M. Thornbull - to see
Mr Bowday
file

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.,
No. 10 Downing Street,
London SW1

7 October, 1983

Dear Robin.

I enclose a copy of Roy Griffiths' report on NHS Management, as promised. — dated 6/10

My own view is that it is excellent - just what I was hoping for. It validates all I have been doing - with Norman Fowler's enthusiastic backing - and gives us a base for moving forward.

We are handling the report on a very restricted basis at the moment because it is essential that it be presented to the NHS in terms of our choosing and not via a press leak. We want to pave the way in the Secretary of State's speech to the Party Conference. And we then want to promulgate it with announcement of immediate action so that it hits the ground running.

I have one reservation which I have already mentioned to Robert Armstrong. The Report deliberately and wisely avoids the single-bullet prescription (page 18) for establishing the general manager function but breaks its own rule for the Department as to the size, composition and (implicitly) grading of the Health Services Management Board. The idea of the Board as an effective device for getting things done is good. But I doubt if we need it to be souped up to the point where we have, in effect, another Permanent Secretary and five more Deputy Secretaries in the Department, three of them at £80,000+ salaries! The effect on the NHS pay scene can be imagined.

I am copying this letter and its enclosure to Robert Armstrong and Peter Middleton.

Yours ever

Ken.

NHS MANAGEMENT INQUIRY
Room D402
Alexander Fleming House
Elephant and Castle
London SE1 6BY

Telephone: 01 407 5522 X7684/ 6604

PERSONAL

6th October, 1983

The 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,

I attach a letter from the Management Inquiry team. It has been drafted in two distinct parts; first the recommendations, which are reasonably self-contained and, secondly, a background commentary which briefly gives the main reasons why we have arrived at the particular recommendations.

The recommendations themselves have been drafted to meet our own assessed requirement of rapid implementation, should it be so decided. For that, amongst other good reasons, we have not recommended any kind of statutory corporation for the Health Service. One of the arguments, however, in favour of a separate statutory body was that it might have been easier to recruit and reward people to be brought in from outside. We feel, however, that in any case, no obstacle should be placed in the way of such outside recruitment necessary, at least at the outset, to give both credibility and experience to the change in management style which is necessary.

It is important to appreciate the impact which a few very able professional top managers could make, both on the quality and cost of the Service. To attempt to implement the recommendations without these catalysts would be to accept the form but not the substance.

Equally, we emphasise that we are not talking simply about more appointments at the Centre.

/ Cont....

The Rt. Hon Norman Fowler, M.P. 6th October, 1983

We should, even in the short term, be talking about a considerable reduction in numbers.

It would have been presumptuous to have included any timetable for implementation and it is probably unnecessary even to emphasise that implementation right through the NHS will be a long hard job and will require considerable skill, sensitivity and leadership. We believe, however, that it is both necessary and possible, almost regardless of the level of resources to be committed to the NHS.

Equally, we have not mentioned any priority of implementation, but clearly this would be to take action at the Centre to establish the nucleus of the Supervisory and Management Boards at an early date.

If there is any clarification or further justification needed of any of the recommendations, then we are available to help.

Very best wishes.

Roy Griffiths

E.R. GRIFFITHS

Attach:

FOR RETURN TO C/E

COPY NO. 23

NHS MANAGEMENT INQUIRY
Room D 406
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
Tim Stevens

The Rt Hon Norman Fowler MP
Secretary of State for Social Services
Department of Health and Social Security
Alexander Fleming House
Elephant and Castle
LONDON SE1 6BY.

6 October 1983

Dear Secretary of State,

NHS MANAGEMENT INQUIRY

This letter is not intended to be a major addition to the already considerable library of National Health Service literature. We were asked by you in February to give advice on the effective use and management of manpower and related resources in the National Health Service; to inform you as our inquiries proceeded; and to advise you on progress by the end of June. In particular, it was emphasised that we had not been asked to prepare a report, but that we should go straight for recommendations on management action. You have been kept in touch with our work and we have reported progress to you.

