PREM 19/1091

National Health Service Manpower Inquiry

[redacted]

Correspondence from Ralph Howell MP.

NATIONAL HEALTH

February 1981

PREM 19/1091

Referred to	Date	Referred to	Date	Referred to	Date	Referred to	Date
~~19.2.81~~							
~~25.2.82~~							
~~24.3.82~~							
~~16.3.82~~							
~~13.5.82~~							
~~22.12.82~~							
~~2.2.83~~							
~~11.3.83~~							
~~8.4.83~~							
~~18.5.83~~							
~~7.6.83~~							
~~16.6.83~~							
~~22.6.83~~							
~~26.7.83~~							
~~27.7.83~~							
15.11.83							
~~24.11.83~~							
2.12.83							

Dd 533270 5M 2/78 8362633 JET

Published Papers

The following published paper(s) enclosed on this file have been removed and destroyed. Copies may be found elsewhere in The National Archives.

National Health Service Reorganisation Act 1973, NHS Act 1977 and Health Services Act 1980: Accounts 1980-81
House of Commons Paper 279
HMSO, 19 March 1982

Signed C Wayland Date 18 April 2013

PREM Records Team

MSC

9 added Hurst to PM's visitors

DEPARTMENT OF HEALTH & SOCIAL SECURITY

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

Telephone 01-407 5522

From the Secretary of State for Social Services

Michael Scholar Esq
Private Secretary
10 Downing Street

27 July 1983

Dear Michael

NHS MANPOWER

You should know that the new manpower targets for the NHS are now being communicated to Regional Health Authorities, although on the basis that each Region is only being given its own figures. We have also made public the overall reduction which we are expecting of $^{3}/_{4}$ - 1 per cent between 1 April 1983 and 31 March 1984. This amounts to a reduction of some 6,000 - 8,000 staff. Because of the redistribution of resources between regions which is still taking place, the absolute reductions in numbers required will be greatest in the Thames Regions while some regions in other parts of the country will still be able to increase their staffing to cope with new developments. We do not propose to comment on individual regional figures which are indicative at this stage and subject to discussion between the Department and the Regions.

I attach brief speaking notes both on the overall reductions and the particular question of the reductions in numbers of nurses. The latter came up several times at Question Time on Tuesday when the Minister for Health refused to be drawn although it is certainly the case that the number of nurses will have to be reduced in some parts of the country.

Yours

S A Godber
Private Secretary

NOTES FOR THE PRIME MINISTER

REDUCTIONS IN NHS STAFF

We want to make the NHS more efficient and to get the best value for money from it. That means also making the best possible use of staff. To promote this, my rt hon Friend has asked Health Authorities to revise their plans for this year to achieve an overall reduction in manpower of between $^{3}/_{4}$ and 1 per cent in 1983/84. The saving will be greatest among staff not involved in direct patient care. In total, we expect the NHS to be employing 6,000 - 8,000 fewer staff by the end of the year. That is by no means an unreasonable target for Health Authorities to meet.

REDUCTIONS IN NUMBERS OF NURSES

We have to look for greater productivity from all NHS staff. Health Authorities should be reviewing their use of nursing manpower along with other groups. Indeed some authorities have already been planning to reduce the number of nurses they employ. It is not for me to predict what the right answer will be; that needs to be worked out locally.

KR

Mr. Scholar

DEPARTMENT OF HEALTH & SOCIAL SECURITY

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

Telephone 01-407 5522 ext 6981

From the Permanent Secretary

Sir Kenneth Stowe KCB CVO

Robin Butler Esq
10 Downing Street

26 July, 1983

Dear Robin.

I enclose an article on the Griffiths Inquiry which you may find interesting. It sets out his approach very well; first, you must say what it is you need to do to achieve your aims and only then can you decide both how many staff you require and how they should be organised. I think he has a lot to tell us.

Yours ever.

Ken.

For the first time since the NHS management inquiry was set up its chairman has spoken extensively about the team's progress. In an exclusive interview with Roy Griffiths, Stephen Halpern reports on the themes of the inquiry — general management, clinical budgeting and the delivery of care to the patient

I shld send a copy to Robin B. KW

The quality quiz

The Griffiths inquiry is not about instituting a tier of chief executives throughout the NHS or general managers or full time chairmen. It is about tracking down responsibility. While the NHS management inquiry set up earlier this year could end up recommending any of the numerous solutions already suggested by previous reports, it is at the moment still at the stage of asking questions rather than supplying answers.

Inquiry chairman Roy Griffiths is very careful to steer clear of the concept that he and his team are said to have taken on board. 'I've not talked specifically about the concept of a chief executive. But, he adds, his primary form of inquiry is 'to trace executive responsibility throughout the NHS — not simply executive responsibility but general management responsibility, that is who is bringing together all the factors which bear on any course of action'.

While Mr Griffiths and his team will be tracing the whole length of decision making in the NHS they appear to be concentrating on specific areas, namely at DHSS level and at hospital level, where the bulk of resources are spent.

At hospital level Mr Griffiths wants to develop a general management concept to establish who is exercising the overall responsibility for matching resources to the results which are trying to be achieved.

'I'm not interested in reorganisation'

But whatever changes his inquiry may bring Mr Griffiths says there will not be another structural reorganisation. 'I'm not interested in reorganisation,' he points out, adding: 'I believe that reorganisations should only be done rarely and then they should be done superbly well'.

'In the first place I'm talking about the spelling out of responsibilities and I think there are certain questions one has to ask as to whether responsibilities need to be reshaped. But I think it would be unacceptable to start making a lot of new appointments within the NHS — at least at hospital level.

Cliff Graham secretary to the management inquiry (left), and its chairman Roy Griffiths.

However, although he plans to spell out responsibilities within the existing structure, it is likely that his eventual report will be more than just fine tuning.

'Fine tuning implies that the whole of the music is already there, whereas in some cases I don't believe it is.'

The Griffiths team is also analysing the whole area of management budgeting. Mr Griffiths wants to go 'beyond clinical budgeting' because it tends to be limited just to those costs which relate to direct clinical activity.

He says most hospitals tend to have budgets broken down between functions. One can speculate that Mr Griffiths wants budgetary control to be linked directly to the type of managerial responsibility he wants to see at hospital level. While it would be an injustice to bandy about terms such as medical superintendent, it does appear that the managerial involvement of clinicians in deciding how to spend resources will be upgraded in some form.

Of course one could also speculate that the decision making will shift in an opposite direction and that a general administrator will directly control and manage a hospital or a given part of it. However, the political niceties of the NHS are a bridge that Mr Griffiths has yet to cross.

While the focus of the inquiry team is at the extremities of the chain of command, the regional and district roles will not be neglected. He does not feel it is necessary to take an axe to the intermediate management tiers.

In view of the fact that the NHS has 2,000 hospitals, he said, '14 regions and 190-odd health authorities may sound a lot but not in the context of a business as large as the NHS, particularly when you reflect that any one of those 14 regions would be in the top handful of British companies, in pure cost terms, if they were registered as businesses'.

Of course the one area that springs to mind when talking about the looseness of accountability is the position of authority members and chairmen in relation to officers. The Griffiths eye has already been cast in that direction.

'I don't think the nature of the job is sufficiently clarified,' he said, with regard to 'which decisions are to be retained at district level as distinct from what is being delegated'. He also wanted some clarification of 'the full role of the district chairman.

'Someone or some body of people have to take the general management responsibility for what is going on in the district, he said.

This part of the inquiry has prompted a rash of district chairmen to stand up at various conferences and talk about chief executives. However, this is not to deny the methodology of the Griffiths inquiry. They are still asking questions.

'Is that sufficiently spelt out?'

As Mr Griffiths puts it: 'How you structure that is the second question once you've answered the first which is "Is that sufficiently spelt out?" In order to alter things you you've got to understand the present position and that is by no means clear.

'I think the position of the district chairman in relation to the management team in executive terms isn't clearly spelt out'.

While the inquiry will run parallel to a number of small studies Mr Griffiths says his team has deliberately avoided setting up large working parties and bringing in consultants at an early stage. He says the work done on the NHS over the past 20 years is 'formidable' but, asked whether enough action has been taken over them he replied: 'The question is who was there to take action on the reports and that leads to the very first point of the inquiry which is "Where does the executive responsibility lie?"'

Mr Griffiths also believes management accountability has become less clear over the years. He says that when the NHS was established in 1948 there were clear lines of responsibility

through to the medical superintendent and the board of Governors. He sees the various superstructures set up since then as 'pulling responsibility from the hospitals'. Despite a lot of attention being given to organisation and structure Mr Griffiths feels less has been given to the management role.

He quite firmly wants to put decision making back at hospital level as far as possible and he concedes that there are many decisions which need to be taken outside the hospital but he hints that there are more than are probably necessary

Another theme of the Griffiths inquiry is the patient. He says: 'I see a major need to look at health care from the point of view of the individual patient and to see how things impact on him'.

For example, on matters such as the complexity of the NHS being delivered through several statutory bodies, Mr Griffiths does not believe that the patient would perceive them as such.

'Individual patients do not see the multiplicity of health care organisations. They believe that when they go to the doctor that they are just starting a whole process of medical care for themselves. The fact that it is being provided by a whole variety of different authorities is not wholly understood and perhaps should not be wholly understood by them', he says, adding: 'They simply want to be looked at from the point when they go to the GP to the point when they have finished their treatment'.

The answer lies in market research

The theme of the patient is brought up at every opportunity in the Griffiths inquiry. Mr Griffiths says that on his visits one constant question is: 'How well do you know patients are being looked after?'

The answer to this question, Mr Griffiths believes, lies in market research. He makes it quite clear that by treatment he means both clinical treatment and administrative treatment: how long people have to wait for appointments, the state of outpatient waiting rooms and so on will all be the subject of study.

He obviously feels the NHS has a little way to go in managerial terms if it is to match up to being the largest business in Europe but he is optimistic because of the attitudes he has encountered.

'There is a tremendous commitment to the NHS. People are quite clearly interested in the quality of service . . . and increasingly they are interested in the way reasonably limited resources are used to meet these requirements,' he says.

Mr Griffiths is independent minded enough to report what he feels is right and he has been given a wide brief by Secretary of State Norman Fowler. Nevertheless he is diplomatically polite about the Government over matters such as management cost reductions.

Of course the lack of sophistication in the way that much decision making in the NHS has been made is partly the reason why people like Mr Griffiths have been brought in. He is not unaware of the hostility that surrounded his appointment. 'This is one of the crosses I have to bear throughout the inquiry,' he says, and he admits that there are bound to be differences between running the NHS and a chain of supermarkets. But, he argues, there are certain universal characteristics covering all organisations. 'The NHS is like any other business in that it is seeking to achieve particular ends through the use of particular resources,' he says.

'This feeling that somehow there is a hard-nosed businessman handling private industry when what is required is a much more sensitive individual to handle to the NHS does injustice to both sides. The same process is required', he said.

Mr Griffiths is likely to make some form of recommendation to Mr Fowler in the Autumn and as yet the inquiry is a long way from coming up with detailed answers. 'We are still forming views on it. It would be arrogant after four or five months to suggest otherwise,' he says.

He is also careful to avoid the answers for the present because people will discuss issues such as the chief executive without looking at the whole problem.

While Mr Griffiths is anxious to avoid comments that will further fuel the endless speculation about his team's activities the very nature of his inquiries lend themselves to animated discussion.

While he gives some clues to what he might eventually want to see at hospital level, the same principle of nailing down responsibility becomes even more interesting when applied to what Mr Griffiths describes as the centre.

'This feeling that somehow there is a hard-nosed businessman handling private industry when what is required is a much more sensitive individual to handle the NHS does injustice to both sides. The same process is required.'

If for example the Department is seen as being unable to take executive responsibility for directing the NHS then what replaces it if it is thought there is an executive vacuum at the centre?

Again at health authority level the ridiculous ambiguity of the roles of members and officers has been on the most part cheerfully accepted over the years as being one of the many quaint eccentricities of British public life.

Like most things in the NHS the existing solution has been reached as a compromise between various competing power groups such as local authorities, the professions, central Government and so on. While the solution has possibly left an ineffectual means of executing authority it has achieved some sort of equilibrium between competing groups.

Plurality of interest groups in public sector

Any alteration of that balance could be fraught with difficulty. Perhaps one of the main differences that Mr Griffiths will encounter between the commercial and the public sectors is the plurality of interest groups that are attached to the public sector which could make the type of single mindedness associated with the commercial sector much more difficult to reproduce.

The other aspect of the Griffiths inquiry could sound like music to the ears of some NHS treasurers. At a conference on clinical budgeting some time ago a treasurer described how he had to be restrained from costing down to different specialties details such as the wear and tear on the lino in the corridors. His day may now have come.

Perhaps the ultimate in costing is to do more than present each patient with a nominal bill at the end of his or her treatment. While this would have the benefit of perhaps making people realise the cost of treatment it also has other inherent dangers such as if say a Government in a public expenditure crisis wanted patients to give a small contribution towards the cost of their acute treatment.

But perhaps the most beneficial aspect of the Griffiths inquiry is the emphasis it appears to be placing on the consumer. Possibly the greatest criticism that can be labelled against the NHS is that the comfort of the patient (as opposed to the treatment of the patient) has received too little attention.

Something that should have happened sooner

The market research projects into how patients see the NHS is something that should have happened sooner and should not have been left to CHCs to handle. However Mr Griffiths might do well to look at the CHC role.

What emerges from talking to Roy Griffiths is that he is moving in a fairly definite direction. The publication of *'Patients first'* laid the ground for health authorities to establish the organisation and the structure to devolve decisions downwards. What it did not do was to ensure that those decisions were taken in a sharper way which reflected the activity in a hospital. Who takes the decisions in the hospital is likely to be the hottest part of the inquiry's eventual report.

At the risk of coining yet another management platitude which does not do full justice to the inquiry team's efforts, it seems that the inquiry wants to identify an individual within a hospital who in simple terms is the boss. This is not easy task at the moment. Who they identify as the most appropriate person to take on that role will emerge over the next few months and that is when the fun will really start. □

NOTE FOR FILE

Mr Walker's letter of 20.6.83 to MCS has been returned to Mr Walker at his request.

6.7.83

CONFIDENTIAL

c.c.
WO
SO
NIO
Chf.Sec. Tsy.
CO

10 DOWNING STREET

From the Private Secretary

16 June, 1983.

NHS Management Inquiry

The Prime Minister has considered further your Secretary of State's minute of 16 May, to which was attached Mr. Roy Griffiths' letter to your Secretary of State of 12 May about the NHS Management Inquiry. She has also seen Leon Brittan's minute of 7 June.

The Prime Minister believes that Mr. Griffiths has accurately identified the areas in which action should be taken to improve the very poor management of the NHS. Mrs. Thatcher has commented that the present position in the Health Service is so appalling, and there is such a long way to go, that she would prefer to defer considering publication, both of Mr. Griffiths' preliminary progress report and of the eventual final report, until the remedies proposed have been more fully and more specifically worked out.

I am sending copies of this letter to the Private Secretaries to the other Health Ministers, and the Chief Secretary, and to Richard Hatfield (Cabinet Office).

S.A. Godber, Esq.,
Department of Health and Social Security.

CONFIDENTIAL

(1)

PRIME MINISTER

NHS MANAGEMENT INQUIRY

We have never responded to Mr. Fowler's note of mid-May about the NHS Management Inquiry. Should I write saying:

"The Prime Minister was grateful for your minute and Mr. Griffiths' preliminary progress report. She has also seen Leon Brittan's minute of 7 June.

"The Prime Minister believes that Mr. Griffiths has accurately identified the areas in which action should be taken to improve the very poor management of the NHS. * But she found his report - necessarily, no doubt at this stage - sketchy and * would prefer to defer considering publication until these ideas have been more fully and more ~~concretely~~ spectfully worked out."

N.B.

Ferdie Mount agrees with this line.

MCS

15 June 1983

* But the present position is so appalling and there is such a long way to go that - the *

N.B. Having been in power for 4 years we must take some of the blame for this state of affairs. Let us be sure of the remedy this time. Publication at this stage would be unwise.

Nat. Health

(2)

Prime Minister

Rather a rather striking work!

PRIME MINISTER

Told Mr Fowler's office (Mr Godber) and Sir K Stowe.

NHS MANAGEMENT INQUIRY

Norman Fowler sent me a copy of his minute to you of 16 May covering Roy Griffiths' preliminary progress report.

2. I think the report is excellent. It describes the major and difficult issues with clarity and crispness, and carries with it an enthusiasm for progress which augurs well for the more difficult task of translating the issues into action. Moreover, it recognises, as we have found with the FMI, that progress is not simply a matter of changing mechanics. More important and more time consuming is the need to change ingrained habits and attitudes. I agree with Norman that Roy Griffiths and his team deserve our congratulations, and every encouragement for the next stages of their work.

3. Norman, quite rightly, did not want the Inquiry to become an Election issue. But I think we should consider publishing the report, or a summary of it, once the Election is over. It could encourage constructive debate within the NHS, and dispel speculation about the course of the Inquiry. I would be very much guided by Roy Griffiths' views on this.

4. I am sending copies of this minute to Norman Fowler, Nicholas Edwards, Jim Prior and George Younger and to Sir Robert Armstrong.

J Gieve

for LEON BRITTAN
7 JUNE 1983

[Approved by the Chief Secretary]

Nat Health.
Feb '81. NHS
Manpower Inquiry

FILE RM

B/C NCNEN.

10 DOWNING STREET

From the Private Secretary

18 May, 1983

NHS MANAGEMENT INQUIRY

The Prime Minister has read without comment your Secretary of State's minute of 16 May, with which he enclosed Mr. Roy Griffiths' preliminary progress report on the NHS Management Inquiry.

M. C. SCHOLAR

S. Godber, Esq.,
Department of Health and Social Security

(2)

Prime Minister

To note

LC N.O.

I find too much emphasis here on how well the team are getting on with the NHS and how useful they are finding existing studies. The sharpest statement is at X on p 3. I have highlighted the sentences most likely to generate action; but there a great number of words in this rather short letter.

MS! MLS 17/5

PRIME MINISTER

NHS MANAGEMENT INQUIRY

You agreed at the beginning of February that I should launch an Inquiry, by a team of top businessmen, into the effective use and management in the National Health Service of manpower and related resources. The Team has made even more rapid progress than I asked, and I now enclose Roy Griffiths' preliminary progress report to me, which I find most constructive and encouraging.

2. Roy Griffiths and his team have identified some key areas of NHS management in which changes and improvements are needed. They propose to examine these in more detail over the next few months, and to let me have specific recommendations for action this Autumn.

3. I have discussed the Team's proposals with them and I strongly support the line they are taking, which underlines our strong commitment to improve management in the NHS. It is clear that we need to strengthen management responsibility throughout the health service, to restore a sense of purpose to all its activities and to ensure that the patient and the community as a whole get the best possible service from the resources that we have provided.

4. I have been greatly impressed by the way in which the Inquiry Team have applied their extensive knowledge and experience of business to the underlying issues of NHS management which have been causing us concern. The Team has already won respect and confidence in the health service and in other quarters such as the Royal Colleges. They are action orientated and are well exceeding our original expectations of them, in terms of time and effort, despite their continuing heavy responsibilities in business. They therefore deserve our congratulations for their dedication, determination and resolution.

E.R.

5. I do not envisage publishing this progress report nor making the case for the Management Inquiry into an issue in the Election: Roy Griffiths himself would I think feel embarrassed by that. I am impressed by the strong and widely-based support which he has secured from the NHS for his approach and I have asked him to press on with his studies in order to maintain the momentum.

6. If any of the Opposition parties make the Griffiths Inquiry into an issue in the Election, I would propose to respond on the lines of the second and third paragraphs of this minute.

16 May 1983

N F

NHS MANAGEMENT INQUIRY
Room D408
Alexander Fleming House
Elephant and Castle
London SE1 6BY

Telephone: 01 407 5522 X7684/ 6604

Leader of Inquiry:

Roy Griffiths

Team Members:

Michael Bett
Jim Blyth
Sir Brian Bailey

Support Staff:

Cliff Graham
Kay Barton

Secretary of State for Social Services
Department of Health and Social Security
Alexander Fleming House
Elephant and Castle
London SE1 6BY

12 May 1983

Dear Secretary of State

When the Management Inquiry was launched in February I was asked to advise by the end of June on the progress made by the Inquiry Team towards recommendations on the effective use and management in the NHS of manpower and related resources. Over the past 3 months we have reviewed the current central initiatives relevant to our task and engaged in a full round of activities, involving visits to many NHS and other locations and central Departments and other interest groups. In addition, we have received a full body of mail, particularly from clinicians. We have gained widespread support for our work from within the NHS and the Department, and from outside bodies such as the Royal Colleges. Accordingly, my colleagues and I have been able to reach some preliminary conclusions which are set out below. We aim to submit a further report early in the Autumn, with more specific proposals for implementation in the NHS, if you are content with our first thoughts.

You have required us to propose action not write reports. We are impressed both by the number and by the quality of the many reports and initiatives over the years designed to tackle management problems within the National Health Service. But the recurring question in our minds in considering these reports, and what happened to them, is who at each level within the NHS can take effective action on the recommendations. It is against this background that we propose the following main areas for further work, on which we shall be making more specific recommendations at a later date.

1. Management responsibility from the centre right through to the unit should be clarified and strengthened, especially the general management role of executive leadership at each level of organisation, which ensures and directs that action is taken in accordance with clear plans and objectives and accepts personal responsibility for progress or the lack of it. This is absolutely necessary to provide the appropriate initiative, vitality and urgency at all levels. It will involve an examination of:

    a) responsibility at the centre for management of the NHS; to clarify much more precisely and purposefully who exactly is responsible for the essentials of management ie planning, implementation and control. In particular, executive leadership needs to be strengthened;

b) the role of the clinicians in management at and within unit level; to ensure that their management responsibility is matched appropriately to the power which in fact they exercise in dictating the use of resources. This is already the subject of speedy and purposeful study at local level, tracing the treatment and administrative handling of the patient;

c) the management role of the Chairman, Members and Chief Officers in the regions and districts; to distinguish more clearly their separate requirements. The appointment of Chairmen and Members will also be examined. There is much uncertainty over the role of the Authorities themselves : as to what matters should be referred to the Authority at its regular meetings and what should be delegated by way of executive authority to the Chairman and Officers. The ability of consensus management to provide firm, speedy and decisive action at all levels also needs to be examined. Local management action is made more difficult because the primary reporting relationships of the professional officers, forming part of the management team, are to their functional counterparts at higher levels. This militates against a local management identity and we want to establish whether it has led to over-manning in the professional functions;

d) the management links to the FPCs and the community, particularly at Unit level.

2. A system of management budgeting within the units and particularly in the clinical divisions and teams needs to be devised and introduced. Delivery of appropriate standards of care to the individual patient or patients is the primary unit of cost on the Health Service and budgets need to be set up to reflect this. This is not an accounting device, but a process of attributing overhead costs to the clinical budgets which will sharpen up the questioning by clinicians about efficiency in the use of resources. It is absolutely essential if levels of support staff are to be managed efficiently. Work in this area will take account of existing DHSS work on the financial management initiative and NHS work on clinical budgets and specialty costing. It will also comment on the applicability and relevance of the "Körner" report on health services information and the "Salmon" report on NHS audit.

3. The field of personnel and industrial relations is important, but the immediate remit of the Inquiry is not concerned with specific I.R. problems or detailed questions of pay determination. Two areas will be examined:

a) the Whitley system, to see what constraints it imposes on the operational flexibility of devolved management in the NHS. The purpose would be to identify in what ways the system might at present impede effective management or prevent changes that might be required;

b) the various central initiatives on manpower planning and control, in the context of devolved management in the NHS.

4. An examination of delegated decision taking within the NHS, and between the NHS and the Secretary of State acting through the Department, should be undertaken. Most of the units at hospital level are large enough to be self standing in management terms and enormous frustration can be caused if there are too many levels of authorisation involved in decisions. We intend to undertake immediate studies in each of the main decision areas of management activity, ie capital authorisation, revenue expenditure, personnel, etc to see to what extent the process can be streamlined.

One or two final points. Clearly none of the above implies reorganisation of the National Health Service. Our proposals will embrace the many efficiency initiatives already being progressed, including the requirement on Authorities to make efficiency savings on an annual basis as part of the allocation of finance. But this work will be geared to ensuring that the NHS itself can achieve efficiency as part of its routine and on-going work and that all members of staff are motivated and trained to accept this. The present level of achievement of the NHS is set out in the recent publication "Health Care and its Costs". There are big opportunities for local management to do even more to enhance the quality of service and ensure greater individual patient satisfaction and improved service to the community. You are encouraging management within the NHS to be much more ambitious in its setting of priorities and in reviewing the need for present levels of resources. Management would need to be motivated to achieve these ambitious targets, by being allowed to use savings so generated, at least in part, to secure improvements in service. As things stand at present, we can only venture the comment that the level of improvement in efficiency which is currently being required in the NHS would be regarded in the private sector as so modest as to be almost a denial of the management process.

Contrary to our initial concern, that we might meet with difficulty in securing co-operation, we have been greatly impressed by the ready response of the many people we have been talking to in the course of our inquiries. As you know, we are undertaking studies at hospital level in different parts of the country : in this work we have received the active collaboration of the clinicians and other NHS officers concerned and the Royal Colleges and other national professional institutions.

health services information and the "Salmon" report on

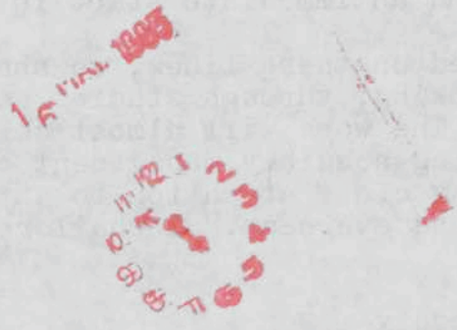
We are confident that further work on the above lines will enable us to formulate more precise recommendations for implementation within the NHS. There can be no doubt that the overall implementation, particularly the strengthening of line management, will be a long and challenging task simply because of the size of the NHS. But the whole emphasis of this letter is on the need for action and an immediate start is essential.

If you are content for us to proceed on these lines, we shall continue to test our ideas and develop our thinking, through studies and discussion with the NHS and your Department. The work will almost certainly involve the use of other resources, including possibly management consultants on specific studies. We shall also pay close attention to any relevant examples from the private sector and overseas. I shall report to you again early in the Autumn.

Yours sincerely

Roy Griffiths.

E R GRIFFITHS



Personal.

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

4 May.

FRCB

Dear Robin,

It was very kind of the Prime Minister to take us back into No 10 "family" after the CBI dinner. It was most enjoyable.

I entrusted, you will recall, dear Roy Griffiths of Sainsburys, whom we have got working on our NHS management enquiry. In due course the P.M. will be receiving an interim report which he has written for Norman Fowler. Meanwhile, you

might find it of interest to see
the enclosed first Draft of it.
You will recognise one or two
thumbprints of mine in it.

I remain enthusiastic.

When Roy G. reports — probably
in September - I think we shall
get something good - not comfortable
but worth having.

As ever.

Ken.

F. E. R. Butler Esq.
10 Downing St.,

The Managing Director's office

SAINSBURY'S

J Sainsbury plc
Stamford House
Stamford Street
London SE1 9LL

01-921 6000

Telex 264241

To Sinclair.

PERSONAL

22nd April, 1983

Rt. Hon. Norman Fowler, M.P.,
Secretary of State for Social Services,
Department of Health & Social Security,
Alexander Fleming House,
Elephant & Castle,
LONDON,
S.E.1. 6BY.

Dear Mr. Fowler,

We are meeting next Monday evening at Stamford House, to discuss the work of the Inquiry Team and seek your guidance on what you might be expecting from me in the way of a preliminary progress report. I am aiming to let you have such a report by the end of next month.

As you know, the Inquiry did not get started in practice until two months ago so we are still at an early stage of our discussions with the NHS and of our work within your Department. Nevertheless, we are reaching preliminary conclusions and I thought it might help us structure the discussion if I let you have the attached note of matters which might find their way into our report. The only thing I can be certain of at this point is that the progress report - or action timetable - will be much shorter than the attached note, unless you really want something longer!

The detailed content of the attached note could well change in the light of our further discussions, but I doubt if this will affect the main areas of management activity identified for further action by the Team.

/ Cont....

Rt. Hon. Norman Fowler M.P. 22nd April, 1983

On this basis, it would therefore be most helpful if we could use next Monday's discussion to clarify our minds on what you really require from us next month, and by the end of September when I hope to make my next report to you, and what we think we can realistically undertake to provide.

For obvious reasons, I do not wish this draft note to go any further at this stage: it has been produced hurriedly to provide points for discussion at next Monday's meeting. On the same basis, I am sending personal copies to Kenneth Clarke, Ken Stowe and John Evans.

Best wishes,

Roy Griffiths

E.R. GRIFFITHS

Enc.

CONFIDENTIAL

NHS MANAGEMENT INQUIRY : BACKGROUND NOTE FOR TEAM DISCUSSION WITH THE SECRETARY OF STATE ON MONDAY 25 APRIL 1983

MAIN TASKS

1. The Secretary of State has described the main task as follows:

1.1 to examine the ways in which resources are used and controlled inside the health service, so as to secure the best value for money and the best possible services for the patient;

1.2 to identify what further management issues need pursuing for these important purposes.

GENERAL OBSERVATIONS

2. In making their comparisons between business management methods and those to be found in the NHS, the Team have been faced with three apparently fundamental differences between management in the NHS and that of business:

2.1 there is no profit motive in the NHS : this is undeniable but it reveals a misunderstanding of the great similarity between the "business" motives of the NHS and companies, for example both organisations are interested in:

- satisfying the customer's real needs;
- securing a satisfied, well trained, well motivated and well rewarded workforce;
- meeting the needs of the ultimate owner - shareholders in the case of the company, Parliament and the public in the case of the NHS;
- achieving the best possible balance between short and long term objectives, investment, performance and return;
- delivering to the client the highest quality of services or products;
- engaging in sufficient research and development to sustain the long term viability of the undertaking.

It is therefore against the background of the great similarity of business management objectives between the NHS and companies that the apparent difference over the question of "profit" has to be judged : even the NHS has to earn a 'profit' for its customers, by delivering them an ever increasing level and quality of service without incurring high penalties in terms of vastly increased taxation;

2.2 the NHS operates on a concept of consensus management which is not found in business. Consensus management is to be found in companies, in the sense that all major issues are subjected to multi professional discussion and consultation before a decision is reached. The difference of approach in the NHS is that the process of consensus is also carried through to the point of management action itself. There is no unalterable reason why this should be the case : RHAs and DHAs, and to some extent the Department and Parliament, operate on the basis of consensus in order to satisfy the democratic, political and representational aspects of health care considerations; and to explore the major issues of strategic planning and resource allocation. There exists no firm requirement that the consensus approach must also condition the management action itself or that it must apply to the internal management of hospitals. Business management also draws a clear distinction between boardroom policy discussion and decision and management executive action.

2.3 there is as yet no Unit management structure in the NHS because the 1982 Reorganisation has not had time to take effect in this respect eg unit managers are still being appointed and management structures have yet to be devised. This apparent disadvantage, in the sense that in general it has not been possible for the Team to observe an existing and well established management process at work inside the Unit, has been turned to advantage by the Team's main proposal that DHAs and District and Unit Management Teams should be provided with further guidance on this before the cement sets on the 1982 Reorganisation. Drawing on their business management experience, the Team suggest that such guidance might include the following:

- the existing competition for resources between different medical firms within the hospital should be made more explicit through the development of management budgets at the level of the medical firm within the hospital;

- the whole hospital management budget should be produced, in the context of the DHA/DMT guidelines, within the Unit;

- ultimate responsibility for resolving disagreements, making final decisions, securing implementation of agreed management action and being accountable for management performance should be vested in one clearly identified person at Unit level;

- the executive responsibilities of the Chairman, Members and Officers of the DHA, and of the Unit Managers, should be clearly spelt out, on an individual and corporate basis.

3. The Team are determined to identify the means of securing effective management action by the NHS itself; not to reinvent the wheel by setting up yet further Working Parties to write even more reports, which in many cases have become a substitute for management action itself. In examining the executive role throughout the service the Team are

concentrating their attention on the Unit level of management and on the DHSS (with further observation at RHA and DHA levels). This tends to bring into question the management structure at all levels but the manifestations of this are different in different places. For example:

3.1 At the hospital level, there is a great deal of functional management and some moves towards greater involvement of the clinician in management but the extent of co-ordination required suggests the lack of a clear executive role, for which co-ordination can provide no substitute. Existing management of the hospital requires its most junior level of administrator ultimately to give effect to the requirements of the Secretary of State, RHA and DHA, by influencing and changing the management practices of its most senior and influential section of staff - the clinicians, who operate on the shop floor and not in the Centre. There is a clear need to build on the "Cogwheel" initiatives of the early 1970s, so that the clinicians can take the leading role in management at the unit level, as the discipline which dictates and directs the use of resources throughout the Unit.

3.2 At the DHA and RHA similar difficulties can be observed : chief officers head functional departments with, recently appointed, part-time Chairmen attempting to provide executive leadership. This functional management approach, which diffuses responsibility for taking action, is further accentuated by the reporting relationships from specialist officers at the local level, eg works and catering, to their specialist colleagues at District, Region and, even, the DHSS.

3.3 At the centre, the functional pattern tends to be repeated; but over and above that there is the problem of other disconnected responsibilities. Ministers and the Permanent Secretary cannot spend all, or even most, of their time on NHS management; and many of their senior officials carry responsibility for major specialist functions and not NHS management as such. There can therefore be even less strong and continuing executive drive from the centre than can be secured from the RHA, DHA and Unit level, except where particular people have decided to take on this role almost by sheer force of personality.

4. The primary question to be addressed by the Team, on a total health service basis, is therefore the clarification of the executive role from the centre to the periphery. This matches the feeling of Parliamentary and other outside concerns, and of the Accounting Officer, which led to the appointment of the NHS Management Inquiry in the first place. But although the primary concern is with executive action - characterised by direction, initiative and urgency - an important secondary question is to comment on the basic mechanics by which the essentially simple processes of deciding on policy, its implementation and control, are set up.

5. Businessmen would normally concentrate on clearly spelling out the executive management responsibility of named individuals and then back this up with a good, not necessarily sophisticated, process of management budgeting. The concept of "management" budgeting gets away from a primary concern with the financial aspects and sets out the objectives and responsibility for delivering health care at all levels. This is then translated into the required resources, within financial and other guidelines already provided, and finally results in firm cash budgets. A good deal of work has already been done by the NHS, with a current emphasis on clinical budgeting. If the clinicians collectively are to be regarded as primarily responsible for delivering the service then, in addition to the normal process of functional budgeting, they should be involved in a system of management budgets. These budgets would be structured according to the management responsibilities of the clinical teams, divisions and committees and build on the "Cogwheel" approach to medical organisation and management. They would contain not only direct costs within the immediate control of the clinicians but also the costs of resources dictated by clinical activity (eg beds, nurses, professional support, functional departments etc) and a proportion of the total hospital overheads.

6. The Team regard the concept of the management budget as most important. It is not simply, or even mainly, an accounting exercise : it is designed to sharpen up the questioning by the people who should be regarded as the real managers of the local business, the clinicians, about efficieny in the use of resources generally. They would appreciate that only by questioning more closely indirect costs, eg functional departments, could they release more real resources for direct patient care. At present, the incentive must be for all non-medical staff to concentrate on providing a service within the resources allocated to them, mainly on an historical basis, instead of being motivated by a driving urgency to carry out existing services at a lower cost or provide improved services at the same cost.

