PREM 19/1318

PART 3

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SECRET

CONFIDENTIAL FILING

NHS Expenditure and Efficiency.

NATIONAL HEALTH

PART 1 : May 1979

PART 3 : March 1984

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20.6.84							
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29.6.84							
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– PART ENDS –

PREM 19/1318

PART 3 ends:-

SS/Wales to SS/DHSS 24/8/84

PART 4 begins:-

DHSS to DB 4/9/84

Published Papers

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

House of Commons HANSARD, 24 May 1984, column 495 to 496: Social Services

House of Commons HANSARD, 4 May 1984, column 642 to 708: National Health Service (Griffiths Report)

Signed _____ Date 27/09/2013.

PREM Records Team

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CONFIDENTIAL

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From The Secretary of State for Wales

The Rt Hon Nicholas Edwards MP

24 August 1984

CONFIDENTIAL

Dear Secretary of State

RECRUITMENT ADVERTISING IN THE NHS

Will Request If Required

Thank you for copying to me your letter of 27 July to Willie Whitelaw about the results of the negotiations agreed in H Committee.

I share colleagues views that the outcome is very satisfactory and that John Patten and his team are to be congratulated. I was particularly pleased to see that the concerns registered by George Younger and by me in correspondence earlier this year appear to have been substantially met and I am content for the arrangements you propose to apply in Wales. I agree with colleagues that the Report should be published.

I am copying this to the Prime Minister, to members of H Committee, to Grey Gowrie and Sir Robert Armstrong.

Yours sincerely

Approved by the Secretary of State
and signed in his absence

CONFIDENTIAL

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

23 AUG 41

The Next Steps

Management in the Health Service

Better Management in Health Authorities in England

The Inquiry

Many of us – in and outside the NHS – believe that we could make a better job of health care if we had better management. The NHS Management Inquiry team was asked by the Government to review NHS management and come up with proposals.

What the Inquiry team found

The Griffiths team found a lack of effective general management at all levels of the Health Authority structure. The result? Too often, frustrating delays and inaction. The need for better management is widely agreed throughout the Health Service and the House of Commons Social Services Committee found that the Griffiths Report's critique "commands general assent."

The key recommendation of the Griffiths Report is that management in Health Authorities should be strengthened so that the NHS can become yet more effective in providing services to patients. And it provided a welcome restatement of the principle which should guide everybody responsible for Health Services – concern for the individual patient.

Its fundamental message was of the need for a more dynamic management style in Health Authorities: getting things done, rather than deferring action. In short, bring in general management.

What is 'general management'?

'General management' enables an organisation to plan, act on, control and measure its decisions and actions effectively and efficiently; and in a way which brings results. The General Manager is the person responsible, and accountable, for ensuring that these decisions are made and actions taken.

The purpose of general management in Health Authorities

By establishing a general management function in Health Authorities, the concern shared by all working in the Health Service for the quality and efficiency of patient services will be more easily translated into effective action; the available resources will be better used and those working in the Service will obtain greater satisfaction from their work. The patient, the community, the taxpayer and the employee will all benefit.

Managing by consensus – that is, managing by agreement – works well some of the time in business and in Health Authorities. Where consensus is working well, no sensible General Manager will need to lose it.

General management will have most effect where consensus **is not** working well. It will help people to take decisions where and when they are needed – thus improving effectiveness.

Consensus management can fail when difficult, perhaps painful, decisions have to be made. Too often in Health Authorities, the power to veto has meant that nothing happens.

Some problems, of course, solve themselves or go away. But others remain and may get worse. This does not improve patient care and it is depressing for Health Authority staff. Effective management means that such problems are tackled not shelved.

The critics: are they right?

The Griffiths team concluded that the processes of decision-making and consultation in Health Authorities are elaborate and that the machinery for implementing decisions is weak. These are the direct results of a lack of clear management.

Many people, in and out of the Health Service, agree. As the BMA's Secretary has put it:

"The criticisms of the Griffiths Report of NHS management will be readily understood by clinicians who have become increasingly frustrated with the inordinate delays which accompany even relatively unimportant issues in the NHS before any action is taken."

And clinicians are not the only people to feel frustrated. Lots of people would like to see improvements.

By clarifying and strengthening the role of management throughout Health Authorities, we are developing the existing arrangements in a positive way.

The Next Step

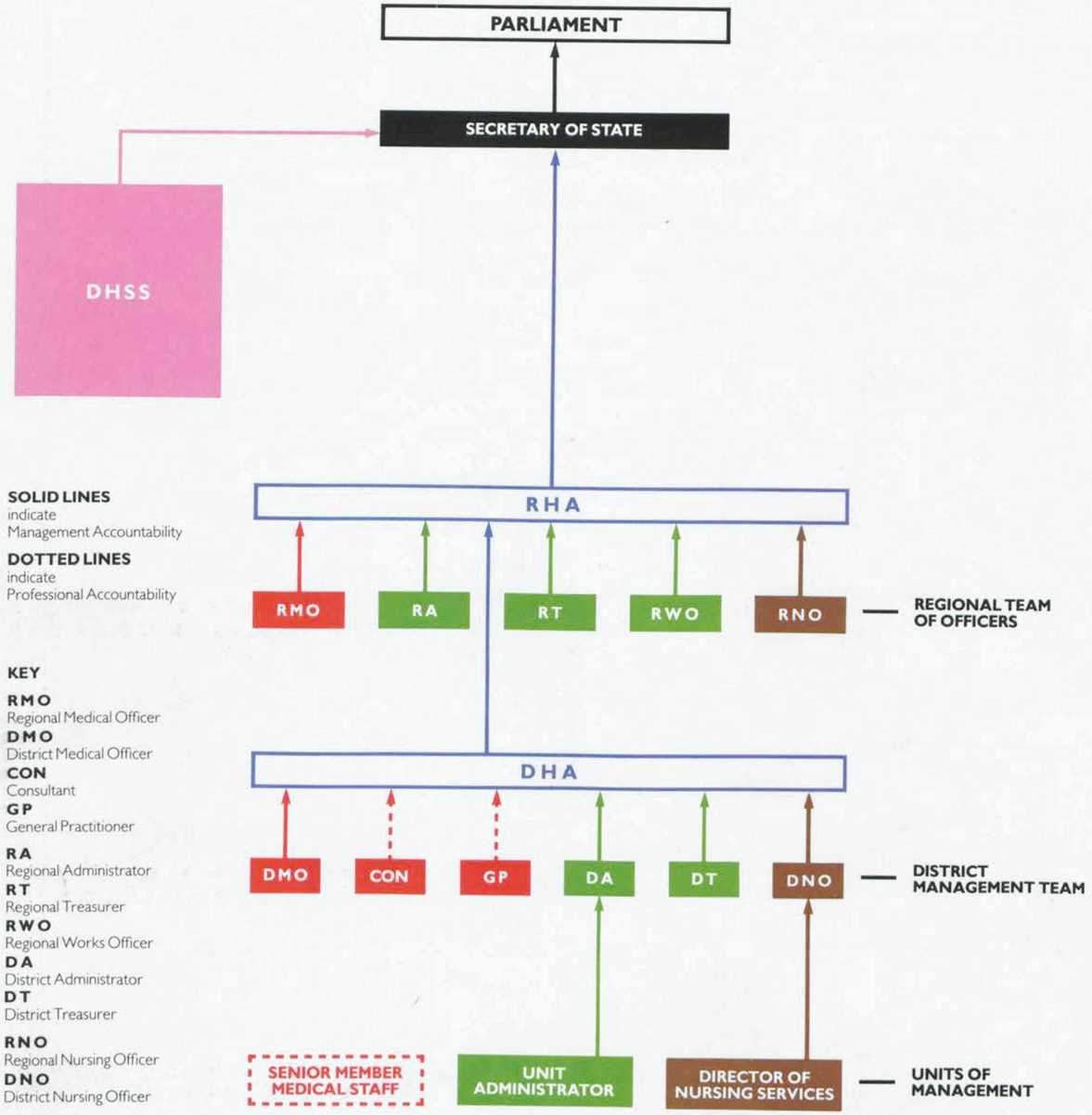
The Government is going to implement the Griffiths Report proposals for general management as the next step in its programme of improving management in Health Authorities.
(See 'What's Going On?')

This is what is happening

- A Health Services Supervisory Board has been set up in the Department to advise the Secretary of State for Social Services on the strategic direction of the Health Service. Members of this Board include the Health Ministers; the Permanent Secretary and Accounting Officer, the Chief Medical Officer, the Chief Nursing Officer; Mr Roy Griffiths and the Chairman of the new NHS Management Board.
- An NHS Management Board is being established within the Department: it will carry out, under the direction of Ministers, those management functions in respect of Health Authorities which the Department must carry out – for example, finance, information and performance review. It will report to the Supervisory Board on Health Authorities' performance; the new Chairman, when appointed, will be a member of that Board.
- Health Authority management is to be strengthened at Regional, District and, later, at Unit level.
- Each Regional and District Health Authority is to identify a General Manager who will then take responsibility – and be accountable to his or her Authority – for the overall managerial performance of the management team and the people under it. When Authorities have done this, District Health Authorities will identify Unit General Managers.
- Regional and District Authorities are being given considerable freedom to propose arrangements which best suit their local requirements, but they and their Units must establish their own general management function and that for their Units, by the end of 1985.
- In line with the intentions of the 1982 reorganisation, decision-making and responsibility is to be devolved wherever possible down the organisation to the Unit, where patient needs are directly met and where the changes must occur to achieve the overall aim of improving services to patients.
- Support for the new and existing management roles is to be provided by the NHS Training Authority through an enhanced management training programme, particularly geared to doctors and nurses.

Health Authority Management – The Present

This is a simplified representation of the main present management relationships in Health Authorities and their links with DHSS, the Secretary of State for Social Services and Parliament.



SOLID LINES
indicate
Management Accountability

DOTTED LINES
indicate
Professional Accountability

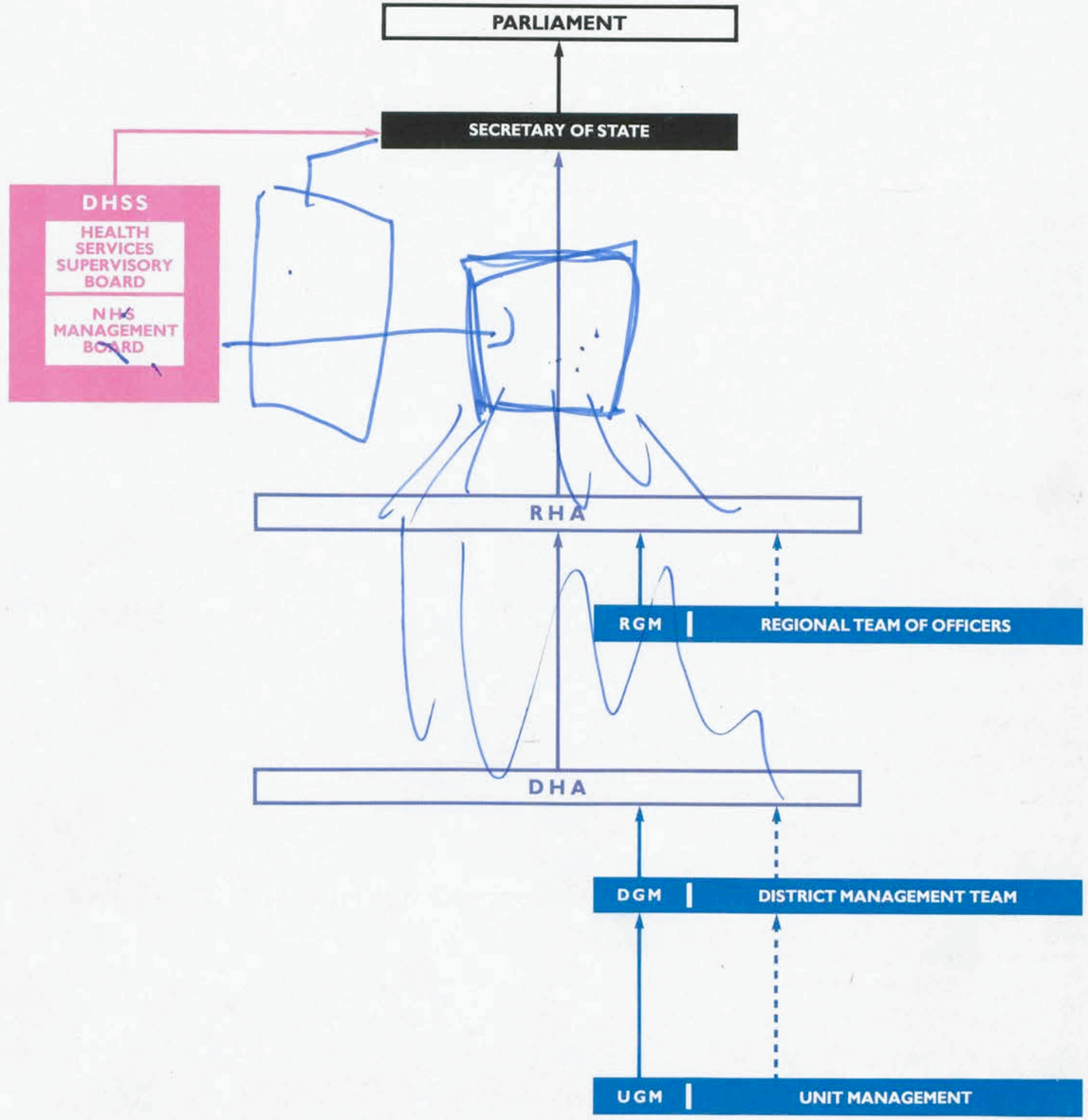
KEY

RMO
Regional Medical Officer
DMO
District Medical Officer
CON
Consultant
GP
General Practitioner
RA
Regional Administrator
RT
Regional Treasurer
RWO
Regional Works Officer
DA
District Administrator
DT
District Treasurer
RNO
Regional Nursing Officer
DNO
District Nursing Officer
RGM
Regional General Manager
DGM
District General Manager
UGM
Unit General Manager

Health Authority Management – The Future

This is a simplified representation of the key future management relationships in Health Authorities and DHSS, how they link to each other, to the Secretary of State for Social Services and to Parliament.

These management developments will all take place within the existing accountability arrangements and statutory framework.



What's Going On?

The introduction of general managers in Health Authorities is not being done in isolation. It is part of a national development programme in NHS management: some parts established already, some happening now, some yet to come.

Developments in 1982

Health Service restructured

Rayner-type scrutinies introduced for the Health Service

System of annual accountability reviews established

Annual review by Ministers of Regional Health Authority performance introduced

Annual review by Regional Health Authorities of District performance introduced

Developments in 1983

Annual accountability reviews extended: DHA reviews of Unit performance

Comparative performance indicators applied

Value-for-money audit programme introduced

Manpower planning tightened up

Manpower information now available more quickly and at quarterly intervals

Competitive tendering introduced

NHS Training Authority established

Griffiths Report published

Health Services Supervisory Board set up by Secretary of State

Developments in 1984

Cash limits, manpower targets and service development brought together

Cost-improvement programmes established

DHSS Headquarters manpower target – 20% reduction since 1979 – achieved

Stock control reviewed

Nucleus of new Health Service Management Board created

and now

Griffiths Report implemented and general management function introduced in Health Authorities

Further action planned or in hand:

Chairman of NHS Management Board to be appointed and Management Board established

Management budgets for DHAs being further developed

Works function being reviewed

Introduction of improved information systems (based on the review of Mrs Körner's Working Group)

Review of communications between DHSS and NHS (led by a Regional Administrator)

Review of possible further developments in Health Authorities' financial management (led by a Regional Treasurer)

NHSTA management training programme being introduced

Questions and Answers

Wouldn't it be better for Government simply to put more money into the Health Service?

The Government **is** putting more money into the Health Service. Spending on the NHS has doubled since 1979 from £7¾ billion to £15½ billion, an increase of 18% more than inflation.

But that's not the whole of the argument by any means. No matter how much money is put into the NHS, we will never be in the position where we will be so rich that we could afford to waste money. There is a duty to be efficient. A sensible management system aids the effective use of resources which are inevitably limited. NHS management must have the authority, and take the responsibility, for promoting efficient use of those resources.

Shouldn't we be allowed to settle down from the 1982 reorganisation before we embark on all this?

This new scheme isn't a reorganisation – it is a development of the 1982 structure. Most peoples' jobs will remain much as they are. It is the process of **managing** the 1982 structure which is being improved. 'Settling down' is a luxury which few organisations can afford, since their clients are constantly becoming more demanding about the services they require.

Not only that, but every time an organisation develops a new system – like the 1982 reorganisation – experience soon shows how to make the next set of improvements. All organisations have to adapt to changing circumstance and the NHS can, and must, continue its long history of evolution in order to carry out its tasks in the best possible way.

Will these new general managers have powers to take decisions and promote action?

Yes. They will be responsible for the effective working of their teams and staff. Responsibility **without** power is the role of the scapegoat. If you want effective management, then responsibility and authority have to be matched. That is what these new proposals aim to achieve.

What happens if the doctors or nurses disagree with the General Manager?

If the disagreement is over a management decision, the General Manager must fulfil his responsibility to see that the decision is taken, if necessary by the Authority itself. This is the job the Authority has given him or her.

If the disagreement is over a professional matter, the doctors and nurses will be able to refer to the Authority, as at present.

Designed and Produced by Hawkshead Communications/Sutton Cooper for the DHSS. Printed by DPL London. June 1984.

MG

DEPARTMENT OF HEALTH & SOCIAL SECURITY

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Telephone 01-407 5522 ext 6981

From the Permanent Secretary

Sir Kenneth Stowe KCB CVO

Sir Robert Armstrong GCB CVO
Cabinet Office
70 Whitehall
London SW1

15 August, 1984

FHRB o.r. (3 Sept)

My dear Robert.

When my Secretary of State and I had our long talk with the Prime Minister on 29 June about some of our immediate staffing problems I realised that we had not served the centre - and her Office - very well in briefing about what this Department's job is and how we do it. I told Robin Butler afterwards that I would set in hand a new version of our basic brief.

The enclosed hand-book on "The Functions, Staffing and Management of DHSS" is an up-dated and expanded version of a standing Departmental brief for Ministers and senior colleagues. It aims to provide a snapshot (with a particular emphasis on the Headquarters role) of what this Department does, how its activity is staffed and managed, and what the major tasks in hand or ahead are.

I hope the hand-book will be of interest also to Peter Middleton, Robin Ibbs, and Robin Butler, to all of whom I am copying this letter and the hand-book. We shall up-date it from time to time. If it appears to you to have any holes in it or leave obvious questions unanswered, please let me know and we can correct it.

Yours ever.

Ken.

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THE FUNCTIONS, STAFFING AND MANAGEMENT

OF THE

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

August 1984

THE FUNCTIONS, STAFFING AND MANAGEMENT OF DHSS

CONTENTS

THE FUNCTIONS, STAFFING AND MANAGEMENT OF DHSS

Introduction

1. DHSS is one of the largest Government Departments, responsible for programmes involving over £53 billion* a year - or over 42 per cent of all public expenditure - and nearly £22 billion in revenue raised from contributions and charges. It is accountable to Ministers and Parliament for five major businesses:-

social security;
hospital and community health services;
family practitioner services;
centrally financed health services
(eg special hospitals, public health laboratories);
personal social services.

2. Chart I (see page 15) summarises the money and manpower involved in the 5 businesses. Key features are:-

2.1 Each business has a distinct management relationship with the Secretary of State:-

social security - direct line management of 529 central, regional and local offices in Great Britain;
hospital and community health services - 214 statutory health authorities in England are accountable to the Secretary of State for the provision of services;
family practitioner services - 53,000 independent businesses under contract to 90 Family Practitioner Committees accountable to the Secretary of State;
centrally financed health services - mixture of direct management and accountable agencies;
personal social services - 110 English local authorities given guidance.

2.2 None of the functions of these businesses is unique to DHSS. Other Departments collect revenue, pay benefits, set health care

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*All figures relate: to 1984/85 unless otherwise stated; to Great Britain for social security and to England otherwise.

policies, allocate resources and take custody of dangerous people. What is distinctive about DHSS is the spread and volume of its responsibilities. (An indication of this is given by the full list of statutes governing the work of the Department - see Fact sheet 1 on page 19). No other Departmental Minister or Accounting Officer has the same direct responsibility for so much detail on such a scale.

3. It is this spread and volume of responsibilities, the variety of functions they entail, and the way the Department is staffed to perform them which this brief summarises.

OVERALL MANPOWER

4. The Department had 89,976 staff in post on 1 July 1984 - a reduction of 8,393 (or over 8%) since 1 April 1979. These figures disguise the true extent of staff savings made over this period:-

- demand-led work increased the staff requirement for local social security offices by 6,500;

- and opening the new Special Hospital for detained patients (a centrally financed service) at Park Lane needed nearly 900 more staff.

So the gross reduction from 1979 to 1984 is about 15,800 (or 16%).

5. Chart II (see page 16) shows how the 90,000 divide between Headquarters in London, the social security organisation outside Headquarters, and the DHSS staff running directly managed health services. It also shows how the numbers in each category have changed since April 1979.

6. Key features are:-

6.1 Over 80,000 (or 89%) work outside Headquarters, the vast majority of them on the operational tasks of determining social security claims and paying benefit. These are statutory requirements which must be carried out both accurately and promptly. The progress of the Department in improving productivity and efficiency in social security operations is detailed in Fact-sheet 2 on page 21. The overall picture

is one of fewer staff dealing with more benefit claims and of a drop in overall administration costs as a percentage of benefit expenditure from 5.0% in 1978-79 to 4.7% in 1983-84 even though the proportion of means-tested benefits, which are substantially more expensive to administer, has increased greatly.

6.2 A further 4,500 staff (or 5%) work, also outside HQ, directly on providing services to particular groups : for detained patients in the 4 special hospitals, for disabled people at the network of artificial limb centres, and for young offenders at Youth Treatment Centres and a further 500 are engaged on NHS superannuation work.

6.3 The vast majority of the Deparmtnet's staff are concentrated in the more junior grades with 93 per cent being of Executive Officer or lower grade. This is reflected in the fact that the average salary cost of a DHSS official is about £6,900 compared to about £8,500 which is the comparable figure for the Civil Service as a whole.

7. It is on the functions of the staff at Headquarters that the following paragraphs concentrate.

HEADQUARTERS MANPOWER

8. At 1 July 1984 the staff of DHSS Headquarters totalled 5,305 (or 5.9% of the total). These include about 1,000 staff working either for independent statutory authorities such as the Mental Health Review Tribunals and the Chief Adjudication Officer or for a number of out-stationed service-providing organisations such as the Regional Medical Service and the Dental Reference Service. A more accurate figure for the core of professional and administrative staff directly supporting Ministers at Headquarters is therefore 4,300. There has been a 24% reduction in HQ manpower since April 1979 and HQ will participate fully in achieving the Department's target for 1 April 1988.

9. Chart III (see page 17) shows the main organisation of Headquarters divided into blocks headed by Deputy Secretaries or Heads of Profession. The staff working within these blocks can broadly be broken down into:

- those working specifically on the management of one of the 5 businesses;

- those working on various aspects of overall social policy (covering not only social security and health and personal social services but also a number of health functions not carried out directly through one of the 4 HPSS businesses); and

- those providing corporate services to the Department as a whole: establishments and personnel management for 90,000 staff; analytical services provided by economists, statisticians, and operational researchers; support services such as legal advisers, press office, library, management services, and office services; research management, etc. Some tightening of the organisation of support services is likely as a result of the inter-departmental study of consultancy, inspection and review capabilities.

The distribution of staff between these broad categories is shown in Chart IV on page 18.

HEADQUARTERS FUNCTIONS

10. Within these broad categorisations is a very wide diversity of tasks and functions.

11. The 5 Businesses:- For each of the businesses the Secretary of State sets the policy objectives designed to fulfil his statutory responsibilities and determines the management action by which to achieve them. The extent and nature of the management action (and so the number of staff employed on it) vary according to the business and the management relationship between the service providers in the field and the Secretary of State and the Department. The relationship for 4 of the 5 businesses (the centrally financed services being too small and varied to be summarised) is broadly:

11.1 Social Security: the management effort at the centre is devoted to the operation and improvement of a directly managed system under which annually 35 million beneficiaries receive payments totalling £35.6 billion (this year) through the 80,000 staff of 529 offices and £19.1 billion in National Insurance contributions is collected (and recorded on computers holding 53 million contribution records).

Illustration: a more detailed picture of the tasks involved here is given by the extract at Annex A on pages 25-26 from the annual divisional management account (DMA) of the Regional Directorate division which manages the Great Britain local office network.

11.2 Hospital and Community Health Services: Ministers' responsibilities here are delivered through the agency of the 14 Regional Health Authorities, 192 District Health Authorities (and 8 special health authorities governing the London post-graduate teaching hospitals). A major management effort is needed to see that these authorities plan and deliver services in line with Government policy and objectives, manage their operations efficiently, and are held properly to account for their performance and use of public funds and of manpower. (Fact-sheet 3 on pages 22-23 lists the main steps taken by the Government as part of this management effort).

In addition, the Department performs certain specific central functions, eg allocating resources (to a total of £9.8 billion in 1984-85) to the health authorities; and negotiating, through the Whitley and Review Body machinery, the pay and conditions of over 1 million staff (in Great Britain) - 135 Whitley Council meetings alone in 1983.

Illustration: a more detailed function of one of the tasks involved here is given by the extract at Annex B on page 26 from the DMA of NHS Division P2 (now in the NHS Management Group).

11.3 Family Practitioner Services (FPS): Services are provided on the Secretary of State's behalf by 53,000 independent family doctors, dentists, opticians and chemists under contracts negotiated centrally by the Department and administered locally by 90 Family Practitioner Committees. To secure the Secretary of State's objectives the Department can operate on the contracts of the practitioners (through negotiations with their representatives) and on the supply and distribution of manpower. Further management effort goes into establishing, monitoring and holding to account the Family Practitioner Committees.

Illustration: for more detail see the extract at Annex C on page 27 from the DMA from NHS Division P3 (now in the Practitioners Group).

11.4 Personal Social Services: The social services departments of local authorities are required by statute to act under the general guidance of the Secretary of State, who, in addition, possesses certain specific powers (eg of formal inquiry, inspection and action in default) and responsibilities (eg in relation to social work training). The Secretary of State does not, however, have the same role of direct resource allocation and systematic monitoring of performance as for health authorities. The Department's management effort therefore has to be devoted to stimulating the social services provision it wishes to see through written guidance, through its contacts with the local authority associations and other representative bodies, through centrally financed initiatives - and through the advisory and inspectorial role of the Department's professional Social Work Service (SWS) central and regional staff. That role will be strengthened with the proposed development of the SWS into a Social Services Inspectorate (SSI): in particular, the SSI will have a new emphasis on promoting efficiency in social services departments and for that purpose will be reinforced by outside people of relevant management disciplines on secondment.

Illustration: for more illustrative detail see the extract at Annex D (on page 28) from the DMA of the Social Work Service.

12. In addition to staff working specifically on one of these businesses, a further group of staff work on various aspects of social policy taken as a whole. This covers social security policy, overall HPSS policy, and specific wider health and social functions (many of the latter being dealt with by staff also working on HPSS or social security policy).

13.1 Social security policy: The staff concerned support Ministers in defining Government policy, monitoring its implementation, and responding to the requirements of Parliament and requests from pressure groups and the media for Government policy initiatives and statements. This entails, for example, analysing available information on existing provision and needs, identifying requirements for further information and research, and developing and costing options for improving the effectiveness and efficiency of provision in the light of the operational capabilities of the social security system. It mean close working with other Government departments - eg with the Department of Employment on Unemployment Benefit or the Department of Trade and Industry on private sector occupational pension provision.

13.2 In addition to these continuing policy functions, the Department has to be capable of responding to the need for more fundamental review of programmes when it arises - as in the 4 current reviews (of pensions, supplementary benefit, housing benefit, and benefits for children and young people), which have required highly qualified support staff and involved the creation of a central co-ordinating unit.

14. Overall HPSS policy: The staff here are principally in the HPSS Policy group (and related professional divisions), working on health and personal social services issues which cross the administrative boundaries between the different HPSS businesses: for example, primary care, the care of the elderly, mentally ill and handicapped, children, and other client groups. The policy function is broadly the same as for social security (para 13.1 above) but it is more complex because of the greater variety of agents for delivering services and the less direct management relationship with them. To be effective, work on HPSS policy requires contacts with many different organisations and groups outside the Department : professional bodies, voluntary bodies, the NHS authorities themselves, local authorities, research units, other government departments, and so on. The role of the Department's professional staff is particularly important here : formulating policy has to take account of developments in professional thinking and knowledge and it will only be successfully implemented if it is understood by, and has the support of, the doctors, nurses and other staff in the front-line of caring for patients. The links of the Chief Medical Officer and Chief Nursing Officer, and their staff, to the professional bodies and to key professional staff in the field are as much a part of the management system for achieving the Government's objectives as the Department's direct relationship with the statutory authorities.

15. Wider health and social functions : Finally, the Secretary of State has, in addition to his responsibility for the main businesses of DHSS, a wide variety of separate, though related, responsibilities, deriving some from specific statutes (see section 2 of Fact Sheet 1), others from his general statutory duty (under the Act of 1919 setting up the Ministry of Health) "to take all such steps as may be desirable to secure the effective carrying-out and co-ordination of measures conducive to the health of the people".

16. These wider responsibilities include : promoting health education and preventive health measures (including preventing, and controlling outbreaks of, infectious diseases); other public and environmental health functions (such as food hygiene); relations with, and control of, the private health sector (including the licensing and inspection of some private facilities, eg for abortion); evaluating the safety and efficiency of health care equipment; licensing medicines; liaison with, and grant-aid to, voluntary bodies; monitoring the professions' self-regulation (registration, education, disciplinary procedures, etc); sponsoring research; and international work (negotiation and operation of reciprocal health agreements; negotiation of relevant EC directives, advice to travellers on health hazards, etc).

17. Key features of these wider health and social responsibilities are:-

17.1 many of them involve executive functions, usually laid down by statute : an illustration is given by the extract at Annex E on page 29-30 from the divisional management account (DMA) of the joint administrative and professional Medicines Division responsible for the licensing of medicines and related procedures. This Division is a good example of work in the Department which is largely demand-led (see quantification attached to DMA extract) and often has a high political profile, usually in the form of pressure on the Department for tighter controls and greater investment of resources;

17.2 a necessary role is played, here again, by specialist professional staff of the Department, who provide technical advice and services not only to the Secretary of State but also to other government departments : an illustration is given by the extract at Annex F on pages 30-31 from the DMA of the medical division responsible for toxicology and environmental protection. Again, an example of work which is largely demand-led, often politically sensitive (witness the public concern over the incidence of leukaemia near the Sellafield Nuclear Fuels site), and, in this case, requires trained staff (toxicologists) in short supply and often sought after by industry and international organisations;

17.3 while some of these wider health and social functions are discrete (eg Medicines Division - 17.1 above), others are performed by staff also working on related mainstream HPSS functions : eg grant-aiding voluntary

bodies concerned with, say, the elderly, is the responsibility of the branch with general responsibility for care of the elderly; and the monitoring of, say, the medical profession's self-regulation is done by the division responsible generally for doctors' pay and conditions, medical manpower planning, etc.

