St Catherine's College Seminars

Managing the National Health Service

PATRICK NAIRNE

Introduction

These words come from a recent *Guardian* leader (12 January 1985):

"The message is that a national health service is about far more than patients being healed or helped by doctors and nurses. It cannot be allowed to be simply a structure within which professionals are allowed to do what they like, spend what they like and generally behave like autonomous blocks of hermetically sealed professionalism. Yet that is precisely what it is. Health Service administration remains essentially a facilitating service for professionals that pays the bills and repairs the fabric (or not, as the case may be)."

Are they unfair? Perhaps. But whether the words are true or untrue they reassured me that this seminar is timely. What I shall, therefore, try to do is to stimulate a constructive discussion about the main issues and problems that are presented today by the task of managing, operating, or running the most important and remarkable of our public services. We may enrich our understanding even if we reach neither conclusions nor consensus.

Changes in organisation and management

My starting point must be the sharp change, dating from 1975-6, in the economic and financial climate. The acute energy crisis of 1973-4 had helped to create roaring inflation, compelling the then Labour government to make drastic cuts in public expenditure; and the Secretary of State of the day was soon struggling to secure for the National Health Service an annual increase in real terms of approaching 2% at the most, in contrast with an annual growth rate of nearly 4%, which the service had enjoyed for many years. As Anthony Crosland remarked in public at the time, "the party was over." The NHS had to apply revenue cuts and also—a new and exacting problem—to accept within the budget of health authorities the extra revenue consequences of new facilities and equipment coming into service as the fruit of the hospital building programme of the 1960s. No wonder that many authorities faced severe difficulties similar to those of bringing the new John Radcliffe II Hospital into service.

Secondly, between 1975 and 1982, the NHS was in a state of unhappy convalescence after the major reorganisation of 1973-4. There was a widespread view—despite full consultation within the service—that the consultants on organisation and management had got it wrong and that the political surgeons had made a serious mistake in the operation. Public concern about the service, and disenchantment within it, had led to the traditional government remedy of a Royal Commission. And the Royal Commission (Sir Alec Morrison) commissioned a study of the reorganised service

from Professor Maurice Kogan of Brunel University, whose report highlighted:

... a great deal of anger and frustration at what many regard as a seriously over-elaborate system of government, administration and decision-making. The multiplicity of levels, the over-elaboration of consultative machinery, the inability to get decision-making completed nearer the point of delivery of services, and what some describe as unacceptably wasteful use of manpower resources ..."

In short (a phrase of the time) there were "tears about tiers." And so, in April 1982, the new Conservative government followed the Royal Commission's advice and introduced a further reorganisation, eliminating one organisational tier [the area] and creating the organisation that we have today, composed in England of 14 regional health authorities and somewhere around 200 district and special health authorities.

But, thirdly, in parallel with the organisational angst, there was the mounting criticism of an undermanaged as well as an over-administered service. The day to day pressures of cuts and cash limits within a labour intensive service of approaching one million full time and part time people; the wider policy objectives of shifting resources to the more deprived areas of England and less advantaged categories of patient (for example, the mentally ill); and, not least, the cases of inadequate management—relating, for example, to hospital building, catering, supplies, land, and prescribing (to mention examples from my six years at the DHSS)—publicly criticised by the Parliamentary Committee of Public Accounts: all these factors shifted the emphasis from structural change to managerial improvement. The then chairman of the Public Accounts Committee, now Sir Edward du Cann, challenged the service (in a parliamentary debate) with these words: "If ever there was an instance of a case where it is necessary to see that the Nation obtains value for money, surely it is the National Health Service. There is the very greatest need for much to be done."

Fourthly, the management inquiry report of Mr Roy Griffiths (of Sainsburys) and his colleagues published in October 1983 and the subject of a policy circular by the DHSS in June 1984 made four principal recommendations: (1) the establishment of the general manager function—through the appointment in each unit, district health authority, and regional health authority of a general manager responsible for planning, implementing plans, and control of performance, without prejudice to the responsibility of professional staff for professional advice; (2) the closer involvement of clinicians in management, especially in unit management; (3) the creation within the DHSS of two new boards—the Health Service Supervisory Board, chaired by the Secretary of State himself, responsible for strategic policies and priorities and resource allocation; and the NHS Management Board to be chaired by the newly appointed Mr Victor Paige, responsible for the national planning of the service and the oversight of performance at the departmental level; and (4) a programme of specific management measures.

