holders assessment of inflation relative to Treasury's forecasts of GDP inflation.

6.5 Special Hospitals

	£million		
	1990-91	1991-92	1992-93
Net Requirement	73.853	78.884	83.885
PES Baseline	62.611	64.177	65.781
Survey Bid	11.242	14.707	18.104

For pay and price assumptions, see Annex B, paragraphs 2 and 16.

Disablement Services Authority

Net Requirement	14.995	15.146	15.908
PES Baseline	14.208	14.190	14.524
Survey Bid	0.787	0.956	1.384

For pay and price assumptions, see Annex B paragraphs 2 and 39.

Youth Treatment Centres

Net Requirement	5.551	5.746	6.054
PES Baseline	4.569	4.682	4.799
Survey Bid	0.982	1.064	1.255

For pay and price assumptions, see Annex B paragraphs 2 and 29.

Artificial Eye Service

Net Requirement	0.786	0.847	0.891
PES Baseline	0.751	0.772	0.792
Survey Bid	0.035	0.075	0.099

For pay and price assumptions, see Annex B paragraphs 2 and 45.

7. EFFICIENCY SAVINGS AND MECHANISMS

7.1 At Annex D is a list of the total efficiency gains in departmental running costs planned for the Survey period. The measures listed cover savings which will be realised through reductions in inputs together with the gains expected from increased outputs without corresponding increases in inputs. Annex D also includes detailed notes on the measures identified.

7.2 In addition increases in departmental administration efficiency and effectiveness has been achieved and is continuously sought through greater promulgation of IT and continuing improvements in communications. The latter has been a particular problem for the Department whose headquarters staff in Central London are currently housed in fifteen buildings. Improved communications is a key feature of the Department's accommodation strategy. These and other major initiatives which are aimed at increasing efficiency (not all of which are amenable to quantified measurement) are discussed below.

7.3 Location of Work. Following the split of the two Departments last year current expenditure on headquarters accommodation for the two Departments is for the present included in the Department of

Health running costs pending implementation of the combined accommodation strategy. The strategy aims to improve the efficiency of the headquarters businesses (which for the Department of Health is the predominant component) by improving communications and morale, and taking advantage of lower rents and other costs outside the South East.

(a) Headquarters Accommodation Strategy

(i) The staff of the Departments of Health and Social Security are currently housed in buildings of inadequate standard and inefficient location. This results in poor communications; delays in decision making; and low morale. A major element of the HQ Accommodation Strategy is the relocation of at least 1000 staff away from London. This aspect is being considered and costed separately. It is necessary to spend a significant amount of money (approaching £30m in the PES period) to fit out, furnish and contribute to the landlord's refurbishment costs for Alexander Fleming House. In addition, a small number of extra staff in Office Services (10 or so) are required to plan and manage the extensive move of staff so that the present dozen or so buildings scattered across London can be reduced by mid-1992 to 2 buildings in the Whitehall area and 2 or 3 at the Elephant and Castle.

(ii) The best value for money option will entail building an extra block for AFH. Analysis of the discounted cash flows indicates that the rental paid for buildings is the major factor in determining the best long term value for money. At £14 per square foot, the refurbished AFH will offer very good value for money for a central London site. The average opportunity cost rental of about £21 per square foot for the 4 or 5 long term HQ building of the two Departments offers good value for money in comparison with Departments based mainly in the Whitehall/Victoria areas where rents are £30/40 per square foot. As AFH is refurbished and re-occupied over the next 3 years or so, the number of buildings occupied will be reduced. In addition to improving communication with HQ, this will allow a gradual reduction of Office Services staff which will eventually result in savings of £350,000 in a full year (ie 35 posts or 5% of Office Services staff costs). The first full year's savings are expected in 1993-94.

(b) Telecommunications Strategy

(i) This project has been approved by Treasury and the first phase (Hannibal House, Eileen House, Friars House and Canons Park) is due to go live in June this year. In essence, the plan is to replace the multitude of, sometimes obsolete, rented switchboards in most buildings by purchasing new switchboards linked by rented high capacity wires ("megabyte links") to become a private network. There are also plans to install an "Inner Core Network" in DSS between London, Newcastle and Blackpool. Voice and data will be carried on the network. The project will be phased over the PES period with the largest expenditure in 1989-90 and 1990-91. The contract has been specially formulated to allow major changes as required. The long term plans for each building will be reviewed before a firm decision is made to install equipment. An updated financial case will be prepared during the course of this year.

(ii) This large capital investment in the purchasing of new telecommunications network is expected to produce efficiency savings by reducing British Telecom charges for the current private switchboards and for the private wires connecting buildings. There will also be some reduction in GTN and BT call charges as more traffic uses the Department's own network. The expected savings are estimated at some £500,000 over the Survey period. And the changeover is expected to lead to a reduced need for telephone operators; and to produce annual cumulative savings of some £12,000.

(c) Relocation

(i) This initiative is an important element in the joint DH/DSS HQ Accommodation Strategy. The Department of Health is examining jointly with the Department of Social Security ways in which at least 1000 HQ posts from both Departments may be relocated away from the South East.