7. In starting their consideration at the Unit level the Team recognised that:

7.1 it is at and below Unit level that most of the resources are consumed and the patient is treated;

7.2 it is at that point in the management chain that the consequences of the lack of a clear executive role can be seen most clearly. The absence of real executive authority, coupled with the requirements of consensus management and the overlapping roles of Chairmen, Members and Officers, provides a recipe for ineffective management activity, which the District Chairmen (helped by the management team) are in many cases trying to fight against;

7.3 the Cogwheel reports in the late 1960s/early 1970s point the way forward but they need further development and updating in the light of existing practice; and,

7.4 there has been no national report or major initiative in terms of the internal management of the hospital service since 1954 (Bradbeer Report).

8. Against this background, and subject ot further discussion with the N[illegible] and DHSS, the Team are inclined to propose further action along the following lines.

GENERAL MANAGEMENT ACTION

8.1 Clarify and strengthen the line of executive authority and management action from the centre to the Units of Management, especially to hospitals at the periphery. This is particularly important given the impending independence of FPCs, the management consequences of which the Team will be inquiring into.

8.2 Distinguish more clearly the different roles of the RHA/DHA Chairmen, Members and Officers. Strengthen the role of the RHA, as the main subsidiary company responsible to the Secretary of State for the delivery of the total health service within the Region. Identify the Unit, as the executive arm of the DHA responsible for securing the necessary management action.

8.3 Develop Unit management budgets, to show the full consequences of the clinical activity, including support services and administration and overheads, proposed by the clinicians.

SPECIFIC MANAGEMENT ACTION

9. The Team have decided to settle for six major management areas for further inquiry, in the light of their first quick survey of the whole scene. These main areas are as follows:

9.1 Internal Management of the Unit, with particular reference to the role of the clinician in NHS management, including management links to the newly independent FPCs and the community. The Team propose to inquire further into these matters by launching purposeful and speedy studies at hospital level in 6 or 7 different parts of the country, with the active co-operation of the clinicians and other officers concerned.

9.2 Management budgets within the Unit, including ways of involving clinicians in the budgetary system so that they can take a central role in NHS management. The Team propose to engage the services of management consultants for this purpose once they have finalised the detailed brief. This will take account of existing DHSS work on the financial management initiative and NHS work on clinical budgets, specialty costing, Körner and Salmon.

9.3 Manpower Use, Management and control within the Unit, including further development, or otherwise, of the Personnel Management function. They will be examining in particular the possibilities of increasing local management responsibility and accountability in place of existing central initiatives.

9.4 The Whitley system. In the light of the current DHSS review and numerous recent reports, the Team intends to examine the scope for introducing further operational flexibility into the system. The Team's purpose is not to review the Whitley system as such, but to examine in what ways it may at present impede effective management or prevent any management changes that might be required; or otherwise provide alibis and excuses for ineffective local management.

9.5 The Management Role of Chairmen, Members and Chief Officers, including the process of appointing Chairmen and members and the career development of Chief Officers and others. The Team will be considering a comprehensive paper to be put to them shortly by Ministers.

9.6 The central responsibility for NHS management, including that of Ministers and the Department.

NEXT STEPS

10. Subject to the views of Ministers, the Team would propose to submit a preliminary progress report at the end of May and a further report by the end of September. Subsequent activity will extend beyond September and will be undertaken in three main phases : first, further validation of the issues covered in this note; second, some testing of these ideas in practice, with particular reference to the hospital-based studies; and third, firm proposals for implementation.

File Nat Health BM

cc: DHSS

10 DOWNING STREET

THE PRIME MINISTER

13 April 1983

Dear Ralph

Thank you for your letter dated 14 March about the NHS Management Inquiry and other NHS matters.

I note what you say about the NHS Management Inquiry and I am glad that you were so greatly impressed with Roy Griffiths. I have now also seen his reply to you dated 31 March. I understand you have discussed all your concerns with Norman Fowler and Kenneth Clarke and they have agreed to continue to keep you in touch with these events. I think therefore it best to leave these matters to them at this stage.

I should add that, on your particular point about the DHSS staff support for the Inquiry, both Norman and myself very much agree with Roy Griffiths. Your quotation from my letter dated 11 October 1982 refers to the team of businessmen not the administrative support staff. You will see from the enclosed press statement that the NHS Management Inquiry Team is made up entirely of high level businessmen from outside Government and the NHS. Roy Griffiths is free to bring in other outsiders, including management consultants, if he so wishes. It would be very difficult for a team of outsiders such as this to operate without assistance from DHSS and I therefore think it is important to have a DHSS officer in charge of the support staff. Roy Griffiths has made it quite clear that he supports this arrangement and he knows that he can both change the leader of his support staff and bring in outside support if he wishes. Indeed, I understand

/ Jim Blyth

DHS

Jim Blyth has already decided to bring in such support from United Biscuits to assist him with one of his tasks.

I still feel that if you have criticisms of the Comptroller and Auditor General and his Department it would be best to refer these to the Public Accounts Committee. But naturally we intend our Inquiry to determine whether the manpower and other resources of the NHS are used effectively.

Yours ever

Margaret

Ralph Howell, Esq., M.P.

Department of Health
and Social Security

PRESS RELEASE

Alexander Fleming House
Elephant and Castle
London SE1 6BY

Telephone 01-407 5522

83/30

3 February 1983

NHS MANAGEMENT INQUIRY

Four leading businessmen are to conduct an independent Management Inquiry into the effective use and management of manpower and related resources in the National Health Service. The Inquiry Team, under the leadership of Mr Roy Griffiths, Deputy Chairman and Managing Director of Sainsburys, have agreed to advise Norman Fowler, Secretary of State for Social Services, on progress by the end of June this year.

Mr Fowler announced the management inquiry in reply to a written parliamentary question from Mrs Jill Knight MP for Edgbaston this afternoon (Thursday) which asked him if he would make a statement on what plans he has to control manpower in the NHS. Mr Fowler said:

"I have today established an independent NHS Management Inquiry into these matters. Health authorities in England have a revenue budget of almost £9 billion; employ about a million people; and spend almost 75% of their revenue on pay. The Government needs to be satisfied that these considerable resources are managed efficiently and give the nation value for money. The Inquiry will be led by Mr Roy Griffiths, Deputy Chairman and Managing Director of J Sainsbury PLC. Mr Griffiths will be assisted by Mr Michael Bett, Board Member for Personnel at British Telecom, Mr Jim Blyth, Group Finance Director of United Biscuits, and Sir Brian Bailey, Chairman of Television South West and of the Health Education Council and formerly Chairman of South Western Regional Health Authority. As my expert advisers, they will give me advice, on the effective use and management of manpower and related resources, as their enquiries proceed. We aim to make the earliest possible impact on the management of the NHS for the benefit of patients and the community as a whole. Mr Griffiths will advise me on progress by the end of June 1983."

The Inquiry Team will be supported by a small group of staff led by Mr Cliff Graham, an assistant secretary at the Department of Health and Social Security. The support staff will also include health service experience and private sector expertise.

Mr Griffiths has not been asked to prepare a report nor will the Team act in any way like a Royal Commission or Committee of Enquiry. The Team will advise on what more needs to be done, within existing resources, to secure the most effective use and management of NHS manpower and related resources. They will identify major management issues for examination by individual team members and the support staff and will transmit their findings to the Secretary of State for early incorporation into NHS and DHSS management practice.

In commenting on the Inquiry, Mr Fowler said:

"Over the last four years this Government has devoted extra resources to the NHS. Next year we will be spending nearly £13 billion on the NHS in England. That represents a real increase in services of 7½% and an increase of 17% against the Retail Price Index. But what matters most is the actual services the patients are getting for this money and the way in which the delivery of these services is managed by the NHS.

"In 1979 we therefore embarked on the essential task of strengthening the management of the NHS and improving its efficiency and effectiveness in the interests of the patients. First, we slimmed down the structure of administration to cut out unnecessary bureaucracy. Second, we developed a new framework of public accountability and review, to clarify and make more effective the management chain from the District to the Secretary of State. Third, we launched a whole series of initiatives, aimed at improving the management efficiency of the NHS; including NHS manpower targets, the development of NHS performance indicators and the introduction of financial targets for efficiency savings.

"What we need to be sure of is that in practice this whole management process is working properly and that it produces, for both patients and public alike, the best possible service from the very large resources allocated to the NHS.

"We are therefore now setting the Inquiry Team two main tasks:

- to examine the ways in which resources are used and controlled inside the health service, so as to secure the best value for money and the best possible services for the patient;

- to identify what further management issues need pursuing for these important purposes.

"We could simply have set up another Royal Commission and then sat back for several years to await its lengthy report, but on past experience that would not lead to effective action. Instead, we have gone straight for management action, with the minimum of fuss and formality. I am grateful to Mr Griffiths and his colleagues for agreeing to carry out this task."

NOTE FOR EDITORS

Mr Griffiths has been Deputy Chairman and Managing Director of Sainsburys since 1979. He joined the company in 1968 from Monsanto Europe, where he was a Director. He became a Director of Sainsburys in 1969 and Deputy Chairman in 1975.

Mr Bett has been on the Board of British Telecommunications since 1981. He was previously Director of Personnel at the BBC.

Mr Jim Blyth, is Group Finance Director of United Biscuits

Sir Brian Bailey is Chairman of the Health Education Council and was, until the end of last year, Chairman of the South Western Regional Health Authority. He is Chairman of Television South West and was an official of NALGO for many years.

VP

DEPARTMENT OF HEALTH & SOCIAL SECURITY

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

Telephone 01-407 5522

From the Secretary of State for Social Services

Willie Rickett Esq
Private Secretary
10 Downing Street
London SW1

11/4/83

Dear Willie

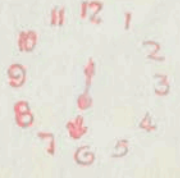
In your letter of 16 March you asked for a draft reply for the Prime Minister to send to Mr Ralph Howell following his letter of 14 March about the NHS Management Inquiry. As you know, it was agreed that we would provide a draft after Secretary of State and Mr Clarke had met Mr Howell and Mr Stainton on 30 March. A draft reply is now enclosed.

I am copying this letter and enclosures to Judith Simpson at the Treasury.

Yours ever

MRS C L SOUTER
Private Secretary

Enc



TH

DRAFT LETTER FROM THE PRIME MINISTER TO RALPH HOWELL MP

Thank you for your letter dated 14 March about the NHS Management Inquiry and other NHS matters.

I note what you say about the NHS Management Inquiry and I am glad that you were so greatly impressed with Roy Griffiths. I have now also seen his reply to you dated 31 March. I understand you have discussed all your concerns with Norman Fowler and Kenneth Clarke and they have agreed to continue to keep you in touch with these events. I think therefore it best to leave ~~all~~ these matters to them at this stage.

I should add that, on your particular point about the DHSS staff support for the Inquiry, both Norman and myself very much agree with Roy Griffiths. Your quotation from my letter dated 11 October 1982 refers to the team of businessmen not the administrative support staff. You will see from the enclosed press statement that the NHS Management Inquiry Team is made up entirely of high level businessmen from outside Government and the NHS. Roy Griffiths is free to bring in other outsiders, including management consultants, if he so wishes. It would be very difficult for a team of outsiders such as this to operate without assistance from DHSS and I therefore think it is important to have a DHSS officer in charge of the support staff. Roy Griffiths has made it quite clear that he supports this arrangement and he knows that he can both change the leader of his support staff and bring in outside support if he wishes. Indeed, I understand Jim Blyth has already decided to bring in such support from United Biscuits to assist him with one of his tasks.

Obviously I still feel that if you have criticisms of the C— and A—G— and his Department it would be best to refer these to the P— A— C—. But Nationally we intend our Inquiry to determine whether the manpower and other resources of the NHS are used effectively.

The Managing Director's office

SAINSBURY'S

J Sainsbury plc
Stamford House
Stamford Street
London SE1 9LL

01-921 6000

Telex 264241

31st March, 1983

Ralph Howell, Esq., M.P.,
House of Commons,
LONDON,
S.W.1A OAA.

Dear Mr. Howell,

Thank you very much for sending me a copy of your letter of the 15th March to the Prime Minister. I believe it was explained to you that I have been away from London (albeit not altogether away from the work of the Inquiry) until this week.

I enjoyed the meeting with yourself and Mr. Stainton. You left me in no doubt as to your concern on manpower in the NHS and on the question of executive authority at the centre. I explained to you the nature of our initial work and am convinced that we are working purposefully on the right lines.

It was very good of you to comment favourably in your letter on our meeting and on myself. I do, however, again assure you, in view of your expressed doubts as to whether a Civil Servant could be sufficiently open minded and independent to head up the support team, that I am quite happy with the position. I was clearly aware of the possible disadvantages of such an appointment, but I concluded that it was vital to have this type of support to facilitate work with the DHSS. The individual concerned, Mr. Cliff Graham, has enormously impressed me, not only with his ability, but by his objectivity and commitment to the work

/ Cont...

envisaged. I make the latter comments as a very considered assessment and not simply as a gesture of reassurance to you.

I have not copied this letter to the Prime Minister, but am quite happy that either you or Norman Fowler, to whom I am sending a copy, should use it as appropriate in discussion with No. 10.

Very best wishes,

Yours sincerely,

E.R. GRIFFITHS

cc. Rt. Hon. Norman Fowler

Jenkins 4/6/4
Before passing this on to PS/Chancellor you will need to get backing papers from Judd

FROM: C H A JUDD
DATE: 25 March 1983

MR DURRANT - MCU

cc Mr Allwood
Mr P M Rayner
Mr Heaver

6 APR 1983

MR HOWELL'S LETTER TO THE PRIME MINISTER
OF 14 MARCH

We never saw what the Prime Minister wrote following the draft provided with Miss Rutter's letter of 22 September but I understand from Mr Scholar that it omitted para 2 of that draft. Mr Howell's new letter suggests that para 4 was followed.

... 2. There is little to add. A draft response to No.10 is attached.

C H A JUDD

PS/ ~~PS~~ FST (M3) C/4

As the FST was quite closely involved in the earlier round of correspondence (see flag A), you may wish to see.

JJ.
6/4/83

DRAFT LETTER TO NO.10 (copy DHSS)

The Treasury does not think it necessary to rise to Mr Howell's further remarks about the C & AG, E & AD and PAC. The Prime Minister's point was that since these bodies carry out external checks on behalf of Parliament (as the St. John-Stevas Bill insists) it is not for the Government to respond to him.

Departments do not of course expect to rely on Parliamentary investigations to discover waste. Their internal management and audit should prevent or discover it first. The Government is strengthening financial management, including internal audit, across all departments.

(1) 11/4 Ralph Howell, MP. 28/3 Ref

10 DOWNING STREET

From the Private Secretary 16 March 1983

I enclose a copy of a letter the Prime Minister has received from Mr. Ralph Howell, M.P.

I should be grateful if you would let me have a suitable draft reply which the Prime Minister might send to Mr. Howell by Monday, 28 March.

I am copying this to Jill Rutter (HM Treasury) since you may wish to consult her over the drafting of the reply because of Mr. Howell's criticisms of the C&AG and the Exchequer and Audit Department.

W. F. S. RICKETT

D.J. Clark, Esq.,
Department of Health and Social Security.

6

RALPH HOWELL, M.P.

HOUSE OF COMMONS
LONDON SW1A 0AA

Prime Minister q IG MCS
Ralph Howell remains unhappy with the form of the NHS inquiry and the effectiveness of the C&AG. I will ask Mr Fowler's office and the Treasury for a draft reply.
WW 15/3

Ack - 16/3
IG - "

14 March 1983

The Rt. Hon. Mrs. Margaret Thatcher, M.P.
Prime Minister

RIS

Dear Prime Minister,

I was very pleased to learn of the establishment of the independent National Health Service Management Inquiry under the Chairmanship of Mr. Roy Griffiths.

Naturally I have been keen to ascertain that the Inquiry will be as fully independent as I had originally suggested.

Keith Stainton and I met Mr. Griffiths last week, together with Mr. Cliff Graham, who has been seconded by the D.H.S.S. to help Mr. Griffiths and his team in their work. Whilst we were greatly impressed by Mr. Griffiths, we were concerned that the Inquiry will not be all that you planned in your letter to me of 11th October, 1982, when you said "accordingly Norman Fowler proposes to follow this up shortly with the establishment of a major manpower inquiry which will bring in a high level outsider supported by his own team and management consultants to help him drive these initiatives forward and to assess what more is needed"

We are not satisfied that a Civil Servant, who has been so closely involved in the D.H.S.S., can be totally open-minded or in any way classified as the independent type of support promised in your letter.

We understand that the team is to present a report to Norman during June. We would like to suggest that it would be desirable for a copy of the report to be submitted simultaneously to the Cabinet Office.

When Keith Stainton and I met Sir Kenneth Stowe we discussed the issue of N.H.S. reorganisation and the allegations which had been made to me by Dr. Hewitt, ex-Medical Officer of Health for Havent, that efforts had been made to ensure that just as many posts remained as existed before reorganisation. Mr. Geoffrey Hulme, Principal Finance Officer at the D.H.S.S., questioned, in a most provocative way, why this should not be so.

Whilst I naturally support the plans to save up to £800M in privatising catering, laundry and other cleaning services, I do not think it makes sense to say that any savings will go back into more services. If this happens we can never reduce the burden of Government expenditure to enable us to reduce taxation. Everybody knows that waste should be reduced, yet we still seem so nervous of actually reducing public expenditure.

Regarding the last paragraphs of your letter of 11th October, I feel you have missed my point completely when I complained about the unsatisfactory performance of the C. & A.G. and Exchequer & Audit Department. The C. & A.G. has been sending numerous reports on manpower and other issues to the Public Accounts Committee, presumably ever since the N.H.S. was set up. The subsequent explosion of manpower and waste generally, which the Public Accounts Committee has done little or nothing to stop, makes me think that it would be a sheer waste of my time to approach the Public Accounts Committee.

My letter and submissions of 31st August 1982 contained a number of very serious allegations. I feel the action taken so far and the measures planned for the future to be inadequate and also too relaxed to deal with these very serious matters.

I would be most grateful if you could find time to see me to discuss these issues.

Yours ever,

Ralph.

NAT. HEALTH.

CONFIDENTIAL

file BTC

cc: J. Vereker

10 DOWNING STREET

From the Private Secretary 14 March 1983

Thank you for your letter of 11 March about the general approach of the NHS Management Inquiry Team as they begin to get on with their task.

I showed this to the Prime Minister over the weekend. She noted it without comment, except to remark, in connection with Sir Brian Bailey's long experience of the working practices within NHS hospitals, that the latter had been a considerable failure in management terms; and that this failure was the main reason why the Inquiry had to be set up in the first place.

M. C. SCHOLAR

D.J. Clarke, Esq.,
Department of Health and Social Security.

CONFIDENTIAL

JP

Prime Minister

2

c/c JV

WR 11/3

DEPARTMENT OF HEALTH & SOCIAL SECURITY

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

Telephone 01-407 5522

From the Secretary of State for Social Services

MC

Michael Scholar Esq
Private Secretary
10 Downing Street
London SW1

11 March 1983

Dear Michael

NHS MANAGEMENT INQUIRY

My Secretary of State was most grateful for the Prime Minister's comments on the approach to be taken by the NHS Management Inquiry, contained in your letter to me dated 2 February. I have delayed my reply so that I can reflect the general approach of the Inquiry Team as they begin to settle to their task.

You will have seen from the revised title for the Inquiry and our original Press Statement, (copy attached for ease of reference) and from the report of Mr Griffiths' recent meetings with the Press, that the Prime Minister's main point has been acted upon. Mr Griffiths is quite clear, and indeed has insisted from the outset, that his main task is to take a searching look at the general management issues underlying our present concerns. The Team will be paying attention to the issues raised in the Graham Turner articles and to all the management issues which have substantial implications for NHS manpower.

My Secretary of State has given careful consideration to the Prime Minister's suggestion that we might consider adding a senior NHS consultant to the team. He decided against this course of action because he did not wish to make the team too large - it already contains one more member than we and Mr Griffiths regard as ideal for effective management - and because he did not wish to provoke claims for similar treatment from the nurses, treasurers, administrators and works officers, especially as the Inquiry is concerned with non-medical manpower. The Inquiry Team is not intended to be representative of the NHS: it is designed to provide us with a sharp, outside business focus on general management issues. This also meets the real needs of the doctors, who would prefer to advise and influence the Inquiry Team through the contact points we have established between their representative bodies and the Inquiry Team. As it happens, Mr Griffiths' first meetings in the NHS will be with senior NHS clinicians in hospitals with which he has personal connections. He is also being guided sensitively in these matters by Sir Brian Bailey, who has long experience of the actual working practices within NHS hospitals.

— which have been such a failure in management terms and which is the reason why the enquiry has to be set up!

Yours ever,

David

D J CLARK
Private Secretary

MC

Department of Health
and Social Security

Alexander Fleming House
Elephant and Castle
London SE1 6BY

PRESS RELEASE

Telephone 01-407 5522

83/30

3 February 1983

NHS MANAGEMENT INQUIRY

Four leading businessmen are to conduct an independent Management Inquiry into the effective use and management of manpower and related resources in the National Health Service. The Inquiry Team, under the leadership of Mr Roy Griffiths, Deputy Chairman and Managing Director of Sainsburys, have agreed to advise Norman Fowler, Secretary of State for Social Services, on progress by the end of June this year.

Mr Fowler announced the management inquiry in reply to a written parliamentary question from Mrs Jill Knight MP for Edgbaston this afternoon (Thursday) which asked him if he would make a statement on what plans he has to control manpower in the NHS. Mr Fowler said:

"I have today established an independent NHS Management Inquiry into these matters. Health authorities in England have a revenue budget of almost £9 billion; employ about a million people; and spend almost 75% of their revenue on pay. The Government needs to be satisfied that these considerable resources are managed efficiently and give the nation value for money. The Inquiry will be led by Mr Roy Griffiths, Deputy Chairman and Managing Director of J Sainsbury PLC. Mr Griffiths will be assisted by Mr Michael Bett, Board Member for Personnel at British Telecom, Mr Jim Blyth, Group Finance Director of United Biscuits, and Sir Brian Bailey, Chairman of Television South West and of the Health Education Council and formerly Chairman of South Western Regional Health Authority. As my expert advisers, they will give me advice, on the effective use and management of manpower and related resources, as their enquiries proceed. We aim to make the earliest possible impact on the management of the NHS for the benefit of patients and the community as a whole. Mr Griffiths will advise me on progress by the end of June 1983."

The Inquiry Team will be supported by a small group of staff led by Mr Cliff Graham, an assistant secretary at the Department of Health and Social Security. The support staff will also include health service experience and private sector expertise.

Mr Griffiths has not been asked to prepare a report nor will the Team act in any way like a Royal Commission or Committee of Enquiry. The Team will advise on what more needs to be done, within existing resources, to secure the most effective use and management of NHS manpower and related resources. They will identify major management issues for examination by individual team members and the support staff and will transmit their findings to the Secretary of State for early incorporation into NHS and DHSS management practice.

In commenting on the Inquiry, Mr Fowler said:

"Over the last four years this Government has devoted extra resources to the NHS. Next year we will be spending nearly £13 billion on the NHS in England. That represents a real increase in services of 7½% and an increase of 17% against the Retail Price Index. But what matters most is the actual services the patients are getting for this money and the way in which the delivery of these services is managed by the NHS.

"In 1979 we therefore embarked on the essential task of strengthening the management of the NHS and improving its efficiency and effectiveness in the interests of the patients. First, we slimmed down the structure of administration to cut out unnecessary bureaucracy. Second, we developed a new framework of public accountability and review, to clarify and make more effective the management chain from the District to the Secretary of State. Third, we launched a whole series of initiatives, aimed at improving the management efficiency of the NHS; including NHS manpower targets, the development of NHS performance indicators and the introduction of financial targets for efficiency savings.

"What we need to be sure of is that in practice this whole management process is working properly and that it produces, for both patients and public alike, the best possible service from the very large resources allocated to the NHS.

"We are therefore now setting the Inquiry Team two main tasks:

- to examine the ways in which resources are used and controlled inside the health service, so as to secure the best value for money and the best possible services for the patient;

- to identify what further management issues need pursuing for these important purposes.

"We could simply have set up another Royal Commission and then sat back for several years to await its lengthy report, but on past experience that would not lead to effective action. Instead, we have gone straight for management action, with the minimum of fuss and formality. I am grateful to Mr Griffiths and his colleagues for agreeing to carry out this task."

NOTE FOR EDITORS

Mr Griffiths has been Deputy Chairman and Managing Director of Sainsburys since 1979. He joined the company in 1968 from Monsanto Europe, where he was a Director. He became a Director of Sainsburys in 1969 and Deputy Chairman in 1975.

Mr Bett has been on the Board of British Telecommunications since 1981. He was previously Director of Personnel at the BBC.

Mr Jim Blyth, is Group Finance Director of United Biscuits

Sir Brian Bailey is Chairman of the Health Education Council and was, until the end of last year, Chairman of the South Western Regional Health Authority. He is Chairman of Television South West and was an official of NALGO for many years.

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

PA

PERSONAL

John Sparrow Esq
Central Policy Review Staff
Cabinet Office
70 Whitehall
LONDON
SW1A 2AS

8 February 1983

Dear John.

I thought you would be interested to see the enclosed paper, in which our Statistics Division have summarised the most recent data on patient activity in the NHS.

I have made the point to Michael Scholar, for the Prime Minister, that there have been enormous increases in activity over the years, in terms of patients treated, especially day patients, which calls for caution in assuming (as many do) that NHS productivity has been falling. Because of the way medicine is developing, the NHS is achieving substantially higher throughput with reduced numbers of beds in relation to manpower. The point is that medical practice (eg in relation to post-operational therapy) can be as big a factor for change as management itself. These latest figures and graphs show both the progress and the potential, for there are wide Regional and District variations concealed in the national (ie England) figures.

I am sending a copy of this letter, with the paper, to Michael Scholar at No 10.

Yours ever

Ken.

Mr Cashman
Mr Scott-Whyte
Mrs Firth
Mr McGinnis
Dr Sweeney
Miss Fraser
Mrs Banks
Mr Birch
Mr Pole
Mr Rayner
Mr A R Smith
Mr Jewesbury
Mr Brereton
Mr Toulmin
Miss Winterton
Mrs Demmery
Mrs Williamson
Mr Luce
Mr Morris

HOSPITAL ACTIVITY STATISTICS FOR ENGLAND - SH3 1981

1. The attached short paper and tables relate the 1981 SH3 Hospital Activity data to the trends which have been observed in recent years. The national and regional summaries of the 1981 SH3 data have now been completed and will be distributed shortly.

2. The main points to emerge from the 1981 data are:-

(i) the number of available beds continued to decline, numbering 352 thousand in 1981 compared with 383 thousand in 1976 and 420 thousand in 1971. The rate of decline, however, appears to be slowing down. The number of beds fell by 1.3% in 1981 and 1.6% in 1980 compared to around 1.9% on average in the preceding three years. The decline in the number of acute beds came to a halt in 1981, and the number of geriatric beds increased slightly (Table 2).

(ii) discharges (including deaths) rose by 1.6% from 5.67 million in 1980 to 5.76 million in 1981. This was somewhat lower than the average annual growth rate of 1.9% achieved between 1976 and 1980, mainly due to the drop in activity in the maternity sector following the fall in the birth rate in 1981. Non-maternity discharges and deaths rose by 2.3% in 1981, compared with an annual average growth rate of 1.6% between 1976 and 1980. (Table 3).

(iii) average length of stay continued to fall but the reduction of 2.7% between 1980 and 1981 was less than that obtained in recent years (3.7% a year on average between 1976 and 1980). Once again, following the pattern in 1980, much of the greatest fall for 1981 was in the geriatric sector where the average length of stay was 4.9% (3½ days) less than in 1980 (Table 5).

(iv) the number of new out-patients and total out-patient attendances both rose by about 1% in 1981 to 8.0 million and 35.6 million respectively. Although the geriatric sector accounts only for a small proportion of out-patient activity, it again showed the largest increase with new patients rising by 8.5% to reach 43.2 thousand and total attendances by 6% to 270.1 thousand. (Tables 6 and 7).

(v) The number of new Accident and Emergency patients rose by 2.6% to 9.5 million in 1981. The total number of attendances, which fell slightly both in 1979 and 1980, rose by 2% to 13.3 million in 1981, still slightly less than the figure of 13.4 million in 1978. (Tables 6 and 7).

(vi) The increase of 6.4% in the number of day case attendances in 1981 to reach 714 thousand was higher than the growth rates achieved in 1978 and 1979 but lower than the average annual growth rate of 7.5% over the period 1972 (the first year when data on day cases were collected) to 1980. Day cases now account for 11.0% of all discharges and deaths plus day cases compared with 8.4% in 1976 and 6.7% in 1972. (Table 8).

(vii) Regular day patient activity continued to expand in 1981 which saw an increase of 10.0% in the number of new patients (to 121 thousand) with geriatric patients accounting for most of the increase. The total number of attendances went up by 2.4% to 5416 thousand (Table 9).

3. A separate note giving a fuller analysis of individual specialties within the acute sector will be circulated shortly. If Divisions would like to see a more detailed analysis of SH3 data relating to other sectors, please let me know. Further copies of this paper can be obtained from Mr Hollingdale (R.Sq 507 ext 3196).

J A ROWNTREE
SR2
R.512 R.Sq Ext 3618

27 January 1983

cc Miss Robson
Mr Ratcliffe
Mr O'Flynn
Mr Lord
Miss Mithani
Miss Barton
Mr. Mears
Mrs. Gardner
Mr. Brewer
Mr. Ko/AHS4

HOSPITAL ACTIVITY STATISTICS FOR ENGLAND 1981

ACUTE SECTOR

1. As indicated in a previous paper, in 1979 the computerisation of SH3 and the consequent need to systematise the submission of "other specialist units" (OSU's), it was necessary to reallocate some OSU's in order to make the sectors (and specialties) comparable with previous years. The known changes were taken into account but there may have been an additional effect which could not be precisely identified. For 1980 and 1981 the medical and surgical sectors were redefined on the basis of advice from policy and medical colleagues to include all appropriate OSU's. Both sets of figures are included for comparative purposes but in the discussion of trends below the 1979 definitions (see footnotes to Table 2) have been used for consistency.

Medical Specialties (Chart I)

2. The gradual decline over the last decade in the number of available beds did not continue in 1981. The number of beds rose slightly from 49.4 thousand in 1980 to 49.8 thousand in 1981. The number of in-patient cases (discharges and deaths) rose by 3.3% to 1.37 million, compared with the annual growth rate of 1.9% between 1976 and 1980 and an annual rate of 2.3% over the decade (1971 to 1981) as a whole.

3. Throughput increased by 2.6% to 27.5 cases per available bed in 1981 while average duration of stay fell by 1.9% to 10.2 days. Both these changes were lower than those achieved in earlier years. Between 1976 and 1980, throughput rose by 4.1% a year and length of stay fell by 3.5% a year on average.

4. The number of day case attendances continued to rise sharply by 14.5% to 145 thousand in 1981, accounting for 9.6% of all discharges and deaths plus day cases. However, day case activity had grown faster than this at 19.5% a year on average between 1976 and 1980.

5. The number of new out-patients, which increased by 1.9% a year between 1976 and 1980, grew very slightly by 0.7% a year to 2.15 million in 1981. The total number of out-patient attendances increased by 1.7% to 10.49 million, again lower than the average rate of 2.6% in recent years.

Surgical specialties (Chart II)

6. The number of surgical beds also picked up slightly from 76.8 thousand in 1980

to 77.1 thousand in 1981. (If pre-convalescent beds are included, the number of beds fell slightly from 79.7 thousand in 1980 to 79.1 thousand in 1981). The number of in-patient cases rose by 1.7% to reach 2.79 million in 1981, in line with the average annual growth rate since 1976.

7. Throughput increased from 35.7 cases per available bed in 1980 to 36.2 in 1981 (+ 1.4%) and average duration of stay fell by 0.1 of a day or by 1.3% to 7.5 days. Both these rates were lower than those achieved in earlier years. Between 1976 and 1980 throughput rose by 2.9% a year and length of stay fell by 3.0% a year on average.

8. Day case activity continued to show the largest increases. The number of day case attendances rose by 4.1% to 521 thousand in 1981 although this rate of growth was lower than the average annual rate of 7.5% between 1976 and 1980. Day cases accounted for 15.7% of all discharges and deaths plus day cases in 1981 compared to 12.8% in 1976 and 10.4% in 1972.

9. The number of new out-patients rose by 1.6% (to 4.7 million) and the total number of attendances increased by 1.1% to 18.57 million.

GERIATRIC (Chart III)

10. After falling for 2 years in 1979 and 1980 the number of available geriatric beds picked up slightly to reach 55.5 thousand in 1981, still below the 1978 figure of 56.0 thousand. The number of discharges and deaths rose by 6.1% in 1981 to 280 thousand while average length of stay fell by 4.9% to 66.7 days. Between 1972 and 1981, average length of stay had fallen by 38 days or 36% (4.9% a year on average).

11. The number of new geriatric regular day patients rose by 15.3% in 1981 to 63.2 thousand, three times the level in 1972. The total number of regular day attendances rose by 2.0% to 1.50 million, nearly double the figure of 805.1 thousand in 1972.

MATERNITY (Chart IV)

12. The gradual decline in the number of maternity beds continued in 1981 with GP maternity beds accounting for most of the fall. Out of 18.2 thousand available beds in 1981 85.1% were consultants' beds compared with 78.3% (out of 22.1 thousand) in 1971. 87.6% of all cases were treated in consultants' rather than GP maternity beds in 1981 compared with 78.5% in 1971.

13. With the fall in the birth rate in 1981, hospital activity in the maternity sector was generally lower than in 1980. Total births (live and still births) fell by 3.4% to 502 thousand in 1981 while NHS hospital births (live and still births as recorded on the SH3) fell by 3.0% to 590 thousand. NHS hospital births accounted for 98% of total births in 1981, compared with 96% in 1976 and 87% in 1971. Although the number of cases (discharges and deaths) fell by 2.7% in 1981, the case per hospital birth ratio in fact rose from 1.34 in 1980 to 1.35 in 1981, continuing a steadily rising trend over the past decade from a figure of 1.26 in 1971. Average duration of stay fell for both obstetric and GP maternity patients. Patients under the care of obstetricians stayed on average for 5.7 days in 1981 compared to 5.9 days in 1980 and 7.3 days in 1971. The average length of stay of GP maternity patients fell from 5.8 days in 1971 to 4.4 days in 1980 and 4.2 days in 1981. Patient throughput in the maternity sector, which had been rising steadily since the upturn in the birthrate in 1978, dropped slightly from 44.5 cases per bed in 1980 to 43.8 in 1981.

14. Out-patient activity appears to have fallen slightly more than the fall in birthrate. The number of new out-patients fell by 4.1% to 738 thousand and the total number of attandances by 3.5% to 3.76 million.