It is possible, and it is certainly to be hoped, that the NHS is entering a period of consolidation, implementing arrangements that may enable it to manage better its current resources of around £13 billion a year while getting on with the job of treating patients. The

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Based on a lecture given at this college on 4 February 1985.

Secretary of State, Mr Norman Fowler, summed it up to the Select Committee of the House of Commons almost exactly a year ago in these words:

"I would not want to see any change in the organisation that we have now reached in the Health Service with the regional health authorities and the district health authorities. I really do think that we have been around that argument so many times over the last decade that the Health Service would simply throw up its hands in despair if we said we were going to change that. I believe that a very much better course to take is to see how we can make that structure work more effectively . . ."

If, however, the NHS structure is to work well and if the introduction of improved management arrangements and measures is to be effectively consolidated I believe that the service also needs to have a better understanding of the complex answers to two simple questions: firstly, who is running the NHS? and, secondly, what is the scope of NHS management?

Who is running the NHS?

Recent years have seen a shift from organisational policy to management policy; but what is part of both, and has become partly hidden, is something most important—the formulation of policies for the improvement and control of the service and the conflict that this can create between the DHSS and the health authorities. The DHSS preaches devolution but often practises, or finds itself compelled to practise, centralisation. Throughout my years at the DHSS there was constant tension between every level of the NHS, but it focused especially on the plea of health authorities that the department should get off its back and on the pull of policy and parliamentary pressures that required the DHSS to oversee and to intervene. There seems to be a risk that the new management arrangements will make the tension more acute (and I am not referring just to intervention over appointments): on the one hand, general managers in the service will want to be left as free as possible to formulate and implement their own authorities; plans with the approval of their own authorities; on the other hand, higher levels of authority and, in particular, the new NHS Management Board at the top will be concerned to ensure that local policies take as much account as possible of the national policies and priorities with which the Health Services Supervisory Board will be concerned. In short, I believe that, at the level of the DHSS, the region, and the district, it will be essential to be ready to grapple constructively and constantly with the balance between centralisation and decentralisation.

A more specific question is, Can we now expect the NHS to be more realistic than in the past in recognising the interdependence and partnership in policy matters which must in practice exist between every level from the Secretary of State to the unit? I must support my question with two points.

Firstly, there is the position of parliament. It has to approve the annual funding of the service, and it regards departmental ministers and the NHS Accounting Officer (now to be the chairman of the NHS Management Board) as accountable to it. Furthermore, the NHS Act (clause 1) states: "It is the Secretary of State's duty to continue the promotion in England and Wales of a comprehensive health service designed to secure improvement in the physical and mental health of the people of those countries, and in the prevention, diagnosis, and treatment of illness, and for that purpose to provide or secure the effective provision of services in accordance with this Act." That clause has actually taken the Secretary of State to court (though the plaintiff had no success) on the plea of excessively long waiting lists. A further example of parliament's position, as quoted in the famous words of Nye Bevan on creating the NHS—"In future when a nurse drops a bedpan on the floor of a hospital ward, its noise will be heard in the Palace of Westminster"—has been illustrated by the surge of national publicity over the recent Oxford case of Mr Derek Sage. Furthermore, the annual scale of parliamentary questions, letters, and adjournment debates devoted to NHS affairs testify to parliament's involvement. The DHSS may be instructed by ministers to stand back from the NHS, but parliament and its committees are not going to stand back.

Secondly, we need to be equally realistic about national policy priorities. When I gave evidence to the Royal Commission on the NHS the first question that the chairman asked me was: "How national did I consider the NHS should be?" The only answer I could give was that, while recognising that in day to day operation the NHS was a local service employing local people to look after local patients, the ministerial and departmental accountability for the service had to mean (and this is close to the words of the Griffiths report) that the DHSS at the centre should give an effective lead in promoting policy priorities. The present government published in 1981 a handbook for health and personal social services under cover of a personal letter (Mr Patrick Jenkin) to chairmen which said:

"We want to give you as much freedom as possible to decide how to pursue these policies and priorities in your own localities. Local initiatives, local decisions, and local responsibility is what we want to encourage. . . . But a National Health Service must also have regard to national policies and priorities, and I must ask you to take account of them, as set out in this handbook in making your plans and decisions."