(ii) The work on Relocation is continuing and it will be a little while before expected savings in running costs at the new location can be estimated. At present no savings are expected within the Survey period.

7.4 Computerisation. In the last six months some 150 stand-alone microcomputers have been installed. On average it is estimated that savings of about [£10,250] (or 1 AO post) can be achieved from such installation. The Departmental Information Systems Strategy Committee is presently considering the Corporate and individual Business Information Strategies to meet the Department's information needs, together with future IT policy including a proposal to instal a terminal on every desk within the Survey period. The rate of installation will be determined in the light of decisions made by this Committee. On the basis of information currently available efficiency gains arising as a result of the introduction of IT are estimated at around £1.3 million; £4.1 million and £7.1 million in the Survey years. Further work is being undertaken in this area and the figures will be reviewed in the light of its findings and as work on Information Systems and IT progresses.

7.5 Purchasing

(a) Office Automation Systems. As part of open procurement arrangements, IT Branch is negotiating on mid-range office systems for preferential discount rates based on the aggregated value of purchases. On micro-computers, the DH currently follows a bulk purchasing policy as a result of which the Department can normally expect to achieve additional discounts of 8% over the basic discounts (about 28%) available through the CCTA standing arrangements. In the light of the recent circular from CCTA on EEC Directive 88/295/EEC Department will in future base bulk purchases upon GATT procurement procedures. IT Branch will adhere to the directives and is in the process of instituting procedures to ensure that the regulations are followed and that high levels of discounts continue to be achieved.

(b) IT Consultancy. IT Branch is in regular contact with IT consultancy firms. It has negotiated standing arrangements with two of these companies to provide general support for its activities. This has resulted in significant savings. Given the high success of this exercise, IT Branch plans to extend these arrangements to approximately 20 companies.

(c) Furniture and Fittings. The Department aims to save 5% of its annual expenditure on furniture and fittings by negotiating bulk contracts for the supply of furniture and fittings to Alexander Fleming House. This will result in savings of about £120,000 to £180,000 in each of the Survey year.

7.6 Energy Efficiency. A Working Group is examining the accounting and monitoring procedures for fuel and utilities. It is expected to report in July. Proposals made in the report will be considered by the Department's Office Services' Management Team with a view to early implementation.

7.7 Efficiency Scrutiny Programme. The Department is participating in two multi-departmental activities in 1989/90. Firstly, the Government funding of the voluntary sector to establish whether grants are in line with objectives and that they are being used for the purposes intended. The Home Office is in the lead on this item. Secondly, the joint scrutiny with the DSS of the use of external consultancy services. The objective being to determine whether the two Departments are securing value for money.

The Department has a suggested programme of further efficiency scrutinies about which it will be in discussion with the Efficiency Unit at No 10. The suggested programme includes two areas, ie the recruitment of professional staff and post-graduate training for professional staff.

7.8 Market Testing. Security guarding of DH HQs buildings will be subject to market testing later in 1989/90. A DSS-led working party is being set up to examine the possibility of other areas for market testing.

8. EXECUTIVE AGENCIES

Active consideration is being given to the future status of the Social Service Inspectorate, Youth Treatment Centres and the NHS superannuation Branch in the context of them being possible candidates for next Steps Agencies. The deliberations are at a very early state at present. In taking forward its thinking with them, the DH will bear in mind the philosophy underlying the creation of such Agencies. Any agencies that are created will have financial regimes set out in "Framework" documents and they will be expected to make an agreed contribution to the savings required by the Department as a whole. As part of implementing the NHS Review, the Department will be examining the possibility of devolving much of the Health Buildings, Procurement and Estate and Property Management, and possibly NHS Information Technology and Health Services Information functions, either to an NHS Common Services Authority or other Agency.

9. MEDICINES CONTROL AGENCY

9.1 Following Treasury agreement in January 1989, the greater part of the Medicines Division was exempted from running costs control from 1 April 1989 and renamed the Medicines Control Agency. The Agency, which is self-financing, remains part of the Department but its costs no longer form part of the Departmental running costs and the bids in respect of the Agency's increased requirement have been identified separately. The Agency has its own business plan which was submitted to the Treasury earlier this year.

10. COMPARISONS

10.1 The predominance of baseline activities required of the Department, the virtual absence of operational business and the almost unique state of flux in which the Department finds itself in this year render comparisons of overall efficiency gains with other Departments and organisations difficult to express and of very limited value.

10.2 In the absence of relevant external benchmarks of efficiency the Department needs to rely on other measures. [These are given in Annex E. DN: This is under consideration]

11. CONTINGENCIES

11.1 In the event that the Department's efficiency savings are lower than estimated, measures such as banning overtime, recruitment of casual staff and recruitment of permanent staff for a fixed period would need to be introduced with the inevitable risks of delays in high priority areas and detrimental effects on other work programmes and staff morale with consequential loss of effectiveness.