18. Accounting to Parliament and the public. A final major function of HQ, affecting all divisions, consists of the day-in, day-out activity of servicing Ministers, Parliament and the public. Fact Sheet 4 on page 24 describes and, where possible, quantifies the burden on Ministers and DHSS HQ which this represents.

MANAGEMENT CONTROL

19. Managing the work-load described in this brief is in itself a major task. The overall record on manpower and efficiency is set out in Fact Sheet 2. So far as HQ is concerned, considerable effort has been devoted in recent years to ensuring that work is necessary, fits with Ministerial priorities, and is performed as efficiently and economically as possible. In 1980 a major review under the direction of Ministers looked critically at all the functions of the Department to see if any were unnecessary or could be better carried out outside the Department. This contributed to the 24 per cent reduction in HQ numbers since 1979. As part of this reduction the number of Senior Open Structure (Under Secretary and above) posts has decreased from 75 in 1979 to the present allocation of 57. Recent developments to the same end are the setting-up and implementation of the Griffiths Report in relation to HCHS management and the externalisation review of the Departmental Works function.

20. The action taken in response to the Financial Management Initiative has further strengthened the system of management control. The key to that system is the Divisional Management Account (DMA) review process. The purpose of this is to enable Ministers and senior officials : to be informed in detail about Departmental activity; to clarify objectives and re-deploy resources accordingly; and to make divisional heads properly accountable for progress towards the objectives and their use of staff and other resources. Under this system:-

- each divisional head submits an account setting out the division's organisation, resources, and functions, progress towards the previous year's objectives and proposed objectives for the coming year;

- each DMA is reviewed by members of the Departmental Management Board (see para 22 below) and a proportion (25% in the 1983-84 round) by Ministers; and

- a summary report is put to Ministers, detailing in particular the achievements of the past year, key objectives and what the objectives imply for the organisation and manpower of the Department.

21. It is a measure of the achievement of this system that this year it has enabled the Department to provide by redeployment staff for the major social security and other programme reviews decided on by Ministers and substantially to increase the staff available for developing the social security operational strategy without an increase in overall staffing and while staying on course for delivering the Department's manpower target for 1 April 1988.

22. The management system of the Department, of which the DMAs are the key, has recently been further strengthened by developing the role of the Departmental Management Board (DMB). The DMB, which now meets fortnightly, is composed of the 3 Permanent Secretaries and Accounting Officers (including the Chairman of the NHS Management Board when in post), the Chief Medical Officer (who also has Second Permanent Secretary rank), and the Principal Finance and Establishments Officers. Through its chairman, the First Permanent Secretary, the DMB is responsible to Ministers for monitoring progress towards the key objectives agreed through the DMA system and for taking corrective action when monitoring shows it to be necessary. For this purpose the Board has instituted a system of quarterly reports on each key objective by the accountable official concerned. The DMB will in turn make quarterly reports to Ministers.

THE TASKS AHEAD

23. The management control system described has enabled the Department to set itself up to carry out for Ministers the major programme of work which lies ahead.

24. This programme consists of both policy and management tasks, the main ones being:

24.1 POLICY TASKS: These include the reviews which, taken together, amount to a comprehensive re-examination of the programmes for which the Secretary of State is responsible:

24.1.1 Social security:

- carry through the 4 fundamental reviews (para 13.2 above) and formulate policy proposals for action, including legislation.

- complete consultation on occupational pension scheme reforms and develop legislation proposals

24.1.2 health services:

- work up and publish a Green Paper on Primary Care (including the FPS)

- review (with other Departments) current activity on prevention and consider scope for development

- develop firmer objectives on other strategic service issues (priorities in hospital care, care of the elderly, medical and nursing manpower)

- work up and publish a 1984 Report on the NHS

24.1.3 personal social services:

- complete an in-house PSS review and publish options in a Green Paper

24.2 MANAGEMENT TASKS

24.2.1 general: implement the proposals resulting from the programme reviews listed at 1. above (social security, primary care, prevention, personal social services)

24.2.2 social security:

- continue to implement the operational strategy
- detailed implementation of the 1983 legislation on adjudication

24.2.3 hospital and community health services:

- establish the general management function in health authorities and units, and follow through other Griffiths recommendations
- thoroughly re-appraise health authorities' short-term programmes (including use of manpower) and performance objectives
- implement new proposals on information for management; and develop a longer-term strategy for information and information technology
- improve the management of the NHS estate
- extend the use of management budgeting by health authorities; and take related action to improve financial management
- review and improve NHS personnel arrangements

24.2.4 Family practitioner services:

- review the contracts of opticians and retail chemists; and negotiate revisions with the professions

- set-up the 90 Family Practitioner Committee (FPCs) as independent authorities accountable to the Secretary of State

- improve the management of FPCs

- develop computerisation in the FPS

24.2.5 personal social services:

- establish the Social Services Inspectorate (para 11.4 above).

24.2.6 internal DHSS management:

- establish the full NHS Management Board in DHSS

- pursue FMI objectives, including developing budgetary control and the divisional management account system;

- continue to work towards 1988 manpower target

- improve monitoring of programme cost-effectiveness

- improve service to Ministers on case-work (PQs, correspondence, etc).

25. Much of this programme of work may, when it is achieved, have implications for the functions and staffing of the Department. Under the continuing pressure exerted through the DMA system and the manpower target exercise the Department will look for proposals for further review. What scope might there be, for example, for moving towards alternative placements in the NHS for the detained

patients in special hospitals? Is there a valid NHS alternative to the service currently given by the artificial limb and appliance centres? These questions are illustrative only; but it is the function of the Department's top management system, under Ministers, constantly to be asking questions of this sort and examining the scope for more efficient performance of functions and use of resources.

CHART I

THE DEPARTMENT'S BUSINESSES

SECRETARY OF STATE FOR SOCIAL SERVICES

SOCIAL SECURITY £ 37.2 bn (GB)

- DIRECTLY MANAGED
- DETAILED LEGISLATION
- SERVICES DELIVERED BY 78,000 DHSS STAFF

Agents: DE, IR and LAs

HOSP. AND CHS £9.8bn (ENGLAND)

- 14 DIRECTLY ACCOUNTABLE REGIONAL HEALTH AUTHORITIES (192 DHAs)
- CENTRAL CASH LIMITS, PAY ETC
- GUIDANCE ON STANDARDS AND PRIORITIES
- ABOUT 800,000 STAFF

FAMILY PRACTITIONERS £3.2bn (ENGLAND)

- 90 DIRECTLY ACCOUNTABLE FPCS
- PAY, PRACTICE EXPENSES ETC DETERMINED CENTRALLY
- GUIDANCE ON STANDARDS AND PRIORITIES
- ABOUT 53,000 CONTRACTORS

- SERVICES DELIVERED BY INDEPENDENT PROFESSIONS

CENTRALLY FINANCED HEALTH SERVICES £0.6bn

- DIRECTLY MANAGED SPECIAL HOSPITALS OR ACCOUNTABLE EG SHAs MEDICINES COMMISSION
- SERVICES DELIVERED PARTLY BY DEPARTMENT'S STAFF AND INDEPENDENT PROFESSIONS

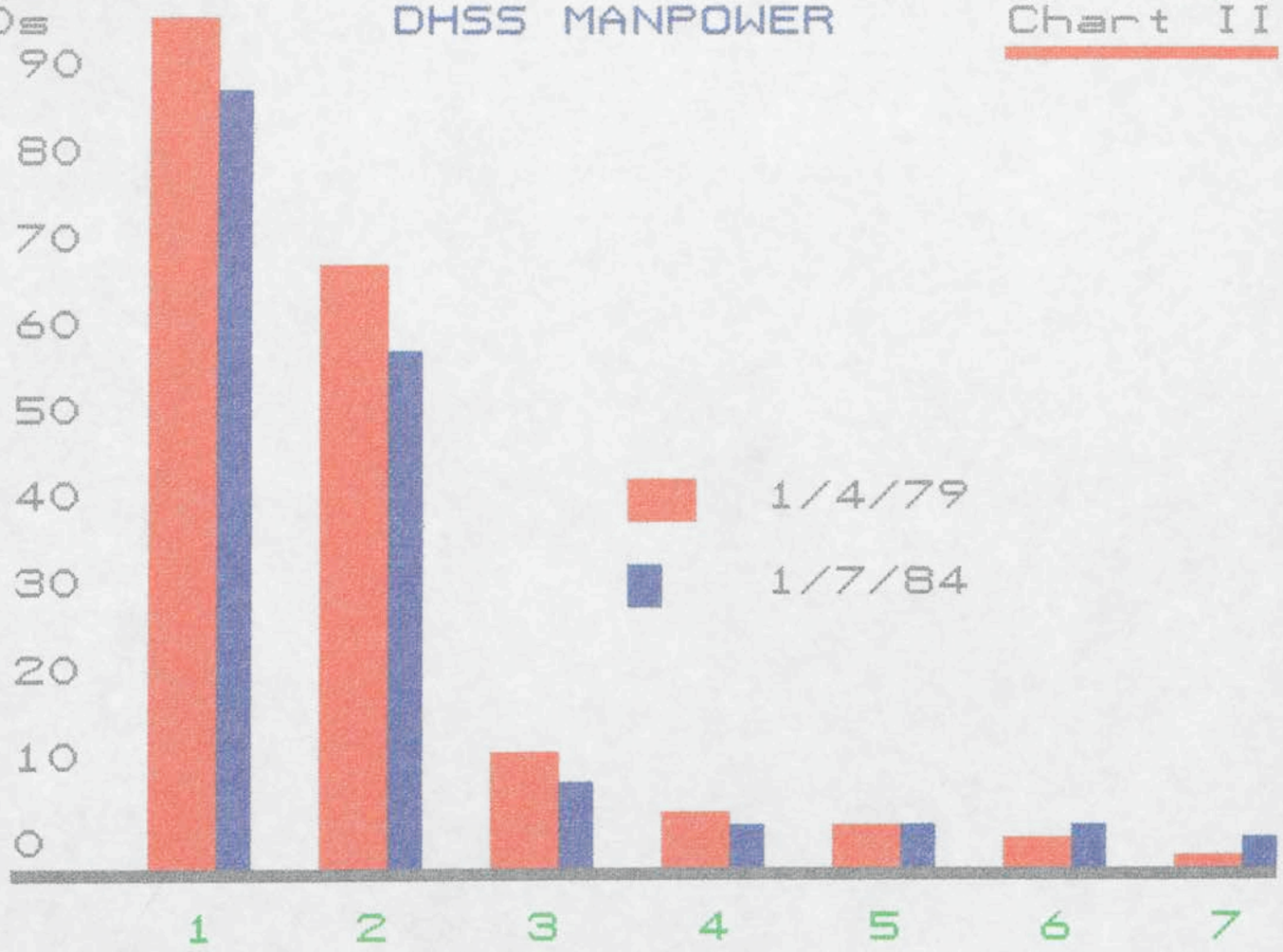
PERSONAL SOCIAL SERVICES £2.7bn (ENG.)

- NOT DIRECTLY ACCOUNTABLE OR MANAGED
- DEPARTMENT'S SOCIAL WORK SERVICE WITH INSPECTORATE ROLE
- GUIDANCE ON STANDARDS AND PRIORITIES
- SERVICES DELIVERED BY ABOUT 200,000 LOCAL AUTHORITY STAFF

DHSS 30297a Op

DHSS MANPOWER

Chart II



DHSS 30297c Op

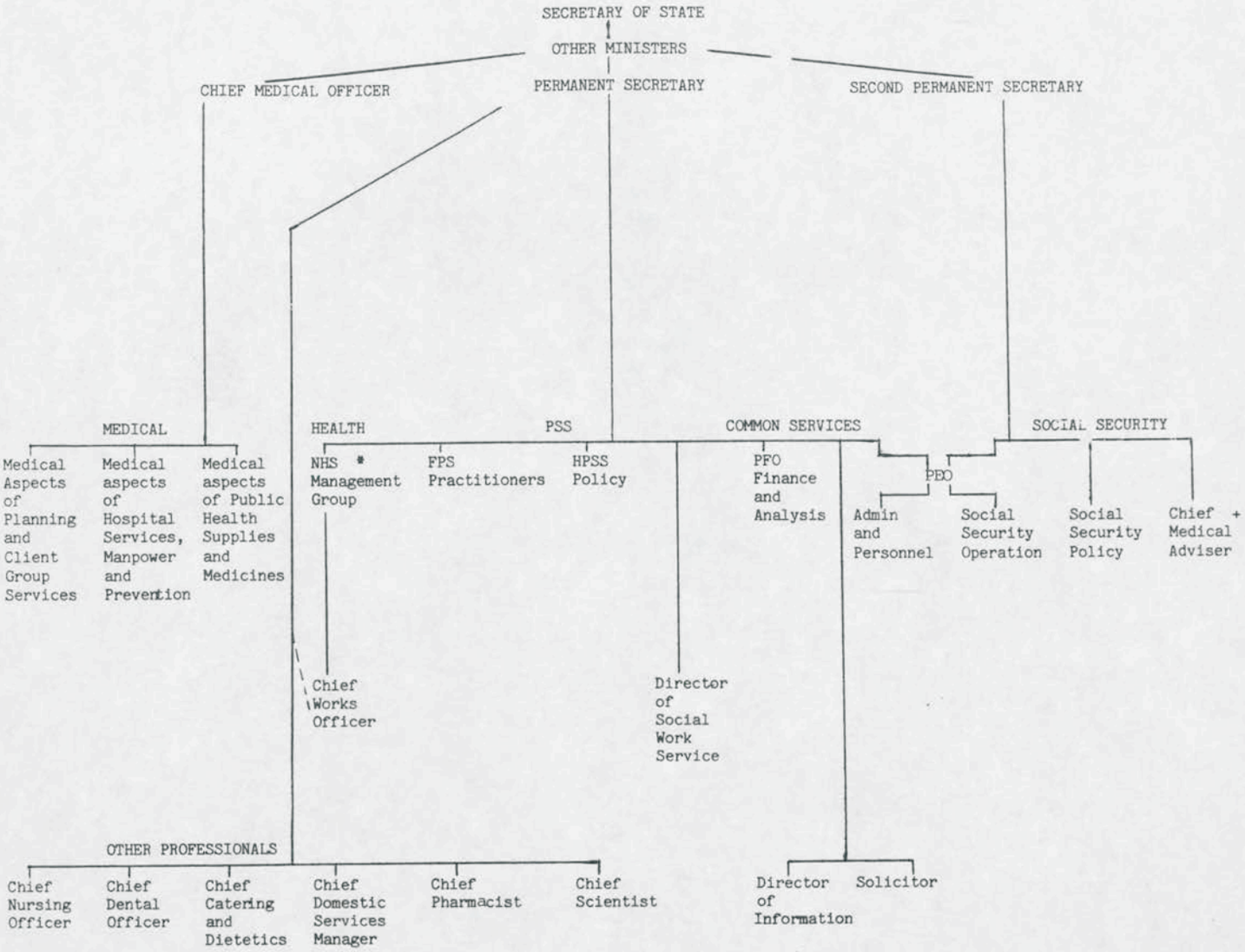
S.I.P.	1/4/79	1/7/84	% change
1 Total DHSS	98,073	89,976	−8
2 Regional Organisation	70,208	65,031	−7
3 Newcastle Central Office	13,082	10,694	−18
4 Headquaters	6,944	5,305	−24
5 North Fylde Central Office	3,977	4,063	+2
6 Centrally administered health services	3,452	4,225	+22
7 Computer Centres	411	658	+60

DHSS 302971 Op

NOTES

The increase in numbers of staff working on the centrally administered health services, column 6 , is accounted for by the opening of a new Special Hospital (a centrally financed service) at Park Lane which needed nearly 900 more staff.

The increase in staff working at the Computer Centres, column 7 , reflects the growing importance of computers in the work of the Department.



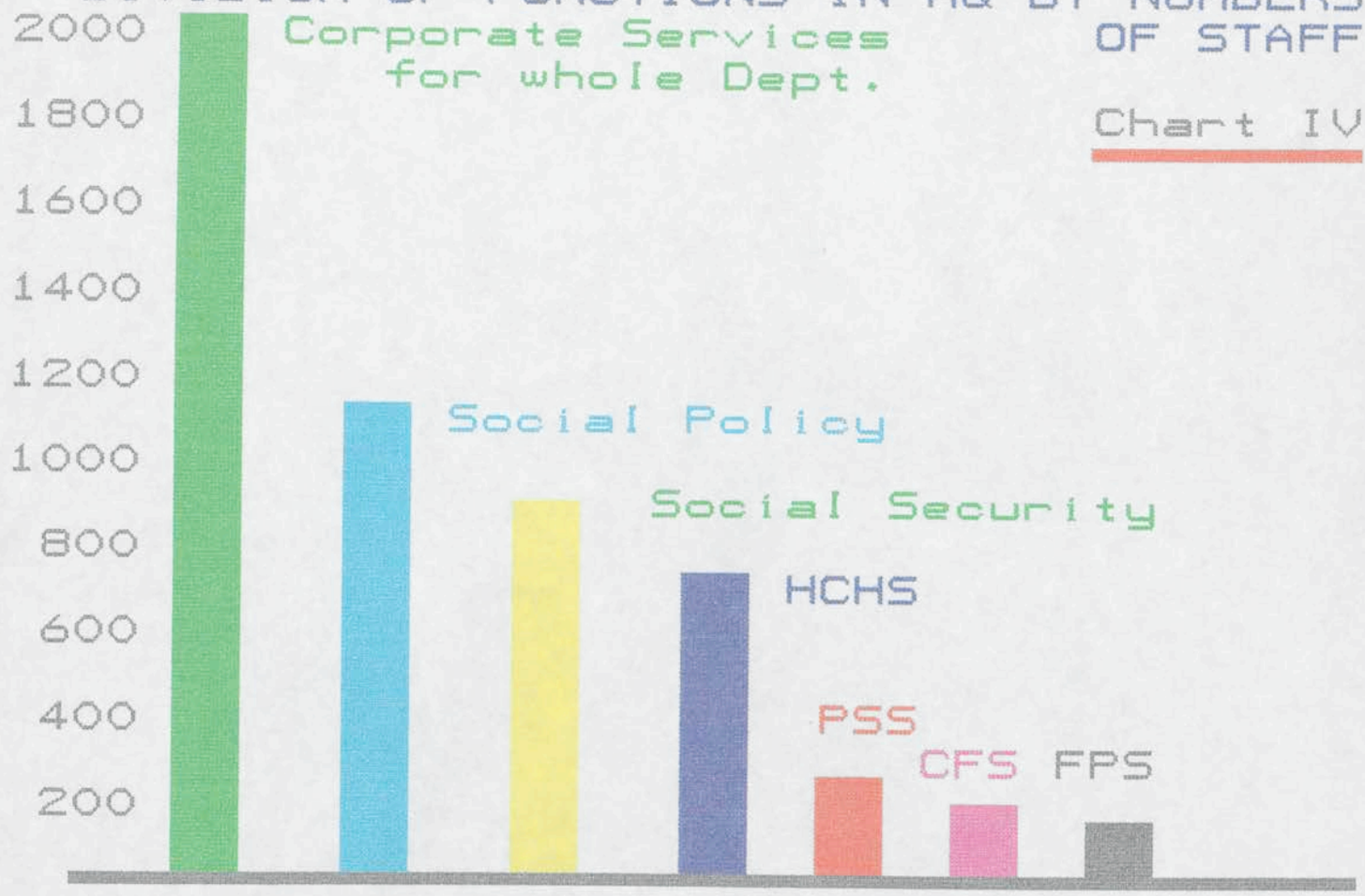
* The NHS Management Group is the nucleus of the NHS Management Board. Like the Board, it is multi-disciplinary, with professional staff professionally accountable to their heads of profession.

+ CMA reports jointly to CMO and Second Permanent Secretary

DHSS 30297b Op

DIVISION OF FUNCTIONS IN HQ BY NUMBERS OF STAFF

Chart IV



DHSS 30297j Op

Notes

This chart shows the breakdown of staff in Headquarters working on:

- the management of the Departments 5 businesses, Social Security, HCHS, PSS, CFS, FPS;
- various aspects of overall social policy (covering not only social security and HPSS but also a number of health functions not carried out directly through one of 4 HPSS businesses;
- Corporate services are provided at HQ for the Department as a whole. They include establishments and personnel management for 90,000 staff; analytical services provided by economists, statisticians, and operational scientists; support services such as legal advisers, press office, library, management services, and office services; research management, etc.

DHSS 30297k Op

PRINCIPAL STATUTES GOVERNING THE WORK OF THE DEPARTMENT

1. HEALTH

Ministry of Health Act 1919
National Health Service Act 1977
National Health Service Reorganisation Act 1973
Mental Health Act 1983
Employment Medical Advisory Service Act 1973
Health Services Act 1976
Superannuation Act 1972
Employment Protection (Consolidation) Act 1978
Health Services Act 1980
Health and Social Services and Social Security Act 1983

2. WIDER HEALTH ISSUES

Cancer Act 1939
Food & Drugs Act 1955
Patents Acts 1949 and 1977
Civil Defence Act 1948
Human Tissue Act 1961
Abortion Act 1967
Radio-active Substances Act 1948
Clean Air Acts 1956 and 1968
Medicines Acts 1968 and 1971
Public Health Laboratory Services Act 1979
Public Health Acts 1936 and 1961
Local Government Act 1972
Local Government (Miscellaneous Provisions) Act 1982
Health Services and Public Health Act 1968
Radiological Protection Act 1970
Health & Safety at Work Act 1974
Control of Pollution Act 1974
Biological Standards Act 1975
Vaccine Damage Payments Act 1979
Anatomy Act 1984
Town and Country Planning Act 1984

3. PERSONAL SOCIAL SERVICES

National Health Service Act 1977
National Assistance Act 1948 (Parts III and IV)
Chronically Sick and Disabled Persons Act 1970
Local Authority Social Services Act 1970
Nurseries and Child Minders Regulation Act 1948
Children's Acts 1948, 1972 and 1975
Children and young Persons Acts 1933-69
Employment of Children Act 1973
Adoption Acts 1958-1976 (1976 Act not yet in force)
Foster Children Act 1980
Child Care Act 1980
Residential Homes Act 1980
Children's Homes Act 1982 (Not yet in force)
Health and Social Services and Social Security Act 1983 (Not yet in force)
Registered Homes Act 1984

/continued

4. HEALTH PROFESSIONS

Doctors

Medical Act 1983

Dentists

Dentists Act 1984

Nurses

Nurses Agencies Act 1957
Nurses, Midwives and health Visitors Act 1979

Midwives

Nurses, Midwives and Health Visitors Act 1979

Health Visitors

Health Visiting and Social Work (Training) Act 1962
Nurses, Midwives and Health Visitors Act 1979

Others

Opticians Act 1958
Professions Supplementary to Medicine Act 1960
Hearing Aids Council Act 1968

5. SOCIAL SECURITY

Family Income Supplements Act 1970
Social Security Act 1973
Social Security Act 1975
Social Security Pensions Act 1975
Industrial Injuries and Diseases (Old Cases) Act 1975
Child Benefit Act 1975
Supplementary Benefits Act 1976
Legal Aid Acts 1974 and 1979
Social Security (Miscellaneous Provisions) Act 1977
Social Security Act 1979
Pensioners' Payments and Social Security Act 1979
Social Security Act 1980
Social Security (No 2) Act 1980
Social Security Act 1981
Social Security and Housing Benefits Act 1982
Social Security and Housing Benefits Act 1983

6. WAR PENSIONS

Personal Injuries (Emergency Provisions) Act 1939
Pensions (Navy, Army, Air Force and Mercantile Marine) Act 1939
Pensions Appeal Tribunals Act 1943
Crown Proceedings Act 1947

DHSS 30Z97d 0p
Fact Sheet 2

DHSS Management and Efficiency

1 Introduction

Programmes for improving the efficiency and general management of the Department's businesses have been a central element in our strategy for some years. The FMI has reinforced this approach.

2 Achievements

2.1 Manpower

	1/4/79	1/7/84	% decrease
DHSS	98,073	89,976	9%
Headquarters	6,944	5,305	24%

Further manpower reductions of 3.2% will be achieved by 1988.

2.2 Overall running costs

Down by £29m (2% in real terms) since 1982/3.

DHSS 30Z97e 0p

2.3 Social Security Administration Costs

The average unit cost of benefit payments fell by 4½% in real terms between 1978/9 and 81/2.For non-contributory benefits,administrative costs as a proportion of benefit expenditure fell from 7.4% in 1978/79 to 5.9% in 1983/84. For the contributory benefits,the costs have stayed roughly constant at 3.8% of benefit.

2.4 Quality of service

Service to the public has improved.This is measured by a wide range of performance indicators. One of these is shown below:

Mobility Allowance

Clearance Time
weeks

DHSS 30Z97h 0p

DHSS 30Z97f 0p

3 Techniques

3.1 Efficiency scrutinies 15"Rayner"type studies carried out yielding savings of over 3,600 posts and £22 million in non manpower costs so far.

3.2 Individual studies. As a result of a traffic study 1,000 posts have been saved by the devolution of work which also enabled the number of Regional Offices to be cut from 12 to 7. Another 1,100 posts were saved through the introduction of a postal claim form for the unemployed.Nearly £5m a year is being saved due to the introduction of a 'courier and trunking'service to carry mail between social security offices.

3.3 FMI The Department's efficiency is being improved through the encouragement of better management in accordance with the principles of the FMI.

DHSS 30Z97g 0p

A top management review system has been developed whereby individual managers account for the progress they have made against agreed objectives and for the resources they control. We have introduced a system of budgetary control for certain item of administrative expenditure and we are currently experimenting on the extension of this to manpower control.Other current measures to improve efficiency include experimental incentive schemes for improved performance and more effective use of resources.

3.4 Staff Suggestions Scheme

The suggestions scheme has recently been improved.It has yielded over £4 million so far in recurring savings over the last two years and the number of suggestions has increased by 38 per cent.3,500 suggestions are expected this year.

IMPROVEMENTS IN NHS MANAGEMENT

Since 1979 the Government has taken the following steps to improve management in the health service.

- In 1982 the structure of health authorities was simplified by the removal of two levels of management - Area and Sector.

- District Health Authorities were established generally serving smaller local populations.

- More responsibility was devolved to hospital and community services at unit level.

- Accountability has been strengthened with the introduction of annual reviews led by Ministers of performance against agreed objectives.

- The review cycle has been established for RHAs and DHAs : it is being extended to units this year.

- Family Practitioner Committees are to be made separately accountable.

- A range of statistical indicators of performance (covering clinical services, manpower and estate management) has been developed : in 1983, all health authorities were sent data on their own performance and that of other authorities.

- Work is under way to improve and extend the range of performance indicators.

- NHS management's need for information has been comprehensively reviewed and improved information systems will be introduced over the next few years.

- More effective monitoring of NHS manpower numbers has been introduced.

- The Rayner Scrutiny technique has been extended to the NHS with a programme of nine studies by NHS officers covering areas such as transport services, recruitment advertising, and staff accommodation : substantial possible savings have been identified.

- Health authorities have been required to test the cost effectiveness of laundry, catering and cleaning services by seeking competitive tenders.

- Health authorities have reviewed arrangements for the control of items in stock and in use, following the advice of the Health Service Supply Council.

- A value-for-money audit programme has been introduced.

- Health authorities have in 1984 submitted short-term planning programmes from which we expect higher productivity and manpower held steady overall and which contain cost improvement programmes worth in all nearly £100 million.

- The development of management budgets has begun with the start of several demonstration projects.

- The NHS Training Authority has been established.

- A study of the administration of FPCs has been undertaken by outside consultants.

- A study of the current flow of communications between the Department and health authorities is being led by a Regional Administrator.

- A study of the responsibilities of the Department in relation to the financial management of health authorities is being led by a Regional Treasurer.

- The Health Services Supervisory Board has been established to advise the Secretary of State on the objectives and direction of health services.

- The NHS Management Board is to be established within the Department as soon as its Chairman has been appointed; an NHS Management Group is already working in preparation for the NHS Management Board.

- Manpower in DHSS HQ has been reduced by 20 per cent since 1 April 1979 following a reduction in the central role.

Workload in DHSS Headquarters: Continuing Activity

At all levels, day in, day out, a great deal of the staff resources, in Headquarters particularly, have to be devoted to servicing Ministers, Parliament and the public. Thus in any one year the Department has to provide, on average:-

- the answers to 5,000 Parliamentary Questions;
- briefing and all other aspects of legislative work on 2/3 DHSS 'lead' bills and other bills on which there is a DHSS interest;
- responses to 30,000 letters from Members of both Houses of Parliament;
- responses to 85,000 letters from members of the public or from people or organisations acting on their behalf;
- advice and briefing for Ministers on 200 Cabinet and Cabinet Committee meetings, often following extensive interdepartmental consultations;
- briefs for Ministers on 100 deputations led by a Minister or a Lord;
- briefs and speeches for Ministers on 30 Adjournment Debates and 40 other Parliamentary debates;
- briefs for 70 Early Day Motions;
- briefs for 2,000 Ministerial meetings with officials and outside individuals or groups;
- briefing and/or speeches for Ministers on 200 official occasions such as visits, conferences/annual dinners;
- responses to 100 cases being investigated by the Parliamentary Commissioner for Administration (the average time spent on dealing with a case is 60 hours); the Department can also be asked to help on cases being investigated by the Health Service Commissioner; and the Permanent Secretaries are also required to give evidence to the Select Committee on the PCA on both PCA and HSC cases;
- evidence to be submitted for 15 Select Committee enquiries;
- briefs for senior officials and Ministers for appearances before 7 Select Committees;
- briefs on 11 topics for Public Accounts Committee meetings involving 22 appearances by senior officials;
- advice to Ministers on all aspects of the Department's work affecting the media (press conferences, major announcements and initiatives, 400 press statements);
- continual liaisons with the media on all DHSS matters;
- advice and guidance in innumerable cases at Headquarters in response to telephone requests from other statutory agencies, the public and a wide variety of organisations, despite the fact that there have been intensive efforts to delegate responsibility for clearing casework at the lowest possible levels.

Parliamentary business varies a great deal from session to session. 1983/84 has seen increased parliamentary interest in DHSS matters. For example almost 7,000 PQs had been answered and 40 adjournment debates taken place by the beginning of July (as against annual averages of 5,000 and 30 respectively).

ANNEX A

REGIONAL DIRECTORATE (Staffing : 194 administrative staff (HQ))

PART D: RESPONSIBILITIES

1. Managing the Regional Organisation

   - Setting operational goals and priorities in accordance with the principles of the FMI

   - Developing and directing an appropriate manpower strategy

   - Developing and planning the network and accommodation requirements of local offices

   - Ensuring the provision of adequate training for staff at all levels.