We need to consider the extent to which the shift of financial resources under the regional resources allocation policy, the priorities thrust in the past 10 years towards the mentally ill, the mentally handicapped, and the aged, and the control of national salary policies have depended on (at least) the encouragement and (very often) the positive direction of ministers of the department.

In giving evidence to the Social Services Committee a year ago, the Secretary of State (Mr Fowler) also said that he was certainly seeking to achieve better delegation and better devolution. Nevertheless, he added that he had made a check on one division of the department and found that it was receiving something like 50 000 telephone calls a year initiated by the NHS (that is, about 200 a day), many on trivial issues which the NHS had chosen to raise with the department. Mr Fowler went on to say: "What has happened in many of those cases is that decisions have been made and attempted but the management process lower down has not been successful in making the decisions stick in the way that it might do."

I know what the Secretary of State meant—most organisations in the field need their hand strengthening from above occasionally—but I think that there is a much fuller explanation of what he had described. Whether we like it or not, all parts of the National Health Service are wired up to the same parliamentary and government circuit, and the source of political and financial power at the top or the centre has to try and exercise a degree of initiative and control, which is bound to mean that between the department and the NHS, and between the region and the district, the application of devolution and delegation will be qualified by the hard facts of interdependence.

So, returning to my question, Who is running the NHS? the answer cannot be a simple one and is certainly not to be provided by the analogy, for example, of parent and subsidiary companies in the private sector. The Griffiths report's bon mot about Florence Nightingale with her lamp today "searching for the people in charge" in the corridors of the NHS cleverly illustrated the case for the general manager, but it did not reveal the complicated character of the corridors and the communication between them. We have to ask: How is the general manager, at the different levels of region, district, and unit, to reconcile his or her new and exacting responsibilities not only with working under an active authority and with a multidisciplinary team but also with the constraints imposed by the policy and political aspects of a national service?

What is the scope of NHS management?

This last question links with my second (apparently) simple question: What is the scope of NHS management? My principal comment is that the special character of the NHS as a public service widens the scope of management well beyond the bounds of its normal definition and the frontiers of the accountant's critical eye. And it is not only the special character; there is the sheer scale and complexity of the service with patient statistics running into millions, with the greatly increased range of services and treatments, and with the growth both of specialised categories of staff

and of trade union activities. I must oversimplify by mentioning briefly—as a basis for discussion—the principal facets of management.

BUDGETARY CONTROL

The control of the NHS budget is a source of admiration outside Britain. We may spend too little on the NHS, but the NHS, chiefly to the credit of its treasurers, has kept remarkably close to the annual spending limits it has been given. That is not, however, to say that it is sufficiently economical. There has been an encouraging development of performance indicators in recent years. Nevertheless, if clinicians are to be more closely involved in management can the NHS do more to reconcile clinical freedom and effective financial management? When I visited hospitals it was usually the clinicians who rubbed my nose in examples of waste, and yet it took too many years to establish improved purchasing arrangements through a supply council. Can the experiments in departmental clinical budgeting be carried further? Can there be a satisfactory reconciliation—to quote a current instance—between the interests of doctors, the pharmaceutical industry, and the DHSS in drug prescribing (10% of NHS spending)?

VALUE FOR MONEY

Value for money in health care raises even more difficult issues. For example, what is the value of intensive care units (sometimes built and then not brought into service) and health centres, particularly when their provision has to be balanced against other, perhaps less glamorous, local requirements? Are diagnostic tests sometimes applied to excess, primarily because they are available? And do health authorities need to consider issues touching the quality of life in order to help clinicians to resolve crucial questions of priorities in treatment or to balance the principles of medical ethics with the demands of reasonable economy? A sensitive area of great difficulty.

PREVENTIVE MEDICINE AND HEALTH EDUCATION

Should health authorities do more to recognise that it is a health service, not an ill health service? Has the service given high enough priority—in the teeth of the pressures of acute medicine—to the role of the community physician? Slowly we have awakened to the damage that can be self inflicted by smoking and diet or can be insidiously inflicted by the environment in which we and our children live. Are health authorities (in conjunction with the local authorities) capable of devoting enough effort—and enough publicity—to local strategies for health promotion and preventive medicine?