MENTAL HANDICAP (Chart V)

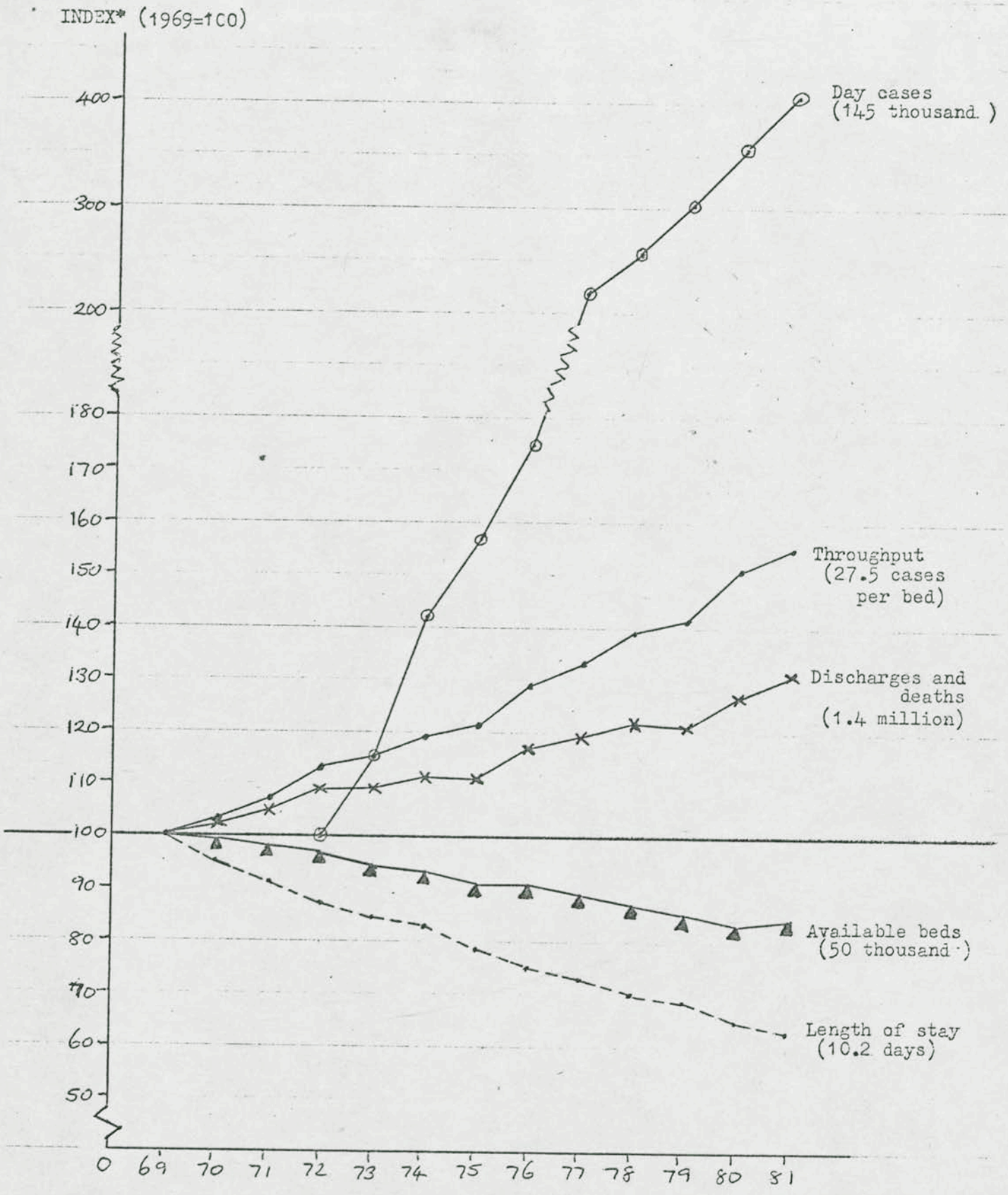
15. The number of available beds continued to decline in 1981 by 3.3% to 47.3 thousand. Over the period 1971 to 1981, the number of available beds fell by 2.1% a year on average. Occupied beds fell faster than this by 3.8% to 42.4 thousand in 1981, and by 2.4% a year between 1971 and 1981. In 1981, there were 3 thousand more discharges and deaths compared to 1980, an increase of 12.5%.

MENTAL ILLNESS (Chart V)

16. The number of available beds fell by 2.2% in 1981 to 85.4 thousand. The annual average rate of reduction over the period 1971 to 1981 was 3.3%. The number of occupied beds fell by 2.4% in 1981 to 73.4 thousand. Over the decade from 1971 to 1981, the number of occupied beds decreased by 3.3% a year on average.

17. The number of discharges and deaths and the number of out-patient attendances both rose by about 2% in 1981 to 188 thousand and 1.73 million respectively. The number of new regular day patients rose by 5.2% to 46 thousand while the total number of attendances increased by 2.0% to 3.1 million.

CHART I ACUTE MEDICAL SPECIALTIES



* Day cases 1972=100

(1981 SH3 figures given in brackets)

SCURCE:SH3

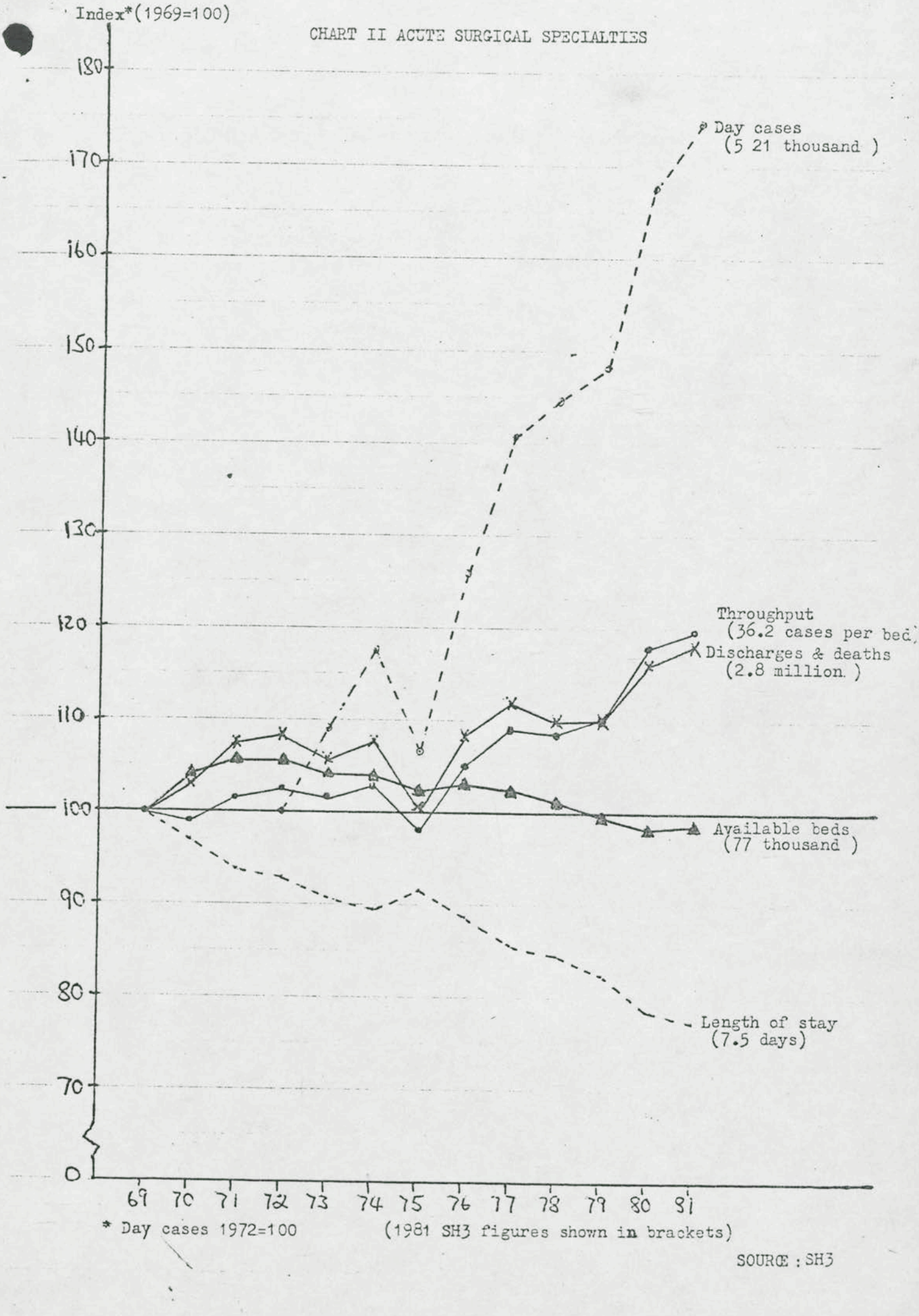
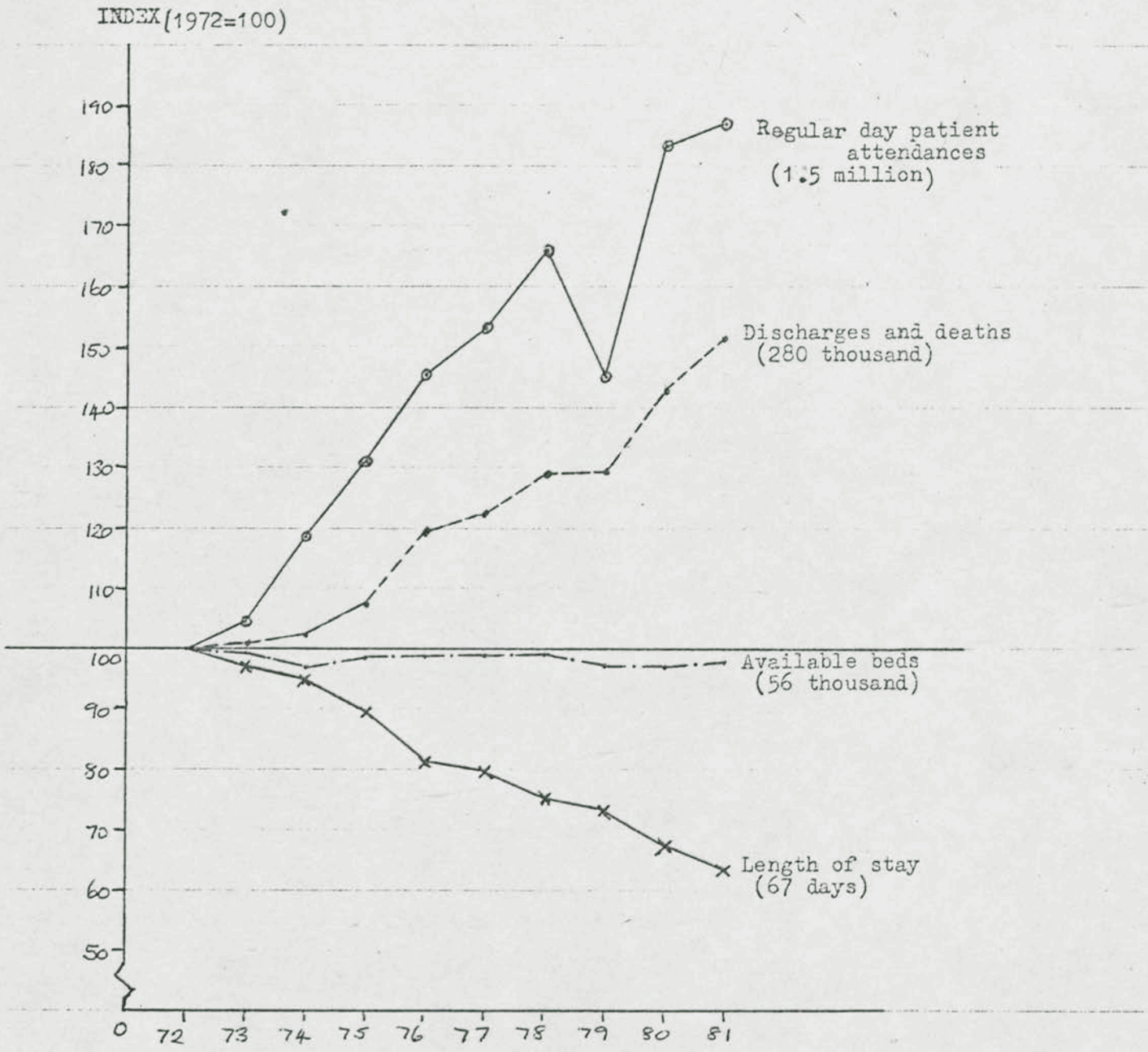

Index*(1969=100)
CHART II ACUTE SURGICAL SPECIALTIES
180
170
160
150
140
130
120
110
100
90
80
70
0
Day cases
(5 21 thousand)
Throughput
(36.2 cases per bed)
Discharges & deaths
(2.8 million)
Available beds
(77 thousand)
Length of stay
(7.5 days)
69
70
71
72
73
74
75
76
77
78
79
80
81
* Day cases 1972=100
(1981 SH3 figures shown in brackets)
SOURCE : SH3

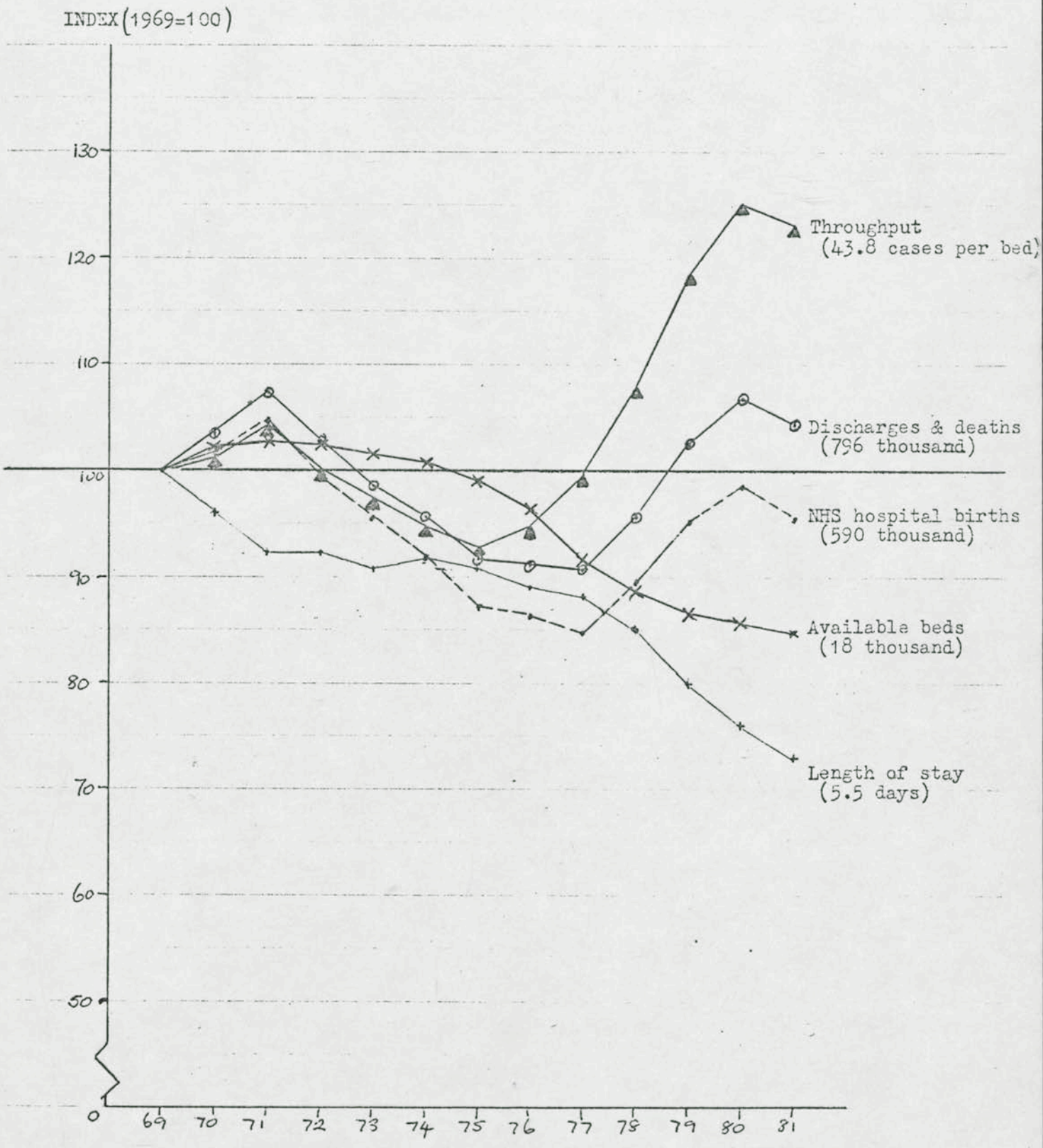
CHART III GERIATRIC



(1981 SH3 figures given in brackets)

SOURCE: SH3

CHART IV MATERNITY(Obstetrics & GP Maternity)

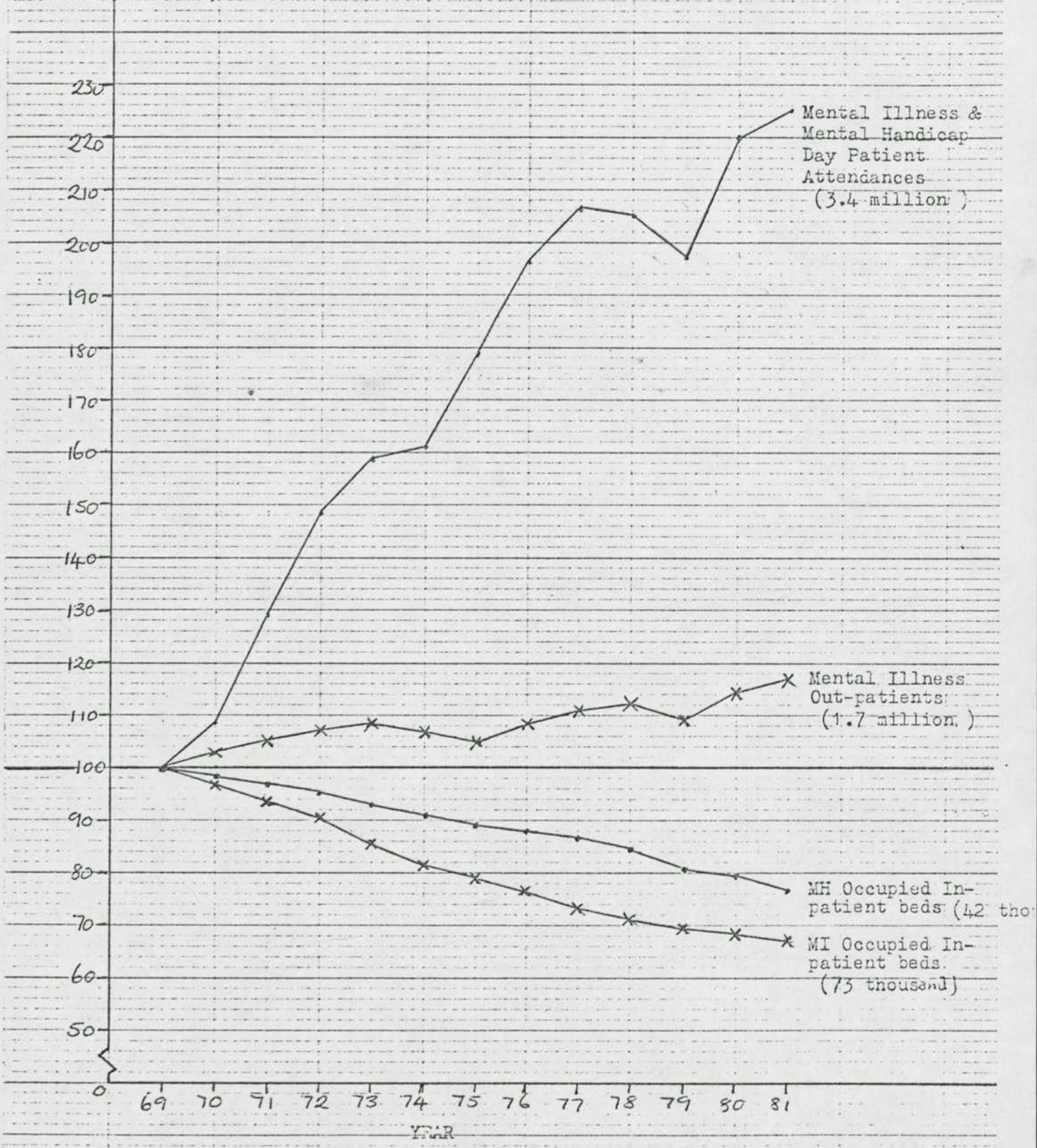


(1981 SH3 figures given in brackets)

SOURCE: SH3

E.R.

CHART V MENTAL ILLNESS AND MENTAL HANDICAP



(1981 SH3 figures given in brackets)

SOURCE: SH3

TABLE 1: HOSPITAL ACTIVITY: ALL SPECIALTIES, ENGLAND

Numbers in thousands

	1969	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980	1981
In-patient discharges and deaths	4968	5012	5171	5223	5132	5172	4976	5255	5345	5370	5400	5670	5760
% change over 1969	-	+ 0.9	+ 4.1	+ 5.1	+ 3.3	+ 4.1	+ 0.2	+ 5.8	+ 7.6	+ 8.1	+ 8.7	+ 14.1	+ 15.9
Day case attendances	na	na	na	376.5	408.5	449.6	421.7	480.5	536.2	562.1	592.4	670.8	713.9
% change over 1972				-	+ 8.5	+ 19.4	+ 12.0	+ 27.6	+ 42.4	+ 49.3	+ 57.3	+ 78.2	+ 89.6
New out-patients	7463	7745	7919	7927	7916	7825	6926	7498	7612	7712	7718	7942	8025
% change over 1969	-	+ 3.8	+ 6.1	+ 6.2	+ 6.1	+ 4.9	- 7.2	+ 0.5	+ 2.0	+ 3.3	+ 3.4	+ 6.4	+ 7.5
Total out-patient attendances	31294	32355	33129	33243	33318	33352	30947	32396	33282	33950	34132	35243	35571
% change over 1969	-	+ 3.4	+ 5.9	+ 6.2	+ 6.5	+ 6.6	- 1.1	+ 3.5	+ 6.4	+ 8.5	+ 9.1	+ 12.6	+ 13.6
New A+E patients	7634	7772	7873	8008	8372	8258	8370	8779	8904	9170	9197	9222	9464
% change over 1969	-	+ 1.8	+ 3.1	+ 4.9	+ 9.7	+ 8.2	+ 9.6	+ 15.0	+ 16.6	+ 20.1	+ 20.5	+ 20.8	+ 24.0
Total A+E attendances	13535	13322	13130	13047	13356	12921	12792	13077	13212	13360	13219	13053	13308
% change over 1969	-	- 1.6	- 3.0	- 3.6	- 1.3	- 4.5	- 5.5	- 3.4	- 2.4	- 1.3	- 2.3	- 3.6	- 1.7

na - not available

Source SH3

TABLE 2 AVERAGE DAILY NUMBER OF AVAILABLE BEDS BY SECTOR, ENGLAND

Thousands

	1969	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980	1981
All specialties[7]	428.7	423.6	419.6	412.7	403.5	396.2	387.6	383.2	375.9	369.2	361.8	356.0	351.5
% change[1]	-	- 1.2	- 2.1	- 3.7	- 5.9	- 7.6	- 9.6	-10.6	-12.3	-13.9	-15.6	-17.0	-18.0
% of all beds	100	100	100	100	100	100	100	100	100	100	100	100	100
Acute medical[2]	59.2	59.1	58.0	57.2	55.8	55.1	54.2	53.7	52.8	51.8	50.5	a. 49.4 b.(50.3)	a. 49.8 b.(50.5)
% change[1]	-	- 0.2	- 2.0	- 3.4	- 5.7	- 6.9	- 8.4	- 9.3	-10.8	-12.5	-14.7	-16.6	-15.9
% of all beds	13.8	14.0	13.8	13.9	13.8	13.9	14.0	14.0	14.0	14.0	14.0	13.9	14.2
Acute surgical[3]	78.2	81.3	82.5	82.4	81.4	81.5	80.1	80.6[8]	80.3	79.1	78.0	a. 76.8 b.(79.7)	a. 77.1 b.(79.1)
% change[1]	-	+ 4.0	+ 5.5	+ 5.4	+ 4.1	+ 4.2	+ 2.4	+ 3.1	+ 2.7	+ 1.2	- 0.3	- 1.8	- 1.4
% of all beds	18.2	19.2	19.7	20.0	20.2	20.6	20.7	21.0	21.4	21.4	21.6	21.6	21.9
Geriatric[4]				56.7	56.2	55.4	55.6	55.7	55.9	56.0	55.1	54.9	55.5
% change[1]				-	- 0.9	- 2.3	- 1.9	- 1.8	- 1.4	- 1.2	- 2.8	- 3.2	- 2.1
% of all beds				13.7	13.9	14.0	14.3	14.5	14.9	15.2	15.2	15.4	15.8
Mental Illness[5]	126.0	123.2	119.5	114.5	109.7	104.4	99.4	96.7	93.5	91.1	89.0	87.4	85.4
% change[1]	-	- 2.2	-5.2	- 9.1	-12.9	-17.1	-21.1	-23.3	-25.8	-27.7	-29.4	-30.6	-32.2
% of all beds	29.4	29.1	28.5	27.7	27.2	26.4	25.6	25.2	24.9	24.7	24.6	24.5	24.3
Mental Handicap	59.6	59.0	58.5	57.5	56.1	55.2	54.2	53.1	52.3	51.3	50.1	48.9	47.3
% change[1]	-	- 1.0	- 1.9	- 3.5	- 5.9	- 7.4	- 9.1	-10.9	-12.3	-13.9	-15.9	-17.9	-20.6
% of all beds	13.9	13.9	13.9	13.9	13.9	13.9	14.0	13.9	13.9	13.9	13.8	13.7	13.5
Maternity[6]	21.5	22.0	22.1	22.0	21.8	21.7	21.3	20.7	19.7	19.1	18.6	18.4	18.2
% change[1]	-	+ 2.3	+ 2.8	+ 2.3	+ 1.4	+ 0.9	- 0.9	- 3.7	- 8.4	-11.2	-13.5	-14.4	-15.3
% of all beds	5.0	5.2	5.3	5.3	5.4	5.5	5.5	5.4	5.2	5.2	5.1	5.2	5.2

1 % change (line 2) is over 1969 except Geriatric 1972

2 Specialties 1-10 (1969 includes 37 - Rehabilitation now in 8) (1979 + 57, 59, 60, 63, 67, , 75, 77)
a. - as for 1979; b. 1980 + 51, 52, 55-60, 62, 63, 65, 67, 68, 75, 77, 78.

3 Specialties 13-25 (1979 + 53, 54, 70, 74)
a. - as for 1979; b. 1980 + 37, 53, 54, 70, 74.

4 11 - Geriatric Medicine. There was a change from Geriatrics and Chronic Sick to Geriatrics + UYD in 1972. So prior data on Geriatrics is not comparable.

5 Specialties 29, 31, 32 (1979/1980 + 61, 72).

6 Specialties 26 + 34 for IP, 26, 27, 34 for OP.

7 The individual sectors do not add to the all specialty total as specialties 12, 28, 35-39 and OSUs (not re-allocated) are omitted.

8 In 1969 a bed borrowed from another specialty was not counted as available in the specialty borrowing the bed but was still counted as available in the specialty from which it was borrowed.

Source: SH3

TABLE 3: DISCHARGES AND DEATHS BY SECTOR[1] ENGLAND

Thousands

	1969	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980	1981
All specialties[3]	4968	5012	5171	5223	5132	5172	4976	5255	5345	5370	5400	5670	5760
% change[2]	-	+0.9	+4.1	+ 5.1	+ 3.3	+ 4.1	+ 0.2	+ 5.8	+ 7.6	+ 8.1	+ 8.7	+14.1	+15.9
Acute medical	1050	1080	1095	1143	1141	1163	1168	1227	1248	1281	1267	1325 (1350)	1369 (1397)
% change[2]	-	+2.9	+4.3	+ 8.9	+ 8.7	+10.8	+11.2	+16.9	+18.9	+22.0	+20.7	+26.2	+30.4
Acute surgical	2367	2438	2538	2558	2507	2550	2376	2564	2649	2604	2605	2745 (2777)	2793 (2820)
% change[2]	-	+3.0	+7.2	+ 8.1	+ 5.9	+ 7.7	+ 0.4	+ 8.3	+11.9	+10.0	+10.1	+16.0	+18.0
Geriatric	Comparable figures not available			185	186	189	199	221	226	238	239	264	280
% change[2]				-	+ 0.5	+ 2.1	+ 7.6	+19.5	+22.2	+28.6	+29.2	+42.7	+51.4
Mental Illness	178	178	179	182	180	176	178	181	178	174	172	184	188
% change[2]	-	-	+0.6	+ 2.2	+ 1.1	- 1.1	-	+ 1.7	-	- 2.2	- 3.4	+ 3.3	+5.6
Mental Handicap	12	13	15	17	16	16	17	17	20	20	22	25	28
% change[2]	-	+8.3	+25.0	+41.7	+33.3	+33.3	+41.7	+41.7	+66.6	+66.6	+83.3	+108.3	+133.3
Maternity	765	792	820	784	755	732	702	697	695	731	78	818	796
% change[2]	-	+3.5	+ 7.2	+ 2.5	- 1.3	- 4.3	- 8.2	- 8.9	- 9.2	- 4.4	+ 2.4	+ 6.9	+ 4.1

(1) See Table 2 for definitions of sectors

(2) All changes are over 1969 except Geriatric - 1972

(3) See Table 3 - Note 7

Source: SH3

TABLE 4: THROUGHPUT (DISCHARGES AND DEATHS PER AVAILABLE BED) BY SECTOR[1] ENGLAND

	1969	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980	1981
All specialties[3]	11.6	11.8	12.3	12.7	12.7	13.1	12.8	13.7	14.2	14.5	14.9	15.9	16.4
% change[2]	-	+ 1.7	+ 6.0	+ 9.5	+ 9.5	+12.9	+10.3	+18.1	+22.4	+25.0	+28.4	+ 37.1	+ 41.4
Acute medical	17.7	18.3	18.9	20.0	20.4	21.1	21.5	22.8	23.6	24.7	25.1	26.8 (26.6)	27.5 (27.7)
% change[2]	-	+ 3.4	+ 6.8	+13.0	+15.3	+19.2	+21.5	+28.8	+33.3	+39.5	+41.8	+ 51.4	+ 55.4
Acute surgical	30.3	30.0	30.8	31.0	30.8	31.3	29.7	31.8	33.0	32.9	33.4	35.7 (34.8)	36.2 (35.6)
% change[2]	-	- 1.0	+ 1.6	+ 2.3	+ 1.6	+ 3.3	- 2.0	+ 5.0	+ 8.9	+ 8.6	+10.2	+ 17.8	+ 19.5
Geriatric	Comparable figures not available			3.3	3.3	3.4	3.6	4.0	4.0	4.3	4.3	4.8	5.0
% change[2]				-	0	+ 3.0	+ 9.1	+21.2	+21.2	+30.3	+30.3	+ 45.5	+ 51.5
Mental Illness	1.4	1.4	1.5	1.6	1.6	1.7	1.8	1.9	1.9	1.9	1.9	2.1	2.2
% change[2]	-	0	+ 7.1	+14.3	+14.3	+21.4	+28.6	+35.7	+35.7	+35.7	+35.7	+ 50.0	+ 57.1
Mental Handicap	0.2	0.2	0.3	0.3	0.3	0.3	0.3	0.3	0.4	0.4	0.4	0.5	0.6
% change[2]	-	0	+50.0	+50.0	+50.0	+50.0	+50.0	+50.0	+100.0	+100.0	+100.0	+150.0	+200.0
Maternity	35.6	36.0	37.1	35.6	34.6	33.7	33.0	33.7	35.3	38.3	42.1	44.5	43.8
% change[2]	-	+ 1.1	+ 4.2	0	- 2.8	- 5.3	- 7.3	- 5.3	- 0.8	+ 7.6	+18.3	+ 25.0	+ 23.0

(1) See Table 2 for definitions of sectors

Source: SH3

(2) All changes are over 1969 except Geriatric - 1972

(3) See Table 3 - Note (7)

TABLE 5 : AVERAGE DURATION OF STAY FOR IN-PATIENT DISCHARGES AND DEATHS BY SECTOR(1) ENGLAND

Days

	1969	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980	1981
All specialties	26.4	25.6	24.5	23.9	23.4	22.7	22.9	21.6	20.9	20.4	19.8	18.6	18.1
% change(2)	-	- 3.0	- 7.2	- 9.5	-11.4	-14.0	-13.3	-18.2	-20.8	-22.7	-25.0	-29.5	-31.4
Acute medical	16.0	15.3	14.7	14.0	13.5	13.2	12.6	12.0	11.7	11.2	11.0	10.4 (10.5)	10.2 (10.2)
% change(2)	-	- 4.4	- 8.1	-12.5	-15.6	-17.5	-21.3	-25.0	-26.9	-30.0	-31.3	-35.0	-36.3
Acute surgical	9.7	9.4	9.1	9.0	8.8	8.7	8.9	8.6	8.3	8.2	8.0	7.6 (7.7)	7.5 (7.6)
% change(2)	-	- 3.1	- 6.2	- 7.2	- 9.3	-10.3	- 8.3	-11.3	-14.4	-15.5	-17.5	-21.6	-22.7
Geriatric	Figures not comparable			104.7	101.5	98.8	93.8	84.9	83.7	79.3	76.7	70.1	66.7
% change(2)				-	- 3.1	- 5.6	-10.4	-18.9	-20.1	-24.3	-26.7	-33.0	-36.3
Maternity													
Obstetrics	7.8	7.6	7.3	7.3	7.2	7.3	7.2	7.1	6.9	6.6	6.2	5.9	5.7
% change(2)	-	-2.6	- 6.4	- 6.4	- 7.7	- 6.4	- 7.7	- 9.0	-11.5	-15.4	-20.5	-24.4	-26.9
GP Maternity	6.4	6.1	5.8	5.6	5.3	5.2	5.2	5.0	4.9	4.7	4.6	4.4	4.2
% change(2)	-	-4.7	- 9.4	-12.5	-17.2	-18.8	-19.8	-21.9	-23.4	-26.6	-28.1	-31.3	-34.4

(1) For definition of Sector see table 2

Source: SH3

(2) All % change 1969-1979 except Geriatrics 1972-79

TABLE 6: NEW OUT PATIENTS [3] BY SECTOR, ENGLAND

Thousands

	1969	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980	1981
All specialties[1]	7463	7745	7919	7927	7916	7825	6926	7498	7612	7712	7718	7942	8025
% change[2]	-	+ 3.8	+ 6.1	+ 6.2	+ 6.1	+ 4.9	- 7.2	+ 0.5	+ 2.0	+ 3.3	+ 3.4	+ 6.4	+ 7.5
Acute Medical	1929.0	1966.8	2009.3	2027.9	2057.4	2042.1	1868.3	1974.7	2027.7	2061.6	2039.2	2131.3 (2164.9)	2146.3 (2177.2)
% change[2]	-	+ 2.0	+ 4.2	+ 5.1	+ 6.7	+ 5.9	- 3.1	+ 2.4	+ 5.1	+ 6.9	+ 5.7	+ 10.5	+ 11.3
Acute surgical	4456.8	4514.6	4643.3	4663.3	4633.2	4580.8	3917.3	4383.3	4482.9	4536.1	4521.5	4628.9 (4628.9)	4704.8 (4704.8)
% change[2]	-	+ 1.3	+ 4.2	+ 4.6	+ 4.0	+ 2.8	- 12.1	- 1.6	+ 0.6	+ 1.8	+ 1.5	+ 3.9	+ 5.6
Geriatric	Comparable figures not available			29.1	29.3	31.8	31.4	35.1	37.0	36.9	35.9	39.8	43.2
% change[2]				-	+ 0.7	+ 9.3	+ 7.9	+ 20.6	+ 27.2	+ 26.8	+ 23.4	+ 36.7	+ 48.5
Mental Illness	218.2	214.8	211.1	211.4	208.6	201.6	187.9	195.9	191.7	187.2	180.4	186.1	187.5
% change[2]	-	- 1.6	- 3.3	- 3.1	- 4.4	- 7.6	- 13.9	- 10.2	- 12.1	- 14.2	- 17.3	- 14.7	- 14.1
Mental Handicap	2.5	2.6	3.2	2.7	4.0	3.3	3.7	4.0	3.5	3.2	2.6	2.3	2.5
% change[2]	-	+ 4.0	+28.0	+ 8.0	+60.0	+ 32.0	+ 48.0	+ 60.0	+ 40.0	+ 28.0	+ 4.0	- 8.0	-
Maternity	823.4	845.2	837.0	799.2	769.1	733.7	700.7	681.5	690.2	727.3	764.2	769.8	738.0
% change[2]	-	+ 2.6	+ 1.7	- 2.9	- 6.6	- 10.9	- 14.9	- 17.2	- 16.2	- 11.7	- 7.2	- 6.5	- 10.4
A and E	7634.1	7771.6	7873.0	8008.1	8372.3	8258.1	8370.2	8778.6	8904.4	9170.2	9197.4	9221.7	9464.0
% change[2]	-	+ 1.8	+ 3.1	+ 4.9	+ 9.7	+ 8.2	+ 9.6	+ 15.0	+ 16.6	+ 20.1	+ 20.5	+ 20.8	+ 24.0

Notes 1 Excluding A and E, also see Table 2 - note 7.
2 % change are over 1969 except Geriatrics (1972).
3 In-patient follow-ups are not counted as new attendances.