   - Developing and maintaining effective monitoring systems

   - Taking whatever steps are necessary to ensure that operational goals are met

2. Liaising with other HQ Divisions

   - Assessing the operational consequences of policy decisions

3. Devising procedures and instructions for the implementation of policies in accordance with agreed timetables

4. Reviewing operational systems and initiating improvements, including the introduction of new technology.

5. Advising and briefing Ministers on operational matters and providing support at meetings

6. Dealing with general enquiries, complaints, PCA cases, MPs letters, PQs etc.

7. Consulting and negotiating with the DTUS and handling industrial disputes in the Regional Organisation.

8. Providing technical and management training and specialised direction and support in relation to the prevention and detection of fraud and abuse in the Regional Organisation.

9. Day-to-day management and administration of HQ Division

ANNEX B

NHS PERSONNEL DIVISION 2 (Staffing : 99 administrative staff)

PART D: RESPONSIBILITIES

1. Advising Ministers on and implementing pay policies for the NHS.

2. Advising Ministers on and implementing personnel and industrial relations policies for the NHS.

3. Advising Ministers on and implementing policies for the improvement of the NHS Whitley system.

4. Servicing the Management Sides of the NHS Whitley Councils (and other negotiating groups) concerned with the pay and conditions of service of administrative and clerical, professional and technical, ambulance and manual staffs - about half a million staff with a total pay bill of £3 billion, together with conditions of service common to all - about one million NHS staff.

5. Representing the Secretary of State on the Management Sides of the negotiating bodies, assisting Management Sides to reach settlements that facilitate and do not impede Ministerial policies, and reporting to Ministers on the prospects and progress of negotiations.

6. Exercising the Secretary of State's statutory powers of approval of pay and conditions of service including variations from standard terms.

7. Personnel casework, including the devolution of this work to health authorities, PO cases and PQs.

8. Advising on the personnel aspects of Departmental policies affecting NHS staff.

9. The assessment of grants for students in a number of paramedical professions and the payment of grants to occupational therapy students.

10. Liaison with other Government Departments, statutory bodies and professional associations.

11. Management of staff. FMI/budgetary control etc.

ANNEX C

NHS PERSONNEL DIVISION 3, branches B and C (Staffing ~~:~~ ~~38~~ ~~ad~~ministrative staff)

PART D : RESPONSIBILITIES - P3B/C

1. General responsibility* for the provision and development of the General Ophthalmic Services.
2. General responsibility* for the provision and development of the Pharmaceutical Service.
3. Negotiations with professional bodies on:- a. the remuneration and terms of service of: i. optical practitioners; and ii. pharmaceutical practitioners. b. the reimbursement of contractors' supply costs: i. optical appliances; and ii. drugs.
4. Advice* to Ministers on: a. optical charges; and b. prescription charges.
5. Secretariat of the Rural Dispensing Committee*
6. Administration and budget control of the Prescription Pricing Authority*
7. Dissemination of policy guidance and information.
8. Ministerial briefing
9. Casework, including PQs and PO cases.
10. Staff management

*Entries relate to England only, though other Health Departments generally reflect policy in England.

ANNEX D

SOCIAL WORK SERVICE

PART D: RESPONSIBILITIES

(Staffing : 97 professional staff : one-third at HQ, two-thirds based in regional offices and relating to local authorities and voluntary bodies responsible for providing residential and community services for families, children, elderly, etc; + 77 administrative staff)

1. With other professional and administrative colleagues support for Ministers in the development, furtherance, and management of effective policies, including management of SWS and of directly administered services.

2. Definition and promotion of good standards of care and practice by means of inspection, advice, development work and consultation.

3. Liaison, advice and service to local authority, private and voluntary field organisations, LAAs and professional associations.

4. Professional advice to other government departments and international work.

ANNEX E

MEDICINES DIVISION (Staffing : 249 professional and administrative staff)

PART D : RESPONSIBILITIES

1. Licensing and related procedures in accordance with UK and EC legislation taking account of the needs of industry, OGDs and other interests, the monitoring of adverse reactions, review licences and certificates. Servicing statutory advisory bodies. Advising Ministers concerning appointments and on specific issues. To consider problems arising from the assessment of applications for new products.

2. To review, instruct solicitors and implement subordinate legislation in relation to legal status, advertising, labelling and packaging of medicinal products.

3. To act as inspection and enforcement authority in relation to the NHS and to UK and overseas commercial manufacturing and wholesaleing sites; to instruct solicitors in prosecution cases.

4. To represent and safeguard UK interests in respect of drug licensing in the WHO, CPMP, EC Pharmaceutical Committee and associated bodies.

5. To oversee and promote the preparation of standards of biological products by the NBSB; to exercise control over the centrally financed programme to re-develop the Board's laboratories.

6. To co-ordinate DHSS interests in the use of animals for tests and experimental purposes.

7. To liaise with and support the work of the BPC

ESTIMATED MD WORKLOAD		1982/83	1983/84
Applications for Product Licences		1150	1150*
Applications for Reviewed Licences		500	2000
Applications for Clinical Trials: Certificates and Exemptions		280	320
Product Licence Variations and Renewals		8000	8000
Manufacturers' Licences: granted and varied		200	200
Wholesale dealers' Licences: granted and varied		160	160
Export Certificates issued		12000	12000
Applications referred to Statutory Advisory Committees:			
	New products	250	280+
	Review	75	1000
Adverse Reactions notified		13000	14000

* May be significantly increased when parallel imports are brought within the licensing system.

\+ Would be increased by about 400 if contact lenses and surgical implants were brought within the licensing system.

ANNEX F

MEDICAL TOXIOLOGY AND ENVIRONMENTAL PROTECTION DIVISION

T D RESPONSIBILITIES

(Staffing : 9½ doctors, 18 scientific officers)

1. To advise Ministers, the Chief Medical Officer, other Departments (especially MAFF, DOE & DOT and, selectively HSE) about the effects on health of chemicals, other than drugs, and the effectiveness of control measures.

(a) by undertaking detailed assessments, including for DHSS advisory committees.

(b) by providing medical and scientific, secretariat services to the committees' (listed below);

(c) by casework on PQs and Ministers' correspondence;

(d) by membership of committees in other Departments etc;

(e) by advising on the commissioning and conduct of research by Departments and other organisations (including the DHSS supported Toxicology Unit at St Bartholomew's).

(f) by provision of an information service (data bank);

2. To answer inquiries on effects of chemicals, selectively, from health, local and water authorities, and others, and to advise press office on response to media enquiries.

3. To participate in selected international programmes in this field. (WHO, EEC, Council of Europe, ECE, OECD, ISO; with special attention to the WHO/ILO/UNEP International Programme on Chemical Safety.)

4. To work towards the development of more satisfactory techniques and criteria for the assessment of hazard and risk from chemicals and the effectiveness of control measures.

5. To operate an inspectorate to ensure that toxicological testing for regulatory purposes performed in UK laboratories is conducted in accordance with the principles of Good Laboratory Practice (GLP) and hence that the data are valid for safety assessments.

6. To encourage the adequate development in the UK of facilities for toxicological training leading to formal qualifications and of facilities for such toxicological work as is needed but cannot be required of industry; especially by the establishment and funding of a Toxicology Unit at St Bartholomew's.

7. To develop the organisation of the division and its facilities, so as to enhance its cost effectiveness and the scientific quality of its work, and to develop the arrangements for commissioning research.

8. To develop a programme for the training of the Division's staff, in conjunction with the Bart's unit and other organisations; on the part of staff, to attend formal courses and to undertake self-teaching and informal updating on developments in toxicology.

9. To secure effective working relationships with related national and international organisations.

CONFIDENTIAL

PRIVY COUNCIL OFFICE
WHITEHALL, LONDON SW1A 2AT

10 August 1984

Dear Norman

RECRUITMENT ADVERTISING IN THE NHS

Thank you for your letter of 27 July reporting on the outcome of negotiations to secure savings on recruitment advertising. I have also seen Peter Rees' letter of 1 August and Grey Gowrie's of 6 August.

The progress made in the negotiations has been most encouraging and I agree that we should settle for reduction of costs in advertising through existing journals. However, I also agree with Peter Rees' suggestion that the jobs register option should be kept open pending a review at the end of 1985 of success in achieving the changes which have been agreed in principle with the publishers. I agree that, as Grey Gowrie suggests, it would be appropriate to publish the report.

I am sending copies of this letter to the Prime Minister, to members of H Committee, to Grey Gowrie, and to Sir Robert Armstrong.

Yours

The Rt Hon Norman Fowler MP

CONFIDENTIAL

PRIME MINISTER (2)

Social Services Inspectorate

You may like to be aware of the attached draft policy statement, on which Norman Fowler is proposing (with Treasury agreement) to consult the Local Authority Associations.

The draft statement proposes turning the existing DHSS Social Work Services into an Inspectorate for the Local Authority Personal Social Services.

The Inspectorate's main function will be to help local authorities give value for money through more efficient and economical use of available resources. The inspections will be of three types:

(i) Initiated by Ministers under their formal powers.

(ii) Initiated by individual local authorities.

(iii) Enquiries into general issues of concern to more than one authority, in accordance with a programme to be agreed with the Local Authority Associations.

The Inspectorate will report formally to the Secretary of State, but its day to day work will be the responsibility of a Steering Group of both central and local government.

Consultation with the local authorities will proceed over the summer, with a view to the Secretary of State making a statement after the recess.

DHB

23 July 1984

FEA

CC AB

Await Chief Secretary

DEPARTMENT OF HEALTH & SOCIAL SECURITY

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

Telephone 01-407 5522

From the Secretary of State for Social Services

The Rt Hon Peter Rees QC MP
Chief Secretary to The Treasury
Treasury Chambers
Parliament Street
LONDON
SW1

July 5th 1984.

Dear Peter.

SOCIAL SERVICES INSPECTORATE

I am grateful for your letter of 26 April and for Patrick Jenkin's letter of 4 April, both in response to mine of 10 March. I have also seen Robin Ibbs's letter to you of 18 May in which he responded to your invitation to his to comment on the Inspectorate proposals.

I have, as Patrick and you suggested, sounded out the Associations again on the revised version of the joint announcement about the Inspectorate. They were not unreceptive and made a few constructive suggestions which are incorporated in the version (6th Draft) which I now enclose. This has not been put to the Associations formally and will not be until I have yours and Patrick's reactions to it; but I think we should take advantage of the further preparatory work that has been done.

I am sorry if I gave the impression in earlier correspondence that the Inspectorate's main thrust would be as - to quote Patrick - "a specialist arm of the Audit Commission". That is certainly not so: the Inspectorate will be an integral part of the chain of command in My Department and available as an instrument of Government policy to a much greater extent than an independent statutory body like the Commission could ever be. The point is that on "specialist" aspects of the personal social services the Inspectorate will be in a position to make a contribution of greater authority on economy, efficiency and effectiveness in the use of resources; and they are better placed to disseminate knowledge of relevant good practices within social services departments. They will be particularly helpful to us in getting over the general message - which I know you regard as important - that we see social services authorities as, in the first place, enablers rather than direct providers of services.

I intend that the Inspectorate will assist local authorities to obtain value for money and contain their expenditure within planned objectives. However, while the Inspectorate can help to establish trends to value for money, it would be quite unrealistic to expect it to secure quantified target savings across all local authorities, since each authority varies in the needs it has to meet; the balance between personal social services and associated services such as housing, health and education; its present efficiency; and the reasonable scope for economy. What matters is that we secure sensible savings where they are to be found, and encourage better and more effective social service.

E. R.

Robin Ibbs wondered whether we could pilot the Inspectorate in some way. That stage is in fact behind us. Social Work Service (SWS) already has extensive experience of inspections and - as you were kind enough to say in your letter of 31 January - these have not led to the kind of pressures for higher expenditure which you and Patrick have feared. My proposals do not seek to break new ground but to extend and improve the present capacity of SWS for analysis, assessment and the management of change.

In my earlier letter I said that I would be content to confine myself at that stage to merely announcing that the Inspectorate would be set up at some future date. I then suggested 1 October. I remain embarrassed by the prolonged delay over a decision, which has led to questions in the House. I was also pressed on the matter by my departmental Select Committee when I gave evidence to them on 20 June: the Select Committee recommended the development of the SWS into an Inspectorate two sessions ago and welcomed my consultative document.

If the delay continues we shall not only be losing opportunities to get on with a job that needs doing but we shall be sacrificing goodwill which the Inspectorate would have enjoyed if set up as originally proposed.

In all the circumstances, I feel I must press you for agreement to my putting the enclosed revised statement formally to the Associations and, if I clear it with them in time, for an announcement before the Summer Recess that the Inspectorate will be established later this year. I would not want to argue with colleagues over the matter of a few weeks, but 1 January 1985 seems to me the latest date we could propose for inauguration of the Inspectorate without complete loss of momentum.

I am copying this to Patrick Jenkin, Robin Ibbs and the other recipients of our earlier correspondence.

Yours ever Norman.

NORMAN FOWLER

6th DRAFT

SOCIAL SERVICES INSPECTORATE : DRAFT JOINT STATEMENT WITH THE LOCAL AUTHORITY ASSOCIATIONS

1. In April 1983, the Secretary of State sent to the chairmen of all social services committees a consultative document proposing development of the Department's Social Work Service - which already exercises inspectorial functions - explicitly into an inspectorate for the local authority personal social services. In the light of a wide range of helpful comments on the consultative document, the Government has now reached agreement in principle with the local authority associations on the way forward.

2. The Inspectorate, like the Audit Commission for Local Authorities in England and Wales, will assist local authorities to obtain value for money through the efficient and economic use of available resources; and the work of the two organisations will be complementary, not competitive. The aim of the Inspectorate will be to help authorities to secure the most effective use of existing professional and other resources, normally by identifying good practice and spreading knowledge about it.

3. Inspections will be of 3 main types:-

a. initiated by Ministers and the Department in exercise of the Secretary of State's formal powers of inspection;

b. undertaken outside formal powers, related to issues of general concern and covering a number of local authorities, by agreement with the authorities concerned and in accordance with a programme agreed by the local authority associations; and

c. undertaken outside formal powers, but at the request of, or in agreement with, an individual local authority and in relation to specific services or activities of that authority.

Reports written as a result of formal inspections will be made in the first instance to the Secretary of State, but all other reports will be made concurrently to the authorities concerned for their social services committees to see. Reports will normally be documents of public access.

4. Formally, the existing statutory powers of inspection (which are considered sufficient for the purposes of the new Inspectorate) are vested in the Secretary of State, and he will be the Minister responsible for the Inspectorate's management and actions. In practice, however, the programme of work of the Inspectorate outside formal powers will be a joint concern of central and local government. This will be reflected in a Steering Group of representatives of the Department and the local authority associations, with the following terms of reference:

> "To consider the proposals of the Social Services Inspectorate for inspections of local authority personal social services (other than those to be made under statutory powers, or in relation to specific services or activities of an individual authority at the request of or in agreement with that authority); to agree annually a programme of such inspections; and to review from time to time the scope for future work of the Inspectorate."

5. The staff of the Social Services Inspectorate will consist of members of the existing Social Work Service, supplemented by staff from relevant disciplines on attachment from local authorities and when appropriate from other organisations, including experts in appropriate branches of management and in performance measurement. The Inspectorate will work closely alongside the Audit Commission and will continue existing collaboration with HM Inspectorate of Schools, the Probation Inspectorate and the Health Advisory Service.

Exp & Epl: NHS A3.

Jill
SAHABS

SECRET

bc. J. Redwood

PRIME MINISTER

Autumn Seminars

When you met Mr. Fowler recently it was agreed that a Seminar should be arranged in late September/early October to discuss the Social Security Reviews. By then, most of the evidence will have been gathered and review teams will be at the stage of marshalling it and drawing preliminary conclusions.

The same seminar could also discuss progress on the implementation of Griffiths and look again at the issues identified at the January meeting for further study:

(i) The basis of remuneration for the contractor professions in the NHS.

(ii) The operation of the Pharmaceutical Price Review Scheme.

(iii) Charging policy.

(iv) The relationship of private provision to the NHS.

A possibility is the afternoon of 4 October at No. 10 - there is a Cabinet meeting in the morning that day. The Wednesday and the Friday of that week have been set aside for work on the speech for the Party Conference which begins the following Monday.

/Agree:

SECRET

CST

Agree:

(i) suggested date for the seminar;

(ii) the suggested agenda.

I assume you will also want to hold a meeting of the Industry Employment Group. A possible date for this is the afternoon of 13 September, following a Cabinet meeting in the morning. The Wednesday and Friday of that week have been kept free to prepare for your overseas visit.

Possible subjects for discussion are:

(i) Continuation of the discussion on employment prospects.

(ii) The study of costs per job of various forms of Government support.

(iii) Wider ownership (on the agenda last time but not reached).

(iv) De-regulation.

I felt the discussion at the last seminar was becoming a bit predictable so we will need to think of ways of generating an infusion of fresh ideas. Do you, for example, want to invite colleagues to put in papers on issues which they believe need to be tackled in the coming twelve months?

Agree:

(i) Seminar on afternoon of 13 September;

/ (ii) preliminary

(ii) preliminary agenda suggested above;

(iii) colleagues to be invited to put in papers?

ANDREW TURNBULL

6 July, 1984

CONFIDENTIAL

CC PR

DEPARTMENT OF HEALTH & SOCIAL SECURITY

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

Telephone 01-407 5522

From the Secretary of State for Social Services

David Barclay Esq
Private Secretary
10 Downing Street

2 July 1984

Dear David

THE NATIONAL HEALTH SERVICE: FAMILY PRACTITIONERS

Thank you for your letter of 27 June about the No 10 Policy Unit's work on the FPS. It is helpful to know that the Policy Unit's ideas to some extent mirror objectives which we are already pursuing - particularly in relation to drug costs. We will, of course, keep you in touch as our work in these areas develops and with the Green Paper itself.

I will let you have a note separately on health maintenance organisations and the Harrow Health Centre. The Chancellor of the Exchequer has also written to us recently about HMOs and the relevance they have shown to cost control in the U S A.

I am copying this letter to David Peretz (Treasury), John Graham (Scottish Office), Colin Jones (Welsh Office), Graham Sandiford (Northern Ireland Office) and Richard Hatfield (Cabinet Office).

Yours

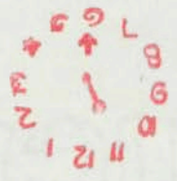
Steve

S A Godber
Private Secretary

CONFIDENTIAL

NAT HEALTH AT3

EXPENDITURE



- 4 JUL 1984

PERSONAL AND CONFIDENTIAL

1. Andrew Turnbull PM
2. David Barclay-to note x/
CF-
3. Pl. file

file

10 DOWNING STREET

From the Principal Private Secretary

29 June 1984

DHSS REVIEWS

Your Secretary of State reported to the Prime Minister on progress with the current social security reviews. He said that the Government had succeeded in opening a debate on the Welfare State and creating a climate in which reforms could be considered. Arrangements were well advanced for collecting evidence and the aim was to move towards conclusions in the autumn. The No. 10 Policy Unit would be kept in touch with progress. There would be advantage in reconvening in late September a further seminar on the lines of the ones held last autumn and in the early part of this year.

X The Prime Minister welcomed this suggestion. Please will you be in touch with our office about possible dates for a seminar at a time when such a seminar may be helpful in giving guidance on the direction in which the reviews should be going. A convenient period from the Prime Minister's point of view might well be in the first week of October.

I am copying this letter only to Sir Kenneth Stowe.

40 CT. 1430-1700

3 Mins +
2 pers secs
Ch Ex
CPT
Middleton
Alan Bailey.

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

PERSONAL AND CONFIDENTIAL

PERSONAL AND CONFIDENTIAL

file VSC

MASTER

NAT HEALTH: NHS Exp: Pt 3

bc: John Redwood.

10 DOWNING STREET

From the Principal Private Secretary

29 July 1984

Dear Steve

The Prime Minister discussed the implementation of the Griffiths Report with your Secretary of State today.

The Prime Minister said that she was concerned about the prospect that it might be necessary to pay a six figure sum for the Chairman of the NHS Management Board. She was prepared to pay what was necessary to secure someone of the necessary calibre to do a worthwhile job. But she would need to be satisfied that the people put forward matched this description. She had been concerned by the draft circular on the management of the Health Service and by the organisation chart which accompanied it: the circular seemed to her to contain too much jargon and the organisation chart had not shown the Management Board in a direct line of responsibility between the health authorities and the Secretary of State. She would not wish the Management Board simply to become an additional layer of administration: inded she hoped that the role and number of the DHSS involved in overseeing the National Health Service would be reduced.

Your Secretary of State said that the Chairman of the NHS Management Board could not be like the chairman of a nationalised industry. Authority over the National Health Service lay with the Secretary of State and the Chairman's authority would derive from the fact that he would be coordinating the various functions of DHSS relating to the Health Service and acting on the Secretary of State's behalf and with his authority. This was a more subtle function, but there was no doubt that the Chairman would be in a position to exercise great influence over the Health Service. The role of the Director of Personnel would also be a crucial one because he would need to reform the Whitley structure which was not well suited in its present form to the management of modern industrial relations in the Health Service. He shared the Prime Minister's belief that it should be possible to reduce further the role and numbers of DHSS staff involved in overseeing the Health Service. But the first step was to get the new structure in operation.

PERSONAL AND CONFIDENTIAL

ECL

There was some discussion of possible candidates for the posts of Chairman of the Management Board and Director of Personnel. The Prime Minister wondered whether it would be possible to persuade Mr. Griffiths to take the chairmanship for two years, perhaps on a part-time basis. She would be prepared if necessarry to try to persuade Sir John Sainsbury to agree to such an arrangement, which would have the advantage that Mr. Griffiths was the person who would feel most responsible for, and committed to, achieving the results envisaged in his report. She suggested that the best way of finding someone of the right calibre for the post of Personnel Director might be through informal contacts with reliable people in industry rather than through the use of management consultants: she would not rule out the possibility of appointing a civil servant, or former civil servant, to this post if someone of the right calibre was available.

Your Secretary of State undertook to take account of these points in considering the next steps on implementing the Griffiths organisation, which he would be pressing ahead with as quickly as possible in the next few weeks.

I am copying this letter only to Sir Robert Armstrong and Sir Ken Stowe.

Yours ever,

Robin Butler

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

SENIOR STAFF IN CONFIDENCE

file

BM.

PRIME MINISTER

DHSS: DEPUTY SECRETARY POSTS

A loose end from your talk with Mr. Fowler this morning is whether you are content, in the light of Mr. Fowler's minute of 26 June, to agree that the three existing Deputy Secretary posts in DHSS which have become vacant should be filled as proposed?

The key figures are in paragraph 7 on page 3 of Mr. Fowler's minute. They show that there are to be two new posts - the Chairman of the NHS Management Board and the Personnel Director - but that these are to be offset by 1 April next year by the saving of one Deputy Secretary post and five Under Secretary posts, making a net reduction of four posts in all.

Are you content on this basis to agree to the appointment of Mr. Graham Hart, on promotion, to fill the post of Deputy Secretary, NHS Management Group and Mr. Brian Rayner, also on promotion, to fill the Deputy Secretary post in charge of Health Practitioners and Health Industries? You have already agreed to the appointment of Mr. France to fill the post in charge of Health and Personal Social Services policy.

E.E.R. BUTLER

29 June 1984

SENIOR STAFF IN CONFIDENCE

Prime Minister
Mr. Fowler wants to start with two minutes strictly tete a tete. Please will you pick up the phone and ask the operator to summon me when you are ready.

FERB
28.6.

CONFIDENTIAL

PRIME MINISTER

MEETING WITH MR. FOWLER

Mr. Fowler is coming to see you on Friday to report on progress on his social security reviews. You will also want to talk to him about the implementation of the Griffiths Report. You might like to divide the time more or less equally.

Benefit Reviews

The pensions review is more advanced than the other three - a good deal of work has been done on private provision leading to the consultation document on personal pensions. The other three reviews - supplementary benefit, housing benefit and benefits for children and young people - have now been established and will be holding public meetings to take evidence during July. The aim is that they should be completed by the end of the year. The attached Policy Unit note (Flag A) sets out some principles and identifies some options.

In the limited time for discussion you may wish to raise:

(i) How far does Mr. Fowler subscribe to these general principles?

(ii) How radical is he prepared to be on the future of SERPS?

(iii) What is the scope for savings through ending abuses in young people's benefit?

(iv) Can HB be made simpler and cheaper?

(v) How can the poverty and unemployment traps be mitigated?

(vi) Can sufficient progress be made to identify options for the public expenditure round?

You could suggest to Mr. Fowler that the reviews could be discussed at a half-day seminar in September when the evidence has been collected and the conclusions are being considered.

On Griffiths, Mr. Fowler has responded to the points we made to his letters on the circular and on the appointment of the personnel director. (Flag B)

Griffiths: New appointments

On the open structure posts, his reply seems satisfactory; the creation of two Griffiths' jobs is being offset by six savings elsewhere. He seeks your approval to three Deputy Secretary appointments.

(i) Do you accept his proposals for the open structure?

(ii) Do you accept his recommendations for specific appointments? (You have already agreed Mr. Fraser).

The key appointment is the Chairman of the NHS Management Board. We need a good man in post as soon as possible. Are we in sight of this? The official shortlist is now down to three candidates, who may not be up to the mark and want very large salaries (please see letter at Flag C). Does Mr. Fowler have any other candidates in mind? If so, whom?

The authority of the Chairman and the Management Board

This is the key question. The Griffiths reforms aim at changing 'custom and practice' within the Health Service without the time-consuming upheaval of legislation. The General Manager has to have the maximum possible freedom (using the Secretary of State's authority) to reform the running of the Health Service. Regional Health Authorities should see him and his Management Board as the Secretary of State's agent, and not as a strange peripheral body to which they are not accountable.

But DHSS argue that this change in 'custom and practice breaks the law. This is how they defend the extraordinary diagram of managerial responsibilities in the attached leaflet (Flag D). And Mr. Fowler says in his note:

> "Because of the statutory position of health authorities, the Management Board cannot have a line management relationship with them".

There are two replies to this. First, it is bad law. Acts of Parliament refer to Ministers and not to Departments, but officials can act with the authority of the Secretary of State. RHAs should not be encouraged to think they are legally responsible only to one individual, the Secretary of State. This is just current practice and it can be changed. The RHAs are also, under existing law, responsible to those who act with the authority of the Secretary of State.

The second reply is that if the DHSS really believe this is the law, why not change the law?

Central DHSS administration

There are 2,200 officials in the DHSS advising on and administering the Health Service. The new Managers should

 / not just

not just supplement all these civil servants, but should displace them. Mr. Fowler (using Mr. Clarke to implement the policy) should recommend a radical reduction in central DHSS administration. Could it be one-tenth its present size? The Ibbs Unit should be associated with this work.

Mr. Fowler may argue that as he remains answerable to Parliament for the NHS, he inevitably has to 'second guess' the activities of the NHS and needs staff, not least to answer PQs and letters. But whilst these enquiries cannot be rejected out of count, they can often be answered in a different way after Griffiths, emphasising that line management responsibility lies elsewhere and referring the questioner to the managers. The problem at the moment is that there is no management which the DHSS can point to, - that and this must be changed.

Conclusions

You might like to seek Mr. Fowler's agreement to the following conclusions:-

- that social benefits should be discussed at a seminar in September

- that the senior staff appointments proposed by Mr. Fowler should be agreed

- that Mr. Fowler should look again at the relationship between the health authorities and the NHS management board

- that it is important to get a first class Chairman of the Management Board (and not to pay him a higher salary than he is worth)

- that Mr. Fowler should investigate, with the Ibbs

Unit, whether he can make substantial savings in DHSS HQ staff.

Andrew Turnbull
28 June 1984

PERSONAL - SENIOR STAFF IN CONFIDENCE

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

28 June, 1984

Dear Robin,

You will now have received from Steve Godber my Secretary of State's minute responding to the Prime Minister on Griffiths and our senior posts.

You will have noted that the minute is perhaps more emollient than the draft we discussed - that reflects the judgement of the Secretary of State. You should be in no doubt, however, that my sense of outrage at the content and tone of the successive messages from No. 10 remains undiminished. More particularly I must leave no-one with any doubt that if the Prime Minister's judgement is that this Department can be managed over the next 2-3 years with less than the 3 existing Deputy Secretary posts, then I would have to say that I am not prepared to carry that burden.

I am copying this letter to Robert Armstrong to whom it will come as no surprise.

Yours ever,

Ken.

PERSONAL - SENIOR STAFF IN CONFIDENCE

SENIOR STAFF IN CONFIDENCE

C

Prime Minister
This letter is giving you early warning that you will have to pay a six-figure salary for the candidates coming forward as Chairman of the NHS Management Board. Are you prepared to do that? (I have had a message that the Chancellor does not regard the people currently under consideration as likely to be worth the money!) FECB 28.6.

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

I have the impression

Robin Butler Esq.,
No. 10 Downing Street,
London SW1

28 June, 1984

Dear Robin.

CHAIRMAN OF THE NHS MANAGEMENT BOARD

The process of identifying a short-list of acceptable candidates is now approaching its climax. I expect to have two or three names for submission to the Prime Minister within about ten days from now.

A key issue will be the salary required by the acceptable candidates. None of those likely to be leading our short-list would be willing to expect less than his present level of remuneration, which in each case is over six figures per annum plus generous pension provision and cars. I have discussed this with my Secretary of State and Peter Middleton has consulted the Chancellor. I think there is agreement that we can only take each candidate on his merits including among his merits the price he puts upon his worth. It would be quite wrong, however, to proceed further with our interviews with them with a view to putting names up to the Prime Minister if at the end of the day they were to be approached with a view to seeing whether they would be prepared to come at e.g two-thirds of their existing salary. Each has made his position perfectly clear and would, I am sure, regard such an approach as tantamount to a deception.

I have talked this over with Peter Middleton and we believe we have no option but to proceed as indicated in my second paragraph above but Peter suggests, in the light of his experience over the Wilson appointment, that I should alert you to the way things are going so that you may offer such advice as you think fit.

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

Yours ever.
Ken.

NHS ETF with DT 27.6

FILE

B/C: MR REDWOOD

RJ7

10 DOWNING STREET

From the Private Secretary

27 June, 1984

THE NATIONAL HEALTH SERVICE: FAMILY PRACTITIONERS

As you know the No.10 Policy Unit have been giving thought recently to possible future developments in the Family Practitioner Service. In the light of this work, the Prime Minister has asked me to write to you as follows.

The Prime Minister looks forward to seeing in due course a draft of the Green Paper on the Family Practitioner Service. She welcomes your Secretary of State's intention to make it a radical document, taking the debate on the Health Service beyond the facts about increased spending since 1979 towards a "patient power" theme.

The Prime Minister was also pleased to learn that your Secretary of State is looking at ideas such as improved output measures. The Policy Unit have suggested that these could cover, for example, average waiting times in clinics and hours spent by GPs actually in patient care. Information from FPCs about standards of service from different GPs would provide a basis for encouraging competition between GPs and greater patient mobility between clinics which she believes are important objectives.