Our main recommendations are set out below. They are presented in the form of the management action to be taken by you, or the Health Authorities or other bodies concerned. You have already set the direction by instituting the regional reviews. There is still an enormous programme of management action necessary. Speed of implementation is essential. To that end the letter is in two parts: first, the recommendations which are self-standing and provide the basis for the necessary action; the second part makes some general observations and sets out the reasoning behind the recommendations.

One important prelude to the recommendations: we believe that a small, strong general management body is necessary at the centre (and that is almost all that is necessary at the centre for the management of the NHS) to ensure that responsibility is pushed as far down the line as possible, i.e. to the point where action can be taken effectively. At present devolution of responsibility is far too slow because the necessary direction and dynamic to achieve this is currently lacking. Staff within the Health Services have to be assured that in future when changes are being made, demands made on them will as far as possible be part of an orderly management process. Government and Parliament must be sure that, whatever level of resources is allocated to the NHS, the means to effect the necessary changes are available. We believe that our proposals would speed up that process.

All our recommendations are designed to be implemented without undue delay: none of them calls for legislation nor for additional staff overall; and all of them are completely consistent with present initiatives to improve costs. You will see that, in respect of our recommendations for management budgets and stronger management at Unit and hospital level, action is already underway in 6 hospitals and 4 District Health Authorities with the support of DHSS and the NHS and the doctors concerned.

RECOMMENDATIONS FOR ACTION

- THE SECRETARY OF STATE

1. The Secretary of State should set up, within 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 DHSS do at present.

3. The role of the small, multi professional, 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, e.g. 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 as Accounting Officer for Health Service 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 might have about nine members drawn from business, the NHS and the Civil Service.

5. The Management Board should cover all existing NHS management responsibilities in 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 management 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 elsehwere in the NHS management process, 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 "Cogwheel" 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 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 service 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 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 co-ordinate 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 of service for management so as to overcome the lack of incentive in the present system and the inability of Chairmen to reward merit 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 staff 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, so that Regional and District Chairmen can re-examine fundamentally 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 a 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.

- 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, e.g. closure or changes of use of health buildings, property transactions, Capricode and Estmancode, 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 CHCs 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

We were brought in not to be instant experts on all aspects of the NHS but, because of our business experience, to advise on the management of the NHS. We have been told that the NHS is different from business in management terms, not least because the NHS is not concerned with the profit motive and must be judged by wider social standards which cannot be measured. These differences can be greatly overstated. The clear similarities between NHS management and business management are much more important. 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 things that Parliament is urging on the NHS. In the private sector the results in all these areas would normally be carefully monitored against pre-determined standards and objectives.

The NHS does not have the profit motive, but it is, of course, enormously concerned with control of expenditure. Surprisingly however, it still lacks any real continuous evaluation of its performance against criteria such as those set out above. Rarely are precise management objectives set; there is little measurement of health output; clinical evaluation of particular practices is by no means common and economic evaluation of those practices extremely rare. Nor can the NHS display a ready assessment of the effectivemeness with which it is meeting the needs and expectations of the people it serves. Businessmen have a keen sense of how well they are looking after their customers. Whether the NHS is meeting the needs of the patient, and the community, and can prove that it is doing so, is open to question.

It therefore cannot be said too often that the National Health Service is about delivering services to people. It is not about organising systems for their own sake. In proposing the NHS in 1944, the Government declared that:

- the real need is to bring the country's full resources to bear upon reducing ill health and promoting good health in all its citizens; and,

- there is a danger of over-organisation, of letting the machine designed to ensure a better service itself stifle the chances of getting one.

Our advice on management action is not directly about the nature of the services provided to patients. But the driving force behind our advice is the concern to secure the best deal for patients and the community within available resources; the best value for the taxpayer; and the best motivation for staff. As a caring, quality service, the NHS has to balance the interests of the patient, the community, the taxpayer and the employees.

One of our most immediate observations from a business background is the lack of a clearly-defined general management function throughout the NHS. By general management we mean the responsibility drawn together in one person, at different levels of the organisation, for planning, implementation and control of performance. The NHS is one of the largest undertakings in Western Europe. It requires enormous resources; its role is very politically sensitive; it demands top class management.