CRM/FB
25 May 1989

BACKGROUND INFORMATION ON INDIVIDUAL RUNNING COSTS BUDGETS IN THE CENTRALLY FINANCED SERVICES

Introduction

1. The efficiency gains in running costs which are planned for the Centrally Financed Services (CFS) are set out and explained in Annex D. This Annex gives more information on the management plans for the individual services and provides the context against which the efficiency measures should be viewed.

2. Pay and prices. Except for Review Body staff (see paragraph 16 below) CFS running costs requirements assume pay inflation of 7.5%: 6.5%: 6%. The budget holder's best assessment of price increases have been used in each case (see paragraphs 16, 29, 39 and 45 below). We shall want to seek extra provision if these pay and price assumptions in the event prove to be too low.

The special hospitals

3. The introduction of a Special Health Authority (SHA) and appointment of General Managers, announced by PS(H) in November 1988, is the major management change affecting the special hospitals. Ministers will expect the SHA to provide more cost-effective management and to address fundamental questions about the future role, size and organisation of the service. The announcement of these management changes coincided with the publication of the Health Advisory Service report on Broadmoor hospital, which made recommendations about organisation, operation and staffing. The SHA will need to take these recommendations on board and also the implications for special hospitals of the White Paper "Working for Patients". It will also need to consider special hospitals admissions policy in the light of Professor Gunn's forthcoming report on the psychiatric profile of the prison population (see paragraph 10 below).

4. The imminent change in management responsibilities presents problems for the management plan. Ministers will want the SHA to have sufficient flexibility to address and resolve the management and resource issues; and to present it, on appointment, with a settled plan which effectively fixes resources and administrative initiatives for the first three years of its life would clearly be unacceptable.

5. We offer two suggestions for resolving this difficulty. First, the table of efficiency gains in Annex D includes specified mechanisms for achieving gains in the special hospitals in 1990-91, but leaves the mechanisms (though not the value of the gains) unspecified for 1991-92 and 1992-93. This gives the new Authority a free hand to plan how these gains are to be achieved in the context of managed change in the medium term. Second, we suggest that any three year settlement agreed for departmental running costs should recognise that discussion may be reopened on the amounts agreed for the special hospitals on the basis that their

role, size and organisation will be under fundamental review by the new SHA.

6. Objectives. When announcing the management changes, PS(H) set six strategic objectives for the special hospitals service as follows.

(a) To protect the public. This is the first priority. Special hospital patients are potentially very dangerous people and security must not be compromised.

(b) To provide a high quality of treatment. The special hospitals should be therapeutic institutions, not prisons. Many patients are unlikely ever to be discharged, but some are curable. The aim is to provide optimum treatment for those able to benefit from it. This requires a variety of therapies and multi-disciplinary skills.

(c) To provide patients and staff with a decent environment. Patients should be afforded a decent quality of life consistent with security; and staff recruitment and morale are not helped by bad working conditions.

(d) To work more closely with Regional and District Health Authorities. The special hospitals have been cut off from mainstream psychiatric services. Their links with the NHS should be closer and clearer.

(e) To become centres of research in forensic psychiatry. (The steps taken by the Royal College of Psychiatrists to promote medical audit are welcome.)

(f) To become centres of staff training, with a view to improving the quality of service for difficult psychiatric cases throughout the country.

7. Some of the practical targets which need to be met are:

(a) to introduce the management changes announced by PS(H) by October 1989;

(b) to agree and implement changes to Broadmoor and the other special hospitals in response to the HAS recommendations;

(c) to introduce Income and Expenditure based accounts by April 1990;

(d) to develop and install a co-ordinated management information system, linked to the new accounting procedures and meeting the needs of General Managers. (Consultants are due to advise on the best way forward by March 1990);

(e) to develop measures of output, performance and value for money by October 1989;

(f) during 1989-90, to open the 16th and 17th wards at Park Lane hospital and to occupy fully the new Broadmoor hospital; and

(g) to improve the throughput of patients assessed as

suitable for admission and discharge.

8. Outputs and performance. As agreed with Treasury, the available information on outputs/performance/targets/VFM for CFS budgets will be supplied separately in support of Ministers' Survey bids. The special hospitals are putting effort into developing improved indicators and management information systems. In the summer of 1988 a working group was set up to develop performance indicators for the special hospitals. However NHS Review pressures meant that the EAO and Treasury representatives had to withdraw; so this work is still at an early stage. The group is now reconvened and aims to make faster progress. It may wish to look to the NHS and elsewhere for advice, for example on developing analytical tools such as "weighted diagnostic groups".

9. In terms of overall costs, though the special hospitals are unique, the following comparisons may be useful:

Cost of maintaining one inmate for one year (1987-88)

Youth Treatment Centres	£78,052
Regional Secure Units	£71,762
State hospital, Carstairs	£40,161
Special hospitals	**£34,781**
Cat A dispersal prisons	£28,964

10. Patient numbers. The number of patients in special hospitals is a major factor affecting resource requirements, but is difficult to forecast. The present judgement is that numbers are likely to remain relatively stable during the Survey period at around 1730, and estimates of requirements have been made on this basis. However, it should be noted that the Home Office Prison Service has told us that at any one time there are in the region of 100 prisoners who would be more appropriately placed in special hospitals. The pressure to accommodate these prisoners is likely to increase, as we understand that a 16% increase in the general prison population is forecast over the Survey period. Professor Gunn of the Institute of Psychiatry is currently undertaking a psychiatric profile of the prison population. He is due to report in about a year, and there may be implications for special hospitals admissions.