The Prime Minister was also interested to learn from the Policy Unit of the Harrow Health Centre, which appears to be a good example of how the health maintenance organisation model can work in primary care. Private centres along these lines can be encouraged without in any way undermining the Health Service. The Prime Minister hopes that their relevance to the NHS will be considered for the Green Paper, and that neither the Department nor the health authorities will obstruct or hinder the operation of the Harrow Health Centre or similar Centres. She wonders whether it would be possible to encourage "patient associations" based on individual clinics.

/No doubt

CONFIDENTIAL

ECL.

No doubt the cost of the drug bill will also be looked at in the context of your work on the FPS Green Paper. The Policy Unit believe that this needs to be dealt with at three points - patient attitudes; doctors' prescribing habits; and the remuneration of drug companies. The Prime Minister shares the view that patients should be encouraged not to regard the prescription of a drug as the natural conclusion of every medical appointment. Charges may help here by causing patients to think twice about the need for a drug.

It is often argued that doctors prescribe drugs too lightly. The Green Paper is an opportunity to set out the case for them prescribing fewer and cheaper drugs. The Prime Minister hopes that means of achieving greater use of generics will be looked at in this context, as well as the possibility of eliminating some brand-name drugs from NHS prescribing altogether, with the NHS inviting tenders for "own label" generics instead.

The Prime Minister is inclined to think that the PPRS may be too generous to drug companies, and she hopes that the current review will identify significant savings. Parallel imports - provided they are safe - should be welcomed as a means of driving down drug prices. But either the NHS itself or the Exchequer must reap the benefit, and this entails reforms to the arrangements for reimbursing pharmacists and to the PPRS.

I am sending copies of this letter to David Peretz (HM Treasury), John Graham (Scottish Office), Colin Jones (Welsh Office), Graham Sandiford (Northern Ireland Office) and to Richard Hatfield (Cabinet Office).

(David Barclay)

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

As you know the No 10 Policy Unit have been giving thought recently to possible future developments in the Family Practitioner Service. In the light of this work, the PM has asked me to write to you as follows.

GR — Pse type fms D 27/6

26 June 1984

DRAFT LETTER FROM DAVID BARCLAY TO STEPHEN GODBER

THE NATIONAL HEALTH SERVICE: FAMILY PRACTITIONERS

The Prime Minister looks forward to seeing in due course a draft of the Green Paper on the Family Practitioner Service. She welcomes your Secretary of State's intention to make it a radical document, taking the debate on the Health Service beyond the facts about increased spending since 1979 towards a "patient power" theme.

The PM was also ~~She is~~ pleased to learn that your SofS ~~that he~~ is looking at ideas such as improved output measures. The Policy Unit have suggested that these could cover, for example, average waiting times in clinics and hours spent by GPs actually in patient care. Information from FPCs about standards of service from different GPs would provide a basis for encouraging competition between GPs and greater patient mobility between clinics which she believes are important objectives.

The Prime Minister was also interested to learn from the Policy Unit of the Harrow Health Centre, which appears to be a good example of how the health maintenance organisation model can work in primary care. Private centres along these lines can be encouraged without in any way undermining the Health Service. ~~and~~ The Prime Minister hopes that their relevance

to the NHS will be considered for the Green Paper, ~~She wonders if it would be possible, for example, to encourage "patient associations" based on individual clinics? She also hopes that~~ neither the Department nor the health authorities will obstruct or hinder the operation of the Harrow Health Centre or similar Centres.

She wonders whether it would be possible to encourage "patient associations" based on individual clinics.

and that

~~The Prime Minister expects that~~ No doubt the cost of the drug bill will also be looked at in the context of your work on the FPS Green Paper. ~~She thinks~~ The Policy Unit advise that this needs to be dealt with at three points - patient attitudes; doctors' prescribing habits; and the remuneration of drug companies. The PM shares the view that patients should be encouraged not to regard the prescription of a drug as the natural conclusion of every medical appointment. Charges may help here by causing patients to think twice about the need for a drug.

~~The Prime Minister fears~~ It is often argued that doctors prescribe drugs too lightly. The Green Paper is an opportunity to set out the case for them prescribing fewer and cheaper drugs. ~~She~~ The PM hopes that means of achieving greater use of generics will ~~also~~ be looked at in this context, as well as the possibility of eliminating ~~She wonders if it would be possible to eliminate~~ some brand-name drugs from NHS prescribing altogether, ~~and possibly for~~ with the NHS ~~to~~ inviting tenders for "own label" generics instead.

The Prime Minister is inclined to think that ~~thinks~~ the PPRS ~~is~~ may be too generous, to drug companies, and she hopes that the current review will identify significant savings. Parallel imports - provided they are safe - should be welcomed as a means of driving down drug prices. But the NHS itself must reap the benefit, and this entails reforms to the arrangements for reimbursing pharmacists and to the PPRS.

DAVID BARCLAY

Tony
SO
WO
N10
RTA

I am sending copies of this letter to David ~~Peat~~ Peatz (HMT), John Graham (SO), Colin Jones (WO) ? (N10) and to Richard Hatfield (Cabinet Office).

SECRET

A (A) 7

PRIME MINISTER

26 JUNE 1984

BENEFIT REVIEW: BRIEF FOR MEETING WITH NORMAN FOWLER

AT YOUR MEETING WITH NORMAN FOWLER, YOU COULD DISCUSS WITH HIM THE PRINCIPLES TO BE ADOPTED IN THE BENEFIT REVIEWS, AND A FEW OF THE OPTIONS.

GENERAL PRINCIPLES

THE CONTRIBUTORY PRINCIPLE. PEOPLE SHOULD FEEL THE COST OF PROVIDING BENEFITS DIRECTLY IN THEIR PAY PACKETS. WHERE POSSIBLE, WHEN BENEFITS ARE PAID BY THE STATE THEY SHOULD BE RELATED TO CONTRIBUTIONS. PEOPLE SHOULD BE ENCOURAGED TO INSURE THEMSELVES FOR INCOME ABOVE THE BASIC STATE PROVISION. THE PRINCIPLE IS EASIEST TO ADOPT FOR PENSIONS, WHERE MORE OF THE BURDEN ABOVE THE BASIC STATE PENSION COULD BE SUPPLIED BY OCCUPATIONAL AND PRIVATE FUNDS.

TARGETING BENEFITS. BASIC BENEFITS SHOULD PROVIDE A SAFETY NET FOR THOSE IN NEED. NON-CONTRIBUTORY BENEFITS COULD BE MEANS-TESTED AND TAPERED SO THAT THOSE WHO DO NOT NEED THEM DO NOT GET THEM. CHILD BENEFIT NOW GOES EVEN TO MILLIONAIRES, AND THE AVERAGE HOUSEHOLDER IN THE TOP ONE-FIFTH OF INCOME-EARNERS GETS £540 A YEAR IN CASH BENEFITS. ??

THE UNEMPLOYMENT AND POVERTY TRAPS. PEOPLE SHOULD ALWAYS BE BETTER OFF IN WORK THAN OUT OF WORK. PART OF OUR STRATEGY

SECRET

FOR JOBS IS TO REMOVE THE CASH BARRIERS TO SEEKING EMPLOYMENT. RAISING THRESHOLDS FOR TAX IS HALF THE ANSWER. THE OTHER HALF IS TO HAVE A REALISTIC TAPERED REDUCTION IN BENEFITS AS INCOME RISES. PEOPLE SHOULD BE AT LEAST 30P BETTER OFF FOR EACH EXTRA POUND THEY EARN.

SAVINGS. ANY REFORM SHOULD YIELD PUBLIC EXPENDITURE SAVINGS SO THAT PEOPLE CAN BE TAKEN OUT OF TAX.

LOSERS. THERE WILL BE SOME LOSERS IN ANY MAJOR REFORM OF TAXES AND BENEFITS, BUT THE POOREST SHOULD NOT BE MADE POORER BY THAT REFORM; NOR SHOULD ANY GROUP OF LOSERS FIND THEMSELVES DRAMATICALLY WORSE OFF.

SIMPLICITY. THE TAX-BENEFIT SYSTEM SHOULD BE AS SIMPLE AS POSSIBLE, AND SHOULD BE EASY FOR ADMINISTRATORS AND BENEFICIARIES TO UNDERSTAND. THERE ARE 77,000 DHSS SOCIAL SECURITY ADMINISTRATORS, AND ANOTHER 58,000 HANDLING PERSONAL TAX IN THE INLAND REVENUE. REDUCING THE NUMBER OF BENEFITS AND REMOVING PEOPLE FROM TAX COULD LEAD TO MAJOR ADMINISTRATIVE SAVINGS.

CO-ORDINATING UNIT

THE CO-ORDINATING UNIT HAS THE TASK OF SEEING THAT SUFFICIENT OPTIONS ARE EXAMINED AND THAT THE DIFFERENT REVIEWS DO NOT TRIP OVER EACH OTHER.

IT COULD LOOK AT:

PRIVATE PROVISION. PRIVATE SAVINGS OR INSURANCE WOULD BE WELL-SUITED FOR TOPPING UP A BASIC STATE PROVISION (THAT IS WHY SERPS IS UNNECESSARY) OR FOR COVERING SPECIFIC AND FORESEEABLE COSTS (SUCH AS FUNERAL OR MATERNITY EXPENSES). FOR THE POOREST, SUPPLEMENTARY BENEFIT WOULD MEET THESE COSTS; FOR EARNERS, PRIVATE INSURANCE WOULD BE BEST.

OTHER CANDIDATES FOR PRIVATE PROVISION ARE SICKNESS BENEFIT AND THE CONTRIBUTORY INDUSTRIAL INJURIES SCHEME.

RAISING INCOME TAX THRESHOLDS. THE OTHER SIDE OF THE BENEFITS COIN IS TAXATION. THE ADMINISTRATIVE AND BENEFIT SAVINGS OUTLINED ABOVE COULD HELP TO FINANCE A FURTHER INCREASE IN TAX THRESHOLDS, WHICH WOULD TAKE MORE PEOPLE OUT OF TAX AND FURTHER WEAKEN THE POVERTY TRAP.

SIMPLER ADMINISTRATION. IT IS POSSIBLE TO SIMPLIFY THE TAX-BENEFIT SYSTEM WITHOUT DESTROYING ITS SENSITIVITY TO INDIVIDUAL NEEDS. THE OPTIONS BELOW ALLOW THE NUMBER AND COMPLEXITY OF BENEFITS TO BE REDUCED. AT THIS STAGE, WE SHOULD ENCOURAGE THINKING ABOUT WAYS OF MAKING A SUBSTANTIAL REDUCTION IN THE COMPLEXITY AND COSTS OF ADMINISTRATION.

EXISTING BENEFITS COULD BE HANDLED BY A SINGLE OFFICE RATHER THAN BY A MULTIPLICITY. UNEMPLOYMENT BENEFIT COULD BE HANDLED IN DHSS OFFICES RATHER THAN SEPARATELY. IN DUE

COURSE, HOUSING BENEFIT COULD ALSO COME BACK TO BENEFIT OFFICES; AND PERSONAL TAXATION COULD EVENTUALLY BE HANDLED THROUGH COMPATIBLE TREASURY/DHSS COMPUTER SYSTEMS.

THE WIDER OPTION. THERE ARE MORE FUNDAMENTAL WAYS OF SIMPLIFYING THE SYSTEM AND REDUCING ITS COSTS, WHILE FOCUSSING ON POOR PEOPLE IN PARTICULAR. THE CONSOLIDATION OF CHILD SUPPORT SUGGESTED IN THE ANNEX COULD BE EXTENDED TO COVER ALL BASIC BENEFITS, INCLUDING SUPPLEMENTARY BENEFIT, UNEMPLOYMENT BENEFIT, HOUSING BENEFIT AND LESSER BENEFITS. IT WOULD BE A FULLY MEANS-TESTED SUPPLEMENTARY BENEFIT COVERING PEOPLE IN AND OUT OF WORK, TAPERING OFF AT, SAY, 35-50P FOR EACH POUND EARNED. THE ADVANTAGES OF THE SINGLE COMPUTATION WOULD BE IN SAVING ADMINISTRATION COSTS, IN MAKING SURE THAT PEOPLE GET THEIR DUE WITHOUT DIFFICULTY, AND IN GIVING PEOPLE GREATER INCENTIVE TO EARN.

CONCLUSION

AT THIS PRELIMINARY MEETING, IT MAY BE BEST TO CONCENTRATE ON THE GENERAL PRINCIPLES SET OUT AT THE BEGINNING OF THIS PAPER (WHICH REFLECT OUR UNDERSTANDING OF YOUR THINKING) AND TO CONCENTRATE ON ONE OR TWO OF THE OPTIONS WE HAVE SUGGESTED IN THE LIGHT OF THOSE PRINCIPLES. WE SUGGEST CONCENTRATING ON:

- ENDING SERPS

- ENDING ABUSES IN YOUNG PEOPLE'S BENEFIT

- MAKING HOUSING BENEFIT MUCH SIMPLER AND CHEAPER.

-

YOU MAY ALSO WANT TO EXAMINE THE CASE FOR A FUNDAMENTAL RETHINK, AIMED AT A MORE UNIFORM MEANS-TESTED BENEFIT FOCUSSING ON THE POOR.

JOHN REDWOOD

(WITH THE HELP OF CHRISTOPHER MONCKTON AND DAVID WILLETTS)

ANNEX

Options

We have set out some options for each of the four reviews, though it is early to become involved in too much detail.

Pensions Review

The basic state retirement pension is a popular pledged benefit and will remain a central part of the National Insurance system. It should continue to be contributory, although the review could ask the question whether it should continue to be compulsory. People might be allowed to opt out if they were a member of an approved private pension plan.

The State Earnings-Related Pension Scheme (SERPS), introduced by Barbara Castle in 1975, should go. There are now about 9.3 million pensioners. Their numbers stay below 10 million until 2005, and then rise steeply to more than 11 million by 2015, and more than 12 million by 2025. This increase coincides with the maturity of SERPS as the "20 best years" rule begins to bite.

Options include:

1. Calculating the SERPS entitlement not on the basis of the best 20 years' earnings, but on the average real

lifetime earnings multiplied by 20. This would make the scheme cheaper.

2. Discontinuing SERPS for everybody from an appointed date. The arrangements would be similar to the winding-up of the Graduated Pension: everyone would receive a written record of his entitlement, which could be uprated annually in line with prices.

3. Discontinuing SERPS from an appointed date, and give everyone his entitlement as a capital receipt to be paid into his own personal pension fund once the portable pension scheme is running. This would extend personal wealth-ownership, but would cost the public sector a great deal on the appointed day. However, it would buy out the expensive entitlements early, rather than allowing them to continue building up.

We recommend option 2.

Supplementary Benefit Review

Supplementary Benefit costs well over £2 per benefit payment to administer. About 15 per cent of all benefit payments are Supplementary Benefit, but almost 40 per cent of staff work on it, because it is means-tested, and because the 15,000 paragraphs of regulations are complex.

Options include:

1. Having simpler and fewer categories of need and fewer special payments. Savings will be in administration rather than in Benefit cuts.

2. At present, anyone with savings of more than £3,000 is not eligible for Supplementary Benefit. Therefore those who are now in work, but who fear they may one day find themselves on Social Security, have a disincentive to save. The reviews should look at the desirability of raising the savings disregards.

3. Supplementary Benefit could be combined with other non-contributory means-tested benefits (Housing, FIS) so that there is a single calculation of need and a single cheque.

Housing Benefit Review

Housing Benefit extends too far up the income scale and helps to force up house prices and rents. It makes people less worried about the level of council rents and rates, and encourages private landlords to overcharge in the knowledge that the state will pick up the bill. And, as central government squeezes the spending of councils, they put up their rents, and the DHSS automatically has to pay out extra Housing Benefit.

Housing Benefit is complex and is a major contributor to the poverty trap. It is paid to more than one-third of all households, and therefore goes to many whose need is questionable. Of the £4 billion total annual cost of Housing Benefit, £2.5 billion goes to people on basic Supplementary Benefit, and they will need to go on having their full rent and rates paid. But savings could be made on the £1.5 billion paid to families not on Supplementary Benefit.

Options include:

1. Simplifying Housing Benefit by meeting the full housing costs of those without any non-state income, as now, and by withdrawing the benefit at a single, uniform rate. This single taper would replace the four existing tapers and the other complicated features of the system. And, if the taper were steep enough, public expenditure would be reduced.

2. A renewed drive to create a private rented sector delivering enough flats and houses at realistic prices.

3. Amalgamating with Supplementary Benefit as above.

Benefits for Children and Young People Review

Young people. Supplementary and Housing Benefit to young people living away from home can be so generous as to deter them from finding work. At its extremes, it can allow young people to live together in seaside hotels at the public expense or allow families to swap their teenagers so that they can claim full Supplementary and Housing Benefit.

At present, a 16-17 year old on Supplementary Benefit of £16.45 a week is better off than a younger person who stays at school (because the parents get only £6.50 a week in Child Benefit). He is also better off than many young people on Government training schemes. This is one of the areas where basic Supplementary Benefit may be too generous. And it contributes to youth unemployment by holding up the wage levels which employers offer, so that they are higher than the value of the labour of large numbers of young people.

Options include:

1. Pay young people only the level of Supplementary Benefit which would apply if they were living at home, unless they have a good reason to be living elsewhere (eg parents dead or divorced).

2. Extend the age-band for young people's reduced rate of Supplementary Benefit to 19 years, and cut the rate by £2 a week.

Child-related benefits. Child Benefit is £6.50 per week per child; FIS starts at £22 per week for the first child, with an addition of £2 per week per subsequent child, and is then tapered at a steep 50p per pound of earnings. The disadvantages are (a) that the FIS taper is the largest single cause of the family poverty trap; and (b) that the combination of FIS, Child benefit and the child elements in Supplementary Benefit is complex.

Options include:

1. Replacing Child Benefit, FIS and the child element in Supplementary Benefit with a consolidated, means-tested Child Benefit which preserves the financial position of the poorest, and is tapered at, say, 20-25p for each pound earned. This would reduce the effects of the poverty trap, and would yield significant savings by no longer paying Child Benefit to richer families. The savings could be passed on in higher tax thresholds.

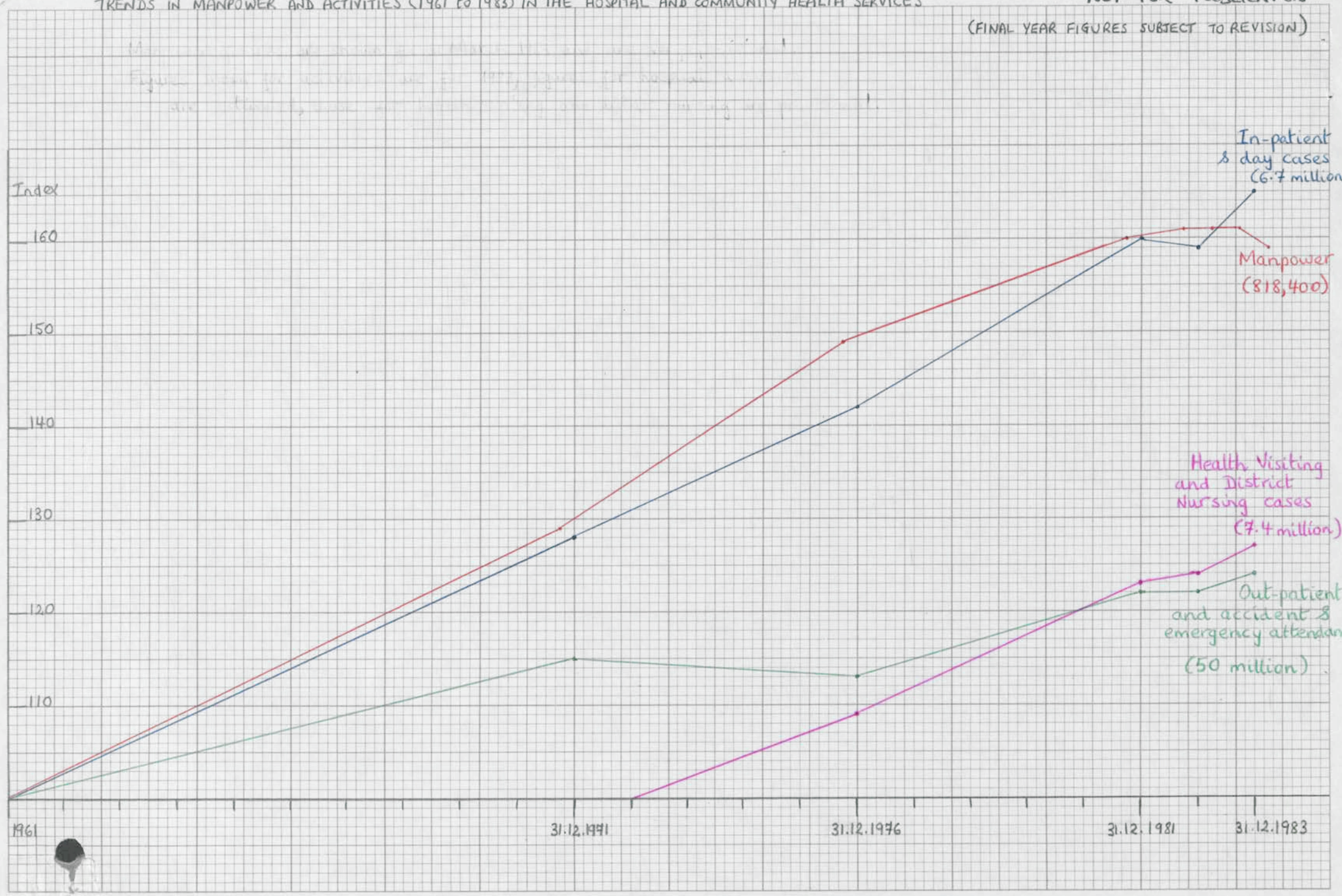
2. Child Benefit could be abolished, with the resulting savings going in part to a beefed-up FIS for poor families and in part as tax relief.

3. Child Benefit could be frozen in cash terms and allowed to wither like Maternity and Death Grants, the savings going to tax relief and better benefits for poor families.

TRENDS IN MANPOWER AND ACTIVITIES (1961 to 1983) IN THE HOSPITAL AND COMMUNITY HEALTH SERVICES

NOT FOR PUBLICATION

(FINAL YEAR FIGURES SUBJECT TO REVISION)

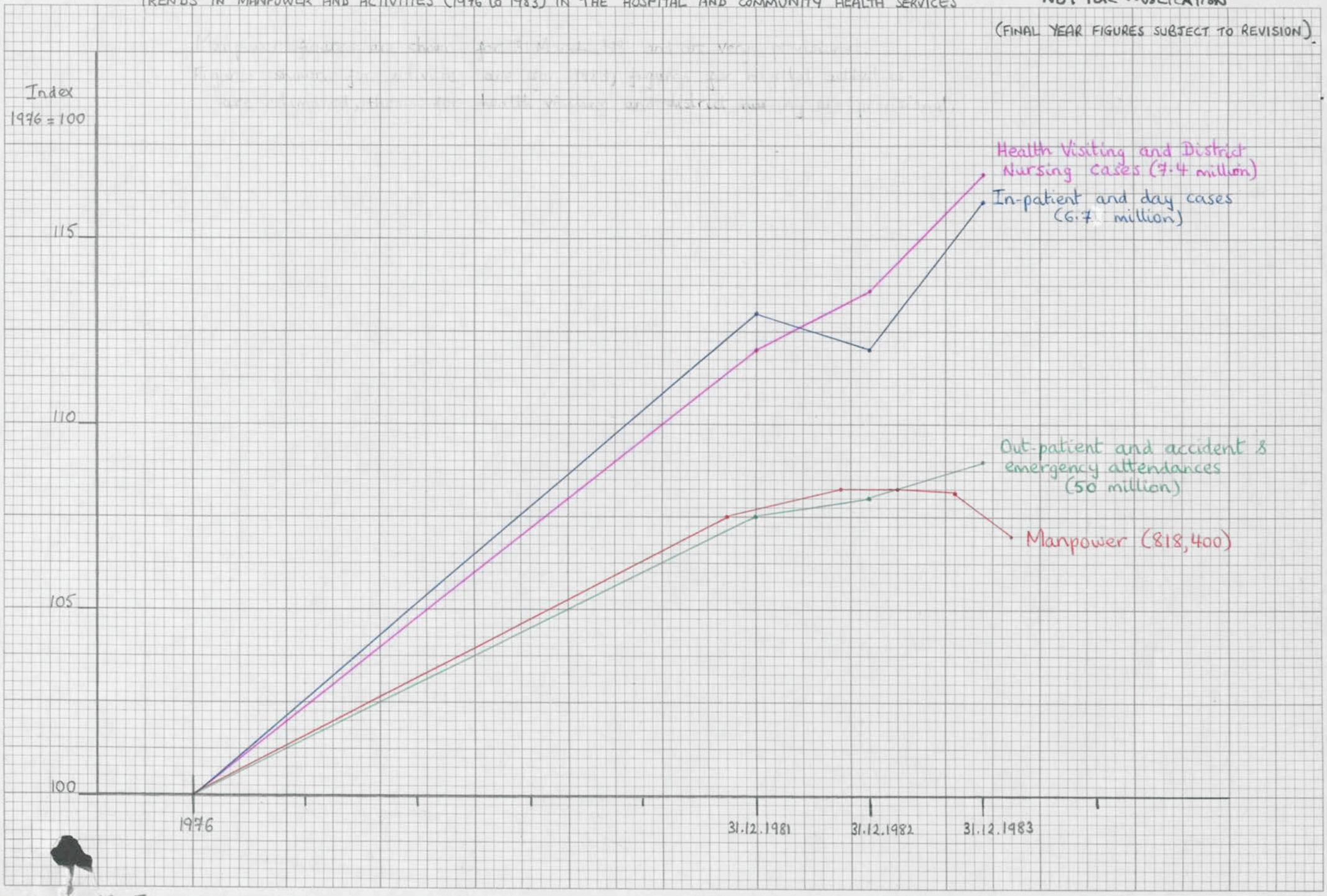


28 June 1984

TRENDS IN MANPOWER AND ACTIVITIES (1976 to 1983) IN THE HOSPITAL AND COMMUNITY HEALTH SERVICES

NOT FOR PUBLICATION

(FINAL YEAR FIGURES SUBJECT TO REVISION)



28 June 1984

B

PRIME MINISTER

NHS: IMPLEMENTATION OF GRIFFITHS

Your Private Secretary's letter of 11 June raised some questions about our approach to the implementation of the Griffiths Report in the NHS and the DHSS. This also relates to the three senior appointments which Sir Robert Armstrong recommended to you, and which I support.

2. For the NHS, I have now issued guidance to health authorities on the implementation of the key recommendation: the appointment of general managers, first at RHA level (14 appointments) and the, over the next 18 months, in the total of about 200 Districts and 1,000 management units (major hospitals or smaller hospital groups and community services). In instructing health authorities to get on with this I have made three things quite clear:

- First, this is not a cosmetic exercise. The general manager has a real job to do and they must not just allow one of their existing chief officers to change his title without changing his role. Where the management skills do not exist inside authorities they should not hesitate to recruit outside the health service;

- Second, this is not a job-creation scheme. There is a new job to be done - that is the essence of the Griffiths proposal. But general managers selected from existing staff will not need to be replaced at

Contd.....

the same level; and some (e.g a consultant appointed as general manager in a hospital) will not be full-time. Every new general manager post (whether an internal or external appointment) will have to be offset - both in terms of numbers and costs - elsewhere within the budget for management in the Region, District or unit concerned;

- Third, I am not going to loosen my grip on this exercise. The proposals from each RHA and DHA will have to be approved by Ministers.

3. In the DHSS, what we are doing is again to implement Griffiths in full. That means setting up the Health Services Supervisory Board (which is now meeting monthly under my Chairmanship and with Roy Griffiths as a member); and the NHS Management Board with - as you have agreed - a Chairman and Personnel Director recruited from outside the Civil Service. Because of the statutory position of health authorities, the Management Board cannot have a line management relationship with them. But the Management Board (and its Chairman) acting on my behalf and with my authority will exercise all the Department's functions in relation to the management of health authorities and give them the leadership they need.

4. That is why I want to get on with the necessary changes. We need to leave room for discussion with the Chairman how the Management Board will operate; although the basic structure was of course settled when we accepted the Griffiths proposals. The same goes for the Personnel Director, whose appointment is needed soon.

5. As for the rest of the Department's senior staffing, I am looking to make further progress (and savings) not only in

the Griffiths area but elsewhere; remembering that Griffiths covered only about one-quarter of my responsibilities - excluding social security, personal social services and the Family Practitioner Services and the support required by Ministers in relation to Parliament. We have already made much progress: our HQ staffing has been reduced by 20 per cent since 1979 and our Senior Open Structure (Under Secretaries and above) has been similarly reduced from 75 at 1 April 1979 to 61 on April 1984.

6. And I expect to do more: despite the two new posts for the Management Board, I will make a net saving of four more open structure posts before next April - a gross saving of six posts . I shall be doing this by reducing the functions of the DHSS in relation to health, in line with the Griffiths approach; getting the Department out of the field of health services research management; and ending the central involvement in design and construction of hospitals, concentrating instead on the better management of the NHS estate (including disposals).

7. In summary this means the following changes in DHSS senior staffing will have taken place:

SENIOR OPEN STRUCTURE 1979-1985

	At 1.4.1979	At 1.4.1984	At 1.4.1985
Grade 1	1	1	1
Grade 1A	2	2	3 (including Chairman of NHSMB)
Grade 2	14	12	11 +1 (Personnel Director)
Grade 3	58	46	41
Total Senior Open Structure	75	61	57

Contd....

8. But if I am to maintain the momentum on all this we will need to get on with the senior staff changes. There are three key Deputy Secretary appointments to be made - as detailed in the Annex to this minute - and recommended by Robert Armstrong with my support:

- the Chairman of the NHS Management Board will need first-class support at Deputy Secretary level from someone who knows the NHS and the Department. John Evans was to have filled this role but he has had to retire because of illness. I think Graham Hart is the right man for this job. We need him appointed now to take control of the interim Management Group, from which the Management Board will take over, and monitor the implementation of Griffiths in the NHS.

- as part of our effort to get better control of expenditure on the family practitioner service I am bringing together responsibility for the main elements of the FPS: the costs and pay of the independent practitioner services and the control of the drugs bill through the PPRS. This post has been filled temporarily by Pat Benner's deferring his retirement. We need a new man - and Brian Rayner is well equipped - to carry this through.

- the third post, where you have agreed that Chris France should take over, will be of great importance in the next few years. We will need fresh thinking in such areas as personal social services and the involvement of the private sector in care of the elderly.

9. Finally, we have already seen how long the process of appointing the Chairman of the NHS Management Board has taken. We cannot afford to delay the process for the Personnel Director. Once the Chairman has been identified we will,

of course, be able to take account of his views on some of the details of the Personnel Director's job and on the candidates. But the main part of the job description and the procedures are agreed and I believe we should start the recruitment process now.