Management is currently provided:

a. by the Secretary of State and the Minister of State (Health), who can spend about half a day a week on it, given that they have to attend to their many other demanding responsibilities within DHSS, Government and Parliament and to the electorate;

b. by a Permanent Secretary who can spend about one day a week on it, given the demands of the other main businesses within the DHSS and the requirement for him to support Ministers in their other responsibilities;

c. at Regional and District level by Chairmen appointed on a non-executive, part-time basis (notionally two days a week, but in practice demanding much more time).

This position is understandable but the problem arises in that the required management support is given at the centre within the DHSS by senior officials and groups, none of which is concerned full time with NHS management; and at Regional and District level by professional officers required to work in consensus management teams where each officer has the power of veto. The

position is complicated by the fact that Unit managers (administrator, nurse and clinician) are still being appointed following the 1982 reorganisation. At no level is the general management role clearly being performed by an identifiable individual. In short if Florence Nightingale were carrying her lamp through the corridors of the NHS today she would almost certainly be searching for the people in charge.

Absence of this general management support means that there is no driving force seeking and accepting direct and personal responsibility for developing management plans, securing their implementation and monitoring actual achievement. It means that the process of devolution of responsibility, including discharging responsibility to the Units, is far too slow. The centre is still too much involved in too many of the wrong things and too little involved in some that really matter. For example, local management must be allowed to determine its own needs for information, with higher management drawing on that information for its own purposes. The Units and the Authorities are being swamped with directives without being given direction. Lack of the general management responsibility also means that certain major initiatives are difficult to implement.

The accountability review process is a good, recent development which provides a powerful management tool. But the management task is so demanding and continuous that, without moving in the direction we are recommending, it is difficult to see how this process can be sustained effectively given the other pressures on Ministers and senior officials. The Review process needs to be extended beyond Districts to Units of Management, particularly the major hospitals, and it should start with a Unit performance review based on management budgets which involve the clinicians at hospital level. Real output measurement, against clearly stated management objectives and budgets, should become a major concern of management at all levels.

Above all, of course, lack of a general management process means that it is extremely difficult to achieve change. To the outsider, it appears that when change of any kind is required, the NHS is so structured as to resemble a "mobile" : designed to move with any breath of air, but which in fact never changes its position and gives no clear indication of direction. There are good reasons as to how this has arisen and, indeed, some argument as to why in fact

it is desirable. But, over the rest of the decade when there is likely to be very considerable pressure on resources, at least as compared with likely demand, the NHS needs the ability to move much more quickly. Equally if the emphasis is on devolution, then it needs a strong management process to enable this to be achieved, simply holding at the centre sufficient control to ensure that appropriate standards and services are maintained.

On the other hand, the presence of a general management process would be enormously important in :

a) providing the necessary leadership to capitalise on the existing high levels of dedication and expertise among NHS staff of all disciplines, and to stimulate initiative, urgency and vitality;

b) bringing about a constant search for major change and cost improvement. It can be argued that the NHS delivers an effective, low cost, medical service to the individual patient. But, given an effective management process, the same level of care could be delivered more efficiently at lower cost, or a superior service given at the same cost. We were not asked to look for detailed ways of increasing efficiency or making savings, or to highlight specific inefficiencies we may have observed. Line management should be free to determine how to achieve this, drawing on established management techniques and recent developments in audit or "Rayner scrutinies". Major cost improvement programmes can and should be initiated within the NHS, aiming at much higher levels of efficiency to be sustained over much longer periods than at present. These should carry with them the inbuilt incentive that a significant proportion of the savings made can be used locally to bring about further change and improvement. It is almost a denial of the management process to argue that the modest levels of cost improvement at present required of the NHS are unachievable without impacting seriously on the level of services;

c) securing proper motivation of staff. Those charged with the general management responsibility would regard it as vital to review incentives, rewards and sanctions. Merit awards would be considered. Redeploying the non-efficient performer would also be important, with dismissal as a last resort;