11. Staffing levels. Within the secure perimeter of the special hospital, security is largely delivered by staff observation of patients. If the staffing level falls, more draconian measures have to be adopted and the therapeutic environment crumbles. The extreme effects of reductions in staff are illustrated by what happens during industrial action. Patients are locked away for long periods; therapy, occupations and visiting are withdrawn, and the environment becomes custodial rather than therapeutic. Patients become agitated, media interest and Ministerial involvement increase, and patients' representatives in some cases have taken legal action.

12. The current target staff:patient ratio is 2:1. Professional advice is that this is insufficient to provide an effective therapeutic environment and to optimise

serious crimes and placed in YTCs in preference to prisons);

(b) to achieve for them some degree of adjustment to themselves and their environment satisfactory to both themselves and society;

(c) to prevent further personality damage to these young people who have already suffered so many rejections;

(d) to increase understanding of the causes of such severe disturbance; and

(e) to contribute to the development of preventive methods.

19. If one or both of the Centres closed, the department would still have to discharge its responsibility for accommodating s53 young offenders, at a cost of over £3 million a year if they were transferred to LA units, and of nearly £1 million if they were transferred to prisons. Neither option could be easily defended in policy terms, given the judgement of the SSI report, and of an interim report in March 1989 a study of YTC outcomes by Dartington Research Unit, that the need for a specialised YTC service continues.

20. Current practical targets are to:

(a) maintain occupancy levels at an average of 64 places, by containing costs as far as possible to minimise the deterrent effect of high fees on LA customers, and by providing an information pack on the YTC service to LAs; and

(b) to revalue rents from staff properties. In 1987-88 these yielded income of £30,000. The target for 1990-91, once PSA have set rents with reference to "fair rents" in the private sector, is to increase this to £58,000 and to maintain it in real terms over the following two years. (This will not affect the running costs cash limit, which applies to gross expenditure.)

21. Service management New Standing Financial Instructions were introduced fully on 1 April 1989. These will make the two YTC Directors directly accountable to a Grade 5 budget holder in DH HQ for local financial control within cash limits. A review of management information, performance indicators and local budgetary profiles is currently in progress.

22. Outputs and performance. As agreed with Treasury, the available information on outputs/performance/targets/VFM for CFS budgets will be supplied separately in support of Ministers' Survey bids. Ministers recognised at the outset that this unique, specialised service would be relatively costly. Indeed cost was seen as a mechanism for resisting inappropriate demand for places. Since 1984, the Centres have moved progressively towards ending the subsidy of placement fees, with local authority users having to bear full operating costs for their placements since April 1987. However, over the same period there has been a rapid increase in the numbers of s53 placements. No income is received from

throughput of patients. Many of the Health Advisory Service recommendations (see paragraph 3 above) carry an implicit requirement for increased care and clinical staff. Given that the patient population is now projected to remain stable, it is proposed to improve the staffing ratio gradually over the Survey period to 2.3:1.

13. It is clearly important to assess the staffing levels needed in individual disciplines to achieve effective care, and to form a clearer judgement of the gains in efficiency and performance that can be expected from an increased staff ratio. An independent study of the nursing requirements at Broadmoor is being undertaken by Mr Telford, a serving NHS Unit General Manager, who hopes to report by the end of August. The caseloadings on medical officers and social workers in the special hospitals currently exceed professionally recommended levels, and a reduction in these loadings is an important key to improving throughput of patients.

14. Resource requirements also take account of the staffing consequences and on-costs of opening new wards at Park Lane and of fully occupying the new accommodation at Broadmoor.

15. The calculation of requirements also takes account of the costs of the new SHA, General Managers and support staff. However it should be noted that the identified efficiency savings are sufficient to offset these new costs.

16. Pay and prices. As for the HCHS Survey bids, the requirements assume that Review Body staff will receive increases of 4%: 3%: 2.5%. Should these be exceeded, we would not expect a three year settlement on running costs to be a bar to the special hospitals and other CFS running costs budgets receiving their share of any additional funding which may be agreed. For pay assumptions for non-Review Body staff, see paragraph 2 above. Price inflation of 4.4%: 3.75%: 3.25% has been assumed for special hospitals' running costs budgets, following the Health Services Price Index used by NHS Health Authorities.

The Youth Treatment Centres

17. The organisation and management of the YTC service is under review following the recent Social Services Inspectorate (SSI) report. In particular the pros and cons of continuing to maintain two sites will be considered. The decisions may affect this management plan.

