NHS management inquiry

Small, central management board recommended

The Secretary of State for Social Services established an independent National Health Service management inquiry in February this year. The inquiry (see box) was set 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.

Mr Griffiths and his team have now reported in the form of a letter to Mr Norman Fowler and this was published on 25 October.

Announcing the publication of the report in the House of Commons Mr Norman Fowler said: “The government very much welcomes the general thrust of this advice and is very grateful to Mr Griffiths and his colleagues. I shall be setting up within my department the health services supervisory board as recommended. Among its first tasks will be to establish the management board and to initiate action in respect of health authorities. Clearly, I shall consult the health authorities and professional and other interests involved, but subject to the outcome of these consultations I would hope that authorities would be able to start implementing the general management function from April 1984. The NHS is one of the largest undertakings in western Europe. The service needs and deserves the very best management we can give it. One of the best contributions we can make to patient care is the improvement in NHS management along the lines recommended in the Griffiths report.”

The recommendations are in the form of the management action to be taken by the Secretary of State, health authorities, or other bodies concerned. All are designed to be implemented without undue delay; none of them calls for legislation or for additional staff overall; and all are consistent with present initiatives to improve costs.

The letter consisted of recommendations, general observations, the reasoning behind the recommendations, and conclusions. The recommendations and the conclusions are reproduced in full.

Recommendations

Secretary of State

(1) The Secretary of State should set up, within DHSS and the existing statutory framework, a health services supervisory board and a full time NHS management board.

(2) The role of the health services supervisory board would be to strengthen existing arrangements for the oversight of the NHS. It would be concerned with:
   (a) determination of purpose, objectives, and direction for the health service;
   (b) approval of the overall budget and resource allocations;
   (c) strategic decisions;
   (d) receiving reports on performance and other evaluations from within the health service.

It should be chaired by the Secretary of State and also include the Minister of State (Health), the permanent secretary, the chief medical officer, the chairman of the NHS management board, and two or three non-executive members with general management skills and experience. It would relate to statutory and professional bodies in the same way as ministers and the Department of Health and Social Security do at present.

(3) The small, multiprofessional, NHS management board would be under the direction of the supervisory board and accountable to it. The role of the NHS management board would be to plan implementation of the policies approved by the supervisory board; to give leadership to the management of the NHS; to control performance; and to achieve consistency and drive over the long term. The board would have no separate corporate status. It would include a chairman, who would perform the general management function at national level—for example, as general manager, chief officer, or director general.

He would act on behalf of, and be seen to be vested with executive authority derived from, the Secretary of State. As such he would ensure that regional chairmen were fully consulted and involved in the discharge of responsibility reserved to the Secretary of State. It would be consistent with these functions for him to be appointed accounting officer for health services expenditure. The membership of the management board would include other functions such as personnel, finance, procurement, property, scientific and high technology management, and service planning.

(4) The chairman of the NHS management board would need to have considerable experience and skill in effecting change in a large, service oriented organisation and the personnel director would need a similar background. To meet these criteria, and to achieve credibility in establishing the new management style, these appointments would initially almost certainly have to come from outside the NHS and the Civil Service. Other functions would have to be strengthened by people with management experience in business, the NHS, and government. For example, the finance function would need strengthening from business, in respect of management accounting, and from the NHS for management budgets. In short, the NHS management board would have members drawn from business, the NHS, and the Civil Service.

(5) The management board should cover all existing NHS management responsibilities in the DHSS, including regional and district health authorities, family practitioner committees, special health authorities, and other centrally financed services.

Regional health authorities and district health authorities

(6) Regional and district chairmen should:  
   (6.1) extend the accountability review process right through to unit managers;  
   (6.2) identify a general manager (regardless of discipline), at authority level, charged with the general management function and overall responsibility for management's performance in achieving the objectives set by the authority;  
   (6.3) be given greater freedom to organise the management structure of the authority in the way best suited to local requirements and management potential;  
   (6.4) clarify the roles of chief officers accordingly;  
   (6.5) make explicit the main decisions reserved to the authority meeting itself; the major reports and regular information required of particular officers by the authority at set times; and how individual members should be involved in particular spheres of interest;  
   (6.6) review and reduce the need for functional manage-
ment structures, at all levels from unit management to chief
officers at authority level, and ensure that the primary reporting
relationship of functional managers is to the general manager;
(6.7) initiate major cost improvement programmes for
implementation by general managers.
(7) Regional chairmen should be directly involved in the
appointment of district chairmen by the Secretary of State.