Source: SHJ

TABLE 7 TOTAL OUT-PATIENT ATTENDANCES BY SECTOR, ENGLAND

Thousands

	1969	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980	1981
All specialties[1]	31294	32355	33129	33243	33318	33352	30947	32396	33282	33950	34132	35243	35571
% change[2]	-	+ 3.4	+ 5.9	+ 6.2	+ 6.5	+ 6.6	- 1.1	+ 3.5	+ 6.4	+ 8.5	+ 9.1	+ 12.6	+ 13.7
Acute medical	8781	8953	9207	9292	9414	9453	8988	9320	9614	9971	9986	10317 (10531)	10489 (10677)
% change[2]	-	+ 2.0	+ 4.9	+ 5.8	+ 7.2	+ 7.7	+ 2.4	+ 6.1	+ 9.5	+ 13.6	+ 13.7	+ 17.5	+ 19.5
Acute surgical	17059	17262	17690	17803	17748	17800	16005	17009	17619	17834	17816	18367 (18367)	18566 (18566)
% change[2]	-	+ 1.2	+ 3.7	+ 4.4	+ 4.0	+ 4.3	- 6.2	- 0.3	+ 3.3	+ 4.5	+ 4.4	+ 7.7	+ 8.8
Geriatric	Comparable figures not available			165.3	164.2	187.1	194.5	212.1	233.8	239.2	223.9	254.8	270.1
% change[2]				-	- 0.7	+ 13.2	+ 17.7	+ 28.3	+ 41.4	+ 44.7	+ 35.5	+ 54.1	+ 63.4
Mental Illness	1480	1522	1561	1586	1603	1579	1548	1601	1640	1661	1618	1689	1727
% change[2]	-	+ 2.8	+ 5.5	+ 7.2	+ 8.3	+ 6.7	+ 4.6	+ 8.2	+ 10.8	+ 12.2	+ 9.3	+ 14.1	+ 16.7
Mental Handicap	7.1	8.9	12.3	11.8	21.5	17.7	19.0	24.5	18.2	20.8	20.4	18.9	20.4
% change[2]	-	+25.4	+ 73.2	+ 66.2	+202.8	+149.3	+167.6	+245.1	+156.3	+192.9	+187.3	+166.2	+ 187.3
Maternity	3787	3907	3896	3699	3611	3483	3356	3337	3377	3622	3835	3897	3761
% change[2]	-	+ 3.2	+ 2.9	- 2.3	- 4.6	- 8.0	- 11.4	- 11.9	- 10.8	- 4.4	+ 1.3	+ 2.9	- 0.7
A & E	13535	13322	13130	13047	13356	12921	12792	13077	13212	13360	13219	13053	13308
% change[2]	-	- 1.6	- 3.0	- 3.6	- 1.3	- 4.5	- 5.5	- 3.4	- 2.4	- 1.3	- 2.3	- 3.6	- 1.7

Source: SH3

Notes 1 excluding A & E also, see Table 2 - note 7.
2 All % change over 1969 except Geriatrics 1972

TABLE 8: DAY CASE[1] ATTENDANCES BY SECTOR[2] ENGLAND

Thousands

	1972	1973	1974	1975	1976	1977	1978	1979	1980	1981
All specialties[5]	376.5	408.5	449.6	421.7	480.5	536.2	562.1	592.4	670.8	713.9
% change over 1972	-	+ 8.5	+19.4	+12.0	+27.6	+ 42.4	+ 49.3	+ 57.3	+ 78.2	+ 89.6
PA[3]	6.7	7.4	8.0	7.8	8.9	9.1	9.5	9.9	10.6	11.0
Acute medical	35.7	41.2	50.8	55.9	62.3	77.9	91.0	107.7	127.0 (139.5)	145.4 (161.6)
% change over 1972	-	+15.4	+42.3	+56.6	+74.5	+118.2	+154.9	+201.7	+255.7	+ 307.3
PA[3]	3.0	3.5	4.2	4.6	4.8	5.9	6.6	7.8	8.7	9.6
Acute surgical	298.3	325.0	349.9	317.7	374.9	419.1	432.0	441.7	500.2 (500.2)	520.9 (520.9)
% change over 1972	-	+ 9.0	+17.3	+ 6.5	+25.7	+ 40.5	+ 44.8	+ 48.1	+ 67.7	+ 74.6
PA[3]	10.4	11.5	12.1	11.8	12.8	13.7	14.2	14.5	15.4	15.7
Geriatric[4]	2.5	2.2	3.0	0.8	0.9	0.9	0.2	0.2	0.7	0.8
% change over 1972	-	-12.0	+20.0	+68.0	-64.0	- 64.0	- 92.0	- 92.0	- 72.0	- 68.0
Mental Illness[4]	25.6	22.6	24.9	25.8	14.7	12.9	12.2	13.9	10.4	9.9
% change over 1972	-	-11.7	- 2.7	+ 0.8	-42.6	- 49.6	- 52.3	- 45.7	- 59.4	- 61.3
Mental Handicap[4]	2.1	1.5	2.4	0.5	0.2	0.0	0.1	0.3	0.04	0.05
% change over 1972	-	-28.6	+14.3	-76.2	-90.5	-100.0	- 95.2	- 85.7	98.1	- 97.6
Maternity	3.0	2.7	2.9	3.3	4.3	5.7	6.6	7.7	9.0	12.0
% change over 1972	-	-10.0	- 3.3	+10.0	+43.3	+ 90.0	+120.0	+156.7	+200.0	+ 300.0

(1) Day cases are defined as persons who come for investigation, treatment or operation under clinical supervision in a planned non-resident basis and who occupy a bed which may be in a ward, a day unit or may be a recovery or observation bed.

(2) See Table 3 for definition of Sectors.

(3) PA - Day cases as a percentage of discharges and deaths **plus day cases.**

(4) The figures for Geriatrics, MI and MH for the years 1972-75 are known to be unreliable due to confusion over the definitions of a day case and a regular day patient. Information on regular day patients is included in Table 10.

(5) See Table 3 - Note 7.

TABLE 9: REGULAR DAY-PATIENT[1] ATTENDANCES, ENGLAND

Thousands

	1969	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980	1981
TOTAL													
New Patients	37.5	44.4	49.7	55.2	61.7	69.3	78.2	89.1	95.7	101.7	98.6	109.6	120.6
% change over 1969	-	+ 18.4	+ 32.5	+ 47.2	+ 64.5	+ 84.8	+108.5	+137.6	+155.2	+171.2	+162.9	+192.2	+221.6
Total Attendances	2167.6	2423.5	2838.7	3281.5	3538.7	3749.9	4151.8	4671.0	4814.6	4986.7	4636.8	5289.0	5416.1
% change over 1969	-	+ 11.8	+ 30.9	+ 51.4	+ 63.2	+ 73.0	+ 91.5	+115.5	+122.1	+130.0	+116.6	+144.0	+149.8
MENTAL ILLNESS AND MENTAL HANDICAP[2]													
New Patients	20.0	22.2	25.6	28.4	31.7	33.3	36.4	40.4	41.6	43.5	41.5	44.6	47.2
% change over 1969	-	+ 11.0	+ 28.0	+ 42.0	+ 58.5	+ 66.5	+ 82.0	+102.0	+108.0	+117.5	+107.5	+123.0	+136.0
Total attendances	1510.6	1641.4	1955.0	2242.2	2407.3	2435.9	2709.7	2966.2	3122.4	3097.9	2978.3	3324.1	3394.2
% change over 1969	-	+ 8.6	+ 29.4	+ 48.4	+ 59.3	+ 61.2	+ 79.4	+ 96.3	+106.7	+105.1	+ 97.1	+120.0	+124.7
GERIATRIC													
New Patients	COMPARABLE FIGURES NOT AVAILABLE			20.7	22.7	28.3	31.7	38.8	41.9	47.0	45.6	54.8	63.2
% change over 1972				-	+ 9.7	+ 36.7	+ 53.1	+ 87.4	+102.4	+127.1	+120.3	+164.7	+205.3
Total attendances				805.1	837.9	951.6	1054.5	1172.1	1232.1	1336.7	1167.5	1474.4	1504.3
% change over 1972				-	+ 4.1	+ 18.2	+ 31.0	+ 45.6	+ 53.0	+ 66.0	+ 45.0	+ 83.1	+ 86.8
OTHER													
New Patients	17.5	22.2	24.1	6.1	7.4	7.7	10.1	9.9	12.2	11.2	11.5	10.2	10.2
% change over 1972	-	-	-	-	+ 21.3	+ 26.2	+ 65.6	+ 62.3	+100.0	+ 83.6	+ 88.5	+ 67.2	+ 67.2
Total attendances	657.0	782.1	883.7	234.2	293.4	362.4	387.6	532.7	460.1	552.2	551.0	490.5	517.7
% change over 1972	-	-	-	-	+ 25.3	+ 54.7	+ 65.5	+127.5	+ 96.5	+135.8	+135.3	+109.4	+121.1

Source: SH3

1 Day patients are defined as those who regularly attend for a course of treatment over a period, who are provided with treatment and care as though they were in-patients, but who return home at night. Each day's attendance counts as a single attendance.

2 Prior to 1979, this sector was Psychiatric, so some of the mental handicap patients may have been allocated to "other". In 1979/80 Psychogeriatric were re-allocated to MI.

3 The figures for Geriatrics, Mental Illness and Mental Handicap for the years 1972-75 are known to be unreliable due to confusion over the definitions of a day case and a regular day patient. (See Table 9).

CONFIDENTIAL

Nat Health BM

bc JV FM

10 DOWNING STREET

From the Private Secretary

2 February 1983

Dear David,

MANAGEMENT INQUIRY INTO NHS MANPOWER

The Prime Minister was grateful for your Secretary of State's minute of 27 January and was pleased to see that he has been able to assemble a high-quality team of businessmen to undertake the Inquiry.

Mrs. Thatcher is content for the Inquiry to be announced by means of a Written Answer, accompanied by a press statement, but she would like Mr. Fowler to take account of the following points in doing so.

Mr. Fowler's detailed brief to Mr. Griffiths and his team concentrates on manpower numbers. The Prime Minister believes that overmanning is only the symptom of bad management, and that Mr. Fowler should make it clear that the central task of the Inquiry is to "take a searching look at those general management issues underlying our concerns".

The Prime Minister also considers that, if the team are to use their business experience in an appropriate manner, they will wish to look at general NHS management issues which are not specifically covered in Mr. Fowler's detailed brief to them but which have substantial implications for manpower. The chain of command within hospitals is the most important of these questions; and perhaps also such related issues as contracting out and purchasing policy. It may not be necessary to spell these issues out in the brief, but Mrs. Thatcher thinks Mr. Griffiths and his team should be made well aware that they are not debarred from dealing with them. In particular, the Prime Minister believes that the questions of authority raised in Graham Turner's important articles last autumn in the Daily Telegraph should be addressed by the team if hospitals are to become efficient and properly managed. The Prime Minister considers that Mr. Turner's articles revealed a total absence of an effective management system in the NHS.

/ The Prime Minister

CONFIDENTIAL

The Prime Minister wonders whether the team might not benefit from the addition of a senior NHS consultant with long experience, such as George Bunton, who would have much to contribute on the changes in atmosphere and working practices within NHS hospitals.

I am copying this letter to John Kerr (HM Treasury), Muir Russell (Scottish Office), Adam Peat (Welsh Office), John Lyon (Northern Ireland Office), Richard Hatfield (Cabinet Office) and Clive Priestley (Management and Personnel Office).

Yours sincerely,

Michael Scholar

David Clark, Esq.,
Department of Health and Social Security

(1)

PRIME MINISTER

MANAGEMENT INQUIRY INTO NHS MANPOWER

Ferdie Mount and I had a word with you on Monday about the setting up of the Management Inquiry into NHS Manpower. You have had advice from Clive Priestley (Flag A). Ferdie and I have somewhat modified this. Content that I write on the lines of the draft at Flag B?

MLS

1 February 1983

bc JVPM Confidential David Clark

DRAFT LETTER FROM MICHAEL SCHOLAR TO GRAEME McCABE (DHSS)

MANAGEMENT INQUIRY INTO NHS MANPOWER

The Prime Minister was grateful for your Secretary of State's minute of 27 January and was pleased to see that he has been able to assemble a high-quality team of businessmen to undertake the Inquiry.

The Prime Minister also

She wonders whether the team might not benefit from the addition of a senior NHS consultant with long experience, such as George Bunton, who would have much to contribute on the changes in atmosphere and working practices within NHS hospitals.

Mrs. Thatcher is content for the Inquiry to be announced by means of a Written Answer, accompanied by a press statement, but she would like Mr. Fowler to take account of the following points in doing so.

Mr. Fowler's detailed brief to Mr. Griffiths and his team concentrates on manpower numbers. The Prime Minister believes that overmanning is only the symptom of bad management, and that Mr. Fowler should make it clear that the central task of the Inquiry is to "take a searching look at those general management issues underlying our concerns".

The PM also considers that,

If the team are to use their business experience in an appropriate manner, they will ~~surely~~ wish to look at general NHS management issues which are not specifically covered in Mr. Fowler's detailed brief to them but which have substantial implications for manpower. The chain of command within hospitals is ~~one of~~ the most important of these questions; and perhaps also such related issues as contracting out and purchasing policy. It may not be necessary to spell these issues out in the brief, but Mrs. Thatcher thinks Mr. Griffiths and his team should be made well aware that they are not debarred from dealing with them. In particular, the Prime Minister believes that the questions of authority raised in Graham Turner's important articles last autumn in the Daily Telegraph ~~need to~~ should be addressed if hospitals are to become efficient and properly managed.

by the team

(This is very important. The PM considers that Mr Turner's articles revealed a failure of an effective management system in the NHS.

NP

I am copying to D/S.O.S. W.O. M.I.O. Hatfield Prices Nay

Agreed not

31 January 1983

MANAGEMENT INQUIRY INTO NHS MANPOWER

The team which you have identified seems to be highly suitable. But if they are to use their business experience in an appropriate manner, they will surely wish to look at several aspects of NHS management which are not specifically covered in your detailed brief to them but which have substantial implications for manpower. Purchasing policy, contracting out, and the chain of command within hospitals are among the most important of these questions. It may not be necessary to spell these issues out in the brief, but I think Mr Griffiths and his team should be made well aware that they are not debarred from dealing with them.

The Inquiry's enthusiasm for tackling such difficult but crucial questions is unlikely to be encouraged by the instructions to "build on initiatives already taken" and "avoid duplicating, for example, the work of the Royal Commission". This Government was unimpressed by and is uncommitted to the findings of the Royal Commission, and we certainly should not be complacent about the effect of initiatives, whether taken by this Government or its predecessor. Thus, while the Inquiry team will obviously wish to concentrate on essentials, it should not be deterred from asking fundamental questions about the management of the NHS. And I am sure you will emphasise to Mr Griffiths and his colleagues your expectation that they will "take a searching look at those general management issues underlying our present concerns".

PRIME MINISTER

Management Inquiry Into NHS Manpower

Do you agree that I should write to Mr. Fowler's Private Office on the lines of the draft attached to Clive Priestley's minute of 28 January (Flag A)?

Ferdie Mount endorses this approach, and would like, too, that the inquiry should not be debarred from going wider than manpower, and should address itself to some of the matters raised in Graham Turner's articles - for example, the chain of command within hospitals, and management responsibility. Agree?

Duty Clerk
pp M. Scholar

31 January 1983

10 DOWNING STREET

Prime Minister

A minute from Clive Priestley is attached reporting Sir Derek Rayner's agreement to the team proposed by Mr Fowler but making suggestions as to the presentation of its work.

Agree that we should respond as proposed by Mr Priestley?

28/1

CONFIDENTIAL

MR FLESHER

cc Sir Derek Rayner

MANAGEMENT INQUIRY INTO NHS MANPOWER

We spoke. I attach a draft letter. This follows from the line Sir Derek Rayner has taken on this exercise as indicated in my minute to Mr Scholar of 17 January. It is self-explanatory.

2. I should add that I understand privately that Mr Griffiths is restive about the way the exercise is being set up. He is far from keen to be associated with a hatchet job on the NHS which he thinks - rightly in my view - is not the point at all. He wants, and Sir Derek Rayner agrees with this, an exercise which will illuminate typical management issues in the NHS, with an emphasis but not a fixation on manpower.

3. I firmly believe that a statesman like and generous line is what the Prime Minister would want here and the draft letter is written accordingly.

C PRIESTLEY
28 January 1983

ENC: Draft letter

CONFIDENTIAL

A

DRAFT OF 28 JANUARY 1983

The Private Secretary to the
Rt Hon Norman Fowler MP
Secretary of State for Social Services

MANAGEMENT INQUIRY INTO NHS MANPOWER

The Prime Minister was grateful for your Secretary of State's minute of 27 January and was pleased to see he has been able to assemble a good quality team of businessmen to undertake the inquiry. Mrs Thatcher is content for the inquiry to be announced /in the course of this week/ by means of a Written Answer, accompanied by a press statement, but she would like Mr Fowler to take account of the following points in doing so.

2. First, the Prime Minister thinks it important to avoid suggesting, in setting up the inquiry, that the NHS is overmanned. To do so would produce a markedly hostile response from the unions and others but, more important, it would alienate those medical, nursing and other staff who worked hard to keep the hospital service going during last year's dispute and whose support for, or at least acquiescence in, the review is necessary for its success. It would therefore be desirable to build as much as possible on the references in the brief to the use of resources generally and on the

references to manpower planning in the short and longer term, playing down or omitting altogether references which appear to assume that Ministers have already made up their minds that the NHS is overmanned.

3. Secondly, the Prime Minister notes that a progress report is invited by the end of June, but that no other reference is made to timing in the papers. Mrs Thatcher thinks that there would be merit in setting a term on the inquiry, to minimise the risk of its being strung out. Precise questions of timing are a matter for your Secretary of State, but the Prime Minister suggests that it would be a pity to allow the inquiry to extend much beyond the end of the year.

4. Thirdly, the Prime Minister also notes the possibility that management consultants may be used in addition to staff working for the inquiry team. Given the controversial nature of the inquiry; the complexity of the issues; and the personal substance and devotion of many working in the NHS at all levels, the Prime Minister hopes that maximum use will be made of staff in the NHS, whether to work with the team or on their behalf to carry out on-the-spot examinations of particular examples of the use of manpower and other resources. This would tend both to reduce the hostility of the NHS to the inquiry and to increase its effectiveness.

5. I am copying this to Muir Russell (Scottish Office), John Craig (Welsh Office), Stephen Boys Smith (Northern Ireland Office), John Gieve (HM Treasury), Richard Hatfield (Cabinet Office) and Clive Priestley (Rayner Unit).

T FLESHER

YMS

cFM.

Prime Minister

Prime Minister

Prime Minister * I gather fm DHSS that ~~Sec~~ Board Rayner also supports Mr Griffiths

28/1

Agree to these proposals?

(Sir R Armstrong and Alan Walters support Mr Griffiths' appointment: see their attached notes) * MCS 28/1

MANAGEMENT INQUIRY INTO NHS MANPOWER

A good note

Earlier minutes set out my proposal for a Management Inquiry into the use and control of Manpower in the National Health Service. I have concluded that the right man to head the Inquiry is Roy Griffiths, the Managing Director and Deputy Chairman of Sainsburys. My view of his suitability is confirmed by Derek Rayner and by Sir John Sainsbury, who is ready to release him part-time. I am glad to say he has agreed to take on this task.

Following discussion with Mr Griffiths I propose and he agrees that he should be assisted (initially at least) by three businessmen, working part-time, and that one of these should be an immediate past Chairman of an NHS Authority. My proposals for these are:

- Mr Michael Bett - Board Member for Personnel, British Telecom;
- Mr Jim Blyth - Group Finance Director, United Biscuits;
- Sir Brian Bailey - Formerly Chairman of South Western Regional Health Authority.

The businessmen will be supported by a small full-time staff led by a DHSS Assistant Secretary and including both health service experience and private sector expertise.

I have given Mr Griffiths and his team a detailed brief and I enclose a copy. As you know, they are not to prepare a formal report nor will they act in any way like a Royal

E.R.

Commission or Committee of Enquiry; rather they will be my advisers, probing into what more we need to do, within existing resources, to secure the most effective use and management of NHS manpower and keep a tight control on numbers. As you will see from the attached brief, I have already set them a number of detailed questions on manpower, but I will also expect businessmen of this high managerial competence to take a searching look at those general management issues underlying our present concerns. For example, to see how the manpower requirements are generated and controlled they may need to probe how the NHS sets its service plans and objectives and how the tempo of activities is controlled. They will also examine the possibilities of substituting other resources for manpower, and look at related personnel management and industrial relations issues.

I envisage that Mr Griffiths and his team will go about their task by identifying major management issues which individual members will enquire into with the support of full time staff and, where necessary, of management consultants if they so choose. Mr Griffiths will then feed back advice as their enquiries proceed, on timetables agreed with me, so that they can make an early impact on our management of the NHS. I have asked him, in any event, to advise me on progress by the end of June.

I aim to announce the setting up of the inquiry team next week by inspired Written Answer accompanied by a press statement.

I am copying this minute to the Secretaries of State for Scotland, Wales and Northern Ireland, the Chief Secretary, Sir Robert Armstrong and Sir Derek Rayner.

27 January 1983

N F

MANAGEMENT INQUIRY INTO NHS MANPOWER

The reason for appointing a team

1. The Government has taken action to streamline NHS organisation, strengthen local management and eliminate unnecessary bureaucracy. Over the last year the Secretary of State has taken further initiatives to strengthen the use and control of manpower - through timely supply of manpower information on a quarterly basis (from a now fully computerised information system), new arrangements for setting health authority manpower targets within a strengthened system for setting objectives and securing accountability for their achievement.

2. He has not however been able to allay concern over NHS manpower levels and he is not yet satisfied himself that enough has been done. He has accordingly announced his intention to appoint a small team of people from industry to carry out a management inquiry into the use and control of manpower.

3. The team will help the Secretary of State and the Department in carrying out their strategic functions for deciding the resources to be allocated to the NHS, for setting strategic objectives and establishing systems to secure those objectives.

4. It will build on initiatives already taken, will help Ministers to use the systems already established and advise on what changes are needed.

5. The team will undertake a closely focussed management inquiry and not a wide ranging, deliberative inquiry. Nor will it be a further review of the organisation of the NHS.

6. It is not intended to change the key management role of the new District Health Authorities. They will remain fully responsible for managing the resources allocated to them.

7. The inquiry, although not concerned primarily with the role of the region, may have changes to suggest in the regional planning, monitoring and accountability functions.

8. The inquiry will be separate from but will need to take account of the various initiatives designed to help NHS management (eg the Rayner scrutinies and pilot schemes for a management advisory service) and may have views on the future pattern of central and regional initiatives.

Questions to be answered

9. The detailed questions to be considered by the inquiry will be for discussion with the person appointed to lead the team. But it is expected to give an independent view on some or all of the following:

a. To what extent the hospital and community health services are over-manned and where;

b. What more should be done by the Secretary of State and by the services to identify and correct over-manning and on what time scale;

c. How fast will this produce savings which can be redeployed on such purposes as Ministers decide;

In particular

d. What would be realistic targets to set for different staff groups (i) in the period up to 1984-85; (ii) in the longer term;

More specifically

e. How should the Department deal with the regional manpower targets for March 1984 due to be submitted by March 1983.

f. What are the main processes by which targets should be set and their achievement secured and what action should be taken by the Secretary of State and the Department to help in those processes;

g. What are the processes by which manpower levels for later years should be decided and what guidance should be given to the NHS;

h. What are the implications for industrial relations and how should these be handled.

Methods of proceeding

10. The Chairman and the team will need to consider the approaches to be adopted but these may include:-

a. Reviewing existing management and control systems and the work that the Department and health authorities have already done in promoting efficiency including

i. Study of the use of resources in the NHS and reasons for increases in staff;

ii. Experience with setting targets for efficiency savings;

iii. The progress with use of performance indicators;

iv. Experience of annual reviews of performance;

v. The new manpower returns;

vi. Any findings emerging from management advisory services studies and Rayner scrutinies.

b. Discussion with Health authority chairmen of the problems as they see them and of any help they need.

c. More generally,obtaining views from the NHS, health authorities, professional organisations and trade unions (it will be necessary to keep this part of the exercise within manageable limits and avoid duplicating, for example, the work of the Royal Commission);

d. Considering external criticism from Members of Parliament and others;

e. Carrying out sample enquiries in particular districts to find out how manpower levels have been arrived at, what the reasons are for growth, how well justified they are, what the arrangements are for review and what would be the likely consequences of reducing manpower levels.

11. The team will have direct access to the Secretary of State, Minister for Health and Senior officials. We envisage that it will work closely with them in reviewing and developing initiatives and it will feed in ideas and advice as it goes along.

Membership of team

12. Membership will be discussed with the chairman but we envisage it will include a small number of people from industry at board member or second-in-line level with a mixture of general management, finance and personnel experience. (The precise number may depend in part on how much time the individuals can give).

A staff officer has been selected to organise departmental support for the team.

MR. SCHOLAR

I would strongly support the appointment of Roy Griffiths, Deputy Chairman and Managing Director of Sainsbury's, to Chair the Management Inquiry into NHS manpower. I have seen Roy Griffiths on a number of occasions and have talked to him at length over the past two years. He should be an excellent appointment, perhaps one of the best we can make.

27 January 1983

ALAN WALTERS

Ref. A083/0275

MR SCHOLAR

MCS 20/12/82

You are expecting a submission from the Secretary of State for Social Services, recommending the appointment of Mr Roy Griffiths, the Deputy Chairman and Managing Director of J Sainsbury Ltd to chair the management inquiry into NHS manpower.

2. From all I know of Mr Griffiths he should be an admirable choice, and I recommend the Prime Minister to approve his appointment.

ROBERT ARMSTRONG

25 January 1983

CONFIDENTIAL

cc DW
FM

PA

cc for information

Mrs Brown (PS/LPS)
Sir Robert Armstrong
Mr Cassels
Mr Peterson

Mr SCHOLAR

MANAGEMENT INQUIRY INTO NHS MANPOWER

As I mentioned when we met by chance at lunch-time, the Secretary of State for Social Services has obtained the agreement of Mr Roy Griffiths, the Deputy Chairman and Managing Director of J Sainsbury Ltd, to chair the inquiry, subject to the approval of the Prime Minister. Sainsbury's are keen for Mr Griffiths to undertake this assignment.

2. A submission will be coming forward from the Department to you later this week. Please let me know if you need advice on the coverage and presentation of the inquiry.

3. You may like to know that Mr Fowler's first choice as chairman, Mr Basil Collins, backed out because he thought that an inquiry now would cause more disaffection within the NHS and much political trouble. While making up his mind, he saw Sir Derek Rayner, who told him that the subject was important; that DHSS would provide him with the support he needed; that the issues were not party issues; and that as they must be tackled some time, they might as well be tackled now. Sir Derek's conclusion was that a failure to secure Mr Collins's services would not be disastrous to the enterprise.

4. Sir Derek has made enquiries - necessarily oblique - about Mr Griffiths, who is in effect his oppositenumber at Sainsbury's and whom he does not know personally. His view is that Mr Griffiths, being a senior man in a successful and dynamic company, must have contributed to that success and dynamism and be a person of substance.

5. On the presentation and substance of the inquiry you may like to know that Sir Derek Rayner takes the view that:

(1) There is the risk of an adverse reaction if the inquiry is set up on the explicit assumption that there is over-manning in the NHS.

(2) Given the importance of getting to grips with the issues, which can be slippery and elusive if dealt with on the basis of conflicting opinions, there is much to be said for testing them on the ground by means of scrutiny-type inquiries; and for making the maximum possible use of people within the NHS of good experience and instinct for this purpose.

6. Both these points have been made to DHSS.

C PRIESTLEY
17 January 1983

SofS Nat Health

(2)

Prime Minister

This is the upshot to the Policy Unit's note.

MLS 23/12

DEPARTMENT OF HEALTH & SOCIAL SECURITY

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

Telephone 01-407 5522

From the Secretary of State for Social Services

Michael Scholar Esq
10 Downing Street

Note Spoke to Sir K Stowe
Mr Collins has turned it down - this side of a general election.
MLS 7/1

22 December 1982

Dear Michael

NHS MANPOWER ENQUIRY

Thank you for your letter of 20 December enquiring about progress on the management enquiry into the use and control of manpower in the NHS.

On terms of reference, the Secretary of State still envisages that the enquiry will cover the ground set out in the note attached to his minute of 4 October and he proposes to settle the precise terms of reference in discussion with the Chairman when he has been selected.

On membership, the Secretary of State noted the Prime Minister's doubts about whether his lead names would be willing to serve and has been taking extensive soundings to find more promising candidates. He has been helped by Sir Derek Rayner and Pro-ned, the private sector organisation which finds non-executive directors for company boards, as well as by the public appointments unit and other Government Departments. He has a number of very suitable names with a good range of relevant experience, which he proposes to discuss with the Chairman designate.

His front runner as Chairman is Basil Collins, who is aged 59 and is in his last year as Deputy Chairman and Group Chief Executive at Cadbury Schweppes and who has recently been appointed to the Board of British Airways. He has achieved outstanding success in drastically slimming down the work-force in the profitable Cadbury Schweppes consortium, with a strike-free industrial relations record. His track record is first-class in the kind of high technology/manpower intensive field we are concerned with. He also, incidentally, has useful health service background as Chairman of the Finance Committee of the Royal College of Nursing. Informal soundings without commitments suggest that there are good prospects that he would be willing and available. He hopes to have discussions with his Chairman and with Sir Derek Rayner and will let us know in early January whether he will be willing to help.

The second choice, who has not yet been sounded, is Roy Griffiths, the Deputy Chairman and Managing Director of Sainsbury.

Either Collins or Griffiths would have to operate as part-time leader of the Team. Derek Rayner suggested, and my Secretary of State agrees, that since this is likely to be the only way of getting the calibre of man we want, we should support him with three or four other part-time outsiders each of whom would, under his direction, look at a particular aspect.

The Secretary of State will want to discuss the method of working with the Chairman and the team but he envisages that they will review initiatives already in hand; give advice on where more effort and changes of direction are needed; identify particular topics and problems on which more detailed work is required; and agree with Ministers deadlines appropriate to the particular tasks - these might vary from a week or two to six months or more depending on the topic and its complexity.

Yours ever,

David

D J CLARK
Private Secretary

Reorganisation of NHS : Nat Health Pt 2

CONFIDENTIAL

Nat Health 085

File

bc: Mr. Mount

10 DOWNING STREET

From the Private Secretary

20 December 1982

NHS MANPOWER INQUIRY

The Prime Minister would be grateful to know of the progress your Secretary of State is making in setting up the membership and terms of reference of the National Health Service Inquiry. She has asked what deadline or deadlines members of the Inquiry would be given for the submission of their reports, and whether Mr. Fowler is having any success in identifying a Chairman who would not be too closely associated with any of the medical institutions.

Could you provide a progress report before this week is out.

M. C. SCHOLAR

David Clark, Esq.,
Department of Health and Social Security.

CONFIDENTIAL

We need a much less formal inquiry. You can have a Royal Commission with (1) management. But we do need the right people with it.

10 DOWNING STREET

Prime Minister

NHS Inquiry

Please see Ferdy's note, attached (based, I believe, on work by Mr Monckton).

I think this goes off in the wrong direction. It seems to envisage a Royal Commission-type approach, which considers every NHS subject one can think of.

What Mr Fowler is after, I believe, is a continuous Rayner-

PTO

style scrutiny which focusses on a highly selected number of topics — manpower, management — and produces a stream of reports to the Secretary of State.

Should I confine my note to 4 (a) — we have already said 4 (c)?

Ask how/when they have got MES 17/12 and their proposals — why. We must have someone who is not bound to see the medical organisation.

17 December 1982
Policy Unit

PRIME MINISTER

NHS INQUIRY

I am rather anxious about the progress of Norman Fowler's setting-up of the NHS Inquiry.

1. Are they looking for the right Chairman? Basil Collins, Deputy Chairman of Cadbury-Schweppes, the leading candidate, has strong connections with the Royal College of Nursing. But would he meet your criterion of knowing about the running of hospitals? Would you like to suggest other names, at least as members of the Committee, eg George Bunton of University College Hospital; or Hugh Elwell, a consultant to PPP with wide experience and connections both in the NHS and in the private sector (he was one of the outsiders on the DHSS Committee on alternative financing of the NHS)?

2. Will the terms of reference be sufficiently wide-ranging? The "Management Inquiry into NHS manpower" described in Norman's Annex of 5 October would not appear to cover the sort of topics you mentioned to him and Treasury Ministers last Tuesday in your discussion on long-term public expenditure - such as privatisation of the general ophthalmic and dental services.

3. We understand that the Inquiry is expected to start work in the New Year and that its probable timescale would be about a year, although the team will be asked to make specific recommendations for action as they go along, and to supervise the carrying-out of their suggestions.

   This recommend-as-you-go approach does have advantages, but I believe they should have a firm deadline to concentrate their minds.

4. I think it might speed things up if Michael Scholar wrote to the DHSS expressing the hope that:

   (a) the membership and terms of reference might be settled soon;

   (b) the Inquiry would be given a deadline for the completion of its work;

(c) the membership would include people who had experience of hospital management, both in the NHS and the private sector (perhaps mentioning Bunton and Elwell);

(d) its terms of reference should be wide-ranging and should cover not only manpower but management and efficiency in the widest sense. We attach a potential draft.

FERDINAND MOUNT FM

DRAFT TERMS OF REFERENCE

We suggest that the terms of reference might be on the following lines:

"The management Inquiry into the National Health Service will consider all questions concerning the management, manpower, efficiency, operations and costs of the National Health Service which its members deem advisable, and all questions submitted for their consideration by the Secretary of State.

"In particular, the Inquiry will consider the following matters:

"Methods of improving the management structure of the NHS; the need for a more formal system of accountable line-management; the balance between the Departments, the Regions, the Districts and the general practitioner network in the light of the recent reorganisation; the division of responsibilities between health authority members and permanent officials.