18. Objectives. The YTCs exist to accommodate young people of both sexes referred by local authorities or the Home Office because other interventions are inappropriate or have failed. Since 1971 when the first Centre was established, the principal service objectives endorsed by Ministers have been:

(a) to provide long term care and treatment in gradations of security for seriously damaged young people who are in the care of local authorities or detained under section 53 of the Children and Young Persons Act 1933 (i.e. found guilty of

the Home Office for these placements which cost £3.13 million in 1988-89. A notional income is assumed for them for the purposes of the memorandum trading account.

23. Service quality is assessed by a professional audit team led by the DH Social Services Inspectorate. As part of the work for their recent report, a research team from Kent University was commissioned by them to examine the comparative costings of LA provision in community homes and secure accommodation, and a user survey was also undertaken. Both studies concluded that YTCs give reasonable or good value for money, although the Treasury agreements on pay (see paragraph 28) mean that unit costs are higher than in LA community homes.

24. Occupancy. With 70 beds available, the YTCs have operated at over 90% occupancy since 1985, compared with 72% in LA secure units. On average just under 64 young people between the ages of 13 and 19 are currently in residence and it is planned to achieve this average in 1989-90 and beyond. The average age at admission has risen, from 13 in 1981 to 16 in 1987, mainly due to LA policies of keeping young people out of residential accommodation for as long as possible. On average, LA care cases stay for two years and s53 cases for two and a half years. Turnover has increased by 50-60% since 1981 because of the changing age structure, while staff numbers have reduced by 11% (see paragraph 27 below).

25. Staff. The two units operate in conditions of mainly maximum security and employ 221 staff, most of whom are highly qualified. This will increase to 223 in 1989-90 with the addition of three Assistant House leaders and the loss of one Senior Social worker post. Care and control is provided round the clock by groupworker teams. Statutory education and recreational facilities are provided on site as well as catering and other residential services. The young people participate in pre-release schemes which are labour intensive, with on average 1:1 escorts off site.

26. Staff numbers cannot easily be varied to reflect short-term volatility in occupancy. Staffing levels must be maintained at all times to avoid life threatening situations (e.g. suicide, self-mutilation, arson, hostage taking, violence, rape etc.). Only qualified teaching, nursing and child care staff can be engaged and there can be no reliance on students or trainees. Time must be allowed for professional and postgraduate training so that staff keep in touch with developments in the field and do not become institutionalised. And because each Centre has national catchment, the staff also have to be available to represent the department and its clients before the courts anywhere in the UK, usually at short notice.

27. A departmental staff inspection in 1983 led to a reduction in complement of around 11%. The SSI review has concluded that the staffing formulae, which are based on those recommended by DH to the LAs, are just about sufficient to meet operating requirements of these highly specialised units. The formulae provide that, where a unit of 10-14 children includes one or two who are severely disturbed, then

4 or 5 staff should be on duty. All the young people in YTCs are severely disturbed, and a lower staff ratio than in community homes could not be defended.

28. Salaries are determined by Treasury Pay Division by reference to nationally negotiated pay settlements outside the civil service. Pay rose considerably faster in 1986-87 for teaching, nursing and child care staff than for civil servants (e.g. 17% for teachers compared with the average rise of 5% for civil servants), and since then pay awards for these groups have continued to outstrip those for the civil service by 2-3% a year. The Treasury are in negotiation with the IPCS about a new grade to cover these disciplines which, with transitional pay protection, would remove the present outside analogues. If the proposals are accepted, it is estimated that, given 12% a year wastage, savings of 10% could accrue over a period of 10 years. The deal would include the start up costs [(£98,000 in year one and £35,000 in year two)] of bringing the rates for residential child care officers (RCCOs) closer to those of nurses and teachers, and the requirements include these start up costs on the assumption that this will take effect from 1990-91.

29. Prices. Requirements assume that price inflation for YTC running costs budgets (including PSA costs) will average 6% a year across the Survey period.

30. Maintenance Building stock is owned by PSA who are responsible for major repairs and maintenance. The PSA accommodation charge rose by 23% in 1988-89. The quality of the buildings has deteriorated badly in the past seven years and this was singled out for severe criticism in the recent SSI report. The young people damage and destroy property on a day to day basis, and repairs need to be made quickly to prevent hazards to life and security and to maintain reasonable standards.

The Disablement Services Authority

31. The Disablement Services Authority (DSA) will not exist after 31 March 1991, when its responsibilities and assets will transfer to NHS Health Authorities. The administration of disablement services will then cease to count as departmental running costs.

32. Objectives. The DSA was established in July 1987 in the light of the recommendations of the McColl review (1984-86) of the Artificial Limb and Appliance Service. It is a Special Health Authority charged with maintaining and improving services to patients and with overseeing their integration with the NHS in April 1991. The services concerned are the provision of artificial limbs and appliances, including wheelchairs, to disabled people, and the provision of these and other appliances to war pensioners.

33. Within their overall remit, the Authority adopted 7 strategic aims:

(a) The artificial limb service. To bring about an

independent prosthetic service capable of fitting a variety of limbs produced by manufacturers in a competitive market, ensuring that each customer's individual needs are met.