Units of management
(8) District chairmen should:
(8.1) plan for all day to day decisions to be taken in the
main hospitals and other units of management. If decisions are
to be taken elsewhere than in the unit chairmen should require
justification;
(8.2) involve the clinicians more closely in the management
process, consistent with clinical freedom for clinical practice.
Clinicians must participate fully in decisions about priorities in
the use of resources. The recommendations in the three "Cog-
wheel" reports (produced by the Joint Working Party on the
Organisation of Medical Work in Hospitals in 1967, 1972, and
1974), and subsequent developments should provide the basis
for such participation. Clinicians need administrative support,
together with strictly relevant management information, and a
fully developed management budget approach. This approach
should prompt some measurement of output in terms of patient
care, and should ensure that the time at present spent by
doctors in meetings, committees, etc, will be reduced and
employed more purposefully.

Closer involvement of doctors is so critical to effective
management at local level that, with the support of the doctors
concerned, the inquiry has already undertaken small scale
studies in six hospitals. These illustrated the practicalities of
involving clinicians in management and have stimulated local
management action. The management board will need to
prompt chairmen to take similar action everywhere;
(8.3) clarify the general management function and identify
a general manager (regardless of discipline) for every unit of
management;
(8.4) see that each unit of management has a total budget;
(8.5) arrange for district procedures to spell out:
(8.5.1) the role of the treasurer's department in providing
management accountant support to unit managers in the
development of their budgets and in monitoring performance
against them;
(8.5.2) rules for virement between unit budgets and
between individual budgets within the unit, including the use
of planned and unplanned savings;
(8.5.3) authorisation limits and the flexible use of total
resources; and
(8.5.4) the financial relationship between unit budgets
and any district wide budgets for functional services on which
the unit may call;
(8.6) ensure that each unit develops management budgets,
which involve clinicians and relate work load and objectives to
financial and manpower allocations so as to sharpen up the
questioning of overhead costs. This is such a vital management
tool that the inquiry has already set up demonstrations in four
district health authorities, under a joint inquiry/DHSS/NHS
steering group, which will maintain the impetus and stimulate
wider implementation pending the appointment of the NHS
management board to drive through this initiative.

Personnel
(9) The Secretary of State should appoint, as a member of
the NHS management board, a personnel director. His main
responsibilities should include:
(9.1) to coordinate the NHS management evidence to the
review bodies and to organise the management sides and
objectives in the Whitley pay negotiations for bodies not covered
by the review bodies, after full consultation within the NHS;
(9.2) to review the remuneration system and conditions for
service so as to overcome the lack of incentive in the present system and the inability of chairmen to reward or take action on ineffective performance;
(9.3) to ensure with line management that a policy for performance appraisal and career development operates, from the unit to the centre, to meet both the aspirations of staff and the management needs of the service;
(9.4) to assess how far the management training of different
groups, including clinicians, meets the needs of the service and to stimulate the provision of appropriate training courses, inside and outside the NHS;
(9.5) to review procedures for appointments, dismissal,
grievance, and appeal; identify any conditions of service which are not cost effective in management terms; and secure the maximum devolution of responsibility for such matters;
(9.6) to carry forward the DHSS work, stimulated by the
management inquiry, in determining optimum nurse manpower
levels in various types of unit, having regard to the needs of the
local situation and the maintenance of professional standards to
so that regional and district chairmen can re-examine funda-
mentally each unit's nursing levels;
(9.7) to secure reviews of manpower levels in other staff
groups.

Property
(10) The chairman of the NHS management board should
ensure that:
(10.1) a property function is developed so as to give
major commercial reorientation to the handling of the NHS
estate;
(10.2) procedures for handling major capital schemes
and disposal of property are streamlined and speeded up and
provide maximum devolution from the centre to the periphery;
(10.3) the DHSS Review of the Works Function gives
priority to the requirements of the NHS management board.

Establishment of inquiry
Announcing the establishment of the inquiry in a written
parliamentary answer on 3 February Mr Norman Fowler said:
"I have today established an independent NHS manage-
ment 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 Tele-
vision 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 inquiries 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."

Levels of decision taking

(11) The chairman of the NHS management board should undertake a general review of levels of decision taking in the NHS, to reduce the numbers and levels of staff involved in both decision taking and implementation.

Consultation

(12) The chairman of the NHS management board should review all consultation arrangements required by legislation or administrative order—for example, closure or changes of use of health buildings, property transactions, Capricode and Estman-code, to speed up and simplify the essential consultation required. Chairmen should take similar action in respect of the local consultation process.

Patients and the community

(13) The management board and chairmen should ensure that it is central to the approach of management, in planning and delivering services for the population as a whole, to:

13.1 ascertain how well the service is being delivered at local level by obtaining the experience and perceptions of patients and the community: these can be derived from community health councils and by other methods, including market research and from the experience of general practice and the community health services;

13.2 respond directly to this information;

13.3 act on it in formulating policy;

13.4 monitor performance against it;

13.5 promote realistic public and professional perceptions of what the NHS can and should provide as the best possible service within the resources available.