d) ensuring that the professional functions are effectively geared into the overall objectives and responsibilities of the general management process. The primary reporting relationship of the functional managers should be to the general manager, who should set, by agreement with the functional managers, the priorities and programmes for their work. The relationship with the professions at other levels should simply be one of seeking guidance or monitoring of the professional aspects of their work. The present position leads to unnecessary duplication of staff; too many purely professional meetings, from the centre to the Unit; and the tackling of overall tasks in a fragmented and divisive manner. Any apparent advantages of the functional specialisms are nowadays more than offset by the need to establish the general management process effectively;

e) making sense of the process of consultation. The NHS is a matter of considerable importance to all members of the community and is political in the best sense. A very great deal of importance is attached to ensuring that the views of the community at all levels are taken into account in any decision. The reality is, however, that by any business standards the process of consultation is so labyrinthine and the rights of veto so considerable, that the result in many cases is institutionalised stagnation - a result particularly enhanced by the fact that the machinery of implementation is generally weak and, as such, cannot ensure that the processes of consultation are effectively implemented and quickly brought to a conclusion.

BACKGROUND TO RECOMMENDATIONS

- SECRETARY OF STATE

We are convinced that you will need to be supported at the centre, by a small, strong, professional management group, able to devote considerable time to running the NHS. This is in no way intended to derogate from your statutory role as Chairman and Chief Executive, but in fact to allow that role to be given expression through a General Manager seen to be vested with your authority and to be acting on your behalf and, as your right-hand man, in ensuring that the statutorily appointed authorities manage the NHS effectively. This appointment would leave undisturbed your clear responsibility for overall policy direction and for the handling of the public and political sensitivities of the service.

A case could be made for an independent corporation as the 1979 Royal Commission recognised. This has a variety of defects, not least that one would have to formalise unnecessarily the role of the corporation vis-à-vis the Secretary of State, which would be extremely difficult in such an intensely politically sensitive operation. Additionally, it would require legislation and would be far too delaying.

The appropriate effect would be achieved by what we propose: a Health Services Supervisory Board chaired by you; and an NHS Management Board chaired by the new "right hand man" we are recommending. This will require major changes in the stance and style of management at the centre and in the public and parliamentary requirements of the NHS management process. For example:

a) it is not for the centre to engage in the day to day management of the NHS. It must make sure that the statutorily appointed Authorities do so effectively in accordance with the requirements of Government and Parliament. Sufficient management impression must be created at all levels that the centre is passionately concerned with the quality of care and delivery of services at local level. As a coherent management process is developed, of planning, implementation and control, the DHSS should rigorously prune many of its existing activities;

b) the NHS Management Board should cover all central aspects of NHS management, including Health Authorities and non-departmental bodies. It should control directly the work of the Supply Council and the NHS Training Authority, together with work on computer policy and health information, since at present their position in the NHS executive management line is not clear;

c) the requirement for central, isolated initiatives should disappear once a coherent management process is established. Parliament and the taxpayer have rightly shown a keen interest in cost control. Since manpower accounts for such a large part of the cost of the NHS, this has attracted particular attention at the centre in the last couple of years. This, in turn, has led to such recent central initiatives as the control of NHS management costs, the establishment of RHA manpower targets, the requirement for particular, isolated, efficiency savings and the development of national performance indicators. We believe that once a tight budgetary system has been established, based on management budgets operating within the context of the total management process we recommend, means of effecting change in the use of resources should be left much more to local management in the light of the local situation;

d) a real demonstration of management will, at the centre, will be required, if the NHS is to break free from the present top-down approach to detailed management and yet be held to proper account for performance and achievement. For example the DHSS must not set out to acquire detailed information on, say, what use is being made of different kinds of specialty beds in every District, so as to give specific instructions to Health Authorities to secure a higher or lower utilisation rate or answer Parliamentary Questions;

e) the DHSS will have to adjust its activities in order to support the new management role of the Supervisory Board and of the Management Board. This should be planned at the outset for immediate implementation.

- REGIONAL HEALTH AUTHORITIES AND DISTRICT HEALTH AUTHORITIES

The role of Regions needs to be strengthened. RHAs are responsible for the total delivery of health services within the Region. They will inevitably concentrate on planning, resource allocation and control. Within this overall statement, Regions will need to ensure that Districts, Hospitals and Units are liberated to get on and manage the service and be held to proper account for performance and achievement.