(b) The wheelchair service. With the support of a local competitive repair network, to meet disabled people's short range mobility needs quickly and cost-effectively.

(c) Organisation - management and human resources. To delegate responsibility and to achieve planned changes in work practice and staffing profiles.

(d) Finance. Within the resources available, to provide the services with maximum economy, efficiency and effectiveness, making full use of the private sector where appropriate.

(e) Quality of service. To perform all tasks so as to provide maximum benefit as quickly as possible to users, and to require the same of suppliers.

(f) Service integration. To hand on to the NHS a decentralised service which has achieved the Authority's main objectives and has committed staff in place, and to secure the agreement of the local health authorities to maintain and develop the service.

(g) Style - response and communication. To communicate the Authority's objectives widely, to report progress against them, and to promote the morale, commitment and coherence of suppliers, staff and patients.

34. Outputs and performance. As agreed with Treasury, the available information on outputs/performance/targets/VFM for CFS budgets will be supplied separately in support of Ministers' Survey bids. In common with other health authorities, the DSA is reviewed annually by Ministers. The last such review was on 1 November 1988. An action plan for the next twelve months was agreed, covering arrangements for integration with the NHS, the outcome of competitive tendering and development of performance indicators. A trial of new indicators will begin during 1989-90.

35. In the last twelve months, the Authority has made significant progress towards achieving its objectives. It has:

(a) introduced competition in the supply of prosthetic hardware;

(b) introduced competition in the supply of prosthetic services;

(c) introduced competition in the maintenance, repair and carriage of wheelchairs;

(d) negotiated the terms of staff transfers to the NHS and begun to employ staff on NHS terms and conditions;

(e) begun a reorganisation of administration systems and procedures;

(f) improved finance information systems and devolved the major part of budgets to accountable Regional Managers; and

(g) made arrangements with each NHS Region to plan for integration of services in April 1991.

36. By April 1990, competitive contracts will be in place for prosthetic services and the supply and repair of wheelchairs. Arrangements for integration will have been settled and any staff migration back to the civil service should be well under way. The balance of management activity will shift to completing the process of integration and increasing efficiency by maintaining downward pressure on staff numbers in the Authority's headquarters.

37. By April 1991, the wheelchair service will have been transferred to DHA management. The limb service will have been transferred to RHA or DHA management, according to the local pattern of services. Management information systems and performance indicators will be in place to meet the needs of successor authorities. Designated Centres of Responsibility for procurement will have been established and will have been prepared for the next round of competitive tendering. While estimates of the financial effects of these changes can only be tentative, projected reductions in running costs of £502,000 are forecast on the information currently available and have been taken into account in estimating requirements.

38. From April 1991, the services will be provided by the NHS. Procurement will have passed to NHS Centres of Responsibility. Of the remaining headquarters functions, financial and operational management, planning and general administration will be part of the costs of successor authorities. The costs associated with the existence of the Authority, the Secretariat and the Senior Management Team will cease and together with gains carried forward from 1990-91 will represent cumulative reductions in what were running costs estimated at £1,076,000 in 1991-92 and £1,171,000 in 1992-93. These reductions have been taken into account in estimating forward requirements on running costs subheads in this year's Survey.

39. Prices. Requirements assume that price inflation for DSA running costs budgets will average 5% a year across the Survey period.

The Artificial Eye Service

40. Ministers decided in July 1988 that the Artificial Eye Service (AES) should be transferred to the NHS. It is planned to transfer it to North Western RHA with effect from 1 April 1990 and the administration of this service will then cease to count as departmental running costs.

41. Objectives. The AES objectives are to fit and supply artificial eyes, cosmetic shells and facial prostheses to NHS patients and war pensioners in England, and to supply artificial eyes and cosmetic shells to Northern Ireland,

Wales and Scotland.

42. Salaries. The AES plans to maintain the number of staff providing a direct service to the patient, i.e. orbital prosthetists and ocular technicians, at the current level. Over the last eight years, investment in clinical training has enabled these posts to be reduced by 23%, from 44 to 34. Further reductions would adversely affect the level and quality of the service. Pay settlements are controlled by Treasury. Non-clinical staff comprise 1 PTO, 2 SPTOs, 4 HPTOs and 4 clerical staff.

43. Travel. The AES has reduced the mileage travelled over the years by monitoring the need for clinics and management travel. Mileage allowances are set by Treasury.

44. Materials. This budget is used to purchase materials and equipment for eye making and fitting. The requirements of the Consumer Protection Act have involved the AES in expenditure on safe work benches. Reductions in this budget would put service and safety at risk.

45. Prices. Requirements assume price increases of 4%: 3%: 2.5% for the Survey period.

ANNEX C(1)

BASELINE ACTIVITY IN DEPARTMENT OF HEALTH

1. At all levels a great deal of staff resources are devoted to work on the day to day running of the Department.

2. The following list, which is not exhautive, gives some examples of baseline activity in 1988/89 and anticipated activity figures for 1989/90, 1990/91, 1991/92 and 1992/93.