"The finances and costs of the NHS; identification of savings to be made; identification of the data necessary for effective financial control and of the methods of collection and analysis of the data; establishment of such standard methods of cost-control as unit-costing and cost-comparisons of medical interventions; budgeting of future current expenditure to be incurred as a result of present or planned capital expenditure; the costs incurred outside the NHS resulting from changes within the NHS.

"The manpower of the NHS; the numbers employed in relation to the number of patients treated; ways of making significant reductions in manpower costs; manpower targets for March 1984 and beyond.

"The balance in the provision of health care between the public sector and the private sector; the scope for further privatisation and contracting-out; the possibilities of attracting private funds into the public sector."

It may be suggested that such comprehensive and detailed objectives cannot reasonably be met by a small inquiry team working for a limited period. However, in the private sector it is commonplace for such reviews to be carried out quickly, with the aid of management consultants if necessary.

It may also be suggested that so wide-ranging a review would amount to yet another reorganisation of the NHS when there have been too many already. We consider that the terms of reference set out above would not necessarily lead to a wholesale shake-up, but would reveal many major areas in which, without substantial dislocation, considerable increases in efficiency and decreases in costs could be achieved. We hold the initiative now that the NHS dispute is over, and we should strike while the iron is hot.

file

cc: DHSS.
B. Ingham
J. Vereker.

JD.

10 DOWNING STREET

THE PRIME MINISTER

11 October 1982

Dear Ralph.

I have discussed with Norman Fowler your proposal for an inquiry into the affairs of the National Health Service. We have concluded that a wide-ranging and necessarily time-consuming inquiry into all aspects of NHS management and organisation would take us forward neither fast nor far enough. There have already been two major, independent inquiries over the last decade, one by management consultants in the early '70s and another by a Royal Commission from 1976 to 1979, and I do not want this Government to add to the stockpile of analyses, but to drive forward a programme of reform.

Norman Fowler has already taken a number of initiatives to this end over the last year, directed in particular at the use and control of manpower. The new District Health Authorities, which have this year taken over the local management of the Service, will work within a much tighter system for setting objectives and securing accountability for their achievement. The planning and control of manpower has been strengthened through timely supply of manpower information which will now be on a quarterly basis, and by the introduction of new arrangements for setting Health Authority manpower targets and use of performance indicators in reviewing manpower levels.

A good deal of use has already been made of managerial and specialist expertise from outside the Service - for example, by appointing people from industry and business as chairmen of the new

/ Health

BMH.

Health Authorities, and in the programme of management scrutinies being developed under the guidance of Sir Derek Rayner.

The right course now, in my view, is to build incisively on the action that has already been taken. Accordingly Norman Fowler proposes to follow this up shortly with the establishment of a major manpower inquiry, which will bring in a high level outsider supported by his own team and management consultants to help him drive these initiatives forward and to assess what more is needed.

The emphasis needs to be on effective action for the future, but Norman Fowler will also be making available shortly to the relevant parliamentary committees an analysis of the use of resources in the NHS responding to questions which you and other parliamentary colleagues have rightly been asking. This work will also be available to and come under scrutiny by the management inquiry.

I attach a table of data as a foretaste of this: it shows what massive increases there have been in our investment in the NHS over the past 20 years, how the manpower has grown in consequence and how the nature of the service being given to the public has also changed, with an especially big growth in day patient activity. This is the field which the management inquiry will need to work over very thoroughly, for as you point out the potential benefits from greater economy in non-medical manpower are very large.

You also seek an inquiry into the performance of the Exchequer and Audit Department in regard to National Health Service matters. The main responsibility for the detailed National Health Service audit lies not with the Comptroller and Auditor General but with the statutory auditors appointed by the Department of Health and Social Security. Norman Fowler has recently set in hand a review of these arrangements. He also has under review the accounting conventions.

/ So far as

So far as the performance of the Comptroller and Auditor General and the qualifications and effectiveness of the Exchequer and Audit Department are concerned these are matters which have been extensively reviewed over the last few years. Substantial changes have been made, and particularly, the Department has obtained more qualified staff and continues to do so.

The Comptroller and Auditor General reports to Parliament, who refer his requests to the Public Accounts Committee and you can of course make your criticisms known to that Committee. The Government has often enough been accused (and wrongly) of interfering in the Comptroller and Auditor General's conduct of his responsibilities. On a matter of this sort it must be for the Public Accounts Committee, rather than for the Government, to respond to you. In all these circumstances, I believe it would be wrong to set up a new inquiry into the past performance of the audit machinery.

Yours ever

Margaret

Ralph Howell, Esq., M.P.

NUMBERS (THOUSANDS) ENGLAND

Activity	1961	1971	1976	1980
Hospital Services				
In-patient cases+ (including day cases)	4,035	5,171	5,735	6,341
Increase during period (% change)		1,136(28%)	564(3%)	606(13%)
Out-patient attendances (including accident emergency	40,133	46,260	45,473	48,296
Increase during period (% change)		6,127(15%)	-787(-2%)	2,823(8%*)
Regular day patient attendances	445	2,839	4,671	5,289
Increase during period (% change)		2,394(538%)	1,832(65%)	618(17%*)
Community Health Services				
Health visiting - cases attended	N/A	4,201	3,887	3,817
Increase during period (% change)		N/A	-314(-7%)	-70(-2%*)
Home nursing - persons nursed	1,341	1,670	2,780	3,421
Increase during period (% change)		329(25%)	1,110(66%)	641(30%*)
Hospital and Community Health Services Activity ϕ - % change		28%	5%	12%* (1981)

Manpower (whole-time equivalent**)	1961	1971	1976	1981 (provisional)
Medical and dental	19	27	33	37
Increase during period (% change)		8(42%)	6(22%)	4(12%)
Nursing and midwifery	239	309	360	388
Increase during period (% change)		70(29%)	51(17%)	28(8%)
Professional and technical	25	39	52	63
Increase during period (% change)		14(56%)	13(33%)	11(21%)
Administrative and Clerical	47	69	95	105
Increase during period (% change)		22(47%)	26(38%)	10(11%)
Ancillary	142	168	174	172
Increase during period (% change)		26(18%)	6(4%)	-2(-1%)
Others	31	37	42	45
Increase during period (% change)		6(19%)	5(14%)	3(7%)
Total NHS directly employed staff	503	648	755	811
Increase during period (% change)		145(29%)	107(17%)	56(7%)

Expenditure (£ million November 1980 prices)				
NHS gross current expenditure	N/A	7618.8	8811.9	9609.5
Increase during period (% change)		N/A	1193.1(16%)	797.6(9%)

/*/†/** see notes overleaf

Notes

+ Statistics on day cases are not available prior to 1972. The same growth rates have been assumed for day cases and in-patients before this date.

* The growth rates given here relate to the period 1976-81 to enable comparison with manpower and activity figures. Activity figures for 1981 are not yet available and the votes have been based on an extrapolation of trends in 1976 to 1980.

Ø This combined growth rate has been derived by weighting the rates of change in the various services by their expenditure share in the base year 1980.

** Figures for 1981 (except Medical and Dental) are provisional. All figures exclude DEB and PPA staff, locum medical/dental staff, agency nursing staff and nursing cadets. The exclusion has been necessary to construct a consistent series covering the period 1961 to 1981. The figures used here cover over 97 per cent of NHS staff in 1971 and 1981.

Figures prior to 1974 have been adjusted to reflect the changes in 1974 when local authority staff providing community health services were incorporated into the NHS. Adjustments have also been made to reflect changes in the basic working week between 1961 to 1981. Mr Howell's analysis of manpower/acitivity figures are misleading for a number of reasons.

i. Figures quoted by Mr Howell for the years 1960, 1970 and 1980 are a mixture of headcounts and whole-time equivalents. The proportion of part-time staff has increased significantly since 1960. (For example the headcount figure of 1,228,000 for the UK in 1980 is equivalent to 990,000 wte).

ii. Mr Howell has treated the transfer of staff from local authorities in 1974 as a true increase without adjusting the figures for earlier years and figures throughout have not been adjusted to take into account changes in working hours.

iii. In comparing these manpower figures to occupied beds over the period, Mr Howell is concentrating on one area of patient activity only - in-patient, and ignoring other areas (eg out-patients, day cases, day patients, community services) which have expanded over the period. More importantly beds are not a good measure of activity. As the activity figures show, more patients have been treated through a reducing number of beds resulting in a more intensive use of resources and lower average costs per case. The aim of the NHS is not to fill beds but to treat more patients and this is not reflected in the bed figures.

CONFIDENTIAL

cc. J.L.

NATIONAL HEALTH.

10 DOWNING STREET

From the Private Secretary

5 October, 1982

Management Inquiry into the National Health Service

The Prime Minister was grateful for your Secretary of State's minute of 4 October about the proposed Management Inquiry into the National Health Service.

She has commented as follows:

"I doubt whether your lead names will be willing to serve. Surely we need someone who knows about running hospitals."

I am copying this letter to John Kerr (Treasury), Muir Russell (Scottish Office), Adam Peat (Welsh Office), John Lyon (Northern Ireland Office), John Gieve (Chief Secretary's Office) and Richard Hatfield (Cabinet Office).

M. C. SCHOLAR

D. J. Clark, Esq.,
Department of Health and Social Security

CONFIDENTIAL

Prime Minister
Content? Please note in particular that Mr. Fowler proposes to trail the announcement in his Party Conference speech. - Agreed MT
FERB 4.10

PRIME MINISTER

I doubt whether your lead names will be willing to serve. Surely we need someone who knows about running hospitals MT

MANAGEMENT INQUIRY INTO NHS NON-MEDICAL STAFFING

When we met on 8 September, we agreed that it would be right to have an independent management inquiry into the non-medical staffing of the National Health Service.

I propose the appointment of a top industrialist (who might have to be part-time) supported by a full-time team of four drawn from inside and outside the NHS. I would expect him to call upon management consultants, for which I can find the necessary resources.

The aim of the inquiry will be to help me to secure more efficient management of manpower in the NHS. It will build upon the initiatives I have already taken to strengthen the planning and control of manpower and to call health authorities to account for their performance against agreed objectives. Annex A to this minute sets out the kind of ground which I expect it to cover and the way in which I envisage it might proceed, but I would not want to finalise this until I have secured the services of the outside leader of this inquiry and can discuss it with him.

The choice of person to head the inquiry will depend in part on who of those suitable has the time available. Ideally I am looking for someone with substantial and successful experience in the management of large-scale enterprises which combine high technology with large-scale manpower requirements. I would like him to be able to spend several days a week over a six to nine month period, but in practice I might have to settle for someone of the right calibre who could give less time but could carry out the task by using a rather larger supporting team.

I propose to take soundings of the following, who have either recently retired or are known to be ready to take on additional public commitments:

Sir David Orr - recently retired Chairman of Unilever and part-time Chairman of the AFRB;

E.R.

Mr Robert Haslam - shortly to retire as Deputy Chairman of ICI;

Mr Leslie Pincott - former Managing Director of Esso and Chairman of Stone Platt;

Mr John Raisman - Chairman of Shell UK.

The names are in order of preference. If it proves necessary to look for someone still heavily committed in industry but who might, with support, head the inquiry with a limited amount of time available, I would sound:

Sir Hector Laing - Chairman of United Biscuits;

Mr F Whiteley - Personnel Director of ICI;

Mr M Betts - Personnel Director of British Telecom, formerly of BBC and of GEC.

I do not think there is any point in seeking to defer an announcement of the inquiry until we have resolved the NHS pay dispute and believe we should seek to find a suitable person to head the inquiry. I would also like to "trail" the announcement in my Party Conference speech. If you are content I will proceed with soundings and report progress.

I am sending copies of this minute to the Chancellor of the Exchequer, the Secretaries of State for Scotland, Wales and Northern Ireland, the Chief Secretary and Sir Robert Armstrong.

4 October 1982

N F

CONFIDENTIAL

MANAGEMENT INQUIRY INTO NHS MANPOWER

Questions to be answered

1. The detailed questions to be answered by the inquiry will be for discussion with the person appointed. The following are the kind of questions on which the inquiry is expected to give an independent view.

a. To what extent the hospital and community health services are over-manned and where;

b. What more should be done by the Secretary of State and by the Service to identify and correct over-manning and on what time scale;

c. How fast will this produce savings which can be redeployed on such purposes as Ministers decide;

In particular

d. What would be realistic targets to set for different staff groups (i) in the period up to 1984-85; (ii) in the longer term;

More specifically

e. How can existing standards of patient care be provided by fewer staff, in order to release resources for needed service improvements.

f. What are the main processes by which the regional manpower targets for March 1984 due to be submitted by March 1983 should be set and their achievement secured and what action should be taken by the Secretary of State and the Department to help in those processes;

g. What are the processes by which manpower levels for later years should be decided and what guidance should be given to the NHS.

h. What further initiatives should be taken to promote efficiency in the service.

i. What are the industrial relations implications of increasing efficiency and how can these best be handled.

Reasons for the proposals

2. The Government has taken action to streamline NHS organisation, strengthen local management and eliminate unnecessary bureaucracy. Over the last year the Secretary of State has taken key initiatives to strengthen the use and control of manpower - through timely supply of manpower information on a quarterly basis (from a now fully computerised information system), new arrangements for setting health authority manpower targets within a strengthened system for setting objectives and securing accountability for their achievement.

3. He has not however been able to allay concern over NHS manpower levels and he is not yet satisfied himself that enough has been done.

4. The inquiry will help Secretary of State and the Department in carrying out their strategic functions for deciding the sources to be allocated for the NHS, setting strategic objectives and establishing systems to secure those objectives.

5. It will build on initiatives already taken, will help Ministers to use the systems already established and advise on what changes are needed.

6. The inquiry will be a closely focused management inquiry and is intended to maintain the key management role of the new District Health Authorities. They will remain fully responsible for managing the resources allocated to them. Whether changes are needed in the objectives set and advice given to them will depend on what the inquiry finds.

7. The inquiry while not concerned primarily with the role of the region may have changes to suggest in the regional planning, monitoring and accountability functions. It might, for example, have suggestions for adjusting the allocations made by the Department to Regions, or by Regions to Districts, by reference to the scope for differential efficiency savings.

8. The inquiry will be separate from but needs to take account of the various initiatives designed to help NHS management (eg the Rayner scrutinies and the pilot schemes for a management advisory service).

9. The inquiry is not intended to deal with clinical matters as such, but will be concerned with the consequences of clinical considerations and decisions in relation to manpower requirements. It will be necessary for the inquiry to have access to informed professional (including medical) advice on clinical matters. They will be able to obtain this from the Department's professional staff and through them, as necessary, from the appropriate professional bodies.

Methods of proceeding

10. It will be for the person holding the inquiry to decide the approaches to be adopted but these may include:-

a. Reviewing the work that the Department and health authorities have already done in promoting efficiency and improving management and control systems including

i. Study of the use of resources in the NHS and reasons for increases in staff;

ii. Experience with setting targets for efficiency savings;

iii. The progress with use of performance indicators;

iv. Experience of regional reviews;

v. The new manpower returns;

vi. Any findings emerging from MAS and Rayner scrutinies.

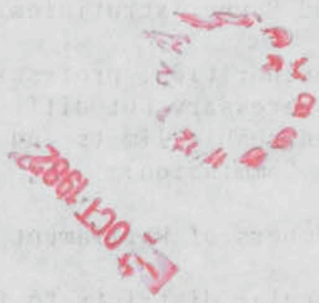
b. Obtaining views from the NHS, health authorities, professional organisations and trade unions (it will be necessary but difficult to keep this part of the exercise within manageable limits and avoid duplicating, for example, work of the Royal Commission);

c. Considering external criticism from Members of Parliament and others;

d. Carrying out sample enquiries in particular districts to find out how manpower levels have been arrived at, what the reasons are for growth, how well justified they are, what the arrangements are for review and what would be the likely consequences of reducing them.

Supporting teams

11. The supporting team will need to be discussed with the person appointed but we envisage a team of four of youngish high calibre people. One from the Department and three others on secondment from Treasury/MPO the NHS and the private sector. They would be able to commission management consultants. They will also be able to draw on the professional and specialist services of the Department.



VR

cc JV
BI
Non type reply for PM

Godt. Nach

DEPARTMENT OF HEALTH & SOCIAL SECURITY

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

Telephone 01-407 5522

From the Secretary of State for Social Services

M Scholar Esq
10 Downing Street

4 October 1982

Dear Michael

You wrote to me on 6 September, enclosing copies of letters which the Prime Minister had received from Mr Ralph Howell MP, proposing an Inquiry into the National Health Service.

The Prime Minister and my Secretary of State discussed the question of an independent Management Inquiry at their meeting on 9 September. They agreed that what was needed was a Management Inquiry which would build on the initiatives already taken by my Secretary of State and would formulate and introduce a progressive programme of action supplementing those initiatives. They agreed that it would not be profitable to have a wide-ranging analytical inquiry, which would require extensive consultation and offer no prospect of early action. My Secretary of State has now submitted a formal proposal to the Prime Minister - his minute of today.

My Secretary of State originally proposed to announce the Management Inquiry when the NHS dispute had been settled. Since this is not now immediately in prospect he is inclined to announce the intention to have an Inquiry as soon as possible. It will not be practicable to make a full announcement, however, until the leader has been secured and consulted, so he would not propose to refer to it in more than general terms. I accordingly attach a suggested draft reply to Mr Howell which indicates that a further initiative is being considered without being specific: we assume that it would go soon after any general announcement.

The table referred to in the draft reply is the one that Sir Kenneth handed to you when he visited No 10 with the Secretary of State and I enclose a further copy (very slightly amended).

Yours ever,

David

D J CLARK
Private Secretary

MS

C

Pl type reply for PM

SUGGESTED DRAFT REPLY TO MR HOWELL

I have discussed with Norman Fowler your proposal for an inquiry into the affairs of the National Health Service. We have concluded that a wide-ranging and necessarily time-consuming inquiry into all aspects of NHS management and organisation would take us forward neither fast nor far enough. There have already been two major, independent inquiries over the last decade, one by management consultants in the early '70s and another by a Royal Commission from 1976 to 1979 and I do not want this Government to add to the stockpile of analyses, but to drive forward a programme of reform.

Norman Fowler has already taken a number of initiatives to this end over the last year, directed in particular at the use and control of manpower. The new District Health Authorities, which have this year taken over the local management of the Service, will work within a much tighter system for setting objectives and securing accountability for their achievement. The planning and control of manpower has been strengthened through timely supply of manpower information which will now be on a quarterly basis, and by the introduction of new arrangements for setting Health Authority manpower targets and use of performance indicators in reviewing manpower levels.

A good deal of use has already been made of managerial and specialist expertise from outside the Service - for example by appointing people from industry and business as chairmen of the new Health Authorities, in the programme of management scrutinies being developed under the guidance of Sir Derek Rayner, and in the experimental use of commercial auditors for the audit of the National Health Service accounts.

The right course now, in my view, is to build incisively on the action that has already been taken. Accordingly Norman Fowler proposes

to follow this up shortly with the establishment of a major manpower inquiry, which will bring in a high level outsider supported by his own team and management consultants to help him drive these initiatives forward and to assess what more is needed.

The emphasis needs to be on effective action for the future, but Norman Fowler will also be making available shortly to the relevant parliamentary committees an analysis of the use of resources in the NHS responding to questions which you and other parliamentary colleagues have rightly been asking. This work will also be available to and come under scrutiny by the management inquiry.

I attach a table of data as a foretaste of this: it shows what massive increases there have been in our investment in the NHS over the past 20 years, how the manpower has grown in consequence and how the nature of the service being given to the public has also changed, with an especially big growth in day patient activity. This is the field which the management enquiry will need to work over very thoroughly, for as you point out the potential benefits from greater economy in non-medical manpower are very large.

~~So far~~

~~I am~~

You also seek an inquiry into the performance of the Exchequer and Audit Department in regard to National Health Service matters. The main responsibility

cc FM

CF/4R

Pl s.v. with DHSS draft

MCS 23/9

Treasury Chambers, Parliament Street, SW1P 3AG
01-233 3000

M C Scholar Esq.
Private Secretary
10 Downing Street
London SW1

22 September 1982

Dear Michael,

In your letter to David Clark of 6 September about Mr Ralph Howell's letter of 31 August to the Prime Minister you asked for a contribution from the Treasury touching on Mr Howell's Exchequer and Audit Department points. I enclose that contribution.

2. The Exchequer and Audit Department was the subject of a Management Review in 1978 which has led and is leading to considerable changes. Training for professional qualifications is being given special attention and the number of qualified staff is increasing all the time.

3. The role of the C & AG has also been the subject of much Parliamentary attention over several years and the Government's White Paper on the subject (Cmnd 8323) which, inter alia, left the NHS arrangements as they are, was not well received. Delicate neogitations are still in progress over this White Paper and a new review now would be positively embarrassing.

4. Finally, Mr Howell has not sent you all of his correspondence with Mr Downey about the provision of information. We have seen other letters which indicate that Mr Downey has done as much as he properly can to satisfy Mr Howell. The point at issue here is whether the C & AG may use information derived from his access to departmental papers for purposes other than his audit reports to Parliament and the PAC. The Government's forthcoming reply to the TCSC will specifically reject this. If MP's want information about departments' business they can and should obtain it from those departments or their Ministers. Mr Howell says that he has written to Sir Kenneth Stowe, as Mr Downey advised, and we understand that he has had a full reply from him.

5. For all these reasons the draft reply, which has been cleared by the Financial Secretary, declines Mr Howell's proposals, but sympathetically.

6. I am copying this letter to David Clark (DHSS), Gerry Spence (CPRS) and Richard Hatfield (Cabinet Office).

Yours,
Jill Rutter

JILL RUTTER

DRAFT REPLY ON E & AD ASPECTS OF
MR HOWELL'S LETTER OF 31 AUGUST

The main responsibility for the detailed ~~NHS~~ National Health Service audit lies not with the ~~C & AG~~ Comptroller and Auditor General but with the statutory auditors appointed by the Department of Health and SOcial Security. Norman Fowler has recently set in hand a review of these arrangements. He also has under review the accounting conventions.

2. As for Mr Downey's response to your questions about linen losses he is in fact right to point you in the direction of the Department for the answers to your questions and I note that you have approached Sir Kenneth Stowe accordingly.

3. So far as the performance of the Comptroller and Auditor General and the qualifications and effectiveness of the Exchequer and Audit Department are concerned these are matters which have come under full review over the last few years. Substantial changes have been made, and particularly, the Department has obtained more qualified staff and continues to do so.

4. I am sure it would be wrong to set up a new inquiry into the past performance of the audit machinery, though I understand the feelings which led you to suggest it. The C & AG reports to Parliament who refer his requests to the Public Accounts Committee and you can of course make your criticisms known to that Committee. The Government has often enough been accused (and wrongly) of interfering in the C & AG's conduct of his responsibilities. On a matter of this sort it must be for the PAC to respond to you, rather than the Government.

Sent

Sarhead

20 September 1982

I am writing on behalf of the Prime Minister to thank you for your two letters of 31 August. I am sorry we have not acknowledged these before now.

The Prime Minister saw these immediately, and has put certain work in hand. I hope that you will have your reply soon after her return from the Far East.

M. C. SCHOLAR

Ralph Howell, Esq., M.P.

CONFIDENTIAL

c.c. Mr. Mount

CPRS
CO
HMT.

10 DOWNING STREET

From the Private Secretary

6 September, 1982.

Dear David,

I attach copies of 2 letters which the Prime Minister has received from Mr. Ralph Howell MP, following her meeting with him early last month. You will see that Mr. Howell proposes that the Prime Minister set up an immediate Inquiry into the National Health Service, that the Inquiry should be carried out by independent outsiders, and that it should also examine the performance of the Exchequer and Audit Department.

The Prime Minister has commented that she has great sympathy with Mr. Howell's views; and, as you know, she has deployed on a number of occasions recently some of the figures which he has produced. She has also further commented that a management Inquiry may be a good idea for the Health Service. The Prime Minister has it in mind that the Cabinet discussion of longer term public expenditure options (set for Thursday, 9 September) may well throw up some suggestions as to how Mr. Howell's proposals might be replied to; she has also considered the possibility of asking the CPRS to conduct an Inquiry into efficiency in the public service, not only in the National Health Service, but also in the other public welfare services. It seems clear, however, that a CPRS Inquiry on these lines would not meet Mr. Howell's concern; particularly if, as would seem desirable, such an Inquiry would need to be confidential within the Government.

B/F

I would be grateful if you could let me have a draft reply for the Prime Minister's signature as soon as possible after the discussion on 9 September. I would be grateful, too, if Jill Rutter (HM Treasury), to whom I am copying this letter and attachments, would let me have a contribution to the draft reply touching upon Mr. Howell's Exchequer and Audit Department points. I am also copying this letter to Gerry Spence (CPRS), and Richard Hatfield (Cabinet Office).

Yours sincerely,

Michael Scholar

David Clark, Esq.,
Department of Health and Social Security.

CONFIDENTIAL

Mr. Scholar
We spoke. I see from Mr. Howell's second letter below that he has already submitted his minute to the TCSC. Did we know that before? and do we know what they have done with it?
FER
6.9.

10 DOWNING STREET

MR. BUTLER

Here is a copy of Ralph Howell's letter, and my note to the Prime Minister. You will probably want to wait until after the meeting on 9 September before deciding how to respond to this, but there is one point that you may want to raise with the Prime Minister; that is, when to consult the DHSS and the Treasury (the latter, given Ralph Howell's remarks about the E&AD).

Mr Butler

So far as I know all we knew abt the TCSC was what RH's letter says. Mr Kemp tells me that after some manoeuvring TCSC are designing into public sector manpower
PTO

3 September 1982

as a whole, the Tsy are doing a paper. They will call for witnesses etc.

This does not, as I see it, overturn the alleged privacy of RH's approach to the PM.

Pl see my letter to DHSS.

MLS 7/9

I have great sympathy with Ralph Howell's views.
I have been using some of his figures.
A management exercise may be a good idea but,

cc: Mr. Butler
Mr. Gow
Mr. Sparrow, CPRS

PRIME MINISTER

Here is the letter that Ralph Howell promised to send. I understand that Ian Gow has persuaded him to keep it private.

He makes three points:

(a) He would like you to set up an immediate inquiry to look specifically at the National Health Service. He does not want the inquiry to look more widely at the public sector as a whole.

(b) He wants the inquiry to be carried out by independent outsiders. He clearly would not be happy with an inquiry by the CPRS.

(c) He wants the inquiry to examine the performance of the Exchequer and Audit Department. He appears to think that the Department is supposed to ensure the effectiveness and efficiency of the National Health Service, and he considers that the Department have failed in this task. This seems to me to be a misunderstanding of the role of C&AG and his Department.

We will let you have a draft reply after the discussion on 9 September. But it seems likely that Ralph Howell may not be satisfied with the promise of an inquiry by the CPRS into the growth of public sector manpower generally, and you may have to have another meeting with him.

CM

3 September 1982

RALPH HOWELL, M.P.

HOUSE OF COMMONS
LONDON SW1A 0AA

31st August 1982

The Rt. Hon. Mrs. Margaret Thatcher, M.P.
Prime Minister

Dear Prime Minister.

Thank you very much for seeing me in early August and giving me so much of your valuable time.

I was very pleased that you recognised the need for an urgent and full inquiry into the National Health Service as a whole and I enclose my formal letter requesting that such an inquiry be set up.

I do hope that you will, in the first place, set up an inquiry separately into the National Health Service. If an inquiry were made into the Public Sector generally, I am convinced it would be very long drawn out and would also lose a considerable degree of impact. An examination of the Public Sector as a whole would achieve much better results after the findings of the National Health Service inquiry had been absorbed and understood.

Secondly, I believe that this inquiry should be conducted by independent individuals in the same way as the Falklands Inquiry which you have instituted. I believe, very strongly, that it would be quite wrong to ask any organisation in any way connected with the Civil Service or the Government to investigate this matter.

May I respectfully remind you of the action you took immediately on becoming aware of the aggression against the Falklands. First you took positive action to prepare the forces to regain possession and then you promised Parliament that you would institute a full and independent inquiry. Therefore, I hope you will not only institute the inquiry that I have requested but that you will similarly take necessary and immediate action to ensure that the British people are able to make full and proper use of the National Health Service which belongs to them and to no other separate faction.

RALPH HOWELL, M.P.

31st August 1982

In my opinion the chaotic state of the National Health Service is more serious than the Falklands invasion. The aggression that Britain and British subjects suffered in the Falklands is small compared to the aggression, suffering and intimidation being perpetrated by the militants within the National Health Service, not only against those who need treatment but also against those sound people engaged in the National Health Service who desperately want to get on with their work.

When you consider that the people of this Country are being forced to pay for overmanning of over 500,000 staff, costing at least £10,000 in overall costs each - £5,000M of their hard-earned taxes wasted in each year - and then that they are denied proper medical services when in need, I believe you will agree that this matter is one of the most urgent which confronts the Nation.

During the Falklands campaign your bold, courageous action brought you ever-increasing support from a huge majority of the British people. There is no doubt in my mind that the time has come when you must stop listening to the weak-kneed councillors of caution around you, and repeat the bold decisions you took to restore freedom to the 1800 Falklanders, and restore freedom and democracy to the 56 million people of Britain.

Yours ever

Ralph

RALPH HOWELL, M.P.

HOUSE OF COMMONS
LONDON SW1A 0AA

31st August 1982

The Rt. Hon. Mrs. Margaret Thatcher, M.P.
Prime Minister
10 Downing Street
London SW1

Dear Prime Minister,

I wish to make a formal request to you to institute an immediate and full inquiry into :-

1. The affairs of the National Health Service, and

2. The performance of the Exchequer & Audit Department with regard to National Health Service matters.

I base my request on the evidence which I have already submitted to the Treasury and Civil Service Committee, a copy of which I enclose (Annex "A"). I would point out that my request to the Treasury and Civil Service Committee is for an inquiry into overmanning in the Public Sector generally and I hope that action will be taken when Parliament reassembles.

1. My request to you is for an inquiry specifically into the National Health Service and mismanagement therein.

The following facts prove that there is no effective control of the National Health Service :-

(i) There is no Chairman or titular head of the National Health Service.

(ii) No one person is in overall executive control of any Health Authority or Hospital within the National Health Service.

Consequently there can be no effective overall management, budgetary, manpower, inventory or audit control either generally, at area or hospital level.

31st August 1982

The figures set out in Annex "B" show the extent of overmanning in the National Health Service.

Annex "C" draws attention to the losses shown in the Statement of Accounts which I believe warrant very careful scrutiny, bearing in mind that losses from theft, fraud, etc., of only .01% are, in my view, impossible. The explanation by the Comptroller & Auditor General that only certain losses appear in Statement 8 is unacceptable - see his letter of 25th June, 1982. (Annex "D")

I also enclose a copy of the Hospital Inventories Report 1967 (Annex "E") and would draw your attention to page 4, paragraph 10 (i) and (ii), and to the fact that the Report of 1982 merely recommends the continuation of the 1967 policies stating that "they remain a sound basis of good practice".

I believe these documents are ample evidence that there is no proper inventory control. The fact that the Daily Telegraph Article has never been refuted, plus reports which constantly circulate regarding National Health Service losses, indicate that very considerable losses are being sustained.

2. I also formally request that you instigate an inquiry into the Exchequer & Audit Department on the following grounds :-

a) The failure of past and present Comptrollers & Auditors General to quantify or arrest the overmanning which has occurred in the National Health Service during the last twenty years.

b) The unsatisfactory presentation of National Health Service Accounts.

c) The lack of qualifications of the Comptroller & Auditor General and also his recruitment and that of his predecessors from the Civil Service itself when, as I see it, his duty is to sit in judgement on the activities of the Civil Service and other public bodies, and to be totally independent.

d) The fact that only a small proportion of the staff are chartered accountants and none of those who are auditing the accounts of the National Health Service are chartered accountants.

31st August 1982

e) The extraordinary statement by the Comptroller & Auditor General in his letter of 23rd July, 1982, paragraph 3, regarding maintaining confidentiality (Annex "F") Parliament is his client and it is quite improper for him to maintain confidentiality for the National Health Service against Parliament itself.

I would also like to draw your attention to the Report of the Comptroller & Auditor General, National Health Service Accounts 1980-81 :-

"2. The Act empowers me to examine the accounts of individual health authorities, etc., and the records relating to them. I direct this examination mainly to the effectiveness of their procedures for financial control and for securing efficiency and economy in the use of resources".

It is my submission that the Comptroller & Auditor General has failed to carry this out.

For all these reasons I ask you to institute immediate inquiries into these two related matters.

Yours ever

Ralph

TR 245

ANNEX "A"

MANPOWER AND AUDIT CONTROL IN THE PUBLIC SECTOR

Note by Mr. Ralph Howell

I SUBMIT :

1. General Public Sector Manpower Facts 1960 - 1980.

2. NHS MANPOWER and related facts.

3. NHS ACCOUNTS 1980-81. Statement 8.
   Losses (1) and (4)
   Daily Telegraph Report - 16.4.82.
   Hospital Inventory Report - 2.6.82.

4. Comptroller & Auditor General Staff employed on NHS Audit.
   Prime Ministers reply - 22nd June (Col.67/68)
   18th May (Col.68/69)
   Chartered Accountants dealing with NHS - NIL.

NOTE : Although the papers relate to manpower, accounts, auditing and losses in the NHS, I am merely using the NHS as an example of what is happening generally in the Public Sector.

These submissions prove that :

(a) There is inadequate control of manpower.

(b) The Comptroller & Auditor General and his staff are inadequately qualified and have insufficient information to audit the accounts.
As far as I have been able to ascertain the allegations made in the Daily Telegraph Article have never been refuted and the Internal Report which I have submitted indicates that there is inadequate inventorial control.

(c) The special relationship between the C.A.G. and P.A.C. has failed to monitor efficiency within the NHS or produce accurate NHS accounts.

Therefore, I request that the Treasury and Civil Service Committee should urgently enquire into thewhole area of both manpower and audit control of the Public Sector. I repeat, I have used the NHS as an example - an enquiry is needed into the Public Sector generally.

STATISTICAL SECTION
HOUSE OF COMMONS LIBRARY
LONDON SW1A OAA

direct line
01-219 3622

switchboard
01-219 3000

12th March 1982

GFL/SJW

Dear Mr. Howell,

Statistics of manpower in the public services

I have been asked to reply to your enquiries. Miss Tanfield will be replying separately to the points about unemployment.

1. The Civil Service

	Thousands, full-time equivalent at 1st April		
	Non-industrial staff	Industrial staff	Total
1960	379.7	262.8	642.5
1970	493.0	207.8	700.8
1980	547.7	157.4	705.1

The Post Office is excluded throughout, but the coverage of the figures has changed during the period because of alterations in the scope of the definition of the Civil Service.

Sources: Annual Abstracts of Statistics, 1970, Tables 138 and 139; 1981, Table 6.5

2. National Health Service, Local Authorities, Public Corporations

	Thousands at mid-year		
	NHS	Local authorities	Public Corporations
1960	n.a.	1,821	1,865
1961	575	1,870	2,200
1970	741	2,559	2,025
1980	1,228	3,027	2,036

In these figures, part-timers are counted as whole units, unlike those of the Civil Service given above. With these figures also, there were changes in definition during the period.

Sources: Economic Trends, Feb. 1976, p.123; Nov. 1979, p.98; Dec. 1981, p.94.

/...