10. I am copying this to Robert Armstrong.

N.F

26 June 1984

ANNEX A

1) NHS MANAGEMENT GROUP

This group will be the major component of the NHS Management Board and embrace responsibility for a multi-disciplinary Departmental team working under the Chairman of the Board. The post holder will be de facto, and perhaps formally, deputy chairman. This is the post currently occupied by John Evans and it is heavily loaded and very active. Given a Chairman of the Board appointed from outside the Civil Service, this Deputy Secretary will have a key role to play in making the board an effective instrument within the department as well as within the NHS. The special requirements for this post are a depth of knowledge of the NHS, of the Department and of the politics of health care plus an ability to support a new Chairman in a positive way - particularly in relation to Ministers and Parliament.

2) HEALTH PRACTITIONERS AND INDUSTRIES

This post comprises the bulk of the existing Deputy Secretary command covering the Family Practitioner Services and Medicines Commission, (the personnel function for health authority staff having been re-allocated to the NHS Management Board - one Under Secretary command) plus responsibility for the department's functions in respect of health care supplies and pharmaceutical industries - a wide range of responsibilities. The desiderata for this post are those of a first-class administrative manager, adviser and negotiator, with broad experience of NHS and health issues and of professional machinery.

3) HEALTH AND PERSONAL SOCIAL SERVICES POLICY

This will be built round the existing post held by Nodder and cover responsibility for the overall policy for social services (other than social security) in the central government, private and voluntary sectors. It ties in closely with the public health responsibilities of the Chief Medical Officer and entails the leadership of many clinical and scientific disciplines in the development of policy. Ministers attach great importance to fresh thinking here. The desiderata for this post (apart from first-class administrative competence) are a penetrating mind, with the ability to bring fresh thinking to complex issues of social policy, a cost-conscious but innovative approach, and an ability to lead a multi-disciplin professional team.

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26 JUNE 1984

IMPLEMENTATION OF GRIFFITHS

THERE ARE FOUR MAIN THINGS THE PRIME MINISTER COULD MENTION TO MR FOWLER.

(i) THE APPOINTMENT OF THE CHIEF GENERAL MANAGER: WE NEED A GOOD MAN IN POST AS SOON AS POSSIBLE. ARE WE IN SIGHT OF THIS? ELABORATE PROCEDURES SHOULD NOW BE AVOIDED.

(ii) THE AUTHORITY OF THE GENERAL MANAGER: THE GENERAL MANAGER HAS TO HAVE THE MAXIMUM POSSIBLE FREEDOM (USING THE SECRETARY OF STATE'S AUTHORITY) TO REFORM THE RUNNING OF THE HEALTH SERVICE. REGIONAL HEALTH AUTHORITIES SHOULD SEE HIM AND HIS MANAGEMENT BOARD AS THE SECRETARY OF STATE'S AGENT, AND NOT AS A STRANGE PERIPHERAL BODY TO WHICH THEY ARE NOT ACCOUNTABLE.

(iii) THE CENTRAL ADMINISTRATION OF THE HEALTH SERVICE: THERE ARE 2,200 OFFICIALS IN THE DHSS ADVISING ON AND ADMINISTERING THE HEALTH SERVICE. THE NEW MANAGERS SHOULD NOT JUST SUPPLEMENT ALL THESE CIVIL SERVANTS, BUT SHOULD DISPLACE THEM. MR FOWLER (USING MR CLARKE TO IMPLEMENT THE POLICY) SHOULD RECOMMEND A RADICAL REDUCTION IN CENTRAL DHSS ADMINISTRATION. COULD IT BE ONE-TENTH ITS PRESENT SIZE? THE IBBS UNIT SHOULD BE ASSOCIATED WITH THIS WORK. THE PROPOSAL TO APPOINT A NEW PERSONNEL DIRECTOR WITHOUT ANY

SECRET

OFFSETTING REDUCTIONS IS AN EXAMPLE OF WHAT MUST NOT HAPPEN.

(iv) ACTION PLAN: IT WOULD BE HELPFUL FOR MEASURING PROGRESS IN FUTURE IF MR FOWLER COULD PROVIDE AN ACTION PLAN SETTING OUT WHAT WAS SUPPOSED TO BE DONE, WHEN AND BY WHOM.

David Willetts

DAVID WILLETTS

cc Master

SUBJECT

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S

RECORD OF MEETING BETWEEN PRIME MINISTER AND MR. ROY GRIFFITHS ON WEDNESDAY 20 JUNE AT 1500 HOURS

NHS REORGANISATION

Mr. Roy Griffiths came to see the Prime Minister to discuss the reorganisation of the NHS. The Prime Minister said she was very concerned at the way this was progressing. She had seen a chart produced by DHSS which showed the Management Board, not in a direct line between the Secretary of State and the Regional Health Authorities, but out of line, creating the appearance of a new specialism of management acting in an advisory role. She was worried that new posts were being created but not enough was being done to cut down the 2,200 DHSS staff supervising the NHS. She was concerned about the quality of applications for the post of Chief General Manager. Finally, she wondered whether the post of Personnel Director was necessary. This would be the first reorganisation of the NHS and it was essential to get it right this time. She wondered if Mr. Griffiths shared these concerns.

Mr. Griffiths said he shared some of these concerns but he was "not too depressed"; substantial progress had been made. He had foreseen three stages - preparation of the report, consultations, and implementation. The report had been completed rapidly in seven months; consultations had been successfully completed though they had taken six months which was rather longer than he had hoped; the exercise had now reached the most important stage of implementation.

Mr. Griffiths said his group had considered

establishing the NHS as a corporation but had rejected this approach. It could have alarmed people unnecessarily and it would have required a long period for legislation and reorganisation. His aim had been to secure a reorganisation which could be put into effect much more quickly and which achieved, in terms of management structure, many of the features of a corporation without incurring those penalties.

He said the way the Management Board was represented on a chart was less important than the way it was implemented in practice. The key to success was that the Secretary of State should invest the General Manager with authority and that the Secretary of State and the Minister of Health between them should devote adequate time to the pursuit of greater efficiency in the NHS. It was vital that the Management Board should not be surrounded and enmeshed by the Department. For the venture to be successful he recommended the following steps:

i) The best Chief General Manager obtainable should be appointed. The Prime Minister should be prepared to reject the first candidates put up if she was not totally satisfied.

ii) The Director of Personnel should be appointed and the equivalent post in the Department should lapse.

iii) The Secretary of State should clarify the role and functions of the Management Board.

iv) The Secretary of State should examine urgently the role and structure of the DHSS in relation to the Management Board. This could not be done internally but should be done using outside consultants reporting to the Supervisory Board. (The Prime Minister suggested a role here for

/v)

v) Adequate Ministerial time should be devoted to the management of the NHS.

He was confident that if these steps were followed cost savings of £1 billion out of £15 billion could be secured in the space of three years.

The Prime Minister queried whether a separate Director of Personnel was required as much of his work would also be the responsibility of the General Manager. She felt the title also had an unhelpful welfare connotation.
Mr. Griffiths felt that the General Manager needed support in the vital area of manpower. Given the structure of pay bargaining and the dominant role of Review Bodies, the Managers of the NHS had only a limited role in determining pay. It was all the more important, therefore, to secure greater productivity by the pursuit of better working practices. There were many restrictive practices enshrined in Whitley agreements which should be removed.

He shared the Prime Minister's doubts about the quality of the shortlist for the post of Chief General Manager, though he had not yet interviewed them personally. They were -

Gregory - the Director of UK and External Affairs at BP;

Wilkinson - Joint Managing Director of Lucas;

Travers-Clarke - Chairman of Express Dairies

He would not have adopted the same selection process. This meant that no candidates were presented to those making decisions until the very end of the process. It might have been better to have pursued a policy of more active search for good candidates and to have brought names up for

/ consideration

consideration earlier so that a bench mark for the search for other candidates could be established. If, under the present procedure, none of the shortlist was acceptable, it would be necessary to go back to square one.

The Prime Minister thanked Mr. Griffiths for giving her his views which she would find very useful in carrying through the reorganisation successfully.

The meeting ended at 1600 hours.

20 June 1984

10 DOWNING STREET

Prime Minister

You are seeing Mr Fowler for a talk on 28 June. You should use the meeting with Mr Griffiths to accumulate ammunition. Mr Willetts' note provides plenty of questions.

There are currently 2,200 DHSS staff administering the NHS. Griffiths believes that by having many of them in the General Managers line of command and by cutting back the extent to which Ministers are answerable for details questions, this could be reduced to 300. You could ask him how.

Would you like Mr Willetts to attend?

AT
19/6

CONFIDENTIAL

19 June 1984

MR BARCLAY

MEETING WITH ROY GRIFFITHS

Roy Griffiths is worried about how the DHSS will implement his report. The meeting is a good opportunity to find out what is going wrong and how to deal with it. I had a useful informal meeting with him on Monday, 18 June, which the Policy Unit had arranged before your meeting.

Roy Griffiths serves on the Secretary of State's NHS Supervisory Board, and on the senior DHSS Committee vetting applicants for the Chief General Manager post. He will not be sitting on the new General Management Board. He is therefore in a tricky position talking to the Prime Minister without DHSS knowledge.

The choice of the new Chief General Manager

This is essential to the implementation of the Griffiths reforms. The appointment has taken far too long. The DHSS have now reduced the field from around 36 names to 3. They are due to be considered by Norman Fowler and Roy Griffiths very soon, and a recommendation will then come to the Prime Minister. It is not fair to judge the candidates at this stage, and Mr Griffiths has not yet interviewed them. But there is a risk that they will not prove up to the mark. If the worst fears are confirmed, then another head-hunt will be necessary; but instead of funnelling candidates up through several layers, any further recruitment process should be short-circuited, and potential candidates put before Norman Fowler promptly. The Prime Minister could ask Mr Griffiths:

- What are the qualities that he is looking for in a new Chief General Manager?

- How soon does he think we might be in a position to appoint one?

- If the current 3 names are not satisfactory, how can we speed up the process?

- Can Mr Griffiths suggest any other candidates?

The new management function and central DHSS administration

Roy Griffiths shares our worry that the DHSS will add a new management function at the centre without shedding any existing administrators. It is important, therefore, that the creation of any new management posts go hand-in-hand with the abolition of administrative posts. And the new Chief Manager must have the power, through the confidence of

LAVAAL

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CONFIDENTIAL

Norman Fowler to achieve independence from DHSS administrators. The Prime Minister could ask Mr Griffiths:

- What future role does he see for the central administration in the DHSS?

- What is the best way of ensuring that radical changes in DHSS administration come about?

In answer to the second question, Mr Griffiths might argue that the DHSS is not going to be able to restructure itself if the Ministers are all too busy and some of the officials are not keen. He may also suggest that the new Chief Manager will be too preoccupied with the NHS to look at the DHSS as well.

The DHSS circular implementing the Griffiths reforms

The Prime Minister may wish to ask Mr Griffiths:

- Is he happy with the DHSS circular, and will it limit the room for manoeuvre of the new Chief General Manager?

He may be relaxed about the thrust of the circular, but there remains the key question of timing and the adequacy of the circular alone.

The new Personnel Director

The Prime Minister could ask:

- What is the role of the Personnel Director?

- When should he be appointed?

- Does Mr Griffiths have any names in mind?

Roy Griffiths may agree that no significant steps should be taken either to define the role of the Personnel Director, or to choose an individual until the Chief General Manager was appointed.

Wider points

Mr Fowler has a tricky task: he is both trying to soothe the fears of the professional interest groups by assuring them that nobody will be riding roughshod over them; and yet, at the same time, he needs to make sure that the report is implemented fully.

- Are we still on track for achieving a major improvement in NHS management, or are the report and

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recommendation already being eroded (eg appointing a nurse to the Supervisory Board)?

- Why is it taking so long?

- How can the new Chairman assemble an action plan and get a grip on the health authorities?

- How should the PR be handled between Mr Fowler and the new Chairman?

- What is the potential for cost-improvement in the NHS if the report is implemented?

- Are targets going to be set for output and efficiency; and if not, why not?

- Has his experience of the past 6 months led Mr Griffiths to change any of the analysis in his report?

- Are we trying to run the NHS like a Corporation but without having to go through legislation and upheaval?

David Willetts

DAVID WILLETTS

LAVAAL

SENIOR STAFF IN CONFIDENCE

10 DOWNING STREET

From the Principal Private Secretary

SIR ROBERT ARMSTRONG

Grade 2 Appointments,
Department of Health and Social Security

Thank you for your minute of 8 June (AO84/1687) which the Prime Minister has considered.

When you sent this minute, you will not have seen the Prime Minister's reaction to the minute of the same date from the Secretary of State for Social Services about the appointment of a Personnel Director of the NHS Management Board. David Barclay's letter of 11 June recorded the Prime Minister's view that the implementation of the Griffiths Report and the creation of any extra posts should be accompanied by savings in the existing DHSS administration: the Prime Minister asked for a report on the Secretary of State's thinking on the implications of Griffiths for the DHSS administrative structure.

The Prime Minister has commented on your minute that she is content to agree to the transfer of Mr Christopher France to DHSS but she is not prepared at present to agree to the other appointments since she would not wish to pre-empt any reductions which the Secretary of State may need to make in the top structure of the DHSS in order to offset the new Griffiths posts.

FERB.

13 June 1984

SENIOR STAFF IN CONFIDENCE

ECL

Prime Minister

Agree the promotion of Mr. Hart and Mr. Rayner, and the transfer of Mr. France from MOD to DHSS?

FERB 11.6.

Ref. A084/1687

MR BUTLER

Grade 2 Appointments, Department of Health and Social Security

Appointments are needed, for different reasons, to three Grade 2 (Deputy Secretary) posts in the Department of Health and Social Security.

2. As you will recall, as part of the Secretary of State's plans for the management of the National Health Service (NHS) in the light of the Griffiths report, a candidate from outside the Civil Service is currently being sought for the new post of Second Permanent Secretary to act as Chairman of the NHS Management Board, and the Secretary of State minuted the Prime Minister recently about the creation of a post, proposed at Deputy Secretary level, of Director of Personnel for the NHS. This submission is not concerned with either of these new posts; but in considering recommendations for the three posts with which this submission is concerned we have taken into account the organisation and requirements of the work following Griffiths, and the experience and qualities that will be needed.

3. The first of the three posts is to be in charge of the NHS Management Group, the major component of the NHS Management Board and embracing responsibility for a multi-disciplinary departmental team working under the Chairman of the Board. The post-holder will be de facto, and perhaps formally, Deputy Chairman. The post (with minor modifications) has been held until this month by Dr John Evans, a doctor aged 50 who had taken with great success to administration and who might well have been a candidate in due course for the post of Chief Medical Officer. He is, sadly, extremely ill, and steps are in train for his early retirement on the grounds of ill health. This is a personal tragedy for him, and a great loss to the Service.

4. Mr Graham Hart is recommended for the succession to this post. Mr Hart, aged 44, is one of the outstanding Under Secretaries in the Service. He has had varied experience of the

Health side of the Department, was Private Secretary to the Secretary of State 1972-74 and was on loan to the Cabinet Office and the Central Policy Review Staff 1982-83. If appointed, he would become the youngest Deputy Secretary in the Service. This post, supporting the new Chairman likely to be from outside the Service, calls for the very best we can put forward. I believe that Mr Hart has the right qualities for it.

5. The second post, in charge of Health and Personal Social Services Policy, covers responsibility for the overall policy for social services (other than social security) in the Central Government, local government, private and voluntary sectors. The post ties in closely with the public health responsibilities of the Chief Medical Officer and entails the leadership of many clinical and scientific disciplines in the development of policy.

6. It is currently held by Mr T E Nodder, aged 54 and a Deputy Secretary since 1978. I am sorry to say that Mr Nodder has lost self-confidence and the confidence of the Secretary of State and the other DHSS Ministers. He has, to put it bluntly, run out of steam. He is willing to take early retirement, and I am satisfied that this is the right course in the circumstances. To replace him I recommend Mr Christopher France, aged 50, a Deputy Secretary from the Treasury but currently on loan to the Ministry of Defence. Mr France was Principal Private Secretary to the Chancellor of the Exchequer 1973-76, and was the Treasury's Principal Establishment Officer 1977-80 before a short secondment to the Electricity Council. The Prime Minister approved my recommendation last July that Mr France should be moved to a Deputy Secretary post in the Department of Health and Social Security, to gain experience of that Department and be a candidate for the eventual succession to Sir Kenneth Stowe. It was not, however, possible to implement that move at the time because of the Griffiths report and the fresh thinking that then had to be done about the Department's top structure. Mr Nodder's post will be an ideal post for Mr France to gain experience of the Department. Mr France will also be available as a long-stop Civil Service candidate for the new Second Permanent Secretary post if the search for an outside candidate is unsuccessful.

7. The third post, in charge of Health Practitioners and Industries, carries responsibility for health care supplies and the pharmaceutical industries. The holder needs to be a first-class administrative manager, adviser and negotiator, with broad experience of NHS and health issues and of professional machinery. It is at present held by Mr P Benner, who has served on slightly past normal retiring age to help the Department while the Griffiths report's implications were assessed. Mr Brian Rayner, aged 52 and an Under Secretary since 1975, is recommended for this post. He joined the Service as a Clerical Officer in 1948, and has had wide experience of the health side of the Department. From 1978-83 he was in charge of the Department's regional liaison division responsible for implementing Ministerial decisions on Health Service reorganisation. In his current post, dealing with pharmaceutical, optical and dental services, his energy and imagination have shown to advantage and have much impressed the Secretary of State and the Minister for Health.

8. These recommendations all have the approval of the Secretary of State.

9. I should be grateful to know if the Prime Minister would be ready to approve the promotions of Mr Hart and Mr Rayner, and the transfer of Mr France from the Treasury. Announcement would be for the Department of Health and Social Security.

RCA

ROBERT ARMSTRONG

8 June 1984

VSCACI

VC.

cc MV Willetts
Pol. Unit
+ RTA

file

10 DOWNING STREET

From the Private Secretary

11 June 1984

THE NHS - IMPLEMENTATION OF GRIFFITHS

The Prime Minister has seen your Secretary of State's minute to her of 19 May, the Chancellor's minute of 5 June, and your Secretary of State's further m inute of 8 June, about the appointment of a Personnel Director of the NHS Management Board.

The Prime Minister welcomes your Secretary of State's determination to carry forward the implementation of the Griffiths recommendations. She has noted his agreement with the Chancellor that the post need not carry any specific civil service grading, and that the initial appointment should be for a period of two or three years. She agrees with your Secretary of State that the possibility of extending this period should be kept open; that there may need to be flexibility as to salary; and that for the reasons set out by your Secretary of State the post should be described as "director" rather than "advisor".

The Prime Minister takes the view, however, that the first priority must be to appoint the Chairman. He can then recommend terms, conditions and candidates for the personnel post. She also believes that the implementation of the Griffiths Report and the creation of any extra posts must be accompanied by savings in the existing burden of DHSS administration. It would look odd if the first steps to reduce overheads involved the creation of new top jobs without the compensating loss of other posts. The Prime Minister would therefore be grateful for a report on your Secretary of State's thinking on the implications of Griffiths for the existing DHSS administrative structure.

The Prime Minister would also be grateful if the note commissioned by Andrew Turnbull in his letter of 4 June could cover wider questions of the implementation of Griffiths, including a timetable for the crucial appointments and decisions which remain to be taken. It would be helpful if your note could also cover the form of

/ the new

the new Griffiths management structure, its inter-relation with existing DHSS administration, and how the new Griffiths team will set about improving the efficiency of the Health Service.

I am copying this letter to David Peretz (HM Treasury), John Graham (Scottish Office), and Colin Jones (Welsh Office).

+ Richard Hatfield

David Barclay

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

A

10 DOWNING STREET

DRAFT

From the Private Secretary

June 1984

THE NHS - IMPLEMENTATION OF GRIFFITHS

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/ the new

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I am copying this letter to David Peretz (HM Treasury).

David Barclay

S.A. Godber, Esq.

Prime Minister (1)

Agree letter to DHSS at flag A?

PRIME MINISTER

DMB 8/6

THE NHS - THE IMPLEMENTATION OF GRIFFITHS

Attached are minutes from the Social Services Secretary and the Chancellor about the appointment of a personnel director of the NHS Management Board.

Mr. Fowler and the Chancellor now agree that:

(i) the appointment should be for two to three years initially;
(ii) it should not be linked to any specific civil service grade.

We suggest you support Mr. Fowler on three further points:

(i) that the possibility of extending this term should be kept open;
(ii) that there may be a need for flexibility on salary;
(iii) that the post should be termed "director" rather than "adviser" and regarded as an integral part of the new NHS management board.

But these are really details. There are some much more important general points which need to be underlined.

First, the new Chief Exeuctive, due to be appointed soon, will have views about the best job specification for his Personnel Director. The announcement should be delayed so that the Chief Executive can influence the post and the appointment.

Secondly, the Griffiths Report must lead to the reduction of bureaucracy. Creating new Civil Service posts without any offsetting savings is hardly a good start. The DHSS is not doing very well in achieving its Wardale targets, and there

/is a risk

is a risk that the existing DHSS administrative structure will remain unchanged with the Griffiths managerial structure added to it. Griffiths was at one stage going to lead to a reduction in Civil Service numbers. Is this still true? Can the DHSS spell out a programme for staff savings which, at the very least, match the new recruitment? And more fundamentally, does the existing central DHSS administration still have a role as the Griffiths management structure is set in place?

Implementing Griffiths

Mr Fowler's letter also provides an opportunity for the Prime Minister to ask about the form of the new management structure and the timetable for the implementation of the Griffiths recommendations. The DHSS could cover these questions in the note which Andrew Turnbull commissioned on the recent circular to Health Authorities.

There is a worrying tendency for the DHSS to see the NHS Management Board as an advisory adjunct to the Secretary of State. The management charts in the attached leaflet published on Monday show this all too clearly. If Griffiths is to have teeth - and it needs them - the new managers on the Board need clear lines of communication and influence direct to the RHAs and DHAs. They need the whole-hearted support and delegated authority that can come from a close working relationship with the Secretary of State. RHAs must

not be led to think that they only need deal direct with the Secretary of State, and that his Management Board is some distinct entity to which they are not responsible.

There has also been unreasonable delay in appointing a Chairman, despite interventions by the Prime Minister from time to time. It would be useful to have a timetable for crucial appointments and decisions from now on. This will encourage urgency, make sure that decisions are taken in the right order, and give us a benchmark against which to measure DHSS progress in future.

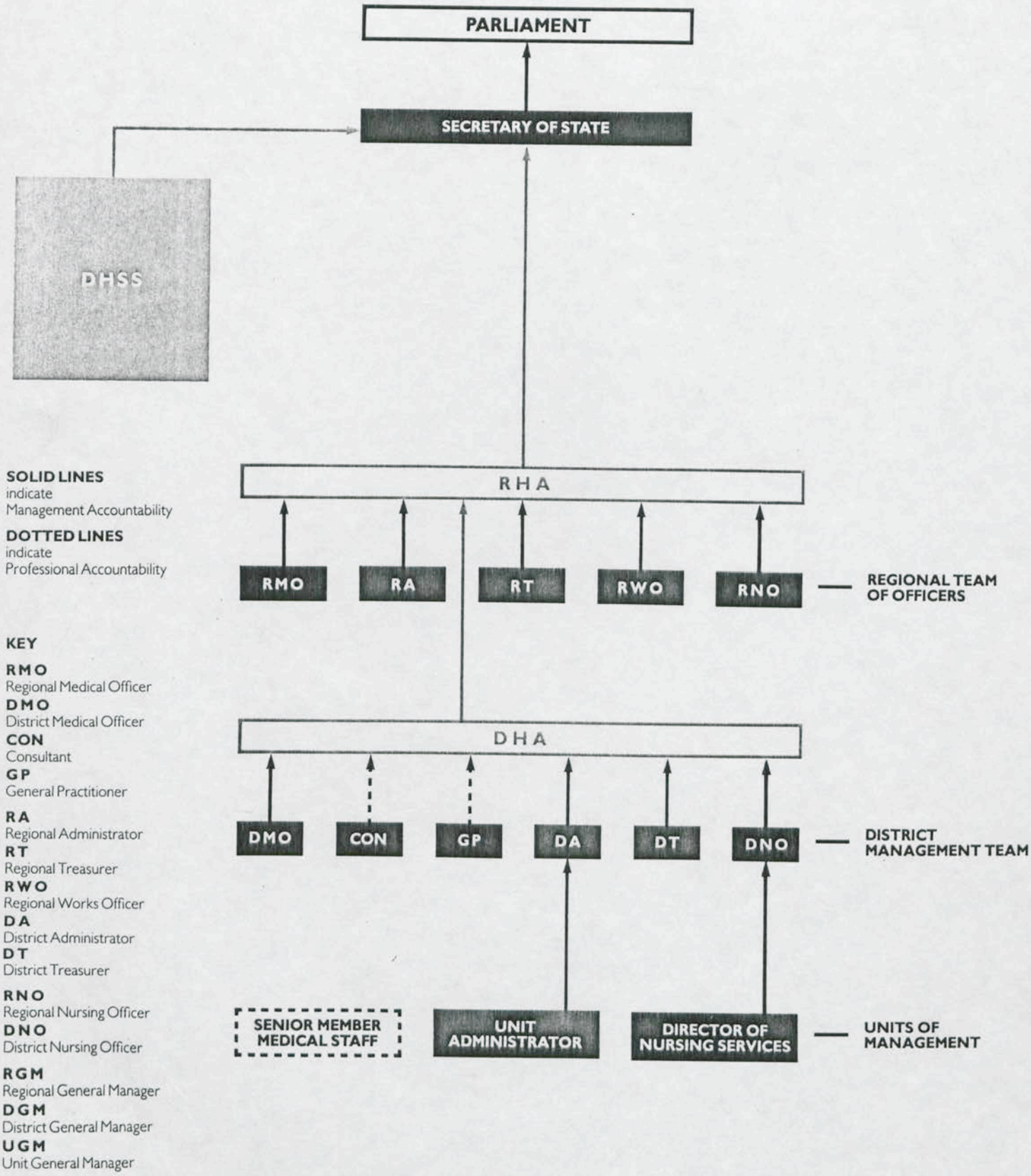
A draft letter is attached.

David Willetts

DAVID WILLETTS

'Health Authority Management – The Present

This is a simplified representation of the main present management relationships in Health Authorities and their links with DHSS, the Secretary of State for Social Services and Parliament.



SOLID LINES
indicate
Management Accountability

DOTTED LINES
indicate
Professional Accountability

KEY

RMO
Regional Medical Officer
DMO
District Medical Officer
CON
Consultant
GP
General Practitioner

RA
Regional Administrator
RT
Regional Treasurer
RWO
Regional Works Officer
DA
District Administrator
DT
District Treasurer

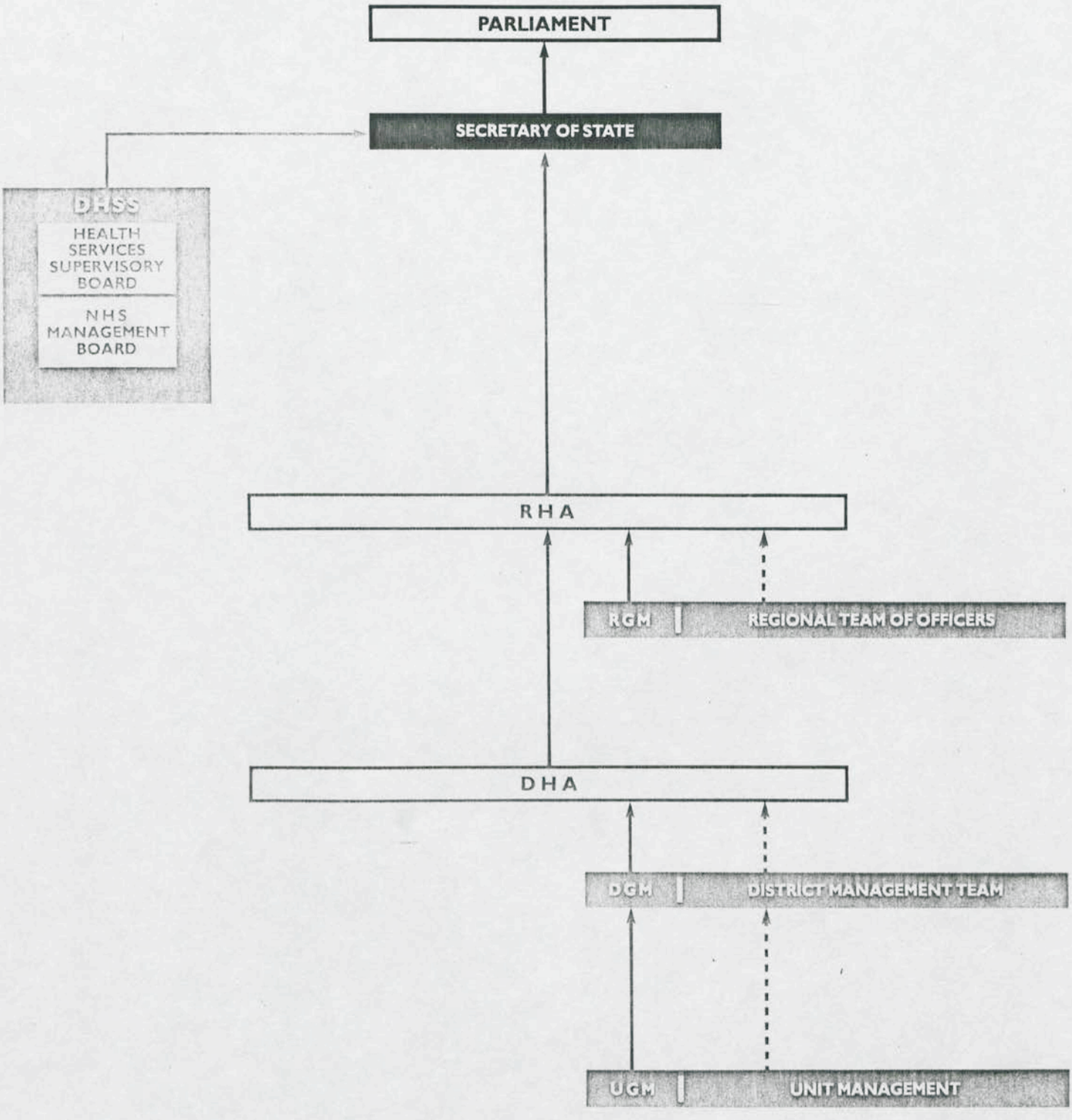
RNO
Regional Nursing Officer
DNO
District Nursing Officer

RGM
Regional General Manager
DGM
District General Manager
UGM
Unit General Manager

Health Authority Management – The Future

This is a simplified representation of the key future management relationships in Health Authorities and DHSS, how they link to each other, to the Secretary of State for Social Services and to Parliament.

These management developments will all take place within the existing accountability arrangements and statutory framework.



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Prime Minister

Agree conclusions (page 10)?

DMB 8/6

PRIME MINISTER

8 June 1984

THE NATIONAL HEALTH SERVICE: FAMILY PRACTITIONERS

The NHS is popular. There is no question of mounting a head-on assault against it. Yet the Health Service is still widely believed to be suffering the death of a thousand cuts. This is untrue, and Ministers rebut the charge by showing the increase in the real volume of spending on the Health Service since 1979. But this is a funny sort of defence in a world of cash planning and cost-effectiveness. It concedes too much ground to the Government's critics - that the sole test of care and concern is the real volume of resources made available to a Department.