COOPERATION WITH LOCAL AUTHORITIES AND VOLUNTARY SECTORS

Local strategies—or at least coherent plans—are also required for effective cooperation with local authorities and voluntary organisations. How successful are health authorities in managing to achieve that? Separate lines of financial responsibility have been an obstacle in the past to continuing schemes for joint financing, though such schemes can often save the cost of institutional care for, say, the elderly or mentally ill. Voluntary work in hospitals has tended to create trade union difficulties—though a shortage of resources argues for the maximum use, in a coordinated way, of good voluntary services where they are available.

PRIVATISATION

Trade union organisations have certainly aggravated the task of privatisation. Part of the country's health care has always been

provided by the private sector—private hospitals and nursing homes: are health authorities now succeeding in establishing more constructive cooperation between the private and public sectors (for example, in planning the provision of beds for the elderly)? While health authorities must examine possible ways of providing logistic services more cheaply by private contract, is it also recognised that, for example, a reliable and efficient NHS laundry service may be better value for money than a cheaper contract service?

CAPITAL INVESTMENT AND PLANNING

I would never wish to make light of revenue savings in what are termed the “hotel services,” but cost effective capital investment and planning are of even greater importance. The shine has gone off the word “planning” in the public sector, and a cumbersome NHS planning system got off to a bad start in the service nearly 10 years ago. But a planning system—now, I hope, simplified—is essential, even if costly in bureaucracy, if the DHSS and health authorities are to make sense of public consultation, and the monitoring of performance, in relation to the policy objectives of the service. The NHS struggled up a long learning curve in hospital building; and my experience of defending the horror stories to the Public Accounts Committee leads me only to express the hope that there are no longer health authorities, resistant to central guidance, who are seeking to “reinvent the wheel” for themselves in their plans for the building and commissioning of hospitals or other new facilities.

Conclusions

The organisation and management of the service are entirely for the purpose of ensuring that—with demand infinite and resources finite—the public and patients receive the best possible service for prevention, diagnosis, and treatment. And that underlines something important that I hope that my introduction has indicated clearly enough—good management in the NHS amounts to a great deal more than the bottom line of a balance sheet. Furthermore, within (I hope) an organisational structure that will not be changed again, devolution and delegation cannot be unqualified. The NHS cannot, and should not, escape political direction and control.

Reference

- 1 Department of Health and Social Security. *Care in action*. London: HMSO, 1981.

The discussion

JEAN GAFFIN

A prolonged discussion was a feature of the St Catherine seminar, a summary of which is printed below.

Central control and local autonomy

The first issue raised was the conflict between central control and the clinician's freedom. There was concern about political decision making and with policy changing when ministers changed. The decision by Enoch Powell, as Minister of Health in the early 1960s, to initiate the policy of closing down large institutions for the mentally ill and handicapped and move towards community care was an example. Implementing this and other policies was difficult: although the NHS might have become good at planning, it was even

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better at departing from the plans. Parliament was accused of willing the ends and not the means.

That it took a politician to initiate this move from large to small institutions was seen as an example of the inertia of professionals working in the long term chronic sector. Professionals were accused of being satisfied with their empires and resistant to change; pressure groups had fought for community care; and ministers such as the late Richard Crossman and David Ennals had kept it on the political agenda.

Cynics at the seminar wondered aloud if the policy of community care was now being pursued for the right reasons: would it be promoted if it was found to be more expensive—as it certainly would be if adequate resources were to be diverted to it? The effectiveness of the policy was challenged: might it mean no more than moving the mentally ill and handicapped from large to small institutions? Politicians were blamed for the view that throwing money at health problems would solve them. This had led to setting up the Resources Allocation Working Party, although there was no evidence that areas given extra resources would thereby solve their health problems. In the case of one major health problem, smoking, doctors had done more than politicians to reduce it.

The analogy on the relationship between the management of the NHS and industry was discounted: the parliamentary and political dimension at the top of the NHS and increased consumer pressure lower down could not be compared with the commercial pressures on either national or local boards of directors in the private sector. The negative effects of central government planning were also discussed: on manpower, for example. The pressure to privatise had meant health authorities were unable to concentrate on more crucial issues such as developing health services sensitive to local needs. As to the Griffiths reorganisation the government had asked the question which had led to the answer it had wanted—more management. Nevertheless, district management teams had been a successful part of the 1974 reorganisation because enthusiasm and a sense of comradeship had developed.