In many cases a management gap exists between the Authority members and their officers, in particular at District level. Each Authority needs to clarify its own role and consequently the general management function by identifying:

- the major decisions the Authority should reserve to itself and the information it requires from its officers and when;

- what should be left to the Chairman;

- what tasks should be undertaken on behalf of the Authority by the general manager and chief officers; and,

- the role of the individual member.

As a consequence of this clarification, the NHS Management Board will need to review the method and process of selecting and appointing Chairmen and Members and advise the Supervisory Board accordingly on adjustments required.

A general manager should be identified from within the existing team or elsewhere according to the Chairman's view of the local requirement. This is not intended to weaken the professional responsibilities of the other chief officers, especially in relation to decision taking on matters within their own spheres of responsibility. It is intended to sharpen up the process, first, of decision taking on other matters where there is disagreement and, second, of implementation, by identifying personal responsibility to ensure that speedy action is taken and that the effectiveness and efficiency of such action is kept under constant review. In this context, it certainly appears to us that consensus management can lead to "lowest common denominator decisions" and to long delays in the management process. It has been suggested to us that the absolute need to get agreement overshadows the substance of the decision required. We therefore propose the identification of a general manager to harness the best of the consensus management approach and avoid the worst of the problems it can present. The general manager would be the final decision taker for decisions normally delegated to the consensus team, especially where decisions cross professional boundaries or cause disagreements and delay at present.

The Chairman of each Authority should be responsible for initiating this change according to local requirements and possibilities. The main criterion should be the identification of general management skills and experience: the further away from direct patient care the more important it becomes to look for such skills not necessarily professional disciplines. There can be no "single-bullet" solution for the whole of the NHS and the timescale will vary according to the task to be tackled.

- THE UNIT

Units of management (particularly the major hospitals) provide the bedrock for the whole NHS management process. It is there where most of the patients are seen, most of the money is spent and most of the staff are employed. Surprisingly, given the welter of reports on almost every aspect of the NHS over the past 30 years, there has been no major review of the internal management of the hospitals since the Bradbeer Report of 1954 (when most hospitals had an individual manager in the shape of the hospital secretary, house governor or medical superintendent). We have therefore commissioned some small-scale studies, with the support of the clinicians at six hospitals, looking, from the perspective of the patient and the clinician, at the management of the Unit as reflected in the treatment and administrative handling of the patient.

The 1982 NHS reorganisation has not yet resulted in the devolution of real decision taking to Unit and hospital level. Many hospitals do not yet have budgets. Most hospitals and Units are big enough in management terms to take all their own day-to-day management decisions. The onus should be on higher management to argue away from this position, if they think there is clear and accepted justification for taking particular decisions at an identified higher level of management.

We believe that urgent management action is required, if Units are to fulfil their role and provide the most effective management of their resources. This particularly affects the doctors. Their decisions largely dictate the use of all resources and they must accept the management responsibility which goes with clinical freedom. This implies active involvement in securing the most effective use and management of all resources. The nearer that the management process gets to the patient, the more important it becomes for the doctors to be looked upon as the natural managers. This should be more explicitly recognised:

- in the doctors' training - undergraduate, postgraduate, in-service, and in preparation for particular clinical management posts; and

- in constructing the system of management budgets in a way which supports this work and meets the medical requirement and interest.

We have not recommended that all consultants' contracts should be held at District level - even though many strong representations were made to us that that should be the position; we believe that if there is a coherent management process, it should not matter where the contract of employment is held. If our recommendations are implemented, we believe the management problems related to the holding of contracts at present felt to exist would disappear.

In identifying a Unit general manager we believe that the District Chairman should go for the best person for the job, regardless of discipline. The main criterion for appointment should be the ability to undertake the general management function at Unit level and manage the total Unit budget.