A more imaginative approach is needed. This would focus not on real volumes of expenditure, but on improving the efficiency and quality of patient care. The right pattern of economic incentives to strengthen the hand of the consumer of health services could also reduce costs.

The implementation of Griffiths is the best way forward for the hospital service. But there has been much less progress on the Family Practitioner Service. The forthcoming Green Paper provids an opportunity to float some radical options. It should not just be another boring account of how more

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real resources are required to meet greater demands on them, and how the Treasury should stump up the money.

Family Practitioner Service

There is a growing body of evidence that the Family Practitioner Service is expensive and inefficient:

- Last year's Binder Hamlyn Report showed that the size of the Family Practitioner Service was not determined by consumer demand or need, but by the supply of doctors coming off the medical school production line.

- Recent research in Manchester suggests that 47 per cent of all GPs in the area spend less than 20 hours a week actually in patient care. It also suggests that different patient list sizes in the 1,500-2,500 range do not appear to correlate with the quality of patient care.

- Family practitioners prescribe too many drugs, and prescribe expensive ones when cheaper, generic substitutes will do. Of the total drug bill of almost £1.5 billion, about £1.2 billion is attributable to the FPS.

- There is widespread public concern about the excessive

use of deputising services.

The Private Sector Example: the Harrow Health Centre

The private sector provides a model of how to improve services and control costs. The Harrow Health Care Centre was set up 18 months ago as Britain's first - and so far only - independent GP service financed directly by private subscription. It is not a Harley Street practice for the elite. For an annual subscription fee of £70, the patient may have as many appointments with a GP in the Centre as he wishes, though home visits are charged at £10 each. An extra £25 annual fee will cover the cost of all drugs prescribed during the year.

The patient list now stands at about 4,000, and the target is to get to 9,000. The Centre does not turn anybody away. A wheezing 75-year-old will be accepted for the normal fee. So unlike some private insurance schemes, this clinic is genuinely universal. Patients are attracted by the better degree of care and attention at the Health Centre. Appointments are punctual, and each patient is always allocated 15 minutes. Elementary tests - such as X-rays - are available on site, so there are no frustrating delays as appointments which are booked at hospital out-patient units. So for anything but hospitalisation cases, it comes close to "one-stop shopping".

The fee structure creates a very effective set of economic

incentives for the Health Centre. They obviously must keep their costs down, unlike the arrangements whereby insurance companies refund costs to private hospitals. And the Centre has to provide a good service to keep its subscribers. It also has an incentive to spot trouble at the earliest stage, and devotes more effort to preventive medicine than does the NHS. Patients are encouraged to stay in touch with the Centre. Fitness and health education classes are provided. The patient knows that he can call on the Centre as often as he wishes, with no extra cost. This model is catching on in the United States in the form of "health maintenance organisations".

The project has had a total start-up cost of about £750,000. It had planned to break even after approximately 2 years of operation, but it now seems likely that this will only happen after 2½ years. A major mistake was to set their fees too low, as potential customers are suspicious that there are hidden costs; and their existing patients would be prepared to pay significantly more. The Centre must become financially viable, and then the plan is to expand to open a variety of such Centres elsewhere. They plan not only to cover prosperous suburbs, but also places like Hackney, tailoring the exact balance of services to meet local needs.

We should be encouraging the development of Centres like this. They are difficult for even the most blinkered critic

to attack. They follow the fundamental NHS principle of universality and, indeed, in one respect - the GPs are salaried - are closer to Bevan's original scheme than the NHS itself. They take the burden off existing NHS practices in the area. And because patients at the Health Centre are healthier than the average, they impose less of a burden on the hospital service.

But the Health Centre has a variety of complaints about niggling DHSS and establishment unhelpfulness:

i. They are not allowed access to NHS files, even with their patients' consent.

ii. The Centre carries out free child vaccinations normally carried out by the NHS. But the NHS will not provide them with free vaccine and, indeed, is trying to block supplies altogether.

iii. NHS obstetricians are making it difficult to integrate their ante-natal care service with maternity arrangements in NHS hospitals.

iv. The BMA has very strict rules about GPs advertising, which means that the dynamic Chief Executive - a qualified doctor, who runs the Centre and publicises it - cannot actually practise there.

Patient Power in the National Health Service

Our approach to the Family Practitioner Service shouldn't just involve encouraging private sector Centres on the Harrow lines. Wherever possible, lessons from the private sector should be applied in the public sector. The ultimate objective would be for NHS clinics to become cost-centres dependent on satisfying their consumers, just as in the private sector. The Green Paper on the FPS should look at the following possible changes:

(a) Encourage the establishment of patient-user associations for individual clinics, just like parent associations in schools. They will bring the community into closer touch with their local GPs, with no extra bureaucracy or expenditure. They can provide a vehicle for preventive medicine. They could ultimately become a source of funding, just as schools associations now buy educational equipment. And they by-pass the Community Health Councils, which are so often taken over by Left-wing activists.

(b) Family Practitioner Committees should give much more information about the General Practitioner services available in their areas - a first step towards advertising. They should not just provide names and addresses, but details of opening times, and refer to

any specialities of the individual GPs. A spirit of competition should develop, and patients be encouraged to change GPs if they are dissatisfied.

(c) The quality of service provided by the NHS should be properly measured. Average waiting times for seeing a GP, and the average time given by the GP given to individual patients, should be recorded. This information should then be put onto the FPC circular so that potential patients can see which Family Practitioners are providing a more efficient service. The Government could even set targets for such measures, though obviously we need to be sure that they could be met without excessive public expenditure.

(d) Simple design features can be copied from the Harrow example. The receptionist areas are open and friendly. There is a play area for children near to the main waiting room, but separate from it. Doctors come out of their rooms to collect their patients. All these little things can increase patient satisfaction at little or no cost.

All these steps can be taken by a Government which cares about the quality of health care, without encouraging the delusion that the only measure of care and effectiveness is

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spending more money.

Drugs

The mushrooming drugs bill is the clearest example of the failure to establish a sensible set of economic incentives within the FPS.

1. The patient expects a prescription every time he visits the doctor.

2. The doctor, under a barrage of advertising and pressure from drug companies, prescribes brand-name drugs when cheaper generics with the same active ingredients will do.

3. The drug companies get cosy contracts fixing high prices for their drugs under the Pharmaceutical Price Regulation Scheme.

We need to act on each of these three stages in the cycle.

First, patient attitudes. It is increasingly recognised that putting chemicals into your body is not something to be done lightly. New trends in medicine support this. Health education campaigns should focus much more on the dangers of taking a drug for every minor ailment, and aim at dampening down expectations of a prescription every time you visit the doctor's. Prescription charges, of course, also help here.

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And straight placebos could be prescribed rather than expensive but ineffective drugs.

Second, change doctors' prescribing habits. They should be educated and encouraged to prescribe generic drugs - an improved Which guide to drugs might help here. Refuse to prescribe on the NHS some basic types of medicine such as Dispirin, which can be bought privately for self-medication. Carry on removing from the NHS list of drugs those which have been proved to be largely ineffective.

The Pharmaceutical Price Regulation Scheme is being reviewed. There is scope for large savings here. Currently, all sorts of costs are allowed for in calculating companies' rate of return on drugs, such as the promotional expenditure to encourage doctors to prescribe the drug unnecessarily in the first place! These costs should be cut out of the calculations. More radically, instead of buying drugs at prices fixed under the Price Regulation Scheme, the NHS could tender for drugs in the same way Marks and Spencer or Sainsbury deal with their suppliers. The NHS would specify the active ingredients that were needed for a drug, and then accept the cheapest bulk tender. The patient would then be prescribed an NHS "own brand" antiobiotic.

Parallel imports can help push down drug companies' prices. Parallel imports obviously need to be safe, and regulations issued last month will ensure this. But there should be no

question of keeping out imports just because their cheapness makes life awkward for British drug companies. The important think is that the DHSS gets the benefit of these cheap drugs rather than it being pocketed by pharmacists, who are reimbursed by the DHSS on the basis that they had paid the full UK price.

Conclusions

1. Write to Kenneth Clarke pressing him to produce a radical Green Paper on the FPS. Positive themes would include:

   - shifting the debate from real resources to output;
   - encouraging the measurement of output and service quality;
   - strengthening patient power through patient association and information encouraging competition between clinics.

2. Encourage Harrow-type Health Centres and remove obstacles to them.

3. Ensure DHSS tackle the high FPS drug bill at all three points - patient, doctor and drug companies.

David Willetts

DAVID WILLETTS/JOHN REDWOOD

PRIME MINISTER

PERSONNEL DIRECTOR OF NHS MANAGEMENT BOARD

I have seen the Chancellor's minute to you of 5 June. There is, I think, no difference between us about what the essence of the personnel task is and about the formal arrangements for instituting the post. I, certainly, am not greatly concerned about the Civil Service grading which might be attached to the post. Indeed, like Nigel, I shall be quite content for no specific grading to apply. What matters is that we are able to pay the salary needed to get the right man for the job. I am also quite content for the initial appointment to be for a limited period - indeed this was in the job description I sent you. But the task which we want the Personnel Director to perform is not only to devise the right solution to the personnel problems of the NHS but also to carry through the new arrangements, both in negotiations and with health authorities. While I would like to think that this will prove possible in a period of two to three years, I think it unlikely. It is therefore essential that we should hold open the possibility of extending the appointment; that is why we intend to recruit by open competition.

So we are in agreement on the substance. But I think Nigel's suggestion that the post should be a "Personnel Adviser to the Chairman of the Management Board" and to me, quite misses the point. I regard the task of the Personnel Director - to break the mould of present NHS personnel management arrangements and recast them according to the Griffiths' prescription - as being central to the management task of the Department and of the NHS Management Board. To appoint a "Personnel Adviser" would be to give quite the wrong message to the health service. What we must do is to give a clear lead to the NHS and leave the Service in no doubt of the importance we attach to the personnel function and to improving personnel management. The fact that 70 per cent of NHS revenue spending is

E.R.

devoted to staff demonstrates how far the Personnel Director's job is at the heart of the new management structure and management arrangements which we are trying to bring about in the NHS.

I hope, therefore, that you will agree that we should go ahead with the appointment of a Personnel Director initially for two or three years (but extendable) and with no particular Civil Service grading attached to it (but with necessary flexibility on salary). I also hope you will agree with me that it is essential to our approach on Griffiths that the personnel appointment should be a Director not an Adviser and an integral part (possibly a Deputy Chairman) of the NHS Management Board and the new management arrangements within the Department.

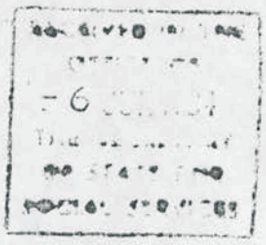
I am copying this minute to Nigel Lawson and (with a copy of his) to Nick Edwards, George Younger, Jim Prior, and Sir Robert Armstrong.

8 June 1984

N F

3.49 CONFIDENTIAL

Ellen
Dispatch



cc CST
FST
MST
EST
Sir P Middleton
Mr Anson
Mr Kemp
Mr Scholar
Mr Watson
Mr N J King
Mr Colman
Mr Bailey
Mr Rayner

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

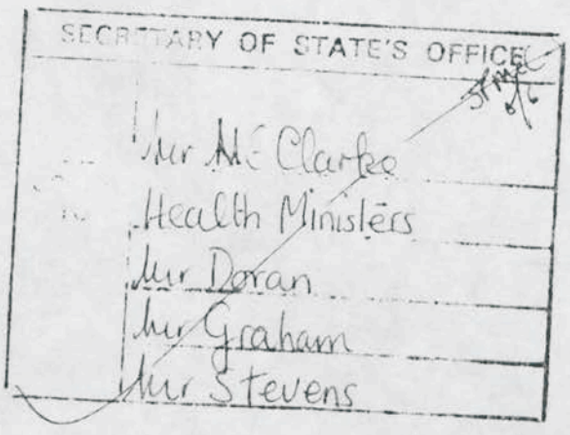
PRIME MINISTER

PERSONNEL DIRECTOR OF THE NHS MANAGEMENT BOARD

I have seen Norman Fowler's minute of 19 May seeking your agreement to Deputy Secretary grading for this post.

2. The job description attached to the minute does not seem to me fully to reflect what the Griffiths Team had in mind. It envisages the post as integrated into the day-to-day management of the NHS, and dealing with routine management matters as well as the essential mould-breaking role. But I fear this would be at the expense of what Griffiths saw as the essential task - reviewing NHS personnel management practices, devising solutions and negotiating the changes required. I myself see the post as more that of a personnel adviser to the Chairman of the Management Board and to Norman, than as an institutionalised part of the management structure. On this view, I think there is much less of a case for deputy secretary grading and I would therefore argue strongly against that. Indeed, I do not think we need to specify any civil service grading for this post. Would it not be better to treat it as a specific but limited assignment for two or three years?

3. I am copying this minute to Norman Fowler.



(N.L.)

5 June 1984

08 JUIN 1984

file ECL

10 DOWNING STREET

From the Principal Private Secretary

7 June 1984

Thank you for your letter of 4 June and for sending me the impressive documents about the implementation of the Griffiths Report in the NHS. I particularly liked the brochure and will keep it handy to show to the Prime Minister at a suitable opportunity.

While I am writing can I thank you also for sending me the two articles from "Pulse". These are useful background.

E.E.R. BUTLER

Sir Kenneth Stowe KCB CVO

CONFIDENTIAL

Appts (now with CF apparently)

Y SWYDDFA GYMREIG
GWYDYR HOUSE
WHITEHALL LONDON SW1A 2ER
Tel. 01-233 3000 (Switsfwrdd)
01-233 6106 (Llinell Union)
Oddi wrth Ysgrifennydd Gwladol Cymru

pa. 8/6

WELSH OFFICE
GWYDYR HOUSE
WHITEHALL LONDON SW1A 2ER
Tel. 01-233 3000 (Switchboard)
01-233 6106 (Direct Line)
From The Secretary of State for Wales

The Rt Hon Nicholas Edwards MP

6 June 1984

Dear Norman.

with PS (CAT?)

Thank you for copying to me your minute of 19 May to the Prime Minister in which you sought her agreement to the appointment of a Personnel Director for your Management Board.

I am very happy that you should do so; indeed as you say the creation of this post is essential to our efforts to provide the right conditions for the effective carrying out of the general management function throughout the NHS.

Most of the work of your Personnel Director would of course have UK wide implications and that is not least true of the specific tasks for early review proposed by Roy Griffiths and his team. For this reason I shall expect the Director of the NHS in Wales (my parallel appointment, following the recommendations of the Inquiry team, to your Chairman of the NHS Management Board) to keep in close touch with your Personnel Director so as to contribute a Welsh perspective and to carry out his parallel personnel functions in Wales. In turn I would of course expect that your Personnel Director should ensure that the Director for Wales is kept informed about his work and is able to make a contribution to it wherever appropriate. In the same spirit, I should of course be glad if you could keep me informed of any material developments in the Personnel Director's appointment and field of operations where political issues affecting Wales are at stake.

I am copying this letter to those who received your minute.

Yours ever

Nicholas

Rt Hon Norman Fowler MP
Secretary of State for Social Services

PRIME MINISTER

Health Service Spending

You may have noticed the attached article in today's Times which reports a book by Professor Brian Abel-Smith who was Special Adviser to Barbara Castle and David Ennals. The essential hypothesise of this book seems to be that, contrary to media impressions, spending on the Health Service has increased and that the Government has protected the Health Service rather better than its continental counterparts. While I do not know if there is anything new in this book it is certainly worth having these assertions from a source such as Professor Abel-Smith. Accordingly David Willetts and I are getting hold of the book to see if we can quarry some useful questions and, more likely, speech material from it.

TF

6 June 1984

The Times 6 June 1984

Health service cuts compared favourably with Europe

By Nicholas Timmins Social Services Correspodent

The Conservatives have been much less tough in imposing health service cuts than other European governments, according to Professor Brian Abel-Smith, Professor of Social Administration at the London School of Economics.

Professor Abel-Smith, special adviser to Mrs Barbara Castle and Dr David Ennals when they were Labour Secretaries of State for Social Services, said that the media picture of the health service in the past five years was "one of successive cuts, increased charges, and long queues for vital services."

"In practice, however, the cuts have largely been in previously planned levels of growth. Overall spending on the NHS has increased considerably".

Charges, particularly for drugs, had risen more than inflation, but no new charges had been introduced.

Professor Abel-Smith said other European countries' growth in health spending had run well ahead of Britain's but they have had to take really vigorous action to contain costs in the past two or three years.

Belgium, France, Germany and the Netherlands have introduced or increased charges for in-patients, for example, while Denmark is reducing hospital spending to the 1980 level. In Italy, budgets were cut in real terms in 1982 and 1983.

Professor Abel-Smith says that Britain starts from a much lower base than European counterparts, and spends appreciably less of its GNP on health.

Between 1966 and 1975, spending as a share of national resources rose by about 2.8 per cent a year. In the rest of Europe, it rose by between 3.5 and 7.4 per cent.

Between 1977 and 1982, however, the British figure rose to 3.1 per cent, while it declined markedly in most of the rest of Europe.

Cost Containment in Health Care: (Bedford Square Press £5.95; or £6.70 by post from Macdonald Evans, Estover Road, Plymouth PL6 7PZ)

3.49 CONFIDENTIAL cc D Willet

Appts

CF: x please

Dms 6/6

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

PRIME MINISTER

PERSONNEL DIRECTOR OF THE NHS MANAGEMENT BOARD

attached x

I have seen Norman Fowler's minute of 19 May seeking your agreement to Deputy Secretary grading for this post.

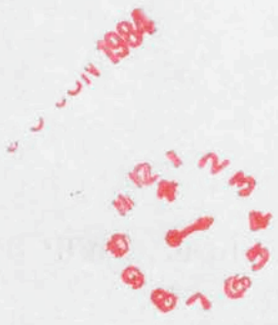
2. The job description attached to the minute does not seem to me fully to reflect what the Griffiths Team had in mind. It envisages the post as integrated into the day-to-day management of the NHS, and dealing with routine management matters as well as the essential mould-breaking role. But I fear this would be at the expense of what Griffiths saw as the essential task - reviewing NHS personnel management practices, devising solutions and negotiating the changes required. I myself see the post as more that of a personnel adviser to the Chairman of the Management Board and to Norman, than as an institutionalised part of the management structure. On this view, I think there is much less of a case for deputy secretary grading and I would therefore argue strongly against that. Indeed, I do not think we need to specify any civil service grading for this post. Would it not be better to treat it as a specific but limited assignment for two or three years?

3. I am copying this minute to Norman Fowler.

NL

(N.L.)

5 June 1984



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

F E R Butler Esq
10 Downing Street
LONDON
SW1

4 June 1984

Dear Robin

You may be interested to see the attached documents which show how we are implementing the Griffiths Report in the NHS. In themselves they represent a change in management style - a sharp emphasis on getting things done, a clearly signalled determination to monitor performance actively and an attempt to communicate management's stance to all members of staff. The latter is best shown by the brochure (a "first" in our parish) - which is backed up by a presentational video.

Yours ever

Ken.

LMT

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

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

Telephone 01-407 5522

From the Secretary of State for Social Services

To all Regional, District and
Special Health Authority Chairman

June 4th 1984.

Dear Chairman.

Last October I asked your Authority and the other key management and professional interests concerned for their comments on my proposals for taking action on the Griffiths Report. We have delayed reaching final decisions so that we could take account of the views of the House of Commons Social Services Committee and of Parliament itself. I enclose a circular which announces the Government's decisions.

Authorities are required to start work straightaway to establish the general management function and to identify individual general managers at Authority and unit levels. The circular provides considerable flexibility to take account of local circumstances. It requires regional authorities to make their proposals by the end of September but allows district authorities until the end of 1985 to complete action at unit level. There will be a good deal of careful work for each Authority in thinking through what to do. I am looking to you to take the same personal responsibility for ensuring that the necessary action is taken by your Authority as I shall be doing at the Department.

As part of the new management style we need to establish, I attach particular importance to ensuring that authority members and staff at all levels have an early opportunity to learn what is proposed and the likely effects at local level. The Department and the NHS Training Authority have prepared material to help you in this, which I hope you will find useful.

Yours Sincerely.

NORMAN FOWLER

ENC

HEALTH CIRCULAR HC(84)13

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

To:
- Regional Health Authorities
- District Health Authorities
- Special Health Authorities for London Postgraduate Teaching Hospitals

for action

- Family Practitioner Committees
- Community Health Councils
- Special Health Authorities other than for London Postgraduate Teaching Hospitals

for information

June 1984

HEALTH SERVICES MANAGEMENT

IMPLEMENTATION OF THE NHS MANAGEMENT INQUIRY REPORT

SUMMARY

This circular amplifies the Government's response to the NHS Management Inquiry Report, published in October 1983, and sets out action now required of health authorities.

THE NHS MANAGEMENT INQUIRY REPORT - THE GOVERNMENT'S VIEW

1. The Government's overriding concern is to see that the National Health Service provides the best possible service to patients within the available resources. We are seeking to ensure that the expenditure devoted to the Service - currently £13 billion a year in England - does reach its target: improvement in the physical and mental health of the people and in the prevention, diagnosis and treatment of illness. We have, with health authorities, already established a programme to improve the effectiveness and efficiency of the NHS which is summarised in Annex A. The most important features are the establishment of systems for planning, for annual review of performance against agreed objectives, and for Regional Health Authorities to draw together their plans for services, manpower and the estate within their resource allocations; the pilot projects for management budgets; and improved audit procedures. These initiatives are designed to promote the more efficient use of what must always be limited resources; they are also steps towards the Government's broader aim to ensure that the management of the health service is geared primarily to the interests of patients.

2. The Management Inquiry Report endorsed our view of the management task and stated: "It 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 ... the driving force behind our advice is the concern to secure 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."

3. The report recommended, for this purpose, a further programme of management action which is summarised in Annex B. Many of the Report's recommendations call for continued action on the initiatives already underway, such as the further development of management budgets. We agree with the Report's call for urgent action to begin implementing all its recommendations, while recognising that there must be different timescales for the results of this action. In the short term, further improvements in the management arrangements of the NHS can be achieved through the establishment of the general management function. In the longer term, steps taken now to develop management tools and to strengthen management training, especially for clinicians - doctors and nurses, will enhance the management potential already existing in the health service. This will enable the clinical professions to play a more active role in management, particularly at unit level.

THE GENERAL MANAGEMENT FUNCTION

4. The Management Inquiry Report identified the importance of a clearly defined general management function - which draws together responsibility for planning, implementation and control of performance - as the key to achieving the management drive necessary to ensure that the standards and range of care provided in the health service are the best possible within available resources. After consultation with health authorities, and taking account of the Report of the Social Services Committee of the House of Commons and the Parliamentary

debates, we accept that the lack of a clearly defined general management function is a weakness in present management arrangements at all levels. We have, therefore, decided that health authorities should now begin to make the necessary arrangements to establish the general management function. The simple aim in establishing the general management function is to ensure that the concern shared by all in the health service for the quality and efficiency of services delivered to patients is translated into action. This means developing present arrangements carefully to secure effective management which has the requirement and capability to plan, guide and implement strategies for improvement and development.

5. The Management Inquiry Team recommended that the general management function should be clearly vested in one person (at each level) who would take personal responsibility for securing action. We accept this view; and believe that the establishment of a personal and visible responsibility for the general management function is essential to obtain a guaranteed commitment throughout the health service for improvement in services and concern for the well-being of every individual patient. In reaching this conclusion, we do not undervalue the importance of consensus in a multi-professional organisation like the NHS. But we share the Report's view that consensus, as a management style, will not alone secure effective and timely management action, nor does it necessarily initiate the kind of dynamic approach needed in the health service to ensure the best quality of care and value for money for patients. We have decided that in order to begin to bring about the improvements in the NHS through the various initiatives already established or recommended in the Management Inquiry Report a general manager will be identified for each RHA, DHA, hospital SHA and unit to take responsibility for the general management function, as detailed in Annex C.

ESTABLISHING THE GENERAL MANAGEMENT FUNCTION

The Unit

6. The initiatives already taken following the publication of "Patients First" and the Report's recommendations are fundamentally about providing better health services for patients. This means looking for improvements at the point where the patient receives a service - in hospital and in the community. The primary objective for health authorities in implementing the Report's recommendations must therefore be to achieve changes at unit level and below. If there were no observable improvement in services at that level, in the eyes of patients and the community, within three to five years, then there would have been no point in making changes at DHA level or above.

7. There can be no sustainable improvement at unit level if it does not rest upon the fullest involvement and commitment of all the professions concerned with the delivery of health care, particularly the doctors and nurses.

8. It is most important that the implementation of the Management Inquiry Report's recommendations at unit level should develop from the 1982 reorganisation. Developments already in train or planned in this way, are:

- the preparation of regional outline strategies, and regional and district strategic plans and short-term programmes (drawing together money, manpower, service development, and the estate and containing substantial proposals for cost-improvement) in accordance with HC(84)2;

- the development and implementation of management budgets, taking account of the expressed requirements of professional staff;

- the overall strengthening and development of the professional advisory machinery to ensure that there are effective arrangements for the advice of doctors and nurses to inform managerial decisions at unit as well as district and regional levels.

9. The key to further progress at the unit is to establish a responsibility for the general management function. It will require careful preparation and consultation. We envisage that a period of up to 18 months - to the end of 1985 - will be needed to develop and introduce proposals for the establishment of the general management function at unit level.

Clinicians in management

10. We strongly endorse the Report's view that clinicians should be both encouraged and enabled to play a more active role in management and especially unit management. In practice, it is clinicians who determine the way many of the health service's resources are used by the decisions they take about the clinical care of individual patients. At the same time, resources available for health care are not unlimited, and the way resources are allocated will affect the range of decisions open to clinicians in the individual treatments they prescribe. To ensure that available resources are deployed where they are most needed, it is important that decisions about the management of resources take full account of the priorities of patient care and the advice of clinicians. In order that clinicians can play an enhanced role in management, they need access to relevant and timely information; adequate administrative support; and a reduction in time spent on unnecessary bureaucracy and committee work. Health authorities should seek to stimulate action to meet these needs. Further management training for clinicians is also needed and from the earliest possible stage of training. The results of these changes will not be fully realised for some time; but, with the active support of clinicians, a significant start can be made now, concurrently with the establishment of the general management function in units.

Health Authorities and DHSS

11. While authorities are developing their proposals for the units, to secure the establishment of the general management function and the closer involvement of clinicians in management, they and the Department will continue to make the changes in their organisations necessary to support and sustain improvements in health services at unit level:

- we will continue to develop, within DHSS and the existing statutory framework, the Health Services Supervisory Board to help us to establish policies and priorities, and will set up the National Health Service Management Board, as soon as a Chairman has been appointed - meanwhile a multi-disciplinary Management Group has been set up with responsibility for the NHS management programme;

- RHAs and DHAs will begin the process of establishing the general management function and identifying a general manager at regional and district level.

PROCEDURE

12. The Inquiry Team emphasised that, once clear directions had been given by the centre, authorities should be allowed the maximum flexibility in making their own management arrangements. In keeping with this, we accept that:

- there should be some latitude in the timescale in which authorities should be required to establish the general management function and identify general managers;

- authorities should have adequate scope to take due account of local management needs and potential;

- authorities will, therefore, proceed at different speeds but the general management function should first be established at RHA, then at DHA within each region and at unit level only thereafter - the pace will consequently vary as between DHAs/units within a region.

13. We now require health authorities to establish a general management function, drawing on the recommendations in the NHS Management Inquiry Report - paragraphs 14-16 in particular - and following the procedural guidance set out in Annex C. RHAs and DHAs must identify a general manager - at region, district and unit level - to take personal and visible responsibility for carrying out the general management function, in accordance with DHSS guidance as supplemented by RHA and DHA requirements. Hospital SHAs must similarly identify a general manager.

ENQUIRIES

14. Enquiries about this Circular should be addressed to:

Miss A M Williams
Room D918
Alexander Fleming House
Elephant and Castle
LONDON SE1 6BY
Tel. 01-407-5522 Ext 6866

ACTION

15. Health authorities are required:

15.1 to establish the general management function and identify general managers in accordance with the procedural requirements in Annex C;

15.2 to carry forward the further programme of management action identified in Annex B, within the context of the action already in hand and planned in Annex A.

From:

Regional Liaison Division
Alexander Fleming House
Elephant and Castle
LONDON
SE1 6BY

Tel. 01-407-5522 Ext 6866

MNE 22

Further copies of this Circular may be obtained from DHSS Store, Health Publications Unit, No 2 Site, Manchester Road, Heywood, Lancs OL10 2PZ quoting code and serial number appearing at top right-hand corner.

ANNEX A
(HC(84)13)

IMPROVEMENTS IN NHS MANAGEMENT

Since 1979 the Government has taken the following steps to improve management in the health service.

- In 1982 the structure of health authorities was simplified by the removal of two levels of management - Area and Sector. Nos?
- District Health Authorities were established generally serving smaller local populations.
- More responsibility was devolved to hospital and community services at unit level.
- Accountability has been strengthened with the introduction of annual reviews led by Ministers of performance against agreed objectives.
- The review cycle has been established for RHAs and DHAs: it is being extended to units this year.
- Family Practitioner Committees are to be made separately accountable.
- A range of statistical indicators of performance (covering clinical services, manpower and estate management) has been developed: in 1983, all health authorities were sent data on their own performance and that of other authorities.
- Work is under way to improve and extend the range of performance indicators.
- NHS management's need for information has been comprehensively reviewed and improved information systems will be introduced over the next few years.
- More effective monitoring of NHS manpower numbers has been introduced: manpower limits have been settled, complementing authorities' cash limits.
- The Rayner Scrutiny technique has been extended to the NHS with a programme of nine studies by NHS officers covering areas such as transport services and recruitment advertising.
- Health authorities have been required to test the cost effectiveness of laundry, catering and cleaning services by seeking competitive tenders.
- Health authorities have reviewed arrangements for the control of items in stock and in use, following the advice of the Health Service Supply Council.
- A value-for-money audit programme has been introduced.
- HC(84)2 required all health authorities to initiate cost improvement programmes.
- Health authorities will have to show how their cost improvement programmes have released resources for the development of services to patients.

- The development of management budgets has begun with the start of several demonstration projects.

- The NHS Training Authority has been established.

- A study of the administration of FPCs has been undertaken by outside consultants.

- A study of the current flow of communications between the Department and health authorities is being led by a Regional Administrator.

- A study of the responsibilities of the Department in relation to the financial management of health authorities is being led by a Regional Treasurer.

- The Health Services Supervisory Board has been established to advise the Secretary of State on the objectives and direction of health services.

- The NHS Management Board is to be established within the Department as soon as its Chairman has been appointed; an NHS Management Group is already working in preparation for the NHS Management Board.

- Manpower in DHSS HQ has been reduced by 20 per cent since 1 April 1979 following a reduction in the central role.