Parliamentary Questions - 6500 (1988/89), 7000 (1989/90), 7400 (1990/91), 7800 (1991/92), and 8200 (1992/93).

Briefing for Adjournment and other debates - 100, 110, 115, 120, 125.

Briefing for Early Day Motions, Leader of the House and for the Prime Minister - 590, 630, 700, 770, 840.

Responses to letters from Members of both Houses of Parliament - 20000, 30000, 33000, 36000, 39000.

Responses to letters from members of the public or from organisations - 34000, 50000, 55000, 60000, 66000.

Press notices - 300, 315, 330, 350, 365.

Press conferences - 33, 35, 37, 40, 43.

Calls to public enquiry office - 7000, 7350, 7720, 8100, 8500.

Calls from the media - 49400, 52000, 54600, 57300, 60200.

Written evidence to Select Committees, including replies - 17, 19, 21, 23, 25.

Briefing for Ministers/officials appearing before Select Committees - 7, 8, 9, 10, 11.

Briefing for officials appearing before PAC - 7, 8, 9, 11, 14.

Briefing for Ministers/officials for meetings, visits etc - 2850, 3000, 3150, 3300, 3500.

ANNEX C(1)
(continued)

The Department also in 1988/89;

made arrangements for 94 visits of Health Officials from 46 foreign countries;

supplied some 6000 artificial eyes and provided aftercare to almost 8000 patients;

received 500000 references to define entitlement to a range of Social Security benefits, 40% of which required medical examination;

provided briefing and all other aspects of legislative work on DH "lead" bills, and other bills on which there was a health interest;

provided liaison with 86 Non-Departmental Public Bodies.

ANNEX C(2)

Division	Workload Measure
HS	Authorisation of pay beds.
FMD	Processing of annual accounts and financial returns from Health Authorities.
	Analyses of quarterly monitoring returns from Regions and Special Health Authorities.
Private Office	Parliamentary Business (PQs; Early Day Motions; briefing for PM etc).
	Correspondence from MPs and members of the public.
Med MME	Para 190 and Manpower Appeals.
MHRT	Number of cases reviewed (Trinbunals heard).
ID	Contact with the press.
RL	NHS Review projects eg self-governing hospitals.

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ANNEX D

DEPARTMENTAL RUNNING COSTS: PLANNED EFFICIENCY GAINS

(NOTE: Figures are provisional)

		Cumulative Value (£ million) 1990-91	1991-92	1992-93
Departmental Administration				
1.	Improved Working Practices	0.430	0.640	0.934
2.	Computerisation	1.339	4.088	7.080
3.	Consultants	0.028	0.048	0.022
4.	Special printing	0.156	0.187	0.117
5.	Telecommunications	0.605	0.542	0.691
6.	Office Machine maintenance	0.060	0.079	0.100
7.	Contract cleaning	0.008	0.008	0.008
8.	Postage	0.032	0.033	0.034
Special Hospitals				
9.	Withdrawal of assisted travel	0.577	0.598	0.618
10.	Rationalisation of duties	0.167	0.346	0.356
11.	Computerised patient information	0.098	0.102	0.105
12.	Computerised food management	0.128	0.133	0.137
13.	Computer developments in stock control, administration, personnel, payroll and patients' cash	0.042	0.044	0.045
14.	Telecommunications	0.042	0.044	0.045
15.	Measures to be identified/agreed by the new Special Health Authority	-	1.000	2.000

ANNEX D
continued

Youth Treatment Centres

16. Shift working changes	-	0.016	0.017
17. Recruitment of RCCO groupworkers	0.042	0.050	0.054
18. Restructuring of working arrangements at Glenthorne	-	0.015	0.016
19. Reduced use of agency staff at St Charles	0.042	0.045	0.047
20. Reduced accommodation charges following disposal of staff housing at St Charles	-	0.014	0.014
21. Catering efficiencies	-	0.011	0.012
22. Maintenance savings	0.002	0.002	0.002
23. Post saved at St Charles if open facility is agreed	-	0.027	0.028
Total efficiency gains	3.798	8.072	12.482
Departmental Running Costs net of these gains (as detailed in Survey bids and excluding the MPC, DSA and AEU: see notes A to C below).	273.804	285.430	301.939
Gross Running Costs Requirements	277.602	293.502	314.421
Percentage Value of efficiency gains	1.4%	2.8%	4.0%

General notes.

A. Treasury have agreed in principle that the Medical Practices Committee, as an executive NDPB, should cease to be treated as subject to running costs controls. Subject to resolving some technical difficulties, this will take effect from 1990-91. The MPC has therefore not been included in the management plan.