Table 2 Teaching and non-teaching staff of education departments, Great Britain and England and Wales

Thousands

		1960(a)	1970	1974	1975 Old basis	1975 New basis	1976	1980
Great Britain								
Lecturers and teachers:	full-time	336.0	453.0	561.6			587.6	603.7
	part-time	76.0	155.4	181.1			152.8	151.4
	total	412.1	608.4	742.7			740.4	755.1
	total f.t.e.(b)						623.0	635.8
Other education dept. staff:	full-time	88.5	201.8	237.2			252.5	226.2
	part-time	99.6	394.6	473.5			529.0	521.1
	total	188.1	596.4	710.7			781.5	747.3
	total f.t.e.						481.1	452.2
All staff, full-time and part-time:	crude totals	600[illegible]	1,204.8	1,453.4			1,521.9	1,502.8
	total f.t.e.						1,104.2	1,088.0
England and Wales								
Lecturers and teachers:	full-time	298.3	406.8	505.2	515.9	517.1	527.9	540.8
	part-time	74.3	147.3	171.5	186.4	160.4	144.6	145.7
	total	372.6	554.1	676.7	702.3	677.5	672.5	686.5
	total f.t.e.					552.8	560.2	570.7
Other education dept. staff:	full-time	80.5	181.1	210.9	220.0	222.1	222.6	201.0
	part-time	90.4	370.4	443.9	486.4	490.4	495.4	484.2
	total	170.9	551.5	654.8	706.4	712.5	718.0	683.3
	total f.t.e.					432.6	435.4	410.0
All staff, full-time and part-time:	crude totals	543.5	1,105.6	1,331.6	1,408.7	1,390.0	1,390.5	1,369.7
	total f.t.e					985.4	995.6	980.8

Note: (a) excluding canteen staff who are included in subsequent years. "Other" education staff in Great Britain rose by 150,700 between 1960 and 1961 (a rise of 105,000 in the total of part-time women separately) and most of this rise is probably accounted for by the inclusion of canteen staff.
(b) full time equivalent.

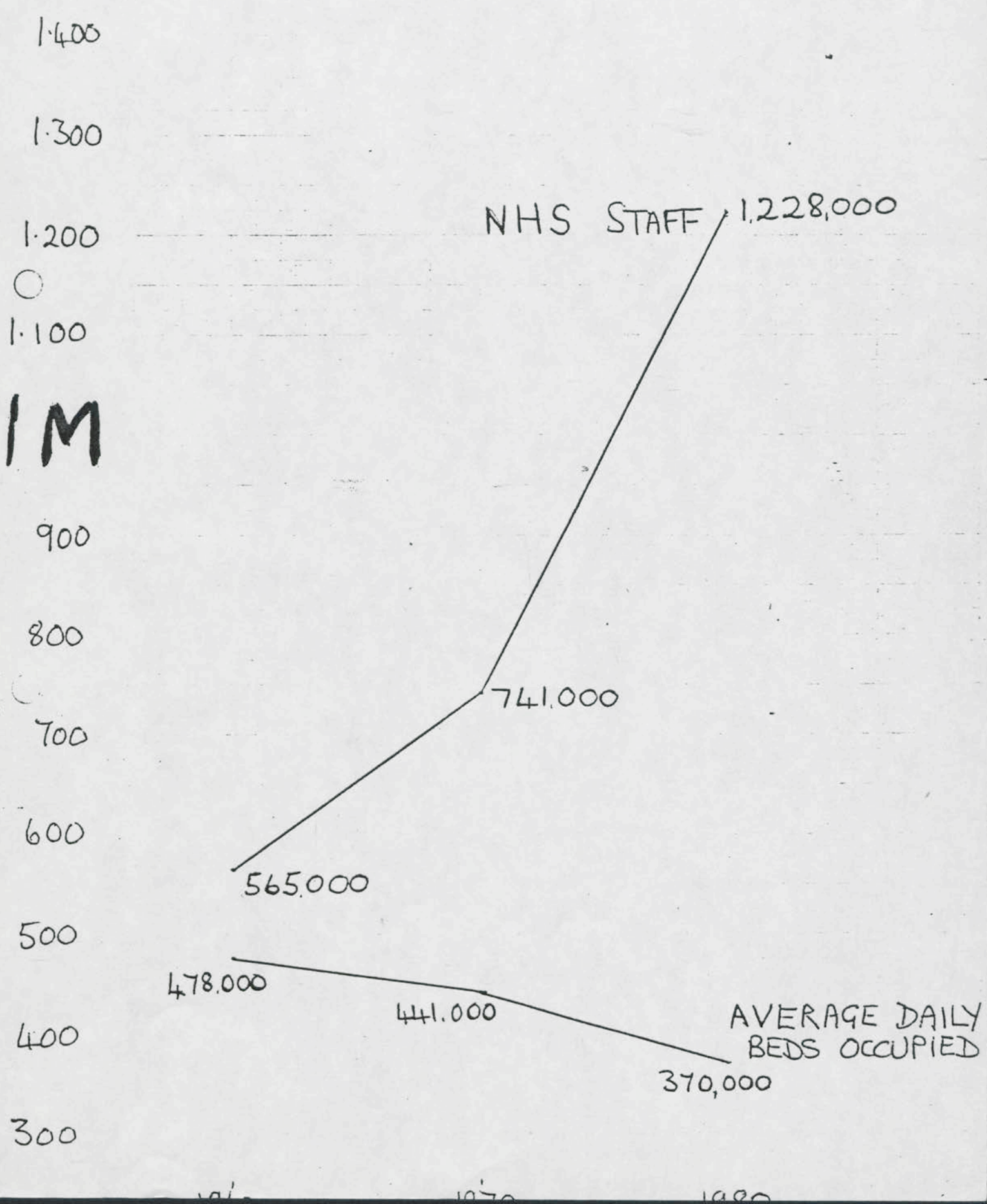
Sources: Ministry of Labour/Department of Employment Gazette, Dec. 1960, p.468; Nov. 1970, p.1028; Dec. 1974, p.1141; Nov. 1976, p.1252; Nov. 1977, p.1218; Dec. 1977, p.1372; and Dec. 1981, p. S11 and S13.

Local Authority Financial Statistics, England and Wales. 1976/77, p.8 and 1979/80, p.51.

THOUSANDS

RALPH HOWELL, M.P.

ANNEX 'B'



IS THE NATIONAL HEALTH SERVICE OUT OF CONTROL ?

In the Conservative Manifesto of 1979 we said -

"In our National Health Service standards are falling - there is a crisis of morale - too often patients' needs do not come first. It is not our intention to reduce spending on the Health Service - indeed we intend to make better use of what resources are available. So we will simplify and decentralise the service and cut back bureaucracy".

It is generally accepted that in 1960 our National Health Service was unequalled in the World.

Nobody could make such a claim today.

The facts below show what has been happening in the last twenty years and how we have failed to alter the general direction of overmanning, restrictive practices and falling standards.

	1960	1970	1980	Source
Total U.K. population.	52,559,000	55,522,000	56,010,000	
Population covered by NHS.*	98.11%	96.43%	93.61%	HANS.1.12.81 Col. 88.
Total Staff.	565,000	741,000	1,228,000	
INCREASE Population between 1970 & 1980			- 488,000	
INCREASE Staff		" " "	487,000	

* The numbers of people joining BUPA and similar private schemes has now reached 4,000,000 (1,250,000 in 1960) and is increasing rapidly.

	1960	1970	1980	
HOSPITAL WAITING LISTS (England only)	401,216	493,330	611,748	HANS.18.1.82 Col. 49/50.

	1960	1970	1980
Average daily no. of beds occupied (U.K.)	478,000	441,000	370,000
Ratio of staff to occupied bed.	1.2	1.7	3.3

BREAKDOWN OF STAFF

Totals of Staff (Great Britain) (WHOLETIME EQUIVALENTS)

	1960	1970	1980 (Provisional)	Source
Medical & dental	19,919	27,301	46,450	1960 & 1970 figs. Library 21.1.82.
Nursing & midwifery.	236,711	343,682	448,870	1980 HANS. 23.11.81
Other	n.a.	387,228	468,235	Col. 270.

Totals of Staff (Great Britain) (WHOLETIME EQUIVALENTS)

	1979	1980 (Prov)	Increase	Source
Medical & dental	45,150	46,450	1,300	
Nursing & midwifery.	437,405	448,870	11,465	
Professional & tech.	71,407	77,500	6,093	
Works	6,856	7,085	229	
Maintenance.	25,655	26,100	445	
Admin. & clerical	121,900	124,890	2,990	
Ambulance	20,177	21,035	858	HANS. 23.11.81 Col. 270.
Ancillary	211,114	211,625	511	
Totals	939,664	963,555	23,891	

INCREASES

		Source
May 1979	939,664	
Est. 1981/82	981,200	HANS. 23.11.81 Col. 270.
INCREASE	41,536	
LATEST FIGURE	67,000	HANS. 19.1.82. Col. 152.

QUESTIONS WHICH SHOULD BE ASKED

WHY when we have more than 200,000 nurses over and above the 236,000 employed in 1960, do we still need to increase nurses at the rate of 11,000 a year?

WHY increase administrators by nearly 3,000 between 1979 and 1980?

WHY did we need to increase ambulance personnel by nearly 1,000 between 1979 and 1980?

Further facts which demonstrate the lack of control of National Health Service expenditure :-

	1960	1970	1980	
	£m	£m	£m	
NHS Expenditure	863	1,954	11,444	Leon Brittan's reply 8.6.82
% of GDP	3.4	3.8	5.1	

Number of staff employed by Exchequer & Audit Dept. on NHS audit.	34	Prime Ministers reply 18.5.82. Cols. 68/69.
Chartered Accountants	Nil	
Qualified members of Chartered Institute of Public Finance & Accountancy.	3	
Passed Departmental Training examinations.	14	
Undergoing training.	17	

Computers in NHS		
Number of computers installed since 1960.	Not known.	Prime Ministers reply 16.3.82.
Cost of computers installed since 1960.	Not known.	
Register of computers in NHS to be established in JUNE 1982.		Kenneth Clarke's reply 7.4.82.

NHS STAFF - Number of Grades of staff.	5,000	Geoffrey Finsberg's reply 19.5.82.

Is there any overall target for the eventual size of the National Health Service or is it totally out of control?

Is the overmanning which has occurred in advance of the proposed reorganisation of the National Health Service, a repeat performance of what happened in Local Government reorganisation in 1972?

The increase of 67,000 in National Health Service personnel has cancelled out the reduction of 56,000 which the Government has laboriously achieved in the Civil Service.

After two and a half years the overall reduction in public sector manpower is less than 1%.

The firm monetary policies have succeeded in effectively reducing overmanning in the private sector.

The effect on the public sector has been abysmal.

ANNEX "C"

STATEMENT 8 (England)

STATEMENT OF LOSSES, ETC.

YEAR ENDED 31 MARCH 1981

	Number of cases	Amount	Recoveries
		£	£
1. Losses of cash due to:			
(*a*) theft, fraud, etc.	669	72,986	1,005
(*b*) overpayments of salaries, wages, fees and allowances	769	210,836	1,976
(*c*) other causes, including unvouched or incompletely vouched payments, overpayments other than those included under 1(*b*); loss by fire (other than arson); physical cash losses and losses of stamps, or similar cash equivalents	1,101	63,527	866
2. Fruitless payments (including abandoned capital schemes)	229	52,128	108
3. Bad debts and claims abandoned:			
(*a*) Road Traffic Act claims	36,486	111,964	859
(*b*) other	16,788	13,733,738	12,295
4. Stores losses (equipment and property) due to:			
(*a*) theft, fraud, arson, etc.	3,254	833,478	13,003
(*b*) incidents of the service (as a result of fire, flood, etc., motor vehicle accidents, damage to vehicles)	5,144	2,686,242	144,821
(*c*) other causes	3,414	724,499	243,009
5. Compensation payments (made under legal obligation)	2,825	3,440,227	448,569
6. *Ex gratia* payments:			
(*a*) extra-contractual payments to contractors	60	374,070	44
(*b*) compensation payments (including payments to patients and staff for loss of personal effects)	6,692	251,299	2,052
(*c*) private street works charges	2	2,101	—
(*d*) other payments	185	22,487	60
7. Extra-statutory and extra-regulationary payments	4,550	204,735	615
	82,168	22,784,317	869,282

NOTES:

(i) Included at item 3(*b*) is an amount of £13,288,000 in respect of an abandoned claim and item 6(*a*) includes a related payment of £98,655 both of which arose through a contractor going into liquidation. Item 6(*a*) also contains an amount of £163,740 in respect of a separate but similar case. Item 4(*b*) contains six cases each in excess of £75,000 and amounting to £1,026,133 due to fire damage. Item 5 includes 3 cases each in excess of £75,000 and totalling £508,263.

(ii) One area health authority included an entry of £1,490,500 (Cr) at item 4(*a*) in its Statement of Losses in order to adjust a larger entry recorded in a previous year. To avoid distorting the national figures this adjustment has been omitted from the above statement.

(iii) Sample checks by Family Practitioner Committees of prescription forms on which patients have claimed exemption from dental, optical and prescription charges indicate a loss estimated to be of the order of £2,177,000 from non-payment of charges due. This sum is not however included in the foregoing statement.

NATIONAL HEALTH SERVICE

DAILY TELEGRAPH

16.4.82 p14

LINEN THEFTS COST HEALTH SERVICE £1m A YEAR

By CON COUGHLIN

THE National Health Service is losing at least £1 million a year in stolen linen because of inadequate security arrangements, it was claimed yesterday.

Sheets, blankets and nappies are being stolen by staff, patients and visitors because few, if any, checks are made on them.

Mr Ernest Parkinson, district security advisor for Camberwell Health Authority, said health authorities expected to lose at least 10 per cent. of their linen each year through theft.

Speaking at a conference organised by the International Association for Hospital Security, Mr Parkinson said: "It is impossible to estimate exactly how much linen is stolen each year because there are no methods of strict stock control.

"The Health Service estimates it lost more than £1 million in linen last year, but this is a conservative figure. With proper security measures these thefts could be avoided."

Petrol check

At one hospital staff had to buy an extra 40 sheets, 50 blankets, 50 pillow slips, 20 counterpanes and 20 draw sheets each month to compensate for the losses. In one district half the stocks of baby nappies were lost in a year.

Mr Ken Sneath, principal Health Department auditor, said that at one hospital large quantities of petrol were stolen regularly. The fraud was only discovered by looking at how many miles hospital vehicles were doing to the gallon. The average was found to be two miles to the gallon.

Overseas calls

At a mental hospital a charge nurse was found to have ordered £500 worth of cigarettes for patients who did not smoke. Some nurses had relatives overseas and made long-distance telephone calls which could cost £200 a time.

Mr Parkinson said the Health Service needed to take a more realistic attitude to security, with more security staff and more [illegible]

[illegible] even," he said

HOSPITAL INVENTORIES

1. A Working Party was established in the North Western Region to review the Ministry of Health report on "Hospital Inventories".

2. The group felt that the principles contained in the 1967 report remained a sound basis for good practice.

3. It was therefore considered superfluous to go through the whole process again when the advantages and disadvantages of inventories had been thoroughly examined and clearly set out in the 1967 report.

4. It was felt that a number of additional factors were now of relevance:-

   (a) the use of computer facilities and mathematical techniques in determining stock levels, store layouts, and for the provision of costing and budgetary information can all contribute towards achieving better overall control.

   (b) whilst accepting the general arguments proffered against the maintenance of traditional inventories it was felt that high value, desirable items of stock and equipment should be the subject of some form of inventory style logging and checking procedures.

   (c) the use of computerised inventory systems can enable much of the "routine slog" to be taken out of the compilation, update and maintenance of inventories.

   (d) the periodic, independant review of procedures for ordering, receiving, storing and disposing of goods and equipment is an essential element in achieving sound controls. It is felt that Internal Audit has a role to play here.

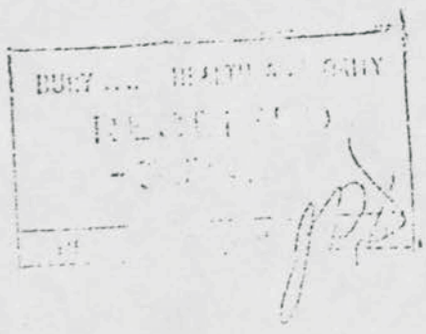
   (e) the maintenance of inventories encourage staff to be aware of the need for adequate control of property.

5. The North Western group, felt that the 1967 report should be re-issued and the attention of Health Authorities drawn to the need to encourage staff to be concerned with:-

   (a) the security of property,

   (b) the avoidance of loss,

   (c) the need for economy in the use of resources.



Comptroller and Auditor General

18·5·82
(Cols 68/69)

Mr. Ralph Howell asked the Prime Minister, pursuant to her answer to the hon. Member for Norfolk, North, 19 April, *Official Report*, c. 19, what is the total number of staff of the Comptroller and Auditor General; how many of these people are qualified accountants; and if she will list separately the qualifications of the 36 staff of the Comptroller and Auditor General who are employed on the audit of the National Health Service.

The Prime Minister: The present staff of the Comptroller and Auditor General for England, Scotland and Wales numbers 766, of whom 621 are audit staff, and the remainder supporting staff. The Department has 60 staff who are qualified as members of accountancy bodies. A further 235 are at various stages of training for such qualifications.

Thirty-four audit staff are currently employed on the audit of the National Health Service in England, Scotland and Wales. Of these, 14 have passed the departmental training examination; three are qualified members of CIPFA; and 17 are undergoing training for that qualification. The Comptroller and Auditor General for Northern Ireland employs four staff on NHS audit and their qualifications are: one FCCA; one ACIS and two unqualified.

Comptroller and Auditor General

22·6·82
(Cols 67/68)

Mr. Ralph Howell asked the Prime Minister (1) pursuant to her answer to the hon. Member for Norfolk, North 18 May, *Official Report* c. 68-69, how many of the present staff of the Comptroller and Auditor General for England, Scotland and Wales, are chartered accountants, split between those who audit within *(a)* the Civil Service, *(b)* local government, *(c)* the National Health Service and *(d)* all other Government bodies;

(2) pursuant to her answer to the hon. Member for Norfolk, North 18 May, *Official Report* c. 68-69, if she will give details of the qualifications of the 60 staff employed by the Comptroller and Auditor General who are qualified as members of accountancy bodies, and also state how many are chartered accountants.

The Prime Minister: The Comptroller and Auditor General currently employs 63 staff who are qualified as members of accountancy bodies, as follows:

	Staff
Institute of Chartered Accountants	8
Association of Certified and Corporate Accountants	7
Chartered Institute of Public Finance and Accountancy	40
Institute of Cost and Management Accountants	8
The eight members of the Institute of Chartered Accountants are assigned to audits in the following areas:	
Civil Service	6
National Health Service	NIL
Other Government Bodies	2

The C&AG does not undertake audits within local government; these are the responsibility of the District Audit Service or commercial accountancy firms.

ANNEX "D"

EXCHEQUER AND AUDIT DEPARTMENT
AUDIT HOUSE VICTORIA EMBANKMENT
LONDON EC4Y ODS

Comptroller and
Auditor General
Gordon Downey C.B.

GSD 464

25 June 1982

Ralph Howell Esq MP
House of Commons
London SW1

Dear Mr. Howell,

REPORTING OF LOSSES IN NHS SUMMARISED ACCOUNTS

You asked David Myland on the telephone on 23 June for information on a number of points relating to the NHS Summarised Accounts for 1980-81.

2. On the question of the relationship of the Losses Statement (Statement 8) to the main expenditure statement in the Summarised Accounts of Health Authorities in England, any cash losses, overpayments, compensation payments etc arising in the financial year will be charged in the main statement as revenue or capital expenditure, and will be reflected in one of the other Statements which analyse expenditure to objective heads eg Statement 2. But these losses, compensation payments etc are not identified in those Statements. This follows long-standing practice in the Appropriation Accounts, where losses and special payments are charged to normal subheads and not identified therein, but included in overall Losses Statements appended to the Accounts. The practice of opening special losses subheads in accounts was dropped in 1961 with the concurrence of the Public Accounts Committee; this was because such subheads were misleading as they covered cash losses only to the extent of sums relating to the year of account, and they did not include all categories of cash loss. Furthermore stores losses, and claims abandoned, could not be included in such subheads. On the other hand a Losses Statement can exhibit the full amount of all losses coming to light in the year, whether relating to cash lost or disbursed in that year or an earlier year, fraud in any year, losses of stores etc acquired in an earlier year, and shortfalls in receipts in the current or earlier years. Thus the reader can see at one point the entire picture for a year, and does not need to search through the accounts for a series of disconnected items. Even if the current year cash element of losses were shown in the Statements relating to the various services within the NHS, this would not provide a complete breakdown of losses. Notes would have to be added to reflect earlier year, stores, etc items. And to do so would run counter to the further simplification of Losses Statements in

/the Appropriation

the Appropriation Accounts which the PAC have recently endorsed in their Eighteenth Report of the present Session.

3. You expressed doubt whether the 1980-81 figures relating to cash and stores losses due to theft, fraud etc, were representative of the actual level of such losses in the NHS. The position is that Statement 8 is compiled by aggregating similar statements prepared by each of the individual health authorities. Those authorities maintain accounting systems under which they are required to record all such losses which come to light, and their annual losses statements form part of their accounts which are subject to independent audit and certification by the DHSS Statutory Auditors. E&AD carry out test checks to verify the work of those auditors and are satisfied on that basis that in general it can be relied on to ensure that Health Authorities produce sound figures for incorporation in the Summarised Accounts.

4. In the past both the statutory auditors and E&AD have found evidence of weakness in the stores and inventory control and stocktaking procedures of individual health authorities. But the health authorities have made improvements and we have no current evidence that this has led to a material understatement in the level of reported losses.

5. You enquired whether it was possible to secure a breakdown under subjective heads of the total cost of the NHS, so that you could compare the level of losses against the level of relevant expenditure. I can confirm that DHSS prepare this information for their own internal use, but do not publish it, and it does not form part of the accounts audited by E&AD. Accordingly I suggest that you should approach DHSS directly for any details you require.

Yours sincerely,

Gordon Downey

GORDON DOWNEY

RALPH HOWELL, M.P.

21st July 1982

Gordon Downey Esq., CB,
Comptroller & Auditor General
Exchequer & Auditor Department
Audit House
Victoria Embankment
London EC4Y ODS

Dear Mr. Downey

I am experiencing some difficulties in understanding the National Health Service Accounts 1980-81, and I am particularly concerned at the very small amount which is shown for theft, fraud, etc. under items 1-4, Statement 8. These amounts total less than one million, which is roughly .01% of total expenditure. I understand that in normal business a 1% loss from such causes is recognised as extremely good.

When I met you and Mr. Myland in June, Mr. Myland mentioned a report into linen or laundry losses - I cannot remember which. Since our meeting I have tried unsuccessfully to find such a report. I would be most grateful for any information you can give me on the subject.

I telephoned you recently and I asked if the report in the Daily Telegraph on 16th April, 1982, concerning £1m linen losses, had been refuted by you or your Department or by the National Health Service. I would be grateful if you would confirm or deny whether this statement, reputed to have been made by Mr. Sneath, Principal Health Department Auditor, has been refuted.

Yours sincerely

ANNEX "E"

MINISTRY OF HEALTH

WORKING PARTY ON HOSPITAL INVENTORIES

REPORT

WORKING PARTY ON HOSPITAL INVENTORIES

Chairman: L. B. JACQUES, F.C.A., Ministry of Health.

Hospital Service Members

J. D. BANKS, M.A., F.H.A., House Governor,
King's College Hospital.

Miss E. A. BELL, S.R.N., S.C.M., R.N.M.S., R.M.P.A.,
Regional Nursing Officer, East Anglian Regional
Hospital Board.

Miss R. M. JONES, S.R.N., R.S.C.N., S.C.M., Matron,
Bristol Royal Hospital

MOSTYN DAVIES, F.S.S., F.H.A., Secretary and Supplies Officer,
Mid Glamorgan Hospital Management Committee.

J. K. RHODEN, F.H.A., M.Inst.P.S., Supplies Officer,
Enfield Group Hospital Management Committee.

M. S. RIGDEN, F.C.A., F.H.A., Treasurer,
Sheffield Regional Hospital Board.

D. SHERREN, F.C.A., Treasurer,
The London Hospital.

B. G. SPENCER, F.C.A., F.I.M.T.A., F.H.A., Treasurer,
Tunbridge Wells Group Hospital Management Committee.

H. W. WHITE, O.B.E., F.H.A., F.C.C.S., J.P., Secretary,
South Western Regional Hospital Board.

Departmental Members

J. ALLAN, Ministry of Health

Miss M. S. HARDIE, " "

H. G. JONES, " "

Miss M. C. SCHURR, " "

G. W. H. WOODMAN, " "

J. S. DICK, (Observer) Scottish Home & Health Department

R. B. REEVE, (Secretary), Ministry of Health.

Miss S. P. WHITE, S.R.N., S.C.M., attended two meetings in place of Miss BELL; other Ministry officers attended as necessary.

CONTENTS

		Paragraphs
I.	INTRODUCTION	1-3
II.	BACKGROUND TO THE PROBLEM	
	Existing guidance to hospital authorities	4-12
III.	CONTROL OF PROPERTY OUTSIDE THE HOSPITAL SERVICE	
	Government Departments and the Armed Services	13-15
	Local Government	16
	Hotel organisations and commercial firms	17-19
IV.	SPECIAL FEATURES OF THE HOSPITAL SERVICE	
	Arguments for and against the traditional system of control by inventories in hospitals	20-24
	The extent of losses revealed by the present system	25-26
V.	RECOMMENDED FORMS OF CONTROL OVER HOSPITAL PROPERTY	
	Management's aims	27
	How these aims can be achieved	28-29
	Classification of equipment	30
	Control over items of limited life	
	(a) Scrutiny of issues	31-33
	(b) Determination of linen holdings	34-37
	Control over items of long life	38-41
	Control over other items	42
VI.	SECURITY ARRANGEMENTS	43-48
VII.	SUMMARY OF RECOMMENDATIONS	
	(a) Control over items of limited life	49-51
	(b) Control over items of long life	52-53
	(c) Control over other items	54
	(d) General	55-59
		Page
	Reservation by Mr. J. D. Banks	13
VIII.	APPENDIX	
	Items suitable for inclusion in a Register of Special Equipment	14

I. INTRODUCTION

1. We held five meetings between March and September, 1967.

2. Our terms of reference were "to examine the present procedure for the preparation, maintenance and checking of hospital inventories, to consider to what extent the procedure provides an effective measure of control over hospital property and to make recommendations as to any improvements considered to be necessary having regard to present conditions in the hospital service and the need to conserve manpower".

3. We were helped in our task by a report on hospital inventory controls of a research team of the Association of Hospital Treasurers which appeared in the October, 1966 issue of Hospital Service Finance, the official journal of the Association. This report proposed a master list of inventory items to which hospital authorities would be free to add other items which were small in bulk but of significant value.

II. BACKGROUND TO THE PROBLEM

Existing guidance to hospital authorities

4. The N.H.S. (Hospital Accounts and Financial Provisions) Regulations, 1948 - regulation 23 states that hospital authorities "shall maintain inventories of such articles of equipment, not held on store charge, and in such form as the Minister may from time to time require".

5. R.H.B.(50)17/H.M.C.(50)17/B.C.(50)15 set out the lines upon which such inventories should be prepared, maintained and checked, and classified hospital equipment into three groups for inventory purposes, as follows:-

Group 1 - Permanent or fixed equipment, i.e. equipment:-

(i) fixed permanently to the building and not subject to removal, or

(ii) fixed to the building but subject to removal and having long life, e.g. boilers, lifts, machinery, pumps, etc.

Group 2 - Furniture and surgical, diagnostic and therapeutic apparatus, comprising:-

(i) movable equipment having a more or less fixed location in the hospital,

(ii) items having sufficient individuality and size to be easily identified and controlled,

(iii) items having a minimum life of 5 years, i.e. beds, chairs, desks, office machines, sterilizers, operating tables, oxygen tents, mobile and portable X-ray equipment, etc.

Group 3 - Utensils, instruments and bedding, covering:-

(i) equipment having no fixed location and subject to requisition or use by various departments,

(ii) items small in size,

(iii) items having a life of less than 5 years, i.e. bedpans, dressing jars, syringes, catheters, glassware, pots and pans, sheets, blankets, bedding, etc.

6. Items in Group 1 were specifically excluded from inventories. Items in Group 2 were required to be placed on inventories but hospital authorities were given discretion as regards categories of articles falling within Group 3. It was visualised that most items falling within Group 3 would appear ultimately on inventories but authorities were asked to have regard to what was practicable in particular hospitals. Heads of departments, ward sisters, etc., were to be responsible for the custody, upkeep and regular checking of inventories. The Chief Financial Officer was to have general responsibility for the system and for independent test checks. The guidance also included a suggested form of inventory and a list of items which would normally appear on inventories. The list was not exclusive.

7. R.H.B.(50)H.M.C.(50)80/B.C.(50)76 issued seven months later recognised that the preparation of inventories would require increases in administrative staffs. It asked authorities to use wide discretion in the selection of Group 3 items for inclusion in inventories and to aim to have a system of at least limited inventories in operation in 1952.

8. H.M.(54)45. Progress in preparing inventories was slow owing to limitations in staff and accommodation and also doubts as to the effectiveness of inventories. These difficulties and doubts were recognised in the circular which went on to ask that in hospitals where no inventories had been set up, authorities should concentrate on completing, as a minimum requirement, inventories of those classes of equipment most vulnerable to loss, viz., bedding and linen, hardware, and articles small in bulk but of high value. The scope of these "minimum" inventories was to be extended as opportunity arose. The "minimum" inventories were required to be completed by the end of 1955. At the beginning of 1955 (H.M.(55)7) the Ministry asked for progress reports on the preparation and maintenance of "minimum" inventories.

9. No further progress reports have been asked for and, apart from linen, no further general guidance has been given on the question of inventories. Although H.M.(54)45 urged the setting up of "minimum" inventories at those hospitals where none existed it did not specifically modify the general requirements of R.H.B.(50)17/H.M.C.(50)17/BC(50)15 and those authorities which had inventories already in operation were asked to extend their scope in the light of what was practicable.

10. In December, 1956, the Ministry asked the Central Health Services Council for advice on the laundering of linen with particular reference to the need to avoid infection and to maintain adequate control over linen stocks. The matter was referred to a Committee of the Central Health Services Council and their Report on Hospital Laundry Arrangements made two major recommendations:-

(i) that counting of soiled linen in wards and departments should cease; and

(ii) that where ward stocks were reduced to a single day's requirements ward inventories and, as an experiment, total linen inventories should be discontinued together with the counting of all soiled linen; where these conditions did not prevail a proportion of hospitals should, as an experiment, be allowed to discontinue ward inventories and soiled linen counting.

11. The Committee considered that the system of ward inventories and movement recording had not only failed to achieve its objects but was uneconomic. In the light of this criticism the Ministry issued new guidance on the control of linen (H.M.(61)52); this relaxed the requirement to maintain hospital linen inventories where alternative procedures were in operation based on the control of issues from stores and/or central linen room.

12. The Ministry's recommendation that the control of linen in use in hospitals should be effected entirely by means other than inventories went further than those made by the Committee on Hospital Laundry Arrangements. Although linen has always been the main source of losses because it is in constant circulation and changing hands in the process, there was at that time no review of the inventory system as a whole. Other items continued in theory, if not in practice, to be subject to the inventory procedures laid down some 13 years before in R.H.B.(50)17/H.M.C.(50)17/B.G.(50)15.

III. CONTROL OF PROPERTY OUTSIDE THE HOSPITAL SERVICE

Government Departments and the Armed Services

13. The Ministry of Public Building and Works does not keep a permanent record of furniture, etc., issued for use in Government Departments but control is exercised over issues. Stricter control is exercised by individual Departments over typewriters, dictation machines, etc., and all property released for the personal use of Ministers and senior officials in their own homes. In the Ministry of Health there is a card for each machine or piece of equipment on which movements are recorded. Annually a statement is required from the registered holder of a machine that he still has it in his custody and any discrepancies are investigated.

14. In Service hospitals comprehensive inventory systems cover, generally speaking, everything except "consumable" items and equipment is placed on the personal charge of inventory holders. Responsibility for the care of equipment can be enforced ultimately by deductions from pay under the provisions of the Army Act, etc.

15. In the Services generally the tendency is to omit from inventory records items below a certain value, usually £3 but as high as £25 in some establishments.

Local Government

16. There is great divergence of practice in the keeping of inventories in residential homes, schools, etc. Enquiries of 13 authorities have revealed that in one authority's area all items are included in inventories whereas another includes only portable and valuable items worth £25 or more, together with other important items if attractive for resale or individual use. In between these extremes the other 11 authorities use individual limits of value ranging from £2 to £10 or more for particular items.

Hotel organisations and commercial firms

17. Information has been obtained from two large hotel organisations, one operated by a nationalised undertaking and the other by a commercial firm. In both organisations the control of property is based on comparison of actual stocks at periodical stocktakings with pre-determined stock levels. Any excessive use or losses then revealed are investigated. The prevention of pilfering is regarded as essentially a matter for security measures to be decided by local management and not as requiring inventory controls.

18. The only items recorded on inventories are furniture, office machines and electrical equipment. Furniture is checked against the hotel inventory every five years in the hotels operated by the nationalised undertaking; in the commercial organisation it is recorded at each hotel on a residual value basis.

19. Information has also been obtained from three other large commercial organisations including one operating holiday camps; none of these relies on a system of inventory control but "inventories" are made at the holiday camps at the beginning and end of each season. Experience has shown that the level of losses does not justify the employment of staff to maintain and check inventory records.

IV. SPECIAL FEATURES OF THE HOSPITAL SERVICE

Arguments for and against the traditional system of control by inventories in hospitals

20. Departmental inventories have some theoretical advantages. If properly maintained an inventory system can be used:-

(i) to assess the extent of losses and locate their source;

(ii) as a deterrent to carelessness, to encourage discipline and foster a sense of responsibility in management;

(iii) as a form of reference of the location and extent of hospital equipment;

(iv) as an historical record.

21. On the other hand the following arguments against the inventory system are frequently raised in the hospital service:-

(i) it does not prevent losses. Prevention as distinct from detection of losses can be achieved only by physical controls and the Ministry has already expressed the view (paragraph 6 of H.M.(54)45) that an inventory will not in itself serve to reduce losses except to the extent that it inculcates a greater sense of responsibility in all staff;

(ii) it does not reveal when losses occurred or who was responsible and therefore provides no help in investigating them;

(iii) it is unreliable as a means of revealing the extent of losses. Discrepancies revealed on checking may arise not from actual loss but from failure to amend the inventory in respect of items condemned but not replaced, or transferred from one ward or department to another, or sent away for repair. Valuable items are invariably missed long before an inventory check is due;

(iv) any properly maintained inventory is costly in terms of staff time; in particular heavy demands are made on the time of nursing staff and major interruptions of hospital activity occur when inventories are checked. For articles in general use a simultaneous check throughout a hospital is needed;

(v) the principle of fixing responsibility on heads of departments and ward sisters for the custody of a large number of items of equipment cannot be adhered to in practice. Much movement of medical equipment takes place and no one person can be in charge throughout the 24 hours in a day. This is in contrast to stores and cash which can and should be locked up in the absence of the person responsible;

(vi) departmental inventories can only be effective if in the last resort personal responsibility for equipment can be enforced, when inventory holders are deemed negligent, by deducting from their pay the value of the missing items. There is statutory authority for such deductions in the Armed Services but no equivalent authority in the hospital service.