OTHER ASPECTS OF MANAGEMENT

- PERSONNEL

In the personnel field, as in all other aspects of our recommendations, the essential changes required will need to be led from the top by an energetic, new style of management. We have accordingly proposed the appointment (initially from outside the NHS and the Civil Service) of a Personnel Director whose main responsibility would be to ensure that personnel relations support the new style of management we are recommending. The opportunities to influence pay, career appointment and retention of staff are all important aspects of line management's responsibility to ensure real motivation of all staff, characterised by the more thrusting and committed style of management which is implicit in all our recommendations. In particular the Personnel Director would ensure that formal structures of communication and informal means of consultation were established to secure the full commitment and involvement of staff.

To achieve this the Personnel Director will need to lead a review of Whitley agreements, pay structure, terms and conditions of service etc., examining each to ascertain whether greater devolution is possible. He will need to be given a period of years to achieve the target resulting from his review, with the full support of the Secretary of State and the Chairman of the NHS Management Board.

Devolution in personnel matters will imply a strengthening of the personnel function at each level and its close support of line management. The most important development to be achieved is one of morale and attitudes: this will be done by the line management leadership, and the perceived professional competence of the Personnel Director and an injection of enthusiasm and pride in the quality of personnel service provided.

Line managers need to accept their responsibility for their staff and will require better training in personnel matters. This is only part of the general upgrading of the quality of management which the NHS requires. As in any process of change, there will be a need to take staff along in a positive sense, by top-class communications and training. There must be incentives for staff, through proper reward for performance and career prospects. The sanction of removing the inefficient performer must also be more easily available than at present, though always as a last resort.

Senior managers, in particular, must be given proper incentives, by way of greater opportunities for career progression, both through to the new NHS centre and also out of their primary professionalism.

To effect change, some outside catalysts will be required; but there are enough people at all levels within the NHS enthusiastically committed to wanting change and capable of making a contribution to ensure that it can largely be effected from within. Staff in general can only benefit from changes to be brought about. A better-run service, more local say in decisions, a more satisfied customer, better communications with management, proper reward for performance, better career prospects: all these should add up to a happier working environment and a more satisfied staff.

- PROPERTY

A property function needs to be established as part of the general management responsibility. An important aspect of this is the commercial exploitation of the NHS estate, so that property is regarded as an active contributor to overall NHS resources. Direction of this approach is needed at the centre. At the same time, the Works Function throughout the NHS should be critically examined, because of its large demands for professional staff, and the ability of any capital project to spawn meetings, expenses and travel within and between the different levels in the organisation.

- LEVELS OF DECISION TAKING

Works is an outstanding example of a function where analysis is needed of the level at which decisions are taken and professional work actually carried out.

There is no doubt that at the moment such analysis is not tackled effectively either in Works, Personnel or other functions. The level at which decisions are taken affects the needs for services and for professional and other staff elsewhere. The qualities required by the Managers at each level, the design of communication networks, and the way in which controls are set up are all important factors in this analysis. The present lack of a stringent approach and emphasis on functional management mean that staffing is too heavy and there is unnecessary delay in decisions being taken and activity carried out.

- PATIENTS AND THE COMMUNITY

Underlying all that we recommend is the desire to secure the best possible services for the patient. At present consumers' interests are principally in the hands of the lay members of Health Authorities and of the Community Health Councils (CHCs). We have not made any judgments about the effectiveness with

which they perform this function, although we have been impressed with the grass-roots work of some CHCs. We have concentrated, rather, on the management angle: on ensuring that management plays an active, not merely a reactive, role in relation to patients and the community, and makes them central to its activities.

CONCLUSION

As you know, we have conducted this Inquiry mainly through discussions with individuals, groups and associations, and by visiting GPs, hospitals, Community Health Services, Health Authorities and other bodies. We have had many discussions in 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. Nonetheless, 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. In particular, we should like to pay tribute to the Permanent Secretary in DHSS and his senior staff, who have helped in the formulation and discussion of the recommendations.

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 DHSS and the professions; but we have had discussions with GPs and their representatives which provide support for our general views. Hospitals, FPS and CHS 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 proposing. 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, GPs and Community Health Services staff take real management action to shift resources (and patient care) between the various sectors.

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 canvas 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;

- 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 intitiatives 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 of, 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.

On behalf of the Management Inquiry Team

Yours sincerely,

E.R. GRIFFITHS.