General observations

The team has emphasised the similarities between NHS management and business management. In many organisations in the private sector profit does not immediately impinge on large numbers of managers below board level. They are concerned with levels of service, quality of product, meeting budgets, cost improvement, productivity, motivating and rewarding staff, research and development, and the long term viability of the undertaking. All these are things that parliament is urging on the NHS.

Although the NHS is enormously concerned with control of expenditure it lacks any real continuous evaluation of its performance. There is a lack of a clearly defined general management function throughout the NHS. At no level, the team says, is the general management role clearly being performed by an identifiable individual. This means that the process of devolution of responsibility, including discharging responsibility to the units, is far too slow.

The team has welcomed the accountability review process but says that it needs to be extended beyond districts to units of management, particularly the major hospitals. It should start with a unit performance review based on management budgets which involve the clinicians at hospital level.

Lack of a general management process means that it is difficult to achieve change. The NHS needs to move much quicker if as seems likely there is a considerable pressure on resources.

Conclusion

"As you know, we have conducted this inquiry mainly through discussions with individuals, groups, and associations and by visiting general practitioners, hospitals, community health services, health authorities, and other bodies. We have had many discussions in the DHSS, and we have visited Wales and Scotland. We have reviewed all existing central management initiatives and considered the appropriate reports. We have faced no significant or serious objection to the general line of inquiry we have been pursuing and we have gained general support for our developing ideas. We have emphasised that we are not a royal commission in search of evidence and in pursuit of a major report. None the less, we have been besieged with evidence and points of view during and following all the many meetings we have attended. It is extremely heartening to find that so many people working in, or related to, the NHS care so passionately about the service and the way it should be managed.

"We have listened to all that has been said and we have read all that has been written for us. We clearly cannot set out all the many points of view in a document which must be brief and action oriented; but our advice really does reflect all that has been put to us even where we have not agreed with a particular point of view. Indeed, in many of the specific areas drawn to our attention, we have gone further and made our views available to the DHSS so that those concerned with acting on our main advice can take the points put to us into account in the implementation phase.

Concentration on hospital services

"Our advice has tended to concentrate on the hospital services. We recognise, however, that both community health services and family practitioner services play a most important role in delivering health care. On your advice, we have stayed clear of a detailed consideration of these particular areas because of the current work going on at the centre between the DHSS and the professions; but we have had discussions with general practitioners and their representatives which provide support for our general views. Hospitals, family practitioner services, and community health services clearly interact with, and affect, each other; and, more important, the patient observes no such separate services; he just deals with the NHS. But much more needs to be done to recognise this interaction, in everyday management, in policy making and planning, and in the allocation of resources. There is a clear need for these issues to be brought within the scope of the coherent management process we are now considering. For example, at the centre they should be the responsibility of the chairman of the management board and his fellow board members. At unit level and below, in the absence of more fundamental reorganisation, there should be a general management forum to ensure that hospital clinicians, general practitioners, and community health services staff take real management action to shift resources (and patient care) between the various sectors.

Major social factors

"At the same time, we have recognised that it is impossible to review the NHS without appreciating the major social factors which cause extensive demands on the service and actually have little to do with medical treatment. This is the broader canvass of government, both national and local. No part of the health service can be self contained.

"It must be emphasised that our task was not:

- a manpower inquiry: it is pointless to discuss manpower except in the context of the overall task and objectives of the NHS. Nevertheless, manpower does account for over 70% of total NHS costs, so better management of resources must mean better use of manpower;

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Police and Criminal Evidence Bill

Unlike its predecessor, which fell because of the general election, the Police and Criminal Evidence Bill (introduced into the House of Commons on 27 October) no longer includes power to use intimate body searches for evidence. If a search must take place—for example, if a senior officer believes that it is necessary to remove a concealed weapon or other dangerous object—the police must see whether it can be done by a doctor. If not the search may be carried out by a police officer of the same sex as the suspect on the further authorisation of a superintendent.

The secretary of the BMA, Dr John Havard, has made the following comment on the proposals in the new Bill:

"The BMA welcomes the deletion of the statutory powers for intimate body searches in cases where they are needed by the police for the purposes of providing evidence in support of a criminal prosecution. The BMA has always accepted that there may be a need in exceptional cases for an intimate body search to be carried out without the consent of a person in police custody where the purpose of the search is to remove an object which is of immediate danger to the life or personal safety of the suspect and those in proximity. However, we have made representations to the Home Office ministers that in such cases the search should always be carried out by a medical practitioner as recommended in the report of the royal commission on which the Bill is based. Therefore, we would like to see the removal of the option contained in the Bill for such examinations to be carried out by lay police officers of the same sex."