22. The case against attempting to achieve control over hospital equipment by the traditional system of comprehensive ward and departmental inventories, with responsibility resting at that level, seems to be overwhelming. It is certainly a fact that the efforts to induce hospitals to introduce and maintain a comprehensive inventory system were clearly recognised by the Ministry to have failed when in 1954 in circular H.M.(54)45 it was acknowledged that partial inventories existed in only about half the hospitals in the service. No general guidance has been issued since then and it is common knowledge that inventories, where they exist, are rarely properly maintained or checked. Some hospital authorities have abandoned them altogether.

23. This situation reflects not only the doubts which have existed for some years in the hospital service about the value of the traditional system but also the practical difficulties of operating it within a service in which demands on staff are constantly increasing, which often lacks suitable accommodation for equipment, and uses an increasing amount of highly specialised medical equipment which is continually being moved from one ward or department to another.

24. The sense of personal responsibility of ward sisters and other staff for equipment has also been conditioned by the increasing use of disposable articles and by a more loosely knit staffing structure. The latter is due to the extended employment of part-time staff, the shorter working week and longer leave allowances which in turn have given rise to more shift working and the employment of more relief staff.

The extent of losses revealed by the present system

25. The total value of items on inventories is not known. Figures of inventory "losses" recorded cannot be accepted at their face value for the reasons mentioned in paragraph 21(iii) of this Report and because they only reflect such checking as is being done. However in 1962/63, the last year in which separate figures were kept, they were recorded as running at the annual rate of £87,000 in England and Wales. Surpluses of £28,000 were also recorded in that year.

26. The most recent figures available are the total "stocktaking losses" recorded in 1965/66. These amounted to £149,000 and included "losses" arising from inventory checks; recoveries and surpluses amounted to £100,000.

V. RECOMMENDED FORMS OF CONTROL OVER HOSPITAL PROPERTY

What should be Management's aims?

27. In our view to verify:-

(i) that the number of items in use is adequate to enable the hospital to function efficiently;

(ii) that these items are available for use when and where required;

(iii) that these items are not being replaced more often than necessary;

(iv) that excessive stocks are not accumulating.

How can these aims be achieved?

28. In general we consider they can be achieved:-

(i) by systematically determining and periodically reviewing the numbers of each item of equipment required by each hospital, ward or department and ensuring that they are available;

(ii) by examining requisitions and analysing issues from stores and direct purchases in relation to expected usage to ensure that these numbers are maintained at the same level, unless an approved change of practice results in a need for the original numbers to be increased or decreased;

(iii) by appropriate arrangements for the security, upkeep, condemnation and subsequent disposal of equipment;

(iv) by fostering cost-consciousness among staff using equipment by bringing to their notice information about its cost;

(v) by publicising the action to be taken immediately a loss is suspected;

(vi) in relation to certain valuable items of long life by also instituting modified inventory procedures based on periodic physical checks.

29. The measures above require to be exercised at two levels. At the "local" level responsibility for the care of equipment falls naturally on those who use it and the measures are intended to encourage them to take care and to report missing articles promptly. "Central" responsibility must be exercised by senior administrative officers who should watch the use of equipment both as a measure of effective hospital operation and as part of financial economy. Our specific proposals are made in the following paragraphs of this Report.

Classification of equipment

30. For control purposes equipment can be divided into three main groups; the first comprises items of limited life where control can be based on scrutiny of issues; the second comprises items of long life which are not susceptible to this kind of control; and the third comprises items falling within either of the first two groups which are issued on loan or are otherwise outside the direct control of a hospital authority.

Control over items of limited life

(a) Scrutiny of issues

31. The regular examination of all requisitions from wards and departments should give early warning of possible misuse or loss of equipment. Where this appears to have occurred all issues of the items concerned to individual wards and departments should be analysed and compared with a pre-determined standard of usage assessed by the hospital authority; this will indicate in which wards and departments excessive use is apparently occurring. This kind of exercise should be more positive and fruitful than the maintenance and checking of inventories because it will also yield information about the suitability and quality of equipment and thus help to obtain maximum value from the use of resources.

32. A responsible officer should undertake the regular examination of the requisitions referred to in paragraph 31 above; this should normally take place before issue is authorised but the precise arrangements will depend on the circumstances. Where it appears that a loss has occurred local procedures should provide for immediate notification to the Treasurer who should then consider, in conjunction with the officers concerned, what further action is necessary.

33. The control exercised by the regular examination of requisitions and the analysis of certain issues should be supplementary to the normal application of budgetary control and to the regular use of information about costs.

(b) Determination of holdings of linen

34. In paragraph 28(i) of this Report we recommend that levels of holdings should be determined for all items; in the case of linen the stock in a central linen room should be determined in the light of the requirements of each item ascertained over a reasonable period, allowing for the incidence of laundry deliveries and Bank Holidays.

35. Stocks in wards and departments should be topped up daily to the pre-determined level by issues from the central linen room.

36. Where it is impossible to have a central linen store the basic stock in each ward and department should be no more than sufficient to cover the longest period during which the laundry is closed plus the laundry turnover time. It may be necessary to have a reserve stock under separate control for use at week-ends or Bank Holidays.

37. The same principles should be applied to patients' clothing.

Control over items of long life

38. There are some items of long life which are not susceptible to controls based on "issues", but which are attractive and portable and are therefore potentially vulnerable to theft. For those items some specific system of control by physical check seems inescapable despite all the weaknesses of such systems to which we have drawn attention in paragraphs 21-24 above. These weaknesses will be minimised if the items needing to be scheduled for physical check are kept to a minimum, if advantage is taken of any scheduling already required for other purposes and if staff time can be reduced by eliminating written communications designed to keep central and departmental records in step.

39. We accordingly recommend the setting up of a simple Register of Special Equipment which would include the kind of items listed in the Appendix to this Report and any others of a similar nature which a hospital authority consider it essential to add. The Register would show separately those items which normally remain within the control of a ward or department, for whose oversight (but not maintenance of the Register) heads of departments and ward sisters should accept responsibility, and those in general use within a hospital, which would be included in a general list and for which the hospital secretary or other senior officer should be himself responsible. The articles should be checked regularly against the Register at least once a year by the responsible officers (see paragraph 41).

40. It should not, however, be necessary to include on the Register items subject to special security measures, such as cheque-signing machines, postage franking machines, fire-fighting equipment and radio-active [illegible] a hospital authority is satisfied that the arrangements made are adequate preventive maintenance in accordance with the advice given in H.M.(65)24.

or arrangements made under contract for the regular servicing of equipment, achieve all the objectives of these recommendations, equipment covered by those arrangements may be omitted from the Register; discrepancies discovered during planned maintenance checks should be notified by the Engineer to the appropriate responsible officer, but heads of departments should still be made responsible for reporting losses as soon as they are discovered and the Treasurer should be informed. The Treasurer would need to make occasional test checks of the equipment.

41. The following procedures are recommended for the preparation and maintenance of the Register of Special Equipment and for checking the items included in it (references to the hospital secretary should be read as applying to any senior officer who may be designated to perform these functions by a hospital authority):-

(i) the initial preparation of the Register of Special Equipment should be the responsibility of the hospital secretary under the supervision of the group administration. The contents of each list should be agreed with the person to be held responsible for the equipment. Where an article has a serial number this should be recorded.

(ii) it may be found convenient to keep the Register in loose-leaf form, the folios being serially numbered and subject to the normal security arrangements for numbered documents. Each folio would relate to items under the control of a named officer and a copy of it, preferably by photocopy or other automatic process, should be given to that person as an indication of his responsibility.

(iii) additions to and deletions from the Register should also be the responsibility of the hospital secretary, who should see the relevant documentary evidence. To avoid internal correspondence, the amended folios could also be automatically copied, dated, and the duplicate copy sent to the named officer concerned in substitution for the earlier copy, which should then be destroyed.

(iv) each named officer responsible for items in the Register should be required to undertake a check of the items at least annually, to certify to the hospital secretary that this has been done and to report the result. Any discrepancies, including any arising from the hospital secretary's own check of items included in the general list mentioned in paragraph 39, should be notified immediately they are discovered in accordance with local procedures; the Treasurer should be among those so informed.

(v) the Treasurer should be responsible for independent test checks in conjunction with the persons responsible for the equipment, and for general supervision of the system.

Control over other items

42. In addition a record of the following items should be maintained:-

(i) equipment, other than minor items, on temporary loan to patients;

(ii) equipment on personal loan to staff;

(iii) furniture and other contents of furnished lettings.

In each case a receipt and undertaking to return the equipment should be obtained and one copy of the receipt and undertaking filed on the patient's case notes or the employee's personal record; a duplicate copy should be held by the hospital secretary or other senior officer who should arrange periodically for the existence and serviceability of the equipment to be checked.

VI. SECURITY ARRANGEMENTS.

43. In H.M.(63)52 the Ministry asked hospital authorities to continue to apply a number of security and control measures and specific reference has been made in paragraphs 34 to 37 of this Report to the determination of linen holdings. An essential feature of any security arrangements is that there should be a clear understanding by all concerned of the action to be taken and the persons to be informed when items of value are missed.

44. Wherever practicable articles should be marked as hospital property and where they are on personal charge they should be individually identifiable, e.g., by a number or other mark. The Main Report of the Specification Working Group on Bed Linen (paragraph 24) recommends that interweaving of linen should be discontinued but there remains the need, as a security measure, for satisfactory modern methods of marking.

45. The Committee of the Central Health Services Council on Hospital Laundry Arrangements suggested in their Report (paragraph 60) that an extension of the practice of employing security officers might be useful but the Ministry have made no recommendation on this subject.

46. In our view the employment of security officers or the engagement under contract of security organisations is a matter for local discretion. Hospital authorities will need to consider what measures are appropriate and economical bearing in mind the location of premises, ease of access and any special security risks, such as premises unoccupied at night or at weekends. They will no doubt also take into account the benefits to staff and to good order generally which can be provided by such officers and organisations. If such appointments are made they do not remove the responsibility of hospital officers for the checking of equipment records and the reporting of losses, nor the responsibility of the Treasurer for the system and its effectiveness.

47. Hospital authorities should also give consideration to the part internal audit staff may be able to play in preventing losses by, for example, drawing attention to defects in systems of control, by reviewing independently rates of issues from stores and by identifying apparently excessive demands from wards and departments which may arise from the need to replace goods lost.

48. It is important that procedures for the disposal of obsolete and unserviceable equipment should cover all items and that condemned articles should be branded, removed to safe custody pending disposal, or physically destroyed, so that they cannot be produced again as requiring replacement. The branding should not however interfere with the conversion of condemned articles to other uses.

VII. SUMMARY OF RECOMMENDATIONS

(a) Control over items of limited life

49. Each hospital authority should systematically determine and periodically review the numbers of each item of equipment required by each

hospital, ward or department and ensure that they are available (paragraph 28(i)).

50. All requisitions from wards and departments should be regularly examined by a responsible officer (paragraphs 28(ii), 31 and 32).

51. Where there appears to have been misuse or loss of equipment, all issues of the items concerned to individual wards and departments should be analysed and compared with a predetermined standard of usage assessed by the hospital authority (paragraphs 28(ii) and 31).

(b) Control over items of long life

52. Certain items of long life which are also attractive and portable should be included in a simple Register of Special Equipment and they should be checked regularly at least once a year (paragraphs 28(vi), 39 and 41(iv)); such items may however be omitted from the Register if a hospital authority is satisfied that regular inspections for maintenance or other purposes achieve the same objective (paragraph 40).

53. A senior officer, normally the hospital secretary, should be responsible for the Register of Special Equipment (paragraph 41).

(c) Control over other items

54. A record should be kept of equipment issued on loan and in furnished lettings; a receipt and undertaking to return such equipment should be obtained and it should be subject to periodic checks (paragraph 42).

(d) General

55. The employment of security officers should be a matter for local discretion; hospital authorities should however consider the part which security officers or organisations and internal audit staff may be able to play in preventing losses (paragraphs 28(iii), 46 and 47).

56. Condemned articles should be branded, removed to safe custody pending disposal, or physically destroyed (paragraphs 28(iii) and 48).

57. Cost-consciousness among staff using equipment should be fostered by bringing to their notice information about its cost (paragraph 28(iv)).

58. There should be a clear understanding by all concerned of the action to be taken and the persons to be informed when items of value are missed. The Treasurer should be among those so informed (paragraphs 28(v), 32, 40, 41(iv) and 43).

59. The Treasurer should continue to be responsible for independent test checks and for general supervision of the system (paragraphs 41(v) and 46).

Reservation by Mr. J. D. Banks in respect of paragraphs 38 to 41.

I agree with the main body of the Report but wish to make the following reservation.

The Working Party accepts that the arguments set out in paragraphs 21 to 24 present an overwhelming case against attempting to achieve control over hospital equipment by the "traditional" system of inventories.

Paragraphs 27 to 37 develop a reasonable system of control of certain classes of articles by control or scrutiny of issues, but this method is only applicable to articles which are regularly issued.

Paragraph 38 states that for items of long life some system of control by physical check seems inescapable, despite the weaknesses of such systems, to which attention is drawn in paragraphs 21 to 26. I cannot agree with this. These paragraphs set out reasons why control by physical check is ineffective and is not worth the expense of attempting; and they are as applicable to the "Register of Special Equipment" now proposed as to any "traditional" inventory in the past. The "Register of Special Equipment" is a new name for a list which would be largely the same as the old inventory of articles small in size and large in value, which has been found ineffective, and I cannot see any reason why the Register should be any less damned by the arguments in paragraphs 21 to 26 than any other inventory.

It seems to me entirely illogical to prove the invalidity of the inventory system and then recommend the setting up of an inventory in each hospital.

I think that the Working Party has found a partial solution to the problem inthe encouragement of planned preventive maintenance and the use, for inventory purposes, of lists used in connection with contract maintenance of equipment. These lists will be kept up to date because they are in active use and will provide an effective means of control over a proportion of the items in question.

In my view, the Working Party would have done better to recommend action directed towards increasing the proportion of the items that are controlled through maintenance records. I recommend that hospitals should be required to overhaul their maintenance arrangements, which would have the double effect of improving both maintenance and control and would reduce to a minimum the number of items for which, it should be admitted, no effective method of control exists. I think it would be franker to make this admission than to seek to resuscitate, for lack of anything better, an inventory system discredited by the Report itself.

Items suitable for inclusion in a Register of Special Equipment

Adding machines
Auroscopes
Balances
Blankets - electric
Calculating machines
Cameras and associated equipment
Cine equipment
Clocks - portable, electric
Dictating machines
Fans - electric
Film projectors and equipment
Fires - portable, electric
Floor polishers
Gauges
Hair driers
Hedge trimmers - electric
Irons - portable, electric
Kettles - electric
Meters (for testing)
Microscopes
Mowers
Ophthalmoscopes
Photocopying machines - portable
Radios and radiograms
Razors - electric
Record players
Sewing machines
Sphygmomanometers
Spin driers
Stop watches
Tape recorders
Television sets
Toasters - electric
Tools - portable, electric
Typewriters
Vacuum cleaners
Washing machines - portable

Notes:

(i) This list is intended to be exemplary and not exhaustive - see paragraphs 38 to 40.

(ii) Where equipment becomes obsolescent but continues to have some limited use, e.g., for training purposes or as a stand-by item, any entry in the Register should be annotated to indicate that the equipment is obsolescent.

ANNEX "F"

EXCHEQUER AND AUDIT DEPARTMENT
AUDIT HOUSE VICTORIA EMBANKMENT
LONDON EC4Y ODS

Comptroller and
Auditor General
Gordon Downey C.B.

GSD 501

23 July 1982

Ralph Howell Esq MP
House of Commons
London SW1A OAA

Dear Mr. Howell,

Thank you for your letter of 21 July about linen losses in the National Health Service.

2. As I told you by telephone the other day, I am afraid I am not in a position to provide you with the detailed information you require. In the first place, as you know, although E&AD staff have a right of access to the NHS authorities, the extent of our detailed audit of them is limited. My specific statutory responsibility is to audit the summarised accounts, leaving the DHSS statutory auditors to examine the accounts of the individual authorities. It is therefore the DHSS that has ready access to detailed information on losses.

3. As I also explained to you the other day, however, such information as is available to my Department on linen losses has come to us on the basis of our audit access to the DHSS and the NHS. I am free to make use of this information in reporting to Parliament but am not empowered to divulge it to others. This does, of course, reflect the normal confidential relationship between auditor and client. It follows that, although I cannot speak for anyone else, my Department has neither confirmed nor denied the statement attributed to Mr Sneath.

4. To overcome these difficulties I did, as you know, speak to Sir Kenneth Stowe, Permanent Secretary of the DHSS. He said that he would be very pleased to give you any assistance he could over this matter of linen losses and I suggested that you should pursue your enquiries with him. I am not sure whether you have done so, but I do feel that this is the only way that you will be able to

/get the

get the additional information you require. If you would like me to pass your letter on to Sir Kenneth Stowe with a request that he should reply to you, I will willingly do so. Alternatively, you may wish to get in touch with him direct.

Yours sincerely,

Gordon Downey

GORDON DOWNEY

RALPH HOWELL, M.P.

10th August 1982

Gordon Downey Esq., CB,
Comptroller & Auditor General
Exchequer & Auditor Department
Audit House
Victoria Embankment
London EC4Y ODS

Dear Mr. Downey

I have received your letter of 23rd July regarding losses in the NHS, in reply to my letter of 21st July.

With reference to paragraph (3) I am very surprised that you state "this does, of course, reflect the normal confidential relationship between auditor and client" - I understand you to mean that the DHSS and/or the NHS are your clients. I do not see it this way. I would have thought that Parliament itself is your client and that you are working in the interests of the nation as a whole in trying to ensure that the Bodies for which you are responsible, in your capacity of Comptroller & Auditor General, are maintaining proper accounts. If the DHSS and/or the NHS are your clients and you have to maintain normal confidentiality between auditor and client, then I feel you make it impossible for any Member of Parliament to carry out his job properly in trying to establish whether or not the accounts of any such body are in order.

I would also like to point out that you have not commented on the first paragraph of my letter in which I state that theft, fraud, etc. under items 1 & 4, Statement 8, amount to roughly .01% of total expenditure. Would you now send me details of the component amounts of each area health authority and any other authority included in items 1 & 4, which go to make up those figures, and would you also show the combined totals of items 1 & 4 as a percentage of overall expenditure for NHS in England. I would then be grateful if you could compare this percentage with all other such losses included in the accounts of other government bodies and authorities for which the Exchequer & Audit Department is responsible.

I would be grateful for your views on the miniscule amount shown for theft, fraud, etc. in the accounts and whether you would agree that 1% is considered to be extremely good for normal losses in such organisations.

10th August 1982

Regarding your letter of 25th June, I find this very difficult to follow. Can you list the type of losses which are contained in Statement 8 of the overall NHS Accounts (England) and also the type of losses which would be included in the individual health authorities accounts and which are not shown in the principal statement of accounts. How is it possible for anybody, yourself included, to have any idea of what the overall losses are since it seems to me that they are never brought together in one statement and why do you condone the fact that the losses shown in Statement 8 are quite meaningless in giving a true picture of actual losses.

In paragraph (4) of your letter of 25th June you state "In the past both the statutory auditors and E.& A.D. have found evidence of weakness in the stores and inventory control and stocktaking procedures of individual health authorities" But in the Hospital Inventories Report of 2 June (?July), 1981, it was stated "A Working Party was established in the North Western Region toreview the Ministry of Health report on "Hospital Inventories". The group felt that the principles contained in the 1967 report remained a sound basis for good practice". This seems to contradict your comments in the remainder of paragraph (4).

With reference to paragraph (5), I cannot see how you can check the affairs of the NHS without a breakdown under subjective heads. Again, I would welcome your comments on this point.

I am also writing to Sir Kenneth Stowe as you suggested.

Yours sincerely

REPORT OF THE COMPTROLLER AND AUDITOR GENERAL

Accounts and audit

1. These accounts comprise:

(i) summarised accounts prepared by the Department of Health and Social Security and the Welsh Office from the accounts of health authorities and Boards of Governors;

(ii) the accounts of the Dental Estimates Board and the Prescription Pricing Authority; and

(iii) summarised accounts of trust funds held by special trustees, health authorities and Boards of Governors.

The accounts of the individual bodies are audited by auditors appointed by the Secretaries of State (the "statutory auditors"). Section 98 of the National Health Service Act 1977 requires me to examine, certify and report on these summarised and other accounts. My examination includes a continuing review of the nature and extent of the statutory audit and scrutiny of the auditors' reports.

2. The Act empowers me to examine the accounts of individual health authorities, etc., and the records relating to them. I direct this examination mainly to the effectiveness of their procedures for financial control and for securing efficiency and economy in the use of resources. My resulting observations are contained in paragraphs 2 to 64 of my Report on the Appropriation Accounts (Volume 8: Classes XI and XII) 1980–81.

3. Similar accounts for Scotland are published separately.

Gordon Downey
Comptroller and Auditor General

Exchequer and Audit Department
3 March 1982

Printed in England by Her Majesty's Stationery Office at St. Stephen's Parliamentary Press
Dd 627670 C8 63162 11 4/82

ISBN 0 10 227982 9

PRICING AUTHORITY

ENDED 31 MARCH 1981

1979–80 £	PAYMENTS	£
	6. (*a*) Salaries, wages, etc., of all employed staff, including national	
7,029,537	insurance contributions (Authority's share)	8,797,849
406,486	(*b*) Superannuation contributions (Authority's share)	506,352
	7. Other expenses	
12,953	(*a*) Travelling and subsistence expenses of staff	12,700
8,997	(*b*) Travelling and subsistence expenses, etc., of members	9,950
74,114	(*c*) Purchase, construction, adaptation, etc., of premises	18,577
36,479	(*d*) Repair, maintenance, decoration, etc., of existing premises	28,415
351,612	(*e*) Rent, rates, heating, lighting, cleaning, etc.	438,357
59,218	(*f*) Furniture and equipment	53,114
61,165	(*g*) Stationery and printing	84,353
37,724	(h) Postage and telephones	54,107
36,423	(*i*) Incidental expenses	42,890
8,114,708		10,046,664
	8. Agency:	
460	(*a*) Printing for the Department	227
138,870	(*b*) Computer project: salaries and administration	159,532
8,254,038	TOTAL PAYMENTS	10,206,423
52,876	9. Balance, being cash in hand at 31 March 1981	26,417
£8,306,914	TOTAL	£10,232,840

Kenneth Stowe
Accounting Officer

30 November 1981

I have examined the above Account on the lines recorded in my Report, I have obtained all the information and explanations that I have required, and I certify, as the result of my audit, that in my opinion the above Account is correct.

Gordon Downey
Comptroller and Auditor General

For Report of Comptroller and Auditor General see page 36.

NOTE FOR THE FILE

cc: Mr. Butler (on arrival)
Mr. Gow
Mr. Walters

Mr. Sparrow will be meeting the Prime Minister at 12 noon on 31 August in order to discuss his minute of 5 August about the CPRS's work programme, reference Qa06020.

As recorded in my letter to Gerry Spence on 10 August, the Prime Minister will no doubt wish to raise with Mr. Sparrow the suggestion made by Mr. Ralph Howell, M.P., that there should be an inquiry into the reasons for the ever increasing manpower levels in the public sector, an inquiry which could also make proposals for dealing with this problem. Mr. Howell made this suggestion when he called on the Prime Minister at 1130 on 5 August. The example he chose to illustrate his case was the NHS. He produced figures to show that staffing levels in the NHS were now double what they were in 1960. He pointed out that the number of beds had fallen in the same period, and that the staff per bed ratio was now 3.2, compared with 1.2 in 1960. He argued that there should be some form of public inquiry.

The Prime Minister told Mr. Howell that she shared his concern. She suggested that he should write to her setting out the facts and figures and calling for an inquiry, and that he should make this letter public. She promised that she would try to send him a positive and forthcoming reply, which would also be made public.

In my note to her of 5 August, I set out the arguments against a public study, which were largely that it could cause serious problems with the public sector unions, and could be particularly difficult in the case of the NHS pay dispute. Mr. Gow has agreed to put these arguments to Mr. Howell and to persuade him to write privately to the Prime Minister. Mr. Howell's letter is expected at

/the end

the end of August. As I have said, the Prime Minister will wish to give Mr. Howell a positive reply, and it would be helpful if the subject could be discussed with Mr. Sparrow on 31 August.

CM

13 August 1982

Alan

Yours, Kay

6/7

10 DOWNING STREET

From the Private Secretary

5 July 1982

Further to our conversation on the telephone last week, I am writing to confirm that the Prime Minister is looking forward to seeing Mr. Howell in her room at the House at 1630 hours on Tuesday, 13 July.

CAROLINE STEPHENS

The Private Secretary to
Ralph Howell, Esq., M.P.

MO
cc DHSS
1
Brief by c. of Play
9.7.

DHSS manning level?.

Nat Health JL

cc NALGO &
BTB

Alan
We don't keep this sort of thing — will you? — Or perhaps Press?
Jamie 3/5

10 DOWNING STREET

From the Private Secretary

13 May 1982

Thank you for your letter of 12 May, in which you sought clearance for the publication of a letter by Mr. Finsberg in answer to points raised by Mr. Keith Jerome of NALGO.

As I told you on the telephone this morning, the Prime Minister has no objection to Mr. Finsberg writing as proposed.

mcs

Mrs. J.R. Walden,
Department of Health and Social Security.

TF

Prime Minister ①

Agree that Mr Finsberg send this (rather unnecessary) letter to the FT?

MLS 12/5

DEPARTMENT OF HEALTH & SOCIAL SECURITY

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

Telephone 01-407 5522

From the Joint Parliamentary Under Secretary of State

HCS.

Duty Clerk
10 Downing Street

12 May 1982

DIRECT LABOUR IN THE HEALTH SERVICE: RESPONSE TO A LETTER IN THE FINANCIAL TIMES, 6 MAY 1982

I attach a copy of the reply Mr Finsberg wishes to send to the Financial Times answering the points raised by Mr Jerome. I would be grateful if you would arrange for the letter to be cleared.

Janet R Walden

MRS J R WALDEN
Private Secretary
D809 AFH

TF

Draft

DEPARTMENT OF HEALTH & SOCIAL SECURITY

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

Telephone 01-407 5522

From the Joint Parliamentary Under Secretary of State

Mr Jerrome of NALGO in his letter of 6 May claims that contract NHS services provided by the private sector are likely to cost more than direct labour. Let me make clear the Government's position on the use of private contractors.

Broadly this Government believes that the costs for hospital support services, now running at well over £1,000 million pa should be critically assessed with the object of making savings - savings that can be used to improve patient care to show that we really mean "patients first".

The market place is the one clear test of cost efficiency. Only by going to tender for services like domestic, catering and laundry services can health authorities be sure of the cost position. But, of course, it is essential that the exercise of comparing direct labour costs against contract costs is done on a fair and open basis. We recognise that health authorities may not always be able to act in the absence of advice on the complex issues involved. We will shortly be issuing guidance that will assist health authorities to test out their costs objectively and to make the right decisions - in the interests of their patients. This policy is not a doctrinaire one but is based on the sensible realisation that we must make best use of resources.

Mr Jerrome did not give details of the two cases he mentioned to "justify" his view point, but certainly his second allegation that contract domestic services at Aylesbury are more expensive than direct labour costs was disproved by a detailed professional survey in 1979. I cannot believe that the re-letting of the contract last year has changed the position but I would be very pleased to analyse the cost details on which he bases his claim.

GEOFFREY FINSBERG

Letters to the Editor

The Falklands: the future for the islanders

From Mr I. Stewart-Fergusson

Sir,—In his letter (May 1) attacking the Government's foreign policy over the Falklands Mr Roderick Campbell regrettably omits to describe in any detail the alternatives he would propose in lieu of the measures to which he is so obviously opposed.

Faced with President Galtieri's *fait accompli* and understandable intransigence as far as all but the most minor issues were concerned, Mr Campbell would I suppose have conceded Argentina's claim, certainly without using force against force, conceivably without even resorting to diplomatic and/or economic counter-measures—on the pretext that the fate of 1,800 islanders thousands of miles away would merit neither the risk to the Britons in Argentina itself, nor the military expenditure now being incurred on behalf of the Falklanders (an attitude which incidentally would seem to prevail also among many of the Anglo-Argentinian community, if the broadcast interviews are anything to go by).

In pure cost-benefit terms Mr Campbell is probably correct. If one disagrees with his peace-at-all-costs approach, then, on the basis of moral principles, not to react as we have done would amount to abandoning all the principles of justice and freedom which we claim to stand by. In the face of the subjugation of the Falklanders it is not difficult to imagine the howls of protest which would be raised by Mr Campbell and many others enraged at the Government's sell-out to the Argentinians.

In the circumstances, and with "Afghanistan" at the back of one's mind, we are probably also forced into choosing between military counter-measures and a climb-down, even if diplomatic/economic retaliation is indeed permitted as part of the Government's efforts towards re-establishing the status quo. (Without the threat of military back-up, the effectiveness of such retaliation is open to question.)

Granted that if and when the status quo is finally achieved the diplomatic problems of negotiating a longer term settlement will have only just begun, it must surely be both a "sensible" and a "coherent" foreign policy to strive now both diplomatically, economically and militarily to establish a strong negotiating position, if only to get the best possible deal for the Falklanders as they become over time ever more dependent on their closest neighbour geographically. Indeed, if the controlled use of our armed forces is ruled out even in response to such blatant unprovoked aggression, we must then seriously question the justification for maintaining the armed services in the first place.

I. G. Stewart-Fergusson,
9, Hotspur Avenue,
Bedlington, Northumberland.

From Mr L. Palmier

Sir,—The justification for the Falklands operation lies in the demonstration that we are prepared to defend what is ours. The number of people there is irrelevant; the same argument would apply if the islands were deserted or heavily populated. So, also, on the other hand, is the character of the Argentinian regime; the case would not be different if, for example, France invaded the Channel Islands (as part of the old duchy of Normandy, some kind of French claim could no doubt be erected for them). Several other countries, of more moment than the Argentine, would have been most interested to observe that we had lost the will to look after our own.

When the Argentines are expelled, the future of the islands must then be settled. It is clear we no longer have the capacity to maintain a far-flung empire; they should therefore be relinquished. To give a population of some 2,000 their independence is hardly feasible, if only because they are unlikely to retain it for long. Since Argentina is the closest state, it is expedient that the islands come under her administration (claim or no claim). "In victory, magnanimity." The British population should be offered the choice of relocating elsewhere, with full compensation borne entirely by the Argentines. At a time when so many people in this country are having to relocate to find work, it is not unreasonable to ask those in the Falklands to make similar sacrifices for the common good.

Leslie Palmier.
Hazelrise,
St Catherine's Close, Bath.

Direct labour in the health service

From the Secretary,
Health Services Committee,
South-East Regional Council,
Trades Union Congress

Sir,—You report (April 29) the publication of a document "Reservicing health" by Michael Forsyth which appears to reiterate the political platform already advanced by the Minister of Health, who wrote to health authorities on August 20 last year asking them to consider the introduction of contracts for various services, and seeking a detailed reply.

On September 28 1981 Lady McCarthy, the Oxfordshire area health authority chairman, responded indicating that even allowing for the difficulty arising from the different accounting practices between the public and private sector "it had good reason to doubt that financial savings would result from more extensive moves towards contract services." On the one cleaning contract in the area it could be demonstrated that this cost one third more to clean than National Health Service direct labour. The contract has been terminated. An exercise on laundry services showed that a private laundry would charge four times the NHS cost. An examination of pharmaceutical products indicated considerable savings through producing fluids within the NHS. Consideration of sterile supply products compared to commercial alternatives showed no benefit by switching to the private sector, and reports from neighbouring authorities demonstrated that cost comparisons for complex sterile surgical packs are even more favourable to in-house production.

Both in the maintenance of medical equipment and transport vehicles technical staff and mechanics were being increased in order to save money because of the rapid escalation of manufacturers' maintenance costs and charges by local garages.

Trade union experience with a cleaning contract in a neighbouring authority—Buckinghamshire—revealed that a saving of £60,000 per annum would accrue if a domestic cleaning contract covering Stoke Mandeville and St John's hospitals were not re-let to a private contract but undertaken in-house.

The claims made in this pamphlet and similar political utterances appear to be based on rhetoric rather than any real study of comparative costs of providing services within the NHS and by private contractors.

Keith Jerrome.
59-65 London Street,
Reading,
Berks.

Tapioca pudding from Brussels

From the President,
Grain and Feed Trade Association.

Sir,—Your leading article of April 28 prompts me to draw attention to the European Commission's seemingly confused objectives in negotiating, or seeking to negotiate, limitations on exports of materials alternative to cereals in animal feeding stuffs, such as tapioca (manioc) or maize gluten feed.

The Commission argues that producers have a right to expect an income based on the target price for cereals; and that, to their detriment, very heavy imports of "cereal substitutes" have depressed prices to intervention levels. In British terms, this would mean that the intended level of support prices should rise from around £113 (the current intervention price) to £141, or by 20 per cent. What this implies is self-evident, namely, the prohibition rather than the limitation, of imports of raw materials other than cereals and a swingeing increase in the price of all animal feeding stuffs.

The Commission must know that its problems are caused by excessively high support prices for cereals that have increased production in 10 years from around 90m to 120m tonnes and which have made cereals increasingly uneconomic for use in animal feeding (apart from the fact that selective breeding has so reduced the size of the rumen in the most productive cows that they could no longer thrive on a diet of cereals!). The Commission also knows full well that, had those prices been 20 per cent higher, at the level of the target price, their problems would have been unmanageable, and that the effect on the prices of, and the consumption of, livestock products would have been very grave indeed.

To sum up. May I plead for a strong counter-dose of realism in the Council of Ministers when it comes to decide, as it must, on the Commission's proposals. The first task is to bring the price of cereals down to a competitive level, not to increase it. More particularly, we need a reduction in target prices, particularly for wheat and maize. In the interests of the producers of that 60 per cent of all Community output, namely, livestock products, until and unless cereal prices are brought down to a realistic level, no further restrictions should be put on imports of competing raw materials, whether tapioca, cereal brans, corn gluten feed, citrus pellets, or other residues. It is worth recording that these have replaced imported cereals, mainly maize, to the extent of 6.2m tonnes since 1973.

L. J. Wright,
Baltic Exchange Chambers,
24-28 St Mary Axe, EC3.

HANSARD.

National Health Service (Manpower)

Mr. Hordern asked the Secretary of State for Social Services whether he has yet received figures of National Health Service staffing in England in September 1981; whether he will publish them in a table showing how numbers have increased since 1979; and if he will make a statement.

Mr. Fowler: The table which follows gives provisional figures in whole-time equivalent terms, for all the main National Health Service staff groups for September 1981, compared with the numbers employed in 1979. As explained in the footnotes to the table the differences between the figures are partly accounted for by reductions in the nurses working week.

The provisional overall increase in staff over the period was just over 47,000. Nurses and midwives accounted for about 34,000 of this increase. This reflects Government policy to improve our health services and in particular to increase expenditure on direct services to patients.

NHS Directly Employed Staff: England, 30 September 1981

	Whole-time Equivalents			
	1979	*1981 provisional*	*Provisional change 1979-81*	
	wte	*wte*	*wte*	*percentage*
Nursing and Midwifery Staff	358,400	392,200	33,800	9·4
Medical and Dental Staff	37,100	39,000	1,900	5·1
Professional and Technical	60,100	63,300	3,200	5·3
Works	5,600	6,100	500	8·1
Maintenance	20,100	21,000	900	4·4
Administrative and Clerical	103,000	108,600	5,600	5·4
Ambulance (including Officers)	17,100	18,200	1,100	6·5
Ancillary	171,900	172,400	500	0·3
All Staff	773,400	820,700	47,400	6·1

Notes:

1. The figures for nursing and midwifery staff include agency nurses and midwives and health visitor students. In 1980 the working week was reduced from 40 hours to 37½ hours and part of the increase of 33,800 (whole time equivalent) will be accounted for by additional staff recruited as a direct result of this change.