B. In April 1991, the Disablement Services Authority will cease to exist, the services it provides will pass to the NHS health authorities and the administration of these services will no longer count as departmental running costs. Meanwhile the Authority is steadily reducing its staff and will be transferring some elements of its work to the health authorities on a contract basis, with corresponding reductions in departmental running costs. The budget holder has identified running costs reductions estimated to be worth £0.502 million in 1990-91, and cumulative reductions in "running costs type expenditure" of £1.076 and £1.171 million in years 2 and 3 of the Survey. These reductions are explained in Annex B (which gives background on the CFS running costs budgets). As they would distort the picture of efficiency gains for ongoing running costs budgets, it is suggested they are considered separately from the above table.

C. It is planned to transfer responsibility for the Artificial Eye Service to North Western Regional Health Authority with effect from April 1990 and expenditure on this service will then not count as departmental running costs. Further background is provided in Annex B.

Notes on itemised efficiency measures.

Department Administration [Notes currently under preparation].

Special hospitals

1. Withdrawal of assisted travel. This scheme helps staff with travel costs to and from work. It was introduced in line with an NHS scheme which was subsequently withdrawn. It is not part of the terms and conditions of service and it is proposed to phase it out during 1989-90. An adverse staff reaction is expected and a nil cost package may have to be negotiated for 1989-90 in order to secure the full savings from the following year.

2. Rationalisation of duties. In all four hospitals some duties are undertaken by qualified nurses which should more correctly be undertaken by unqualified staff. Rationalisation will produce savings equivalent to the difference in salaries. It is anticipated that this proposal will be resisted, but it is hoped to introduce the new working arrangements during 1990-91 with full savings accruing from 1991-92.

3. Computerised patient information. It is proposed to introduce a computer system holding a central database of patient information and generating the paperwork for tribunals, reviews, etc. to ensure conformity with the Mental Health Act. It will become operational in 1990-91 and will save clerical and typing staff at each hospital.

4. Computerised food management. By January 1990, it is proposed to introduce a computerised food management system called "Feed Back" which manages menus on the basis of the stocks available. This system is already used in MOD and NHS establishments and significantly reduces food wastage. 10% savings in food costs are anticipated.

5. Computer developments in stock control, administration, personnel, payroll,and patients' cash. The continuing development of new technology in the special hospitals provides improvements in the quality of service and information. Developments proposed for 1990-91 are to improve the management of stock, eliminating some duplication of action; to reduce clerical and data processing tasks e.g. connected with implementing pay increases; and to introduce improved management information in line with the Resource Management Initiative. By 1990-91, it is anticipated that computerised systems for handling patients' cash will also provide staff savings.

6. Telecommunications. Improved systems, which have the capacity to monitor and log calls, should produce savings from 1990-91, but accurate forecasts of these are difficult.

7. Measures to be identified/agreed by the new Special Health Authority. See paragraphs 3 to 5 of Annex B. The new Authority will plan how these savings are to be achieved as an integral part of their consideration of the organisation and management of the service. It is hoped that further specific means of increasing efficiency will be identified to provide these savings. The alternative will be simply to operate with lower staff:patient ratios than planned (reducing standards of care rather than efficiency as such), but this clearly is not the preferred option.

<u>Youth Treatment Centres</u>

8. Shift working changes. Nurses attract premium payments if their duties fall within unsocial hours. This is not actual overtime as the extra payments are triggered within normal conditioned hours. In deciding groupworker deployments involving the various categories of profession in post, YTC management will seek to roster nurses in shifts which do not attract premium payments.

9. Recruitment of RCCO groupworkers. Residential child care officers (RCCOs) are the lowest paid professional group. Pending the agreement of a unified pay and grading structure between Treasury and the IPCS, priority will be given to recruiting RCCOs rather than teachers or nurses when filling vacancies.

10. Restructuring of working arrangements at Glenthorne. There will be some rationalisation of duties as between night staff and security staff which will reduce overtime payments.

11. Reduced use of agency staff at St Charles. Agency staff can be obtained at as little as 2 hours notice to cover crucial short term absences. However they are expensive. In future, greater use will be made of cheaper casual staff, restricting use of agency staff to genuine emergencies with a written explanation on each occasion they are used.

12. Reduced accommodation charges following disposal of staff housing at St Charles. St Charles has 13 off-site housing units which PSA wish to sell to staff as sitting tenants. Sale will mean the YTC will no longer have to pay for maintenance. Glenthorne's off-site accommodation has already been disposed of in this way.

13. Catering efficiencies. Glenthorne plans to achieve efficiencies by moving from central to unit kitchen facilities. St Charles will tighten its bulk purchase arrangements in association with local hospitals. The small savings reflect the small proportion of running costs spent on catering.

14. Maintenance savings. There will be a small saving in these costs at Glenthorne following a building refit by the PSA which is due to be concluded in 1991-92. One improvement will be the replacement of flat roofs by pitched ones, which should produce modest savings in maintenance costs, in addition to the energy savings already achieved following implementation of the Departmental Energy Officer's recommendations.

15. Post saved at St Charles from provision of open facility. This is dependent on Ministerial decisions. The SSI report recommended that there should be an open unit at St Charles. As extra provision, this would require more staff, but the working assumption is that it would be achieved as part of a broadly nil cost reorganisation between the two Centres, and that a small staff saving can be achieved.

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