ANNEX B
(HC(84)13)

FURTHER PROGRAMME OF MANAGEMENT ACTION

The NHS Management Inquiry set out its recommendations in the form of a programme of management action to be taken both at the centre and by health authorities. The recommended programme is:

1. Policy of accountability for performance against agreed objectives should be maintained and developed.	(para 6)
2. Accountability reviews should be extended to units.	(para 6)
3. The management function should be developed	
(a) inside the Department	(paras 1-5)
(b) in the NHS.	(para 6)
4. Pilot projects in management budget techniques should be continued with the aim that they be extended to all health authorities in about 2/3 years.	(para 8.6)
5. 11 specific topics should be studied or reviewed	
- the need for functional management structures at RHA/DHA	(para 6.6)
- the role of clinicians in management, in six hospitals	(para 8.2)
- the arrangements for remuneration etc	(para 9.2)
- the assessment of management training	(para 9.4)
- the procedures for appointments etc	(para 9.5)
- nurse manpower levels	(para 9.6)
- other manpower levels	(para 9.7)
- the procedures on capital schemes	(para 10.2)
- the works function	(para 10.3)
- levels of decision-taking	(para 11.0)
- consultation arrangements	(para 12.0)
6. The roles of members and officers in relation to their authorities should be clarified.	(paras 6.4 and 17)

7. The agenda and the procedures for health authority meetings should be clarified and the nature of the reports required by the authority in managing its services should be made explicit.	(para 6.5)
8. Major cost-improvement programmes should be initiated in each health authority	(para 6.7)
9. Each unit should have a total budget and have management accountant support	(paras 8.4 and 8.5)

ANNEX C
(HC(84)13)

REQUIREMENTS FOR ESTABLISHING THE GENERAL MANAGEMENT FUNCTION AND IDENTIFYING MANAGERS

PROGRAMME

1. The general management function should be established by each health authority as soon as possible, and in any event by the end of 1985, under the following procedure, which is intended to give authorities the maximum freedom to develop proposals which best suit local requirements whilst enabling Ministers to monitor their arrangements.

1.1 Not later than the end of September 1984, each Regional Health Authority and Special Health Authority for London Postgraduate Teaching Hospitals must inform the Secretary of State how it proposes to establish the general management function. It should submit a job description for its general manager, and its proposals for identifying a suitable person to carry responsibility for the function and the name of the individual proposed if already identified. This will allow the Secretary of State to perform his role of monitoring health authorities: he will not be attempting to take over the role of the authority itself or to standardise job descriptions to a national pattern. In examining these proposals, the Secretary of State will wish to satisfy himself that the authority has formulated a job description for the manager, which accords with the Secretary of State's management changes within the DHSS; that any additional costs have been suitably offset within the existing provision for management (see paragraph 17) without damaging present and planned provision for direct patient care; and that the general manager as and when identified has the capacity to undertake the general management function. The Secretary of State will arrange a meeting with the RHA Chairman to discuss the proposals and to confirm that he is content for the RHA to proceed to formal decision. Once satisfied, the Secretary of State will approve an interim rate of remuneration for the general manager.

1.2 When the RHA has completed consultation with the Secretary of State, the RHA will ask each District Health Authority similarly to inform the RHA about its proposals for establishing the general management function at District level. Each DHA should submit to its RHA a job description for the District general manager, its proposals for identifying a suitable person to carry personal responsibility for the function and the name of the individual proposedif already idenfified. The RHA should forward to the Secretary of State its recommendations for action. In making their recommendations, RHAs should demonstrate that they have checked their DHAs' proposals in an equivalent manner to the Secretary of State's scrutiny of RHA proposals ie bearing in mind similar factors, but transposed as appropriate to the regional situation. In addition, RHAs will need to check that their DHAs' proposals fit in with the management changes finalised for the RHA, add up to an acceptable management pattern taking the region as a whole and that the suitability of individual general managers, as and when identified, takes into account an assessment of their ability to command the confidence of the representative members of the Management Team. The RHA Chairman will arrange a meeting with each DHA Chairman to discuss the proposals and to confirm that he is content for the DHA to proceed to formal decision, taking account of any views expressed by the Secretary of State. If the RHA Chairman and the DHA Chairman are unable to agree how to proceed, the RHA Chairman should consult the Secretary of State before the DHA proceeds to formal decision. The Secretary of State's approval will be required for the interim remuneration proposed for all general managers.

1.3 After the RHA has assembled the DHA proposals and completed consultation with the Secretary of State, each DHA should be asked to inform the RHA how it proposes to establish the general management function at unit level, of the job descriptions for its unit general managers and its proposals for identifying suitable people to carry personal responsibility for the general management function, including the names of the individuals proposed, where already identified. DHAs will need to demonstrate that job descriptions fit in with the changes already agreed for the DHA itself; that any additional costs have been suitably offset within the provision for management without damaging present and planned provision for direct patient care; that the individual general managers as and when identified are suitable, taking into account an assessment of their ability to command the confidence of the representative members of the Management Team; and, that the individual unit proposals add up to an acceptable management pattern taking the district as a whole. The RHA Chairman should arrange a meeting with each DHA Chairman to discuss their unit proposals and confirm that he is content for the DHA to proceed to formal decision. Action should be completed at unit level by the end of 1985.

2. Where an authority wishes a general manager to be drawn from outside the range of those listed below as normally eligible, the authority should clearly indicate the arrangements proposed to fulfil the requirements of paragraphs 1.1-1.3 above.

THE FUNCTION

3. The essence of the general management function is the bringing together at each level of organisation, responsibility for the planning, implementation and control of the authority's or unit's performance. The general manager will carry personal responsibility for this, and be personally accountable to the authority for its discharge. The authority in its turn must be seen clearly at all times to give full support and backing to the general manager.

4. The general manager's broad areas of responsibility must include as a minimum:

4.1 direct accountability to the authority, or in the case of units to the district general manager, for the general management function within the undertaking;

4.2 direct responsibility and accountability for the managerial performance within the authority or unit;

4.3 leadership of the authority's management team, or unit equivalent, and accountability for the performance of the team as a whole in developing policies and possible courses of action and ensuring the provision of proper advice;

4.4 ensuring that management and administrative practices enable the care of patients to be constantly to the fore;

and to these ends he should -

4.5 ensure that the authority or unit is provided with the range of advice and information it needs to formulate policies, decide priorities, set objectives, and monitor progress;

4.6 ensure that full weight is given to clinical priorities in the light of advice from nurses and doctors;

4.7 ensure that timely decisions are reached;

4.8 ensure that objectives are achieved;

4.9 provide the necessary leadership to stimulate initiative, urgency and vitality in management eg in ensuring a constant search for constructive change and cost-improvement;

4.10 co-ordinate activities, functions and personnel as necessary;

4.11 ensure that responsibility, including the management budgeting responsibility, is delegated to the point where action can be taken effectively;

4.12 secure effective motivation of staff.

MANAGERIAL RELATIONSHIPS

5. The general manager at RHA and DHA will in each case be accountable only to his authority ie not to a general manager at a higher level. The unit general manager will be accountable to the district general manager.

6. Existing guidance on managerial relationships at district and unit level in HC(80)8 is amended by this circular which provides the general framework within which authorities will develop their proposals for revised management arrangements.

7. Professional chief officers are appointed by the authority and will continue to be directly accountable, and have a right of access, to the authority on the provision and quality of professional advice. On matters relating to the fulfilment of the general manager's responsibility, they will be accountable to the general manager for the day-to-day performance of their management functions. The representative members of the District Management Team will also continue to have direct access to the authority.

THE JOB DESCRIPTION

8. A job description should be drawn up for each general manager which should include, as a minimum, details of his function, his relationship to the other chief officers and of the proposed terms of tenure and remuneration. The broad areas of responsibility which should be covered in job descriptions are set out in paras 3-4 above. Although authorities may need to adapt and expand these to suit local needs and constraints, as well as the different requirements at RHA, DHA, hospital SHA or unit, they will be expected to keep within this framework

ELIGIBILITY

9. It is for the authority to identify the general manager, having satisfied itself that the individual has the management capacity to undertake the general management function, including the ability to command the confidence of the representative members of the Management Team. It is expected that regional and district general managers will be identified in the first place from members of the Regional Team of Officers and District Management Team respectively. Authorities may, however, propose instead to seek a general manager either from elsewhere in the NHS or from outside (see also paragraph 15).

10. At regional and district levels, general managers will take full responsibility for the general management task. This does not preclude the discharge of other responsibilities in exceptional cases, but it is essential that the general management function should be performed effectively and therefore it must be given top priority. Where an existing member of the RTO or DMT is identified as general manager, authorities will need to ensure that appropriate steps are taken to secure the proper discharge of his existing responsibilities. Where it is proposed to identify a clinician, authorities will need to be satisfied that such clinical responsibilities as he may retain are consistent with his effective performance as general manager.

11. At unit level, it is expected that the general management function may be combined with other responsibilities but, as at regional and district levels, the general management function must be given top priority. In the first place, those eligible to undertake the function at unit level will be any DHA employee, consultant or general medical practitioner who works within the district. DHAs wishing to make other proposals for identifying a unit general manager should follow the guidance in paragraph 15.

TERMS OF SERVICE

Remuneration

12. In the interim period before long-term arrangments for remunerating general managers have been established, they should be awarded a fixed rate annual payment not exceeding £3,000 in recognition of their extra responsibilities. The detailed method of paying such an allowance to consultants or general practitioners is under consideration and authorities wishing to make such an appointment should therefore consult the Department.

13. In exercising their judgement on what is the appropriate additional payment, authorities should bear in mind that the effect of the flexibility of job description envisaged in this circular will be to place greater responsibilities on some general managers than on others. Differences may arise not only in comparing the different tiers of management (region, district and unit) but also in comparing general managers in the same tier of management. The time judged necessary to perform this role may also vary between posts and be relevant to the level of remuneration that is appropriate. It is to be expected therefore that these differences will be reflected in the amount of additional allowance paid.

14. In order to achieve some consistency in this respect, all DHAs, when submitting a job description to the RHA, should link with it their proposals for the size of the additional allowance. RHAs and hospital SHAs should do the same in their submission to the Secretary of State in respect of their own arrangements. All such additional allowances require the Secretary of State's specific approval under the NHS remuneration statutes.

Outside appointments

15. An authority may propose to seek a general manager from outside those people normally eligible (see paragraphs 9-11). For procedural reasons at this early stage, authorities must first submit such proposals to the Department for prior approval. DHA proposals should be submitted via the RHA. As soon as possible, arrangements will be made to allow authorities to proceed without direct reference to the Department.

Tenure

16. Authorities should identify general managers on a period basis, with an initial fixed-term contract for 3-5 years. After that, the general manager's employment may be extended on the basis of yearly fixed-term contracts. All contracts should contain an agreement to exclude any claims under Section 54 of the Employment Protection (Consolidation) Act 1978. At no stage should the contract be allowed to run beyond the due date, since this may be held to have created a new contract without limit of time.

Costs

17. The full costs of the general management function must not be met at the expense of services to patients. The total cost of the general management function should be therefore specified in the authority's proposals, with details of how it is intended to contain the cost within existing provision for management.

The Next Steps

Management in the Health Service

Better Management in Health Authorities in England

The Inquiry

Many of us – in and outside the NHS – believe that we could make a better job of health care if we had better management. The NHS Management Inquiry team was asked by the Government to review NHS management and come up with proposals.

What the Inquiry team found

The Griffiths team found a lack of effective general management at all levels of the Health Authority structure. The result? Too often, frustrating delays and inaction. The need for better management is widely agreed throughout the Health Service and the House of Commons Social Services Committee found that the Griffiths Report's critique "commands general assent."

The key recommendation of the Griffiths Report is that management in Health Authorities should be strengthened so that the NHS can become yet more effective in providing services to patients. And it provided a welcome restatement of the principle which should guide everybody responsible for Health Services – concern for the individual patient.

Its fundamental message was of the need for a more dynamic management style in Health Authorities: getting things done, rather than deferring action. In short, bring in general management.

What is 'general management'?

'General management' enables an organisation to plan, act on, control and measure its decisions and actions effectively and efficiently; and in a way which brings results. The General Manager is the person responsible, and accountable, for ensuring that these decisions are made and actions taken.

The purpose of general management in Health Authorities

By establishing a general management function in Health Authorities, the concern shared by all working in the Health Service for the quality and efficiency of patient services will be more easily translated into effective action; the available resources will be better used and those working in the Service will obtain greater satisfaction from their work. The patient, the community, the taxpayer and the employee will all benefit.

Managing by consensus – that is, managing by agreement – works well some of the time in business and in Health Authorities. Where consensus is working well, no sensible General Manager will need to lose it.

General management will have most effect where consensus **is not** working well. It will help people to take decisions where and when they are needed – thus improving effectiveness.

Consensus management can fail when difficult, perhaps painful, decisions have to be made. Too often in Health Authorities, the power to veto has meant that nothing happens.

Some problems, of course, solve themselves or go away. But others remain and may get worse. This does not improve patient care and it is depressing for Health Authority staff. Effective management means that such problems are tackled not shelved.

The critics: are they right?

The Griffiths team concluded that the processes of decision-making and consultation in Health Authorities are elaborate and that the machinery for implementing decisions is weak. These are the direct results of a lack of clear management.

Many people, in and out of the Health Service, agree. As the BMA's Secretary has put it:

"The criticisms of the Griffiths Report of NHS management will be readily understood by clinicians who have become increasingly frustrated with the inordinate delays which accompany even relatively unimportant issues in the NHS before any action is taken."

And clinicians are not the only people to feel frustrated. Lots of people would like to see improvements.

By clarifying and strengthening the role of management throughout Health Authorities, we are developing the existing arrangements in a positive way.

The Next Step

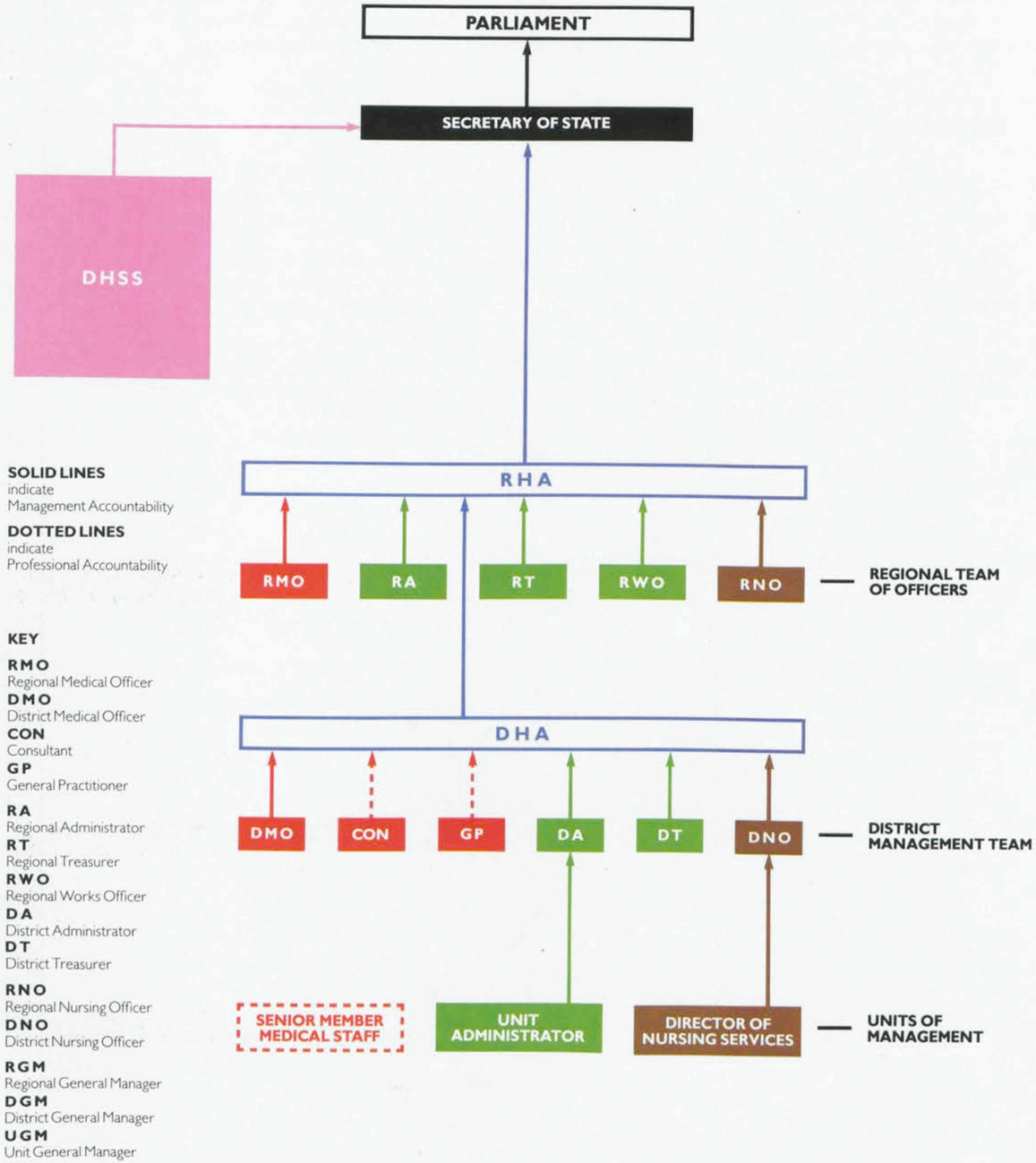
The Government is going to implement the Griffiths Report proposals for general management as the next step in its programme of improving management in Health Authorities.
(See 'What's Going On?')

This is what is happening

- A Health Services Supervisory Board has been set up in the Department to advise the Secretary of State for Social Services on the strategic direction of the Health Service. Members of this Board include the Health Ministers; the Permanent Secretary and Accounting Officer, the Chief Medical Officer, the Chief Nursing Officer; Mr Roy Griffiths and the Chairman of the new NHS Management Board.
- An NHS Management Board is being established within the Department: it will carry out, under the direction of Ministers, those management functions in respect of Health Authorities which the Department must carry out – for example, finance, information and performance review. It will report to the Supervisory Board on Health Authorities' performance; the new Chairman, when appointed, will be a member of that Board.
- Health Authority management is to be strengthened at Regional, District and, later, at Unit level.
- Each Regional and District Health Authority is to identify a General Manager who will then take responsibility – and be accountable to his or her Authority – for the overall managerial performance of the management team and the people under it. When Authorities have done this, District Health Authorities will identify Unit General Managers.
- Regional and District Authorities are being given considerable freedom to propose arrangements which best suit their local requirements, but they and their Units must establish their own general management function and that for their Units, by the end of 1985.
- In line with the intentions of the 1982 reorganisation, decision-making and responsibility is to be devolved wherever possible down the organisation to the Unit, where patient needs are directly met and where the changes must occur to achieve the overall aim of improving services to patients.
- Support for the new and existing management roles is to be provided by the NHS Training Authority through an enhanced management training programme, particularly geared to doctors and nurses.

Health Authority Management – The Present

This is a simplified representation of the main present management relationships in Health Authorities and their links with DHSS, the Secretary of State for Social Services and Parliament.



SOLID LINES
indicate
Management Accountability

DOTTED LINES
indicate
Professional Accountability

KEY

RMO
Regional Medical Officer
DMO
District Medical Officer
CON
Consultant
GP
General Practitioner

RA
Regional Administrator
RT
Regional Treasurer
RWO
Regional Works Officer
DA
District Administrator
DT
District Treasurer

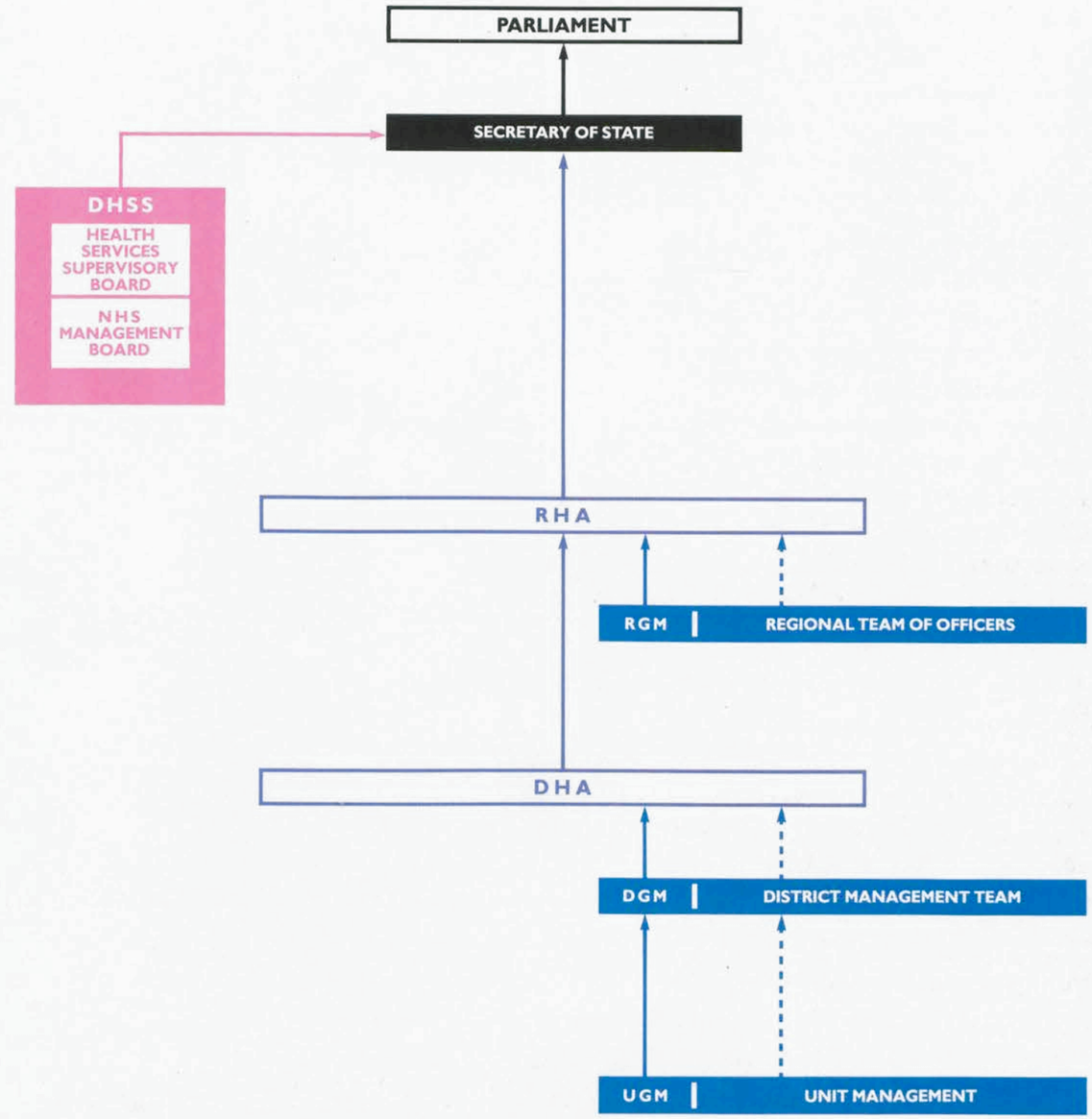
RNO
Regional Nursing Officer
DNO
District Nursing Officer

RGM
Regional General Manager
DGM
District General Manager
UGM
Unit General Manager

Health Authority Management – The Future

This is a simplified representation of the key future management relationships in Health Authorities and DHSS, how they link to each other, to the Secretary of State for Social Services and to Parliament.

These management developments will all take place within the existing accountability arrangements and statutory framework.



What's Going On?

The introduction of general managers in Health Authorities is not being done in isolation. It is part of a national development programme in NHS management: some parts established already, some happening now, some yet to come.

Developments in 1982

Health Service restructured

Rayner-type scrutinies introduced for the Health Service

System of annual accountability reviews established

Annual review by Ministers of Regional Health Authority performance introduced

Annual review by Regional Health Authorities of District performance introduced

Developments in 1983

Annual accountability reviews extended: DHA reviews of Unit performance

Comparative performance indicators applied

Value-for-money audit programme introduced

Manpower planning tightened up

Manpower information now available more quickly and at quarterly intervals

Competitive tendering introduced

NHS Training Authority established

Griffiths Report published

Health Services Supervisory Board set up by Secretary of State

Developments in 1984

Cash limits, manpower targets and service development brought together

Cost-improvement programmes established

DHSS Headquarters manpower target – 20% reduction since 1979 – achieved

Stock control reviewed

Nucleus of new Health Service Management Board created

and now

Griffiths Report implemented and general management function introduced in Health Authorities

Further action planned or in hand:

Chairman of NHS Management Board to be appointed and Management Board established

Management budgets for DHAs being further developed

Works function being reviewed

Introduction of improved information systems (based on the review of Mrs Körner's Working Group)

Review of communications between DHSS and NHS (led by a Regional Administrator)

Review of possible further developments in Health Authorities' financial management (led by a Regional Treasurer)

NHSTA management training programme being introduced

Questions and Answers

Wouldn't it be better for Government simply to put more money into the Health Service?

The Government **is** putting more money into the Health Service. Spending on the NHS has doubled since 1979 from £7¾ billion to £15½ billion, an increase of 18% more than inflation.

But that's not the whole of the argument by any means. No matter how much money is put into the NHS, we will never be in the position where we will be so rich that we could afford to waste money. There is a duty to be efficient. A sensible management system aids the effective use of resources which are inevitably limited. NHS management must have the authority, and take the responsibility, for promoting efficient use of those resources.

Shouldn't we be allowed to settle down from the 1982 reorganisation before we embark on all this?

This new scheme isn't a reorganisation – it is a development of the 1982 structure. Most peoples' jobs will remain much as they are. It is the process of **managing** the 1982 structure which is being improved. 'Settling down' is a luxury which few organisations can afford, since their clients are constantly becoming more demanding about the services they require.

Not only that, but every time an organisation develops a new system – like the 1982 reorganisation – experience soon shows how to make the next set of improvements. All organisations have to adapt to changing circumstance and the NHS can, and must, continue its long history of evolution in order to carry out its tasks in the best possible way.

Will these new general managers have powers to take decisions and promote action?

Yes. They will be responsible for the effective working of their teams and staff. Responsibility **without** power is the role of the scapegoat. If you want effective management, then responsibility and authority have to be matched. That is what these new proposals aim to achieve.

What happens if the doctors or nurses disagree with the General Manager?

If the disagreement is over a management decision, the General Manager must fulfil his responsibility to see that the decision is taken, if necessary by the Authority itself. This is the job the Authority has given him or her.

If the disagreement is over a professional matter, the doctors and nurses will be able to refer to the Authority, as at present.

Designed and Produced by Hawkshead Communications/Sutton Cooper for the DHSS. Printed by DPL, London. June 1984.

MFJ

cc D. Wilkes

10 DOWNING STREET

From the Private Secretary

4 June 1984

Dear Ellen,

The Prime Minister has noted the draft statement which your Secretary of State will be making on the implementation in the Health Service of the Griffiths Report on NHS management which was attached to your letter of 1 June. She has also seen the circular to health authorities.

The Prime Minister queried whether it was right to issue the circular a few weeks before the Chairman of the NHS Supervisory Board is appointed. She wondered whether the circular would constrain his freedom of action in bringing about the desired management changes. You agreed to provide a note on this.

RF Too late!

Yours sincerely

Andrew Turnbull

Andrew Turnbull

Miss Ellen Roberts
Department of Health and Social Security

MFJAAO

CONFIDENTIAL

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NBPM

AT 46

PRIME MINISTER

IMPLEMENTATION OF THE NHS MANAGEMENT INQUIRY IN WALES

As I believe, Norman Fowler has been keeping you in close touch with his proposals for implementing the NHS Management Inquiry in England. I have consulted with him (and with George Younger) and you will wish to know that I propose similar arrangements for Wales, taking into account the somewhat different Welsh context.

I understand that the English arrangements are to be announced on Monday 4 June and I therefore intend to issue my own circular for Wales on Wednesday 6 June.

I shall be appointing as soon as possible a Director of the NHS in Wales who will be a member of my new Health Policy Board and Chairman of that Board's Executive Committee. The appointment will be at Under-Secretary level. The appointee will carry the lead responsibility at official level for discharging my responsibilities in respect of the management of the NHS in Wales and will be appointed as an Accounting Officer for that purpose. The Treasury has agreed to these arrangements.

A copy of the All-Wales Director's job description - which also describes the framework within which the apointment is to be made - is attached for your information. I am copying this letter (without the job description) to Nigel Lawson, Norman Fowler, George Younger and Sir Robert Armstrong.

RE.

4 June 1984

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CONFIDENTIAL

ANNEX 2

JOB SPECIFICATION FOR THE DIRECTOR OF THE NHS IN WALES

1. THE CONTEXT

1.1 The appointment will be to a new post in the Health and Social Work Department of the Welsh Office which is the department of state of the Secretary of State for Wales. The Secretary of State for Wales is responsible for a wide range of Government functions in Wales, including health and social policy and the National Health Service. The new post of all-Wales Director of the NHS will be concerned primarily with the management of the NHS in Wales.

1.2 The establishment of this post forms one part of the implementation in Wales of the principles of the NHS Management Inquiry which, under the chairmanship of Mr Roy Griffiths, the Managing Director of Sainsburys, reported on the management of the NHS in England in October 1983. The Secretary of State for Wales considers the principles of the Inquiry's report to hold equally for the NHS in Wales.

1.3 As its name implies, the NHS is a national service and there are common elements to its policy and management running across England and Wales, although the determination of policy and management within Wales is the responsibility of the Secretary of State for Wales. There has to be close co-operation and regular exchange of information between England and Wales, particularly in relation to personnel matters, such as pay and conditions of service for NHS staff (on which matters in particular the DHSS takes the lead), and in the development of management systems.

1.4 The Secretary of State for Wales discharges his statutory responsibilities for the provision of health services mainly through 9 district health authorities which run hospital and community health services, and also through 8 family practitioner committees which administer the family practitioner services provided by independent contractor general practitioners, dentists, opticians and pharmacists. The Secretary of State exercises certain functions in relation to major capital works, computers and prescription pricing through a special health authority known as the Welsh Health Technical Services Organisation (WHTSO).

WHTSO also acts as the agent of district health authorities for major capital projects. These statutory health authorities employ the equivalent of over 54,000 full time staff and there are nearly 3500 independent contractors. Total expenditure on the NHS in Wales in 1983/84 was over £800 million, most of which was funded by the Welsh Office.

1.5 The Secretary of State for Wales appoints the Chairmen and members of district health authorities and of WHTSO, and subject to legislation now before Parliament will appoint the Chairmen and members of FPCs. He has statutory powers to direct district health authorities and WHTSO and, subject again to legislation, will have such powers in respect of FPCs. NHS staff are accountable to the authority which employs them rather than to the Secretary of State.

1.6 Management of the NHS at the all-Wales level aims to secure that NHS authorities manage services effectively and efficiently in line with the Secretary of State's policies and priorities. Important management functions also have to be carried out, including those in respect of regional services. These are services where the location and capacity is determined by the Secretary of State for Wales and which serve more than one district health authority area. They include renal dialysis, cardio-thoracic and bone marrow transplant services. Other regional functions include the allocation of resources to NHS authorities and regional personnel and management functions.