2. The figures for medical and dental staff include locums; exclude hospital practitioners, part-time medical officers (clinical assistants), general medical practitioners participating in Hospital Staff Funds and occasional Sessional Staff in the Community Health Services. The number of general medical practitioners also increased by 1,400—general practitioners do not appear in this table which deals only with employed staff.

3. The slight discrepancy between the figures shown for individual staff groups and the totals arises through independent rounding of the figures in each group.

Nat Health vb

bc Mr Vereker
Mr Scholar

24 March 1982

Manpower and Efficiency in the NHS

The Prime Minister was grateful for your Secretary of State's minute of 22 March, providing updated information on NHS staff numbers, and in particular on nurses and midwives.

She is content for the new figures to be published in a Parliamentary Answer. She has not yet written to Mr. Hordern, but I expect her to do so shortly.

MA PATTISON

D.J. Clark, Esq.,
Department of Health and Social Security.

10 DOWNING STREET

Prime Minister

Content that these figures should now be published, as Mr Fowler suggests in his final paragraph?

MF
23/3

PRIME MINISTER

MANPOWER AND EFFICIENCY IN THE NATIONAL HEALTH SERVICE

I am sorry that it has taken a little time to follow up my undertaking to report on the latest estimates of NHS manpower and in particular the numbers of nurses and midwives.

I attach a draft PQ and answer which summarises the provisional estimates for September 1981 for all the main staff groups in the National Health Service. The figures are provisional because they have been derived from the payroll computer tapes of the fourteen Regional Health Authorities under new arrangements to secure more timely statistics. As teething troubles in the new arrangements are corrected we will be much better placed to answer questions on changes in the numbers of health service staff.

As you will see between 1979 and 1981 the numbers of staff increased by about 47,000 overall and nurses and midwives accounted for about 34,000 of this increase. It seems to me that it is only right for us to take credit for this as it is our policy that the real growth provided for the health service should be concentrated on those directly providing services to patients. On the other hand it has to be said that the reduction in the working week for nurses and midwives from 40 hours to 37½ hours as part of the 1979/80 pay deal will have accounted for a substantial part of this increase. (The note enclosed details the calculations). Both the draft PQ and the table explicitly refer to this change but I do not think it detracts from the overall message that the bulk of the increased resources have gone to those providing services for patients.

These provisional figures show quite rapid increases in other groups of staff including those not directly concerned with patients (though in some cases such as works staff the numbers involved are relatively small). I will want to look at these closely in the reviews I am initiating with health regions to

establish what these changes actually mean in terms of more services to patients, better care and treatment and efficient use of resources. The figures for staff groups not directly concerned with services to patients deserve even closer scrutiny and I underlined this in a meeting with the Chairman of Regional Health Authorities last week which was attended also by Sir Derek Rayner.

If you are content I will arrange for these figures to be tabled shortly - perhaps through a question from Peter Hordern who is taking a close interest. Meantime I have suggested a more general reply to his letter to you of 4 March.

N F

22 March 1982

DRAFT

SC

To ask the Secretary of State for Social Services whether he has yet received figures of NHS Staffing in England in September 1981; if so, whether he will publish them in a table showing how numbers have increased since 1979; and if he will make a statement.

REPLY

The table below gives the numbers, in whole-time equivalent terms, for all the main National Health Service staff groups for 1979 and 1980 with provisional figures for September 1981. As explained in the footnotes to the table the differences between the figures for the three years shown are partly accounted for by reductions in the working week and increases in annual leave entitlement.

The provisional overall increase in staff over the period was just over 47,000. Nurses and midwives accounted for about 34,000 of this increase. This reflects Government policy to improve our health services and in particular to increase expenditure on direct services to patients.

NHS DIRECTLY EMPLOYED STAFF: ENGLAND, 30 SEPTEMBER

Thousand Whole-time Equivalents

	1979 wte	change 1979-80 wte	change 1979-80 percentage	1980 wte	provisional change 1980-81 wte	provisional change 1980-81 percentage	1981 provisional wte	provisional change 1979-81 wte	provisional change 1979-81 percentage
	1000	1000	%	1000	1000	%	1000	1000	%
Medical and Dental Staff (1)	37.1	1.2	3.1	38.2	0.7	2.0	39.0	1.9	5.1
Professional and Technical	60.1	1.8	2.9	61.9	1.4	2.3	63.3	3.2	5.3
Works	5.6	0.3	5.7	5.9	0.1	2.3	6.1	0.5	8.1
Maintenance	20.1	0.5	2.3	20.6	0.4	2.0	21.0	0.9	4.4
Administrative and Clerical	103.0	2.5	2.4	105.4	3.1	3.0	108.6	5.6	5.4
Ambulance (inc Officers)	17.1	0.6	3.7	17.8	0.5	2.7	18.2	1.1	6.5
Ancillary	171.9	0.1	-	172.0	0.4	0.2	172.4	0.5	0.3
Total excluding Nursing and midwifery staff	414.9	6.9	1.7	421.8	6.7	1.6	428.5	13.6	3.3
Nursing and Midwifery (2) (1979: 40 hour week 1980 and 1981: 37½ hour week)	358.4	11.6	3.2	370.1	22.1	6.0	392.2	33.8	9.4
(1979 converted to 37½ hour week (3) basis in order to be comparable with 1980 and 1981)	(382.3)	(-12.3)	(-3.2)	370.1	22.1	6.0	392.2	9.9	2.6
All staff including nursing and midwifery	713.4	18.5	2.4	791.8	28.9	3.6	820.7	47.4	6.1
All staff including nursing and midwifery (4)	(797.2)	(-5.4)	(-0.7)	791.8	28.9	3.6	820.7	23.5	2.9

adjusted to take account of change to 37½ hour week

MG

NOTES

1. Includes locums; excludes hospital practitioners, part-time medical officers (clinical assistants), general medical practitioners participating in Hospital Staff Funds and occasional Sessional Staff in the Community Health Services. The number of general medical practitioners also increased by 1,400 - general practitioners do not appear in this table which deals only with employed staff.

2. Includes agency nurses and midwives and health visitor students.

3. The line above shows that nursing and midwifery staffs (including unqualified as well as qualified staff) rose by about 33,800 whole-time equivalent on a straight comparison between 1979 figures based on a 40 hour working week and the estimated whole-time equivalent figures for 1981. In 1980 the working week was reduced to 37½ hours and in this line the figures for 1979 have been adjusted to take account of this change.

4. As explained in 3 the line above which shows the change in all staff, including nurses and midwives, compares 1979 figures when the working week for nurses 40 hours with 1980 and 1981 when their working week was reduced to 37½ hours. This line shows the change when the 1979 figures have been adjusted to take account of the reduction in the nurses working week. Some other groups of staff also have had reductions in the working week or changes in leave entitlement over the period.

MG

NURSING AND MIDWIFERY STAFF: THE EFFECT OF THE REDUCTION IN WORKING HOURS

1. The effect of the change in the hours of nursing and midwifery staff from 40 to 37½ hours a week, which took place over a period between April 1980 and 1981, was to reduce the contribution of each full-time nurse or midwife by 2½ hours, or 6¼ per cent.

2. When they introduced the 37½ hour week health authorities had to make up this deficiency, in one of a number of ways:

- by absorbing part of the change through more efficient rostering, where this was possible (an efficiency saving)

- by temporary use of overtime, until more staff could be recruited (overtime does not appear in the whole-time equivalent figures)

- by recruiting more staff.

The great majority of the deficiency had to be made up in this last way, by extra recruitment.

3. The hours of the very large number of part-time nursing and midwifery staff also had to be recalculated on the basis of a 37½ hour week, producing a notional increase in part-time working, in terms of whole-time equivalents. For example a nurse working 20 hours, who appeared as half-time under the 40 hour week, would now appear in the statistics, and be paid, as working more than half time.

4. The Department's published nursing figures for 1980 gave two figures of whole-time equivalent staffing, one on the basis of a 37½ hour week, and one (in brackets) in which the effect of the notional increase in part-time working between 1979 and 1980 was eliminated by basing the 1980 part-time figures on a 40 hour week, but not the extra recruitment made necessary by the change in the working hours of full-time staff.

5. It now seems clearer, and more defensible to present the change in broader terms, offsetting against the change in working hours the whole of the extra recruitment needed to make up the deficiency it created in contractual hours.

6. Over a two year period the whole-time equivalent of nursing staff rose from 358,000 in September 1979 (based on the 40 hour week) to 392,000 in September 1981 (based on the 37½ hour week) an increase of around 9½ per cent. These are historically 'correct' manpower figures, and real in the sense that they represent the contractual hours the NHS is paying for.

7. However, for purposes of comparison, if the September 1979 figure is recalculated on the basis of a nominal 37½ hour week, ie increased by a factor of 40/37.5 or 6.7 per cent, it becomes 382,000 instead of 358,000. We then have a service increase, in terms of contract hours worked, of 2.6 per cent over the two year period, leaving about 6.7 per cent of the 9.5 per cent increase mentioned above as due in one way or another to the change in contract hours. This increase seems a more appropriate measure of manpower growth in resource input terms, and would be used, for example, in a PESC context.

8. Both calculations are shown in the table suggested with explanatory notes.

Monday 8 March 1982
Written Answer

PQ 2168/1981/82
Han Ref Vol 19
Col 334 - 36

NATIONAL HEALTH SERVICE PAY

186 Mr Jim Spicer (C. West Dorset)

To ask the Secretary of State for Social Services, what is the latest position on National Health Service pay in 1982-83.

MR NORMAN FOWLER

My right hon and learned Friend, the Chancellor of the Exchequer announced in his statement on public expenditure on 2 December that expenditure plans for 1982/3 included a 4 per cent pay factor for the public services. Allocations for 1982/83 to Health Authorities in Great Britain accordingly include 4 per cent for increases in earnings from due settlement dates. It remains the Government's view that this is in general an appropriate provision. The Government recognise the need for pay settlements to take account of market factors including their effect on recruitment and the retention of certain types of expensively trained staff in the NHS. An additional £81.9 million will, therefore, now be made available for some specific groups within the NHS responsible for the direct treatment of patients. This money, which includes the cost of related employers' superannuation and national insurance contributions, will be available to finance appropriate pay settlements for nurses and midwives and for the professions supplementary to medicine, to introduce a new contract for ambulancemen and an emergency duty agreement for hospital pharmacists. Two thirds of the additional money will be provided from the contingency reserve and added to the cash limits, and the remaining third will be found by Health Authorities. The pay of doctors and dentists will be considered in the light of the Report of the Doctors and Dentists Review Body later in the year.

cc A.D
J U

Prime Minister National Health

Mr Fowler will be digesting the new figures before suggesting a reply to Ralph Howell.

MHD 26/L.

Prime Minister

NHS MANPOWER

You have put to me a number of questions about the increases in NHS manpower, especially nursing manpower since 1979, and I am most anxious with the increasing interest in this issue among Members, to give you an up-to-date and comprehensive reply which will stand up to attack.

Broad provisional NHS staffing figures for September 1981 have just become available from the NHS Regions. But in order to compare them fairly and effectively with the figures for earlier years, I have had to ask our statisticians to undertake some further work. I hope to be able to present the full picture, answering your detailed questions about nursing manpower, early next week. I would envisage that we might then take the opportunity of an arranged PQ to present these new figures in the way we want them to be seen, providing a basis for future discussion.

The Department of Employment head count - which is of course the best index of the number of individuals with full time and part-time jobs in the NHS - is inevitably far higher than 'whole-time equivalent'. The figure of 1,200,000 in Ralph Howells' recent letter is a head count figure for the UK in 1980. In September 1981 the total number of NHS staff in England, in whole time equivalent terms, was some 820,700.

I am copying this minute to the Chief Secretary, the Secretary of State for Scotland and the Secretary of State for Wales.

26 February 1982

N F

National Health

PRIME MINISTER

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

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

MAP

18 February, 1981

(original on: National Health: Jan 81: Priorities and Policies for Health and Personal Social Services)

SUBJECT

10 DOWNING STREET

From the Principal Private Secretary

MANAGEMENT IN CONFIDENCE

17 February 1981

Dear Don,

NHS MANPOWER

The Prime Minister and your Secretary of State had a brief word this morning about his minute of 16 February 1981 about NHS manpower.

The Prime Minister said that it had come as a very real surprise to her and, apparently, to some other members of the Cabinet to learn that NHS manpower had grown by 25,000 since May 1979. The increase was particularly disconcerting because it came at a time when much of the rest of the public service was being reduced. The Manifesto commitment had been that there would be no reduction in spending on the health service and that better use would be made of what resources were available. The growth which had actually occurred in the health service since the election seemed to go beyond this undertaking.

Mr Jenkin said that he could not understand why any of his colleagues should be surprised at the relatively modest growth in the health service which, for example, had expanded in England by about 19,000 to 20,000 between June 1979 and June 1980. It had been agreed in the run up to the election that the levels of expenditure planned for the NHS by the previous administration should be maintained. This had meant that the service had continued since May 1979 to enjoy a limited measure of growth in real terms. Health expenditure had been discussed by Cabinet on four or five occasions over the last twenty-one months and it had always been on the basis of the same policy that there should be a small measure of growth. In a labour-intensive service a policy of growth meant that there was bound to be an increase in manpower. Most of this, however, had been in the professional sector, e.g. doctors, nurses, physiotherapists and so on, rather than in administrative and clerical staff. If the Government was going to abandon its commitment on the health service, we should make this clear publicly, but it would be seen as a very considerable change of direction.

The Prime Minister said that the ratio of one administrator to four/five professional staff revealed in the breakdown of the total

increase of 19/20,000 seemed unduly high. Moreover, the C & AG's recent report indicated that there were major disparities in staffing levels between different regions of the health service, and this suggested that there might be scope for reducing manning and increasing efficiency in certain areas.

Your Secretary of State said that the health service was doing well in bringing down the costs of its own management. The target for management costs for March 1980 had been 5.25 per cent of the total cost of the service but the proportion actually achieved nationally had been 5.05 per cent. The target for 1984/85 was 4.5 per cent. Moreover, it was important to distinguish between the administrative staff who were employed on management functions and those, like medical secretaries and ward clerks, who were in direct support of professional staff who were providing services to patients. The average period which patients now spent in hospital was dropping. This was due, at least in part, to more intensive nursing, but this could be achieved only if nurses ceased to do clerical work and this made it necessary to employ more ward clerks. Similarly, the recruitment of an additional 2,000 doctors meant that they had to be given appropriate administrative support.

The comparisons between one region of the health service and another drawn in the C & AG's report needed to be treated with care. London, for example, had a very different mix of hospitals from East Anglia and therefore a different requirement for staff. The fact was that his Department did not attempt to impose a detailed manpower scrutiny on the NHS. Rather, they exercised control through the strict application of cash limits. And they were also looking at new systems of efficiency monitoring, including manpower.

The Prime Minister said that she remained surprised at the size of the increase in health service staff. Nonetheless, this growth had now taken place and the Government should take credit for it. She would find an opportunity to mention publicly the increase in the number of doctors, nurses and other professional staff.

I am sending copies of this letter to the Private Secretaries to other members of the Cabinet, to Murdo Maclean and to David Wright.

Yours ever,

Mavis Whitmore.

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

PERSONAL AND CONFIDENTIAL

10 DOWNING STREET

From the Principal Private Secretary

16 February, 1981.

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

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

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

C. A. WHITMORE

David Edmonds, Esq.,
Department of the Environment.

PERSONAL AND CONFIDENTIAL

10 DOWNING STREET

MR. WHITMORE

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

M. A. PATTISON

16 February 1981

file X6

10 DOWNING STREET

From the Private Secretary

16 February 1981

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

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

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

M. A. PATTISON

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

cc Mr Wolfson
Mr Ingham
Mr Duguid

Prime Minister
Mr Jenkin argues that NHS staff growth has been in line with manifesto commitment to some real growth in NHS service: and that this has been concentrated on delivery of services, not bureaucratic back-up. Content?

MAD 16/2

PRIME MINISTER

NHS MANPOWER

I think that I should circulate a minute in order to try to get into clearer focus the question of manpower growth in the NHS. Several Cabinet colleagues have recently expressed critical surprise that NHS staff are growing in numbers; they should not be surprised and I hope the following explanation will help to clear minds.

Government Policy Towards the NHS

Our policy on expenditure on the NHS, based on our Manifesto Commitment, is that it should continue to enjoy a limited measure of real growth, broadly in line with the projected development planned by the previous Administration. This will be of the order of 2% per year on average over the next 2 years. As Cabinet has accepted in our PESC discussions, this growth is needed to cope with the effect of population changes, in particular the increase in the number of very old people; to tackle certain serious deficiencies in the Service, eg waiting lists; and to meet some of the costs of continued medical advance. We agreed before the Election that for all these reasons planned expenditure on the NHS should be maintained and we have earned some credit by sticking to that promise. (The NHS contribution to helping with the PSBR problem has mainly been in the form of increased charges and next April's rise in employees' NHS contributions).

Labour-intensive Service

Manpower accounts for 70% of NHS spending and, in such a labour-intensive business, financial growth must mean more staff. Indeed, it would be extraordinary to increase facilities and equipment and refuse to recruit the additional doctors, nurses and supporting staff required to use them.

A rough count suggests that between June 1979 and June 1980 NHS staff in England grew by about 19/20,000 (though many of these were part-timers). This is an increase of about 2.2% per annum. A broad breakdown of the figures points to an increase of around 2,000 doctors (including doctors in shortage specialties such as geriatrics and anaesthetics), 10,000 nurses and 3,000 professional and technical staff (physiotherapists, radiographers, laboratory technicians etc) - all of them staff who give services directly to patients. In addition, about 4,000 administrative and clerical staff were recruited. But in my view this increase in support staff is equally justifiable. Proper support for doctors, nurses and others giving services to patients - for example, medical secretaries and ward clerks - is essential. The trend over the years has been for a reduced length of stay in hospital, involving more sophisticated and intensive patterns of care from increasingly specialised staff. Without adequate support staff, specialists would be required to spend their own time on routine clerical activities such as maintaining medical records.

Reduction of Bureaucracy

The overall control on the use of resources in the NHS is of course financial and since we came into office the Service has lived within its cash limits. The cash limit is without doubt an effective stimulus to efficiency and better management. In order to reduce "bureaucracy", where criticism of the existing structure has rightly been focussed, we are not only streamlining the structure of the Service, but also operating tight controls on the proportion of NHS expenditure devoted to management. These controls cover staff in the administrative and clerical grades who are not in direct support of patient services. Against a set target for management costs for March 1980 of 5.25%, the proportion actually achieved nationally was 5.05%. I am seeking a further significant reduction in the proportion (to about 4.5%) by 1984/85 from the new, slimmed down, structure.

We are concerned also to increase efficiency in the ancillary grades and the ambulance service where the Clegg Report pointed to restrictive practices and over-manning. There has been a continuing real reduction in the numbers of ancillary staff since 1976, but I am following up personally with the Chairmen of Health Authorities evidence of inefficiency and restrictive practices. I have accepted already a reduction of £25 million for 1981/82 in recognition of our determination to squeeze out such practices and to secure other economies. We are in the process of mounting several experiments in how efficiency monitoring at all levels can be made more effective.

Summary

In brief, NHS staffs have continued to grow in total as a consequence of our policy of continuing to give the Service some measure of real growth each year. But the Service has lived within tight cash limits; it is reducing the cost of the "management" element of its administrative and clerical staffs to a very low proportion of total revenue expenditure; and it is exploring further ways of improving efficiency while embarking on a reorganisation designed to streamline the structure of the Service as a whole. This is the policy on which we fought the election and I want to carry it through.

Copies go to Cabinet colleagues, the Chief Whip and Sir Robert Armstrong.

PJ

16 February 1981

P J

From: Secretary of State for Social Services

PERSONAL

2 MARSHAM STREET
LONDON SW1P 3EB

My ref:

Your ref:

13 February 1981

Dear Clive

My Secretary of State will be grateful if you could put the attached minute before the Prime Minister. As you will see, it is marked "secret and personal". For this reason, and in view of the contents, my Secretary of State has not copied it to Ministerial colleagues.

Yours ever

Dick

D A EDMONDS
Private Secretary

Clive Whitmore Esq
No 10

Prime Minister.

I have a lot of sympathy for N Heseltine's complaint. But he has — desperately — not copied his minute to Cabinet colleagues: you will therefore be able to make only indirect use of it with them. Mr Jenkin's office has confirmed that the figure for the increase in NHS staff over the last year is indeed 25,000. We will be minuting you early next week with an explanation!

SECRET AND PERSONAL

We must go with this very thoroughly indeed. I learned the Tebbit go-Peter Jordan. no

13 February 1981

PRIME MINISTER

I was extremely disturbed by the discussion at Cabinet yesterday morning about manpower in the National Health Service, and the Civil Service.

At the cost of provoking serious personal animosity in local government - an animosity which I fear is felt by members of our own Party too - I have fought for 2 years to bring abour reductions in local government manpower. As you will recall, within days of the election I called for a freeze on manpower. I have made a series of speeches to local government conferences, I have had dozens of meetings with individual authorities or leaders, and I have taken - with the backing of Cabinet - an extremely tough stance on local government current spending, of which 70% goes on wages and salaries. The first real reductions in local authority manpower have now started to come through. After 30 years where the graph inexorably rose - with the exception of a small hiccup in the aftermath of the IMF cuts - as a result of our policy local government manpower is beginning to decline. Since the election, manpower has dropped by 2% - the fastest ever rate achieved - producing a reduction of 42,000 staff in local government overall. I am maintaining the pressure. I very much hope that in the future the rate of decrease will continue.

But I simply do not now know how I can explain to local government that over a single year the manpower employed in the National Health Service has increased by 25,000 or 2.1%. The rate of increase is marginally faster than the rate of decrease achieved in local government. It means that for all the anguish I have gone through to reduce local government numbers the net effect on the public sector is wiped out to a very large extent.

I cannot accept that it is sufficient to argue that local government is over-manned and therefore can bear the strain better than the Health Service. Local government, of course, is over-manned, but many of the services which it provides - such as personal social services - have just as great a case for special concern as those provided by the NHS.

Over recent years a very substantial bureaucratic organisation has been built up in the NHS. For example, table 3.41 of the CSO Annual Abstract of Statistics 1981 shows that between 1971 and 1978 administration and clerical staff in the hospital services have nearly doubled from 54,509 to 106,637. There are grounds for believing that there is just as much, if not more, inefficiency in the use of manual and ancillary staff in the NHS as in local government.

This has made me think again about our commitment to savings in Civil Service manpower. The fact that the NHS can increase by 25,000 in a single year contrasts starkly with the efforts being made in DOE, as well as the policies I seek to bring about in local government. I feel even more bitter when I look at the efforts which my Ministers and civil servants have made in my own Department, with unprecedented controls on recruitment and manning, to secure manpower targets to which I had committed myself. Since the election DOE manpower has been reduced from 56,039 to 50,038 - a drop of 11%. There is now anguished debate as to how we can find the last 50 before April!

These results were achieved without transfers of staff to any other agency or government department or privatisation (with the exception of 4 staff who went to OAL). It was achieved by tight Ministerial control on recruitment and manning; and through the development of a management information system for Ministers which means that, for the first time, I have costed manpower data on the activities of every part of the Department. May I suggest that one of the first priorities of Mr Littler's group is to satisfy you of the existence of equivalent machinery in Whitehall at large?

As you will see from the attached note, I am looking for real manpower reductions of 26% in all, which are greater than those being sought in any other government department, except perhaps for the Lord President. I believe my targets will be achieved. If some of the ideas I have for this area are brought about I should be able to make even greater savings. So I am committed between now and 1984 to a further 16% saving; and this could reach 20% or more. I believe that it would be invaluable if you had made available to you for your own personal consideration a schedule showing the staff in post of each government department at May 1979, showing the run-down and latest SIP, but with details of how it has been achieved, including - on a common format - figures for inter-government transfers, transfers to local authorities, transfers to quasi-public authorities etc.

Staff in post.

In addition, I have brought about the quarterly publication of manpower figures for every local authority. I publish on a quarterly basis the manpower figures for my own Department. All ancillary bodies related to my Department are now going to produce figures. Each has been told clearly the reduced staff levels we expect of them. As you know, this week I sent in teams of accountants to the water authorities: one of their objectives is to look at staffing levels.

The fundamental point I would make is that none of this can be done without an unusual degree of Ministerial commitment to the detail of the processes, without which such results are not attainable. I am resolutely behind holding to the 6% cash limit. But before I can move to the point in my own Department where I have to introduce compulsory redundancy I believe it is only fair to me to be assured that the same management controls operating in my own Department are operating in other Departments. On the evidence of past achievement and future targets, it is difficult to avoid the conclusion that one of the most significant reasons for the wide differences is that the special pleading which I have had to sweep aside from local government - and on occasion, from within my own Department - has been accepted in other areas. As a result, manpower targets have not been hit and we see the results we now see in the Health Service.

I write in these terms because I cannot believe that we should allow ourselves to fail in so critical an area and on objectives to which we were so deeply committed.

Yours

MH

Manpower: Contributions required from Departments by 1.4.84 in order to meet the Prime Minister's 630,000 target

DEPARTMENT	(Overall staff saving required 1.4.79-1.4.84)	
	%(a)	Posts
Lord President	29.9	3,873
Environment	26.1	14,604
Industry	23.1	2,194
Transport	22.9	3,183
Defence	19.3	47,660
Exchequer	19.2	24,305
Agriculture	17.3	2,406
Education & Science	17.3	457
Welsh Office	15.9	412
Trade	15.3	1,515
Energy	14.0	177
DHSS	10.9	10,669
Scottish Office	10.1	11,604
Employment	8.7	988
Foreigh Office	8.2	4,652
Northern Ireland Office	7.5	16
Lord Chancellor	3.1	512
Home Office	+4.2	+1,410
(Others)	0.5	40

Notes

(a) All percentages show staff savings expressed as a percentage of the SIP figure for 1.4.79.

Department	*Staff in post at 1st April 1979*	*Staff in post at 1st October 1980*	*Target Staff in post at 1st April 1984 (Rounded to nearest 100)*
MAFF	13,956	13,406	11,600
Chancellor of the Exchequer's Departments	126,905	115,938	102,600
Defence	247,660	235,226	200,000
Education and Science	2,647	2,571	2,200
Employment Group	53,625	50,912	49,000
Energy	1,267	1,222	1,100
Environment and Ordnance Survey	56,039*	49,360*Ø	41,400++
FCO/ODA	12,078	11,605	11,100
Health and Social Security	98,369	97,917	87,700
Home Office	33,490	34,924	34,900
Industry	9,514	9,120	7,300
Lord Chancellor's Departments	16,518	16,370	16,000
Lord President's Departments	12,957	12,289	9,100
Scottish Office	11,119	10,911	10,000
Trade, Office of Fair Trading and Export Credits Guarantee Department	9,940	9,458	8,400
Transport	13,908	13,291	10,700
Welsh Office	2,607	2,388	2,200
Other Departments	9,723	10,167	9,700
Contingency margin	—	—	15,000
TOTALS (rounded)	732,300	697,100	630,000

* includes Ordnance Survey

++ includes 800 staff to transfer to DTp on 1.4.81

Ø 1276 staff working for the US Forces are excluded

Pc Press Office
NJ's to see
NJS 23/7/80 23/VII

DEPARTMENT OF HEALTH & SOCIAL SECURITY

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

Telephone 01-407 5522

From the Secretary of State for Social Services National Health

Petra Laidlaw
Private Secretary
Chancellor of the Duchy of Lancaster
Privy Council Office
70 Whitehall
London SW1

22 July 1980

Dear Petra

MEDICAL MANPOWER - THE NEXT TWENTY YEARS

I attach correspondence between my Secretary of State and the Secretary of State for Scotland as it proposes a statement by way of a Written Answer in the last week of Parliament.

Copies of this letter and attachments go to Nick Sanders (No 10) and Richard Prescott (PMG's Office).

Yours ever

D.BRERETON
Private Secretary

ENC

DEPARTMENT OF HEALTH & SOCIAL SECURITY

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

Telephone 01-407 5522

From the Secretary of State for Social Services

The Rt Hon George Younger TD MP
Secretary of State for Scotland
Scottish Office
Dover House
Whitehall
London SW1

23 July 1980

Dear George,

Thank you for your letter of 24 June about the Report of the Inter-Departmental Steering Group on Medical Manpower and the proposed statement on the future intake to the medical schools.

I fully agree with you that the Report's conclusions allow for a very broad range of possibilities; and there is certainly a considerable degree of uncertainty about the factors affecting the calculations of the numbers of doctors we should be training. I am therefore quite content to accept virtually the whole of the text of the revised statement which you attached to your letter.

However, as you will see from the enclosed draft, I have suggested one or two amendments. These stem either from comments received at official level from the Treasury and the DES or from my own reservations about your pessimism as regards possible medical unemployment. In spite of the fears of the medical profession (which are also expressed south of the border), the level of medical unemployment is at present negligible (about 0.5 per cent of all registered medical practitioners in Great Britain are registered as unemployed and their numbers have been falling in the last two quarters). Furthermore, while I accept that there is growing concern about the level of financial resources likely to be available in the public sector in the coming years, I feel sure that we must learn from the mistakes of our predecessors and not be blown off what is a very long-term course by short-term considerations. As the submission from my officials reported, the view of the Steering Group was that "although the prospects of medical unemployment could not be completely excluded, it was possible that there would be a short-fall of doctors by the end of the century if the intake to medical schools remained at or below 4,080 per year". In my view it would be premature, on the basis of the evidence available to us at present, to stress the likelihood of either of these alternatives coming about; and for this reason I would prefer to omit the last sentence of your third paragraph from the draft statement.

ENC

E.R.

I am planning to make this statement, by way of a written Reply, in the last week before Parliament rises, and it would therefore be very helpful to know soon whether you and the others to whom I am copying this letter are content with the attached draft. This goes, like yours, to Nicholas Edwards and to Mark Carlisle. My office is copying this exchange of correspondence to the Office of the Duchy of Lancaster, the Paymaster General's Office and to No 10.

Yours ever

Patrick.

MEDICAL MANPOWER

DRAFT STATEMENT IN RESPONSE TO AN INSPIRED PQ

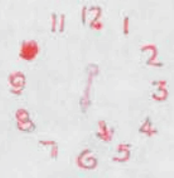
Question - To ask the Secretary of State for Social Services when he expects to make a statement on the size of the future medical school intake following consultations on his Department's discussion paper "Medical Manpower - the next 20 years".

SUGGESTED ANSWER:

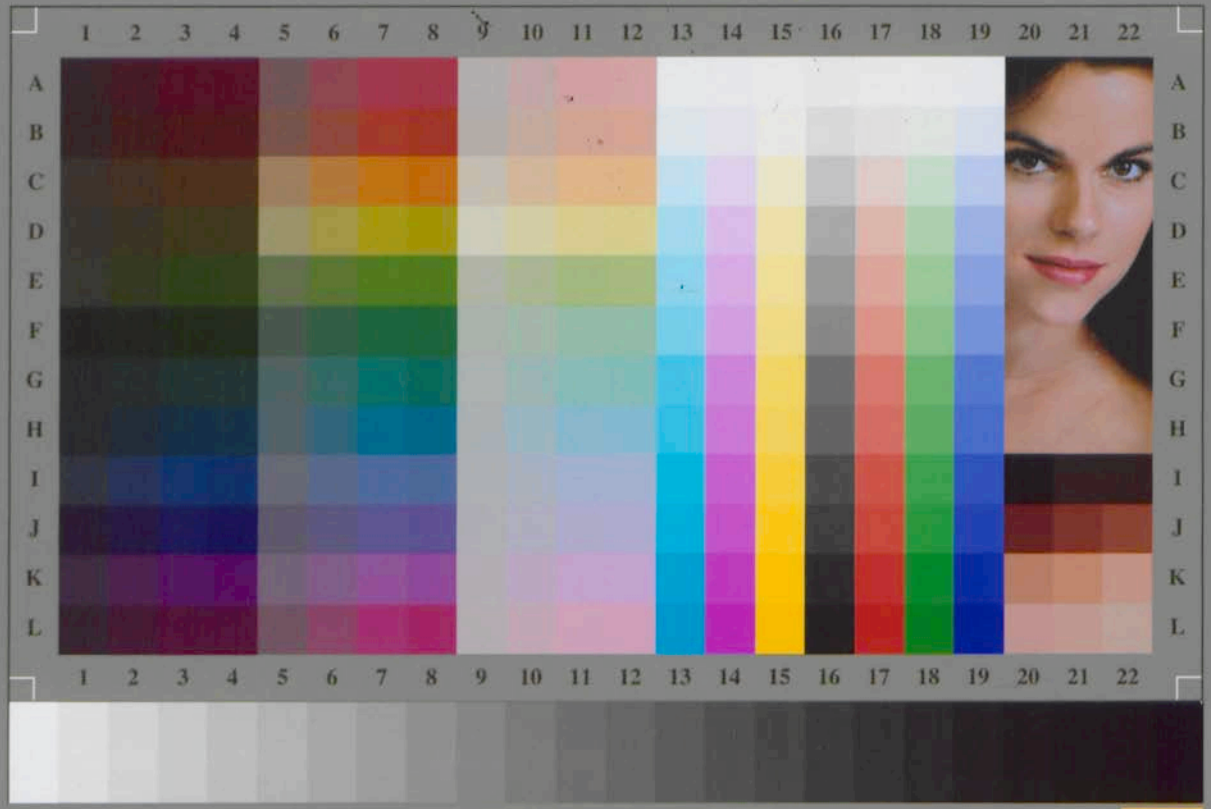
Following the publication in the autumn of 1978 of the discussion paper "Medical Manpower - the next 20 years", comments from more than 100 organisations have been received and analysed. In addition, an Inter-Departmental Steering Group has prepared a report, based on further work by officials, on the country's likely long-term needs for medical manpower. Copies of the Group's report have today been placed in the Library and further copies will be obtainable from my Department on payment.

Because of the length of time it takes to train doctors, medical school intakes have to be planned on the basis of calculations which necessarily make assumptions about long-term trends in a number of factors. These include the level of financial resources likely to be available for the health and education programmes, the contribution made by overseas doctors, the career patterns of women doctors and changing working practices in the Health Service. None of these factors can be predicted with any precision and illustrative projections of ~~the~~ a range of options have been made for the purposes of the Inter-Departmental Steering Group's study. They do not, however, constitute a Government view of how the economy or the Health Services necessarily will or should progress, and they will need to be revised from time to time in the light of experience. Because of the unavoidable uncertainties involved in making these calculations, my rt hon friends and I share the view expressed by the Royal Commission on the NHS, representatives of the medical profession and the Steering Group that it is important for them to be regularly reviewed and the outcome made publicly known. My officials will discuss the arrangements for such reviews with the interests most closely concerned.

The planned annual target intake to medical schools in Great Britain stands at 4,080. The Government have concluded that there should at present be no change in either direction in that target figure, although we recognise that expenditure constraints may delay its complete achievement. In addition to ensuring the supply of an appropriate number of new doctors, it is also important that we make the most efficient use of those already in the Health Service. The Government will therefore do what it can to encourage flexibility in postgraduate medical training and in medical career structures.



KODAK Q-60 Color Input Target



IT8.7/2-1993
2007:03

FTP://FTP.KODAK.COM/GASTDS/Q60DATA

Q-60R2 Target for
KODAK
Professional Papers