Mr Kinnock meets junior doctors

On 25 October representatives of the Hospital Junior Staff Committee met the leader of the Opposition, Mr Neil Kinnock. He is seen here with Mr Douglas Gentleman (left), deputy chairman of the HJSC; Mrs Gwyneth Dunwoody; Mr Stephen Brereton, HJSC chairman; Dr Michael Donnelly; Dr Aubrey Brearley, deputy chairman of the HJSC; and Mr J N Johnson. On the next day senior representatives of the committee lobbied members of parliament on several issues of importance to junior doctors. They expressed their concern at the financial and manpower cuts in the health service and the possible effect that these would have on patient care. They pointed out the implications for health planning of authorities having to make savings in the middle of a financial year.

The HJSC believes that junior doctors are particularly at risk because of their short term contracts. They fear that some contracts may not be renewed. As well as Mr Kinnock and Mrs Gwyneth Dunwoody the juniors met Mrs Jill Knight and Mr David Crouch (Conservative Party); Mr Roy Jenkins, Mr Michael Meadowcroft, and Lord Kilmarnock (Alliance Party); and Mr James Molyneaux and Mr Martin Smith (Ulster Unionists).

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— a remit to change the statutory structure, organisation or financing of the NHS: the NHS is in no condition to take another restructuring, and much more can be achieved by making the existing organisation work in practice. We have tried to give the necessary dynamic to the process;
— a search for specific areas in which costs might be cut: this is the responsibility of NHS management, using established management techniques and incorporating new initiatives such as the 'Rayner scrutiny' and the financial management initiative;
— a search for areas that might be contracted out to the private sector: NHS management itself, however, should continually be asking how services are organised elsewhere; considering whether particular NHS functions could be performed to the same standard outside at less cost; and examining why, if functions can be performed more cheaply, the NHS itself should not do so;
— to cover Scotland, Wales, and Northern Ireland: we have visited the central departments and health authorities in Scotland and Wales and their observations were helpful in framing our specific recommendations for the NHS in England.

"We have shaped our recommendations with an eye to practicality of implementation. We have refrained from over-elaboration because there is a danger of being too prescriptive, particularly over the needs at local level. Our primary remit was not to launch a whole lot of new inquiries but to look at the available evidence. There have been over the years many working party reports on, and much discussion about, many of the areas we have considered. The point is that action is now badly needed and the health service can ill afford to indulge in any lengthy self imposed Hamlet like soliloquy as a precursor or alternative to the required action."

Changes in finance and manpower

The following table sets out the changes in regional health authorities' revenue and capital cash limits that followed the Chancellor of the Exchequer's statement on 7 July and the changes in manpower required for each English region under the government's policy of improving manpower planning and control.

<table>
<thead>
<tr>
<th>Regional health authority</th>
<th>Changes in revenue cash limits (£ x 106)</th>
<th>Changes in capital manpower</th>
</tr>
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<tbody>
<tr>
<td>Northern</td>
<td>- 5334</td>
<td>-186</td>
</tr>
<tr>
<td>Yorkshire</td>
<td>- 5994</td>
<td>-264</td>
</tr>
<tr>
<td>Trent</td>
<td>- 7090</td>
<td>+ 520</td>
</tr>
<tr>
<td>East Anglia</td>
<td>- 3038</td>
<td>+ 374</td>
</tr>
<tr>
<td>North West Thames</td>
<td>- 6195</td>
<td>- 1000</td>
</tr>
<tr>
<td>North East Thames</td>
<td>- 7838</td>
<td>+ 1200</td>
</tr>
<tr>
<td>South East Thames</td>
<td>- 8118</td>
<td>- 1000</td>
</tr>
<tr>
<td>South West Thames</td>
<td>- 5368</td>
<td>- 730</td>
</tr>
<tr>
<td>Wessex</td>
<td>- 4296</td>
<td>+ 40</td>
</tr>
<tr>
<td>Oxford</td>
<td>- 3418</td>
<td>+ 229</td>
</tr>
<tr>
<td>South Western</td>
<td>- 5225</td>
<td>+ 124</td>
</tr>
<tr>
<td>West Midlands</td>
<td>- 8322</td>
<td>- 140</td>
</tr>
<tr>
<td>Mersey</td>
<td>- 4378</td>
<td>- 506</td>
</tr>
<tr>
<td>North Western</td>
<td>- 7340</td>
<td>- 562</td>
</tr>
</tbody>
</table>

Total all RHAs             | - 80 750                               | - 4630                      

Note: The changes in cash limits exclude joint finance areas. They show the differences between the previous limit announced in January and the revised cash limit announced in August.

BMA fees guide

On 24 September (p 924) we announced an agreement negotiated by the BMA's private practice committee with the Department of Health and Social Security on fees paid under the collaborative arrangements, and for special work in the community health service. This agreement was subject to finalisation of the detailed figures. These have now been agreed and replacement pages for the fees guide printed. Members are invited to apply for these, quoting their current membership number and the reference "Fees 41." A stamped addressed envelope would be appreciated.