Local decision making within the NHS

Having shown considerable hostility to political control from the centre, some of the doctors at the seminar argued the case for

devolution: decisions made locally within medical executive committees were more likely to get local priorities right. A contrasting view was that doctors had too much power already. The role of the lay member of health authorities in policy making was emphasised; they had to work towards national priorities. It was not clear how the health authority members should learn the complexities and pressures of NHS management. Current practice included sitting on working parties on issues such as finance, policy planning, and handicap; attending courses; and “sitting next to Nellie.”

This led to a discussion of the implications of the new management structure for nurses. If doctors controlled the budgets what was left for the nurses who, since 1974, had had a critical place in management? This was but one example of the interprofessional complications that compounded the total complexity of the NHS. Responsibility for quality control had been “thrown” to nurses in some districts; professional nurse management and quality control had to go hand in hand if the resources were to be used to their optimum.

Did the best developments originate locally or were they imposed centrally? Developments such as flying squads and confidential inquiries into maternal deaths had started locally, as had hospital formularies, seen by one doctor as an important mechanism developed to protect patients from ineffective drugs.

Evaluating progress

Not surprisingly, there was no agreement within the seminar about the most effective way of judging performance within the NHS. One suggestion was that it can be done only at the very lowest level of service delivery: small multidisciplinary groups working together with shared goals in order to set up, say a primary care planning team, defining what was wanted and then seeing if it was achieved. Productivity was another measure of progress: treating more people for the same amount of money. Such measurement should be carried out within the framework of the total population, a plea that was coupled with regret at the loss of the medical officer of health annual statements on the state of the public's health. The NHS did a lot of monitoring but not much evaluation—performance indicators were being introduced but they were sometimes more about filling in forms than evaluating services.

MATERIA NON MEDICA

Death of a hospital: birth of an art group

I was born in north London and we lived over my father's surgery in the high road, a few hundred yards from what was one of Tottenham's prime assets, the Prince of Wales's General Hospital. It was therefore a particular pleasure for me to come back to Tottenham in 1968 and join the staff of The Prince. However, after only three years I resigned, together with many other young consultants, because we saw that the North East Metropolitan Regional Hospital Board was bent on the hospital's destruction. It took 14 more years for this rationalisation to be accomplished, but the Prince of Wales finally closed its doors to inpatients last year.

It is sad to see the death of a once famous hospital after 117 years of service to its community. Yet if its founder Dr Michael Laseron were to revisit the ward named after him he would be amazed, as I was, by its new role. Haringey Health Authority has over 300 young people employed on Manpower Service Commission schemes in hospitals, clinics, and neighbourhood projects. Laseron ward houses Project PWA, a group of 38 artists who are employed for one year from 1 June 1984 for improvement to patient waiting areas.

There is a manager, two supervisors, four team leaders, an administrative assistant, and 30 artists each working three days a week 9.15 am to 5 pm. Each team has a different project for murals in visitors' areas in the many clinics and outpatient departments of the district. Each mural is painted in

the ward studio in signwriters' enamel on panel, to be taken in sections for installation on site at the clinic.

The artists submit portfolios of work with their applications for employment and are selected for their figurative skills, because all the work is representational. Abstract art tends to be out of fashion in the art schools of the 80s. The topics are all decorative, some evocative of local topography (Alexandra Palace), others are fairgrounds, pastoral scenes, flora and fauna, and there are fairy tale scenes for children. Some of the paintings are restful, others gambolling and frenetic.

The original concept came from the district dental officer. It is therefore only right and proper that some of the murals are to go on ceilings so that when a patient, forlorn and supine in a dental chair, looks upwards for solace, relief of pain and distress comes from distraction by visual beauty aloft.

During these 12 months at The Prince of Wales the artists spend every Wednesday in a life class, and at the end of a year they are, it is hoped, better placed for further and gainful employment. This scheme was originally only for one year but rightly the MSC has renewed what is a most imaginative and innovative project, reducing unemployment and adding art to hospitals. Personally I would like to see a broadening of the aesthetic movements projected at the hospital staff, visitor, and patient—but perhaps the MSC steers clear of a battle of the styles.—J H BARON, consultant physician, London.