2. ROLE AND FUNCTIONS OF THE DIRECTOR

2.1 The Director will carry the lead responsibility at official level for the discharge of the Secretary of State for Wales' responsibilities in respect of the management of the NHS and will be appointed as an Accounting Officer for that purpose. His/her principal functions can be grouped into five main categories, as follows:-

(1) **Functions flowing from the Director's membership of the Health Policy Board and chairmanship of the Board's Executive Committee (see section 4 below):-**

a. to advise the Secretary of State so that he can take management considerations affecting the NHS into account in the development of his wider policies and priorities for health and social affairs.

(2) **To operate in close liaison with the DHSS, which in such matters as pay, conditions of service and certain other personnel matters, negotiates on a national footing:-**

a. to carry out all-Wales personnel functions in respect of pay and conditions of NHS staff, industrial relations, training, career development and manpower planning and control. In the case of the major health care professions there are existing statutory and other national professional bodies responsible for setting standards and prescribing educational and training requirements. The Director will need to work in co-operation with these bodies.

(3) **To manage on behalf of the Secretary of State his direct all-Wales 'regional' responsibilities, comprising:-**

a. the management of regional NHS services in Wales (as defined in paragraph 1.6 above).

b. works management: control of large and regional capital schemes. This will involve a special relationship with WHTSO; and an early task for the all-Wales Director will be to examine the present functions of WHTSO and its relationship with the Welsh Office and the DHAs and to make recommendations for the future to the Secretary of State.

(4) To operate on behalf of the Secretary of State his controlling and monitoring functions in relation to the management of the NHS in Wales, consisting of:-

a. the general management of the NHS - including the review of performance of district health authorities mainly through the conduct of the annual reviews; continuous development of organisation and systems effectiveness; securing effective consultation, communication and information systems within the NHS and between the NHS and the Welsh Office.

b. finance - including advice on the allocation to NHS authorities of such total resources as the Secretary of State may make available for the NHS; financial control; ensuring effective budgeting and financial management systems;

c. NHS service planning - ensuring that the Secretary of State's policies and priorities are translated effectively into plans by NHS authorities and monitoring their implementation. The Director will therefore take the lead, in close collaboration with the policy staff of the Welsh Office , for advising the Secretary of State on the appraisal of district health authorities' 10 year strategic plans and the scrutiny of their annual operational planning statements. Monitoring will be a continuing process but will also be formalised in annual performance reviews of District Health Authorities.

(5) To encourage good management practice by the DHAs in the exercise of their management responsibilities and to lead, co-ordinate and develop the wide range of administrative, financial and other functions relating to the administration of the NHS in Wales, including in particular the following:-

a. ensuring effective management of the NHS estate, including disposal of surplus land and property.

b. procurement - development of cost-effective NHS procurement policies and practices for goods and equipment.

c. scientific and high technology management, including the application of computers and information technology in the NHS.

2.2 Legislation providing for the family practitioner committees to become independent of the health authorities is currently before Parliament. Subject to that legislation, responsibility for introducing the new arrangements will remain initially with the policy side of the Health and Social Work Department of the Welsh Office. However, it is intended that from 1 April 1986 the Director will assume management responsibilities in relation to the FPCs similar to those relating to the district health authorities.

3. PRIORITY TASKS FOR THE DIRECTOR

3.1 The general priority of the Director will be to develop and improve the management of the NHS in Wales. With this aim in mind early action will be needed in particular to:-

4.5. The Director will, in addition to his contact through the Health Policy Board, need to keep in day-to-day contact with the health policy branches of the Health and Social Work Department of the Welsh Office in carrying out his functions generally, but in particular relation to the conduct of the annual performance reviews of district health authorities, the approval of strategic and operational plans of authorities and the general monitoring of their performance in relation to the Secretary of State's policies and priorities.

5. RELATIONSHIPS WITH THE NHS

5.1 The Director will be expected to provide strong leadership at the all-Wales level for the management of the NHS, using to the full the responsibilities vested in him by the Secretary of State. The Director and the Executive Committee will be expected to develop close working relationships with Chairmen and district health authorities on management issues. The Director and the Committee will also need to develop close personal working relationships with the district general managers and other senior staff accountable to the authorities. Equally, Welsh Office Ministers will expect, as now, to meet Chairmen as representatives of district health authorities from time to time to discuss important policy issues.

6. RELATIONSHIPS WITH THE DHSS MANAGEMENT BOARD AND ITS CHAIRMAN

6.1 As noted above (see paras 1.3, 2 and 3.2) the Director and the Executive Committee will be expected to have close links with the DHSS Management Board and its Chairman. This will be of particular importance in relation to matters of common concern to England and Wales, including the reviews of personnel management, levels and decision taking and consultation arrangements and in matters affecting the terms and conditions of NHS staff.

7. REQUIREMENTS FOR THE POST

7.1 The NHS is the largest single employer in Wales. The Secretary of State for Wales' direct accountability to Parliament for the performance of the NHS in Wales, the statutory framework within which he must work, and the complex nature of the issues involved in organising the effective delivery of health care, combine to provide unique and challenging management tasks.

7.2 Qualities and experience required for the post of Director are likely to include considerable experience and success in managing change in large organisations, preferably with a service orientation, and experience in dealing at a senior level with Government. Knowledge or experience of the NHS would also be desirable.

8. TERMS OF EMPLOYMENT

8.1 The post will be graded Under Secretary. The post-holder will be a civil servant for the period of his/her appointment. He/she will not be able to retain any outside appointments.

8.2 The appointment will be a fixed term contract and not longer than 5 years in the first instance. There will be an option open to either party, subject to 3 months notice, to end the contract at the end of the first or second year. A further term or terms of employment may be made in due course by agreement.

i. lead a drive for cost improvement programmes and the more effective use of resources by NHS authorities and in the management of regional service;

ii. continuing to develop the annual performance reviews of district health authorities and ensuring that these are extended to unit level by district health authorities;

iii. implementation with NHS authorities of management budgets, including the completion of the introduction of unit budgets and the greater involvement of clinicians and clinical resources in the management of the NHS;

iv. developing a much stronger commercial orientation for the management of the NHS estate.

3.2 The Director will be expected to co-operate with the Chairman of the NHS Management Board of the Department of Health and Social Security, for example in reviews of:-

i. levels of decision taking in NHS management;

ii. consultation arrangements within the NHS;

iii. procedures for handling major building schemes; and

iv. personnel management.

4. RELATIONSHIPS

4.1 The current responsibility of the Permanent Secretary of the Welsh Office for the organisation, staffing and management of the Department as a whole will not be changed. The Director will be responsible to the Permanent Secretary in line management terms.

4.2 The Chief Medical Officer and the Chief Nursing Officer are responsible to the Secretary of State in their respective professional fields. Against this background and that described in paragraph 4.1 above, the Director will have direct access to the Secretary of State as the senior adviser specifically on the management of the NHS. He will be a member of the Department's Management Committee which covers all the Department's management responsibilities.

4.3 The Director will be a member of the Health Policy Board for Wales. This Board will meet under the chairmanship of the Secretary of State for Wales to advise him on policies and priorities for health and social policy in Wales. Its membership and remit will reflect the need to take into account in the formulation of health policy all Welsh Office health and social policy responsibilities. The Director will chair the Executive Committee of the Board which will be responsible for carrying into effect in the NHS the policies and priorities of the Secretary of State.

4.4 Members of the Executive Committee will be accountable to the Director for the discharge of the managerial functions for which they are responsible eg personnel and finance. The professional members of the Executive Committee, namely the Chief Medical Officer and the Chief Nursing Officer of the Welsh Office, will continue to have direct access to the Secretary of State to advise him on matters relevant to their own professional responsibilities. They will also continue to be responsible for seeking and passing on professional advice from their respective professions.

GA

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DEPARTMENT OF HEALTH & SOCIAL SECURITY

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

Telephone 01-407 5522

From the Secretary of State for Social Services

David Barclay Esq
Private Secretary
10 Downing Street
London
SW1

1 June 1984

Dear David,

As promised, I attach the written statement which my Secretary of State proposes to make on Monday on the implementation in the health service of the Griffiths Report on NHS Management.

Also attached are a copy of the circular which will be issued to health authorities, and the covering letter to authority Chairmen.

No doubt you will let me know on Monday morning if you have any comments on the written statement.

Yours ever,

Ellen

Ellen Roberts
Private Secretary

Prime Minister (2)

To note that Mr Fowler proposes to announce on Monday and circulate on Griffiths style management in the NHS.

The short list of names for the Chairman of the NHS Supervisory Board is expected from head hunters next week. They will be interviewed by a panel and recommendations put to Secretary of State and then to you. Secretary of State can also ask for names not identified by head hunters to be interviewed.

I think it is a decent but circular.

AT 1/6

And it seems ridiculous to send it out a few weeks before the new arrangements take over me

DRAFT

"I am today announcing the Government's decisions on carrying forward the recommendations of the NHS Management Inquiry (Griffiths) Report as they effect England and am writing to chairmen of health authorities to set in hand the necessary action.

When I announced the publication of the Report to the House of 25 October last year, I said that the Government welcomed its main thrust. After wide consultation with health authorities and with professional and other representative organisations, and taking account of the views expressed in the Social Services Committee Report and in the debates in both Houses, the Government has decided to establish the general management function in health authorities in England. We regard this as the key to ensuring that the structure we introduced in 1982 can work effectively to produce the improvement in the delivery of services at local level that the Government regards as its over-riding objective.

The guidance I am giving health authorities today requires them to start work straightaway to establish the general management function and to identify individual general managers at authority and unit levels. The circular provides considerable flexibility to take account of local circumstances. It requires regional authorities to make their proposals to me by the end of September, but allows district authorities until the end of 1985 to complete action at unit level. I will be overseeing authorities implementation of the Griffiths arrangements in accordance with the specific requirements of the guidance circular. In addition, the whole process will be monitored through the accountability review process.

I have arranged for copies of the guidance Circular to be placed in the Library of the House. I have also sent copies to the Social Services Committee, and shall in addition be writing shortly to the Chairman to reply to the specific recommendations made in their Report."

DRAFT LETTER FROM SECRETARY OF STATE TO CHAIRMEN

Last October I asked your Authority and the other key management and professional interests concerned for their comments on my proposals for taking action on the Griffiths Report. We have delayed reaching final decisions so that we could take account of the views of the House of Commons Social Social Services Committee and of Parliament itself. I enclose a circular which announces the Government's decisions.

Authorities are required to start work straightaway to establish the general management function and to identify individual general managers at Authority and unit levels. The circular provides considerable flexibility to take account of local circumstances. It requires regional authorities to make their proposals by the end of September but allows district authorities until the end of 1985 to complete action at unit level. There will be a good deal of careful work for each Authority in thinking through what to do. I am looking to you to take the same personal responsibility for ensuring that the necessary action is taken by your Authority as I shall be doing at the Department.

As part of the new management style we need to establish, I attach particular importance to ensuring that authority members and staff at all levels have an early opportunity to learn what is proposed and the likely effects at local level. The Department and the NHS Training Authority have prepared material to help you in this, which I hope you will find useful.

NORMAN FOWLER

PERSONAL COPY NO. 8

HEALTH CIRCULAR SECRET. HC(84)13

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

To:
- Regional Health Authorities
- District Health Authorities
- Special Health Authorities for London Postgraduate Teaching Hospitals

) for action

- Family Practitioner Committees
- Community Health Councils
- Special Health Authorities other than for London Postgraduate Teaching Hospitals

) for information

June 1984

HEALTH SERVICES MANAGEMENT

IMPLEMENTATION OF THE NHS MANAGEMENT INQUIRY REPORT

SUMMARY

This circular amplifies the Government's response to the NHS Management Inquiry Report, published in October 1983, and sets out action now required of health authorities.

THE NHS MANAGEMENT INQUIRY REPORT - THE GOVERNMENT'S VIEW

1. The Government's overriding concern is to see that the National Health Service provides the best possible service to patients within the available resources. We are seeking to ensure that the expenditure devoted to the Service - currently £13 billion a year in England - does reach its target: improvement in the physical and mental health of the people and in the prevention, diagnosis and treatment of illness. We have, with health authorities, already established a programme to improve the effectiveness and efficiency of the NHS which is summarised in Annex A. The most important features are the establishment of systems for planning, for annual review of performance against agreed objectives, and for Regional Health Authorities to draw together their plans for services, manpower and the estate within their resource allocations; the pilot projects for management budgets; and improved audit procedures. These initiatives are designed to promote the more efficient use of what must always be limited resources; they are also steps towards the Government's broader aim to ensure that the management of the health service is geared primarily to the interests of patients.

2. The Management Inquiry Report endorsed our view of the management task and stated: "It 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 ... the driving force behind our advice is the concern to secure 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."

3. The report recommended, for this purpose, a further programme of management action which is summarised in Annex B. Many of the Report's recommendations call for continued action on the initiatives already underway, such as the further development of management budgets. We agree with the Report's call for urgent action to begin implementing all its recommendations, while recognising that there must be different timescales for the results of this action. In the short term, further improvements in the management arrangements of the NHS can be achieved through the establishment of the general management function. In the longer term, steps taken now to develop management tools and to strengthen management training, especially for clinicians - doctors and nurses, will enhance the management potential already existing in the health service. This will enable the clinical professions to play a more active role in management, particularly at unit level.

THE GENERAL MANAGEMENT FUNCTION

4. The Management Inquiry Report identified the importance of a clearly defined general management function - which draws together responsibility for planning, implementation and control of performance - as the key to achieving the management drive necessary to ensure that the standards and range of care provided in the health service are the best possible within available resources. After consultation with health authorities, and taking account of the Report of the Social Services Committee of the House of Commons and the Parliamentary

SECRET

debates, we accept that the lack of a clearly defined general management function is a weakness in present management arrangements at all levels. We have, therefore, decided that health authorities should now begin to make the necessary arrangements to establish the general management function. The simple aim in establishing the general management function is to ensure that the concern shared by all in the health service for the quality and efficiency of services delivered to patients is translated into action. This means developing present arrangements carefully to secure effective management which has the requirement and capability to plan, guide and implement strategies for improvement and development.

5. The Management Inquiry Team recommended that the general management function should be clearly vested in one person (at each level) who would take personal responsibility for securing action. We accept this view; and believe that the establishment of a personal and visible responsibility for the general management function is essential to obtain a guaranteed commitment throughout the health service for improvement in services and concern for the well-being of every individual patient. In reaching this conclusion, we do not undervalue the importance of consensus in a multi-professional organisation like the NHS. But we share the Report's view that consensus, as a management style, will not alone secure effective and timely management action, nor does it necessarily initiate the kind of dynamic approach needed in the health service to ensure the best quality of care and value for money for patients. We have decided that in order to begin to bring about the improvements in the NHS through the various initiatives already established or recommended in the Management Inquiry Report a general manager will be identified for each RHA, DHA, hospital SHA and unit to take responsibility for the general management function, as detailed in Annex C.

ESTABLISHING THE GENERAL MANAGEMENT FUNCTION

The Unit

6. The initiatives already taken following the publication of "Patients First" and the Report's recommendations are fundamentally about providing better health services for patients. This means looking for improvements at the point where the patient receives a service - in hospital and in the community. The primary objective for health authorities in implementing the Report's recommendations must therefore be to achieve changes at unit level and below. If there were no observable improvement in services at that level, in the eyes of patients and the community, within three to five years, then there would have been no point in making changes at DHA level or above.

7. There can be no sustainable improvement at unit level if it does not rest upon the fullest involvement and commitment of all the professions concerned with the delivery of health care, particularly the doctors and nurses.

8. It is most important that the implementation of the Management Inquiry Report's recommendations at unit level should develop from the 1982 reorganisation. Developments already in train or planned in this way, are:

- the preparation of regional outline strategies, and regional and district strategic plans and short-term programmes (drawing together money, manpower, service development, and the estate and containing substantial proposals for cost-improvement) in accordance with HC(84)2;

- the development and implementation of management budgets, taking account of the expressed requirements of professional staff;

- the overall strengthening and development of the professional advisory machinery to ensure that there are effective arrangements for the advice of doctors and nurses to inform managerial decisions at unit as well as district and regional levels.

9. The key to further progress at the unit is to establish a responsibility for the general management function. It will require careful preparation and consultation. We envisage that a period of up to 18 months - to the end of 1985 - will be needed to develop and introduce proposals for the establishment of the general management function at unit level.

Clinicians in management

10. We strongly endorse the Report's view that clinicians should be both encouraged and enabled to play a more active role in management and especially unit management. In practice, it is clinicians who determine the way many of the health service's resources are used by the decisions they take about the clinical care of individual patients. At the same time, resources available for health care are not unlimited, and the way resources are allocated will affect the range of decisions open to clinicians in the individual treatments they prescribe. To ensure that available resources are deployed where they are most needed, it is important that decisions about the management of resources take full account of the priorities of patient care and the advice of clinicians. In order that clinicians can play an enhanced role in management, they need access to relevant and timely information; adequate administrative support; and a reduction in time spent on unnecessary bureaucracy and committee work. Health authorities should seek to stimulate action to meet these needs. Further management training for clinicians is also needed and from the earliest possible stage of training. The results of these changes will not be fully realised for some time; but, with the active support of clinicians, a significant start can be made now, concurrently with the establishment of the general management function in units.

11. While authorities are developing their proposals for the units, to secure the establishment of the general management function and the closer involvement of clinicians in management, they and the Department will continue to make the changes in their organisations necessary to support and sustain improvements in health services at unit level:

- we will continue to develop, within DHSS and the existing statutory framework, the Health Services Supervisory Board to help us to establish policies and priorities, and will set up the National Health Service Management Board, as soon as a Chairman has been appointed - meanwhile a multi-disciplinary Management Group has been set up with responsibility for the NHS management programme;

- RHAs and DHAs will begin the process of establishing the general management function and identifying a general manager at regional and district level.

PROCEDURE

12. The Inquiry Team emphasised that, once clear directions had been given by the centre, authorities should be allowed the maximum flexibility in making their own management arrangements. In keeping with this, we accept that:

- there should be some latitude in the timescale in which authorities should be required to establish the general management function and identify general managers;

- authorities should have adequate scope to take due account of local management needs and potential;

- authorities will, therefore, proceed at different speeds but the general management function should first be established at RHA, then at DHA within each region and at unit level only thereafter - the pace will consequently vary as between DHAs/units within a region.

13. We now require health authorities to establish a general management function, drawing on the recommendations in the NHS Management Inquiry Report - paragraphs 14-16 in particular - and following the procedural guidance set out in Annex C. RHAs and DHAs must identify a general manager - at region, district and unit level - to take personal and visible responsibility for carrying out the general management function, in accordance with DHSS guidance as supplemented by RHA and DHA requirements. Hospital SHAs must similarly identify a general manager.

ENQUIRIES

14. Enquiries about this Circular should be addressed to:

Miss A M Williams
Room D918
Alexander Fleming House
Elephant and Castle
LONDON SE1 6BY
Tel. 01-407-5522 Ext 6866

ACTION

15. Health authorities are required:

15.1 to establish the general management function and identify general managers in accordance with the procedural requirements in Annex C;

15.2 to carry forward the further programme of management action identified in Annex B, within the context of the action already in hand and planned in Annex A.

From:

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MNE 22

Further copies of this Circular may be obtained from DHSS Store, Health Publications Unit, No 2 Site, Manchester Road, Heywood, Lancs OL10 2PZ quoting code and serial number appearing at top right-hand corner.

ANNEX A
(HC(84)13)

IMPROVEMENTS IN NHS MANAGEMENT

Since 1979 the Government has taken the following steps to improve management in the health service.

- In 1982 the structure of health authorities was simplified by the removal of two levels of management - Area and Sector.

- District Health Authorities were established generally serving smaller local populations.

- More responsibility was devolved to hospital and community services at unit level.

- Accountability has been strengthened with the introduction of annual reviews led by Ministers of performance against agreed objectives.

- The review cycle has been established for RHAs and DHAs: it is being extended to units this year.

- Family Practitioner Committees are to be made separately accountable.

- A range of statistical indicators of performance (covering clinical services, manpower and estate management) has been developed: in 1983, all health authorities were sent data on their own performance and that of other authorities.

- Work is under way to improve and extend the range of performance indicators.

- NHS management's need for information has been comprehensively reviewed and improved information systems will be introduced over the next few years.

- More effective monitoring of NHS manpower numbers has been introduced: manpower limits have been settled, complementing authorities' cash limits.

- The Rayner Scrutiny technique has been extended to the NHS with a programme of nine studies by NHS officers covering areas such as transport services and recruitment advertising.

- Health authorities have been required to test the cost effectiveness of laundry, catering and cleaning services by seeking competitive tenders.

- Health authorities have reviewed arrangements for the control of items in stock and in use, following the advice of the Health Service Supply Council.

- A value-for-money audit programme has been introduced.

- HC(84)2 required all health authorities to initiate cost improvement programmes.

- Health authorities will have to show how their cost improvement programmes have released resources for the development of services to patients.

- The development of management budgets has begun with the start of several demonstration projects.

- The NHS Training Authority has been established.

- A study of the administration of FPCs has been undertaken by outside consultants.

- A study of the current flow of communications between the Department and health authorities is being led by a Regional Administrator.

- A study of the responsibilities of the Department in relation to the financial management of health authorities is being led by a Regional Treasurer.

- The Health Services Supervisory Board has been established to advise the Secretary of State on the objectives and direction of health services.

- The NHS Management Board is to be established within the Department as soon as its Chairman has been appointed; an NHS Management Group is already working in preparation for the NHS Management Board.

- Manpower in DHSS HQ has been reduced by 20 per cent since 1 April 1979 following a reduction in the central role.

ANNEX B
(HC(84)13)

FURTHER PROGRAMME OF MANAGEMENT ACTION

The NHS Management Inquiry set out its recommendations in the form of a programme of management action to be taken both at the centre and by health authorities. The recommended programme is:

1. Policy of accountability for performance against agreed objectives should be maintained and developed.	(para 6)
2. Accountability reviews should be extended to units.	(para 6)
3. The management function should be developed	
(a) inside the Department	(paras 1-5)
(b) in the NHS.	(para 6)
4. Pilot projects in management budget techniques should be continued with the aim that they be extended to all health authorities in about 2/3 years.	(para 8.6)
5. 11 specific topics should be studied or reviewed	
- the need for functional management structures at RHA/DHA	(para 6.6)
- the role of clinicians in management, in six hospitals	(para 8.2)
- the arrangements for remuneration etc	(para 9.2)
- the assessment of management training	(para 9.4)
- the procedures for appointments etc	(para 9.5)
- nurse manpower levels	(para 9.6)
- other manpower levels	(para 9.7)
- the procedures on capital schemes	(para 10.2)
- the works function	(para 10.3)
- levels of decision-taking	(para 11.0)
- consultation arrangements	(para 12.0)
6. The roles of members and officers in relation to their authorities should be clarified.	(paras 6.4 and 17)

7. The agenda and the procedures for health authority meetings should be clarified and the nature of the reports required by the authority in managing its services should be made explicit.	(para 6.5)
8. Major cost-improvement programmes should be initiated in each health authority	(para 6.7)
9. Each unit should have a total budget and have management accountant support	(paras 8.4 and 8.5)

ANNEX C
(HC(84)13)

REQUIREMENTS FOR ESTABLISHING THE GENERAL MANAGEMENT FUNCTION AND IDENTIFYING MANAGERS

PROGRAMME

1. The general management function should be established by each health authority as soon as possible, and in any event by the end of 1985, under the following procedure, which is intended to give authorities the maximum freedom to develop proposals which best suit local requirements whilst enabling Ministers to monitor their arrangements.

1.1 Not later than the end of September 1984, each Regional Health Authority and Special Health Authority for London Postgraduate Teaching Hospitals must inform the Secretary of State how it proposes to establish the general management function. It should submit a job description for its general manager, and its proposals for identifying a suitable person to carry responsibility for the function and the name of the individual proposed if already identified. This will allow the Secretary of State to perform his role of monitoring health authorities: he will not be attempting to take over the role of the authority itself or to standardise job descriptions to a national pattern. In examining these proposals, the Secretary of State will wish to satisfy himself that the authority has formulated a job description for the manager, which accords with the Secretary of State's management changes within the DHSS; that any additional costs have been suitably offset within the existing provision for management (see paragraph 17) without damaging present and planned provision for direct patient care; and that the general manager as and when identified has the capacity to undertake the general management function. The Secretary of State will arrange a meeting with the RHA Chairman to discuss the proposals and to confirm that he is content for the RHA to proceed to formal decision. Once satisfied, the Secretary of State will approve an interim rate of remuneration for the general manager.

1.2 When the RHA has completed consultation with the Secretary of State, the RHA will ask each District Health Authority similarly to inform the RHA about its proposals for establishing the general management function at District level. Each DHA should submit to its RHA a job description for the District general manager, its proposals for identifying a suitable person to carry personal responsibility for the function and the name of the individual proposedif already idenfified. The RHA should forward to the Secretary of State its recommendations for action. In making their recommendations, RHAs should demonstrate that they have checked their DHAs' proposals in an equivalent manner to the Secretary of State's scrutiny of RHA proposals ie bearing in mind similar factors, but transposed as appropriate to the regional situation. In addition, RHAs will need to check that their DHAs' proposals fit in with the management changes finalised for the RHA, add up to an acceptable management pattern taking the region as a whole and that the suitability of individual general managers, as and when identified, takes into account an assessment of their ability to command the confidence of the representative members of the Management Team. The RHA Chairman will arrange a meeting with each DHA Chairman to discuss the proposals and to confirm that he is content for the DHA to proceed to formal decision, taking account of any views expressed by the Secretary of State. If the RHA Chairman and the DHA Chairman are unable to agree how to proceed, the RHA Chairman should consult the Secretary of State before the DHA proceeds to formal decision. The Secretary of State's approval will be required for the interim remuneration proposed for all general managers.

1.3 After the RHA has assembled the DHA proposals and completed consultation with the Secretary of State, each DHA should be asked to inform the RHA how it proposes to establish the general management function at unit level, of the job descriptions for its unit general managers and its proposals for identifying suitable people to carry personal responsibility for the general management function, including the names of the individuals proposed, where already identified. DHAs will need to demonstrate that job descriptions fit in with the changes already agreed for the DHA itself; that any additional costs have been suitably offset within the provision for management without damaging present and planned provision for direct patient care; that the individual general managers as and when identified are suitable, taking into account an assessment of their ability to command the confidence of the representative members of the Management Team; and, that the individual unit proposals add up to an acceptable management pattern taking the district as a whole. The RHA Chairman should arrange a meeting with each DHA Chairman to discuss their unit proposals and confirm that he is content for the DHA to proceed to formal decision. Action should be completed at unit level by the end of 1985.

2. Where an authority wishes a general manager to be drawn from outside the range of those listed below as normally eligible, the authority should clearly indicate the arrangements proposed to fulfil the requirements of paragraphs 1.1-1.3 above.

THE FUNCTION

3. The essence of the general management function is the bringing together at each level of organisation, responsibility for the planning, implementation and control of the authority's or unit's performance. The general manager will carry personal responsibility for this, and be personally accountable to the authority for its discharge. The authority in its turn must be seen clearly at all times to give full support and backing to the general manager.

4. The general manager's broad areas of responsibility must include as a minimum:

4.1 direct accountability to the authority, or in the case of units to the district general manager, for the general management function within the undertaking;

4.2 direct responsibility and accountability for the managerial performance within the authority or unit;

4.3 leadership of the authority's management team, or unit equivalent, and accountability for the performance of the team as a whole in developing policies and possible courses of action and ensuring the provision of proper advice;

4.4 ensuring that management and administrative practices enable the care of patients to be constantly to the fore;

and to these ends he should -

4.5 ensure that the authority or unit is provided with the range of advice and information it needs to formulate policies, decide priorities, set objectives, and monitor progress;

4.6 ensure that full weight is given to clinical priorities in the light of advice from nurses and doctors;

4.7 ensure that timely decisions are reached;

4.8 ensure that objectives are achieved;

4.9 provide the necessary leadership to stimulate initiative, urgency and vitality in management eg in ensuring a constant search for constructive change and cost-improvement;

4.10 co-ordinate activities, functions and personnel as necessary;

4.11 ensure that responsibility, including the management budgeting responsibility, is delegated to the point where action can be taken effectively;

4.12 secure effective motivation of staff.

MANAGERIAL RELATIONSHIPS

5. The general manager at RHA and DHA will in each case be accountable only to his authority ie not to a general manager at a higher level. The unit general manager will be accountable to the district general manager.

6. Existing guidance on managerial relationships at district and unit level in HC(80)8 is amended by this circular which provides the general framework within which authorities will develop their proposals for revised management arrangements.

7. Professional chief officers are appointed by the authority and will continue to be directly accountable, and have a right of access, to the authority on the provision and quality of professional advice. On matters relating to the fulfilment of the general manager's responsibility, they will be accountable to the general manager for the day-to-day performance of their management functions. The representative members of the District Management Team will also continue to have direct access to the authority.

THE JOB DESCRIPTION

8. A job description should be drawn up for each general manager which should include, as a minimum, details of his function, his relationship to the other chief officers and of the proposed terms of tenure and remuneration. The broad areas of responsibility which should be covered in job descriptions are set out in paras 3-4 above. Although authorities may need to adapt and expand these to suit local needs and constraints, as well as the different requirements at RHA, DHA, hospital SHA or unit, they will be expected to keep within this frame

ELIGIBILITY

9. It is for the authority to identify the general manager, having satisfied itself that the individual has the management capacity to undertake the general management function, including the ability to command the confidence of the representative members of the Management Team. It is expected that regional and district general managers will be identified in the first place from members of the Regional Team of Officers and District Management Team respectively. Authorities may, however, propose instead to seek a general manager either from elsewhere in the NHS or from outside (see also paragraph 15).

10. At regional and district levels, general managers will take full responsibility for the general management task. This does not preclude the discharge of other responsibilities in exceptional cases, but it is essential that the general management function should be performed effectively and therefore it must be given top priority. Where an existing member of the RTO or DMT is identified as general manager, authorities will need to ensure that appropriate steps are taken to secure the proper discharge of his existing responsibilities. Where it is proposed to identify a clinician, authorities will need to be satisfied that such clinical responsibilities as he may retain are consistent with his effective performance as general manager.

11. At unit level, it is expected that the general management function may be combined with other responsibilities but, as at regional and district levels, the general management function must be given top priority. In the first place, those eligible to undertake the function at unit level will be any DHA employee, consultant or general medical practitioner who works within the district. DHAs wishing to make other proposals for identifying a unit general manager should follow the guidance in paragraph 15.

TERMS OF SERVICE

Remuneration

12. In the interim period before long-term arrangments for remunerating general managers have been established, they should be awarded a fixed rate annual payment not exceeding £3,000 in recognition of their extra responsibilities. The detailed method of paying such an allowance to consultants or general practitioners is under consideration and authorities wishing to make such an appointment should therefore consult the Department.

13. In exercising their judgement on what is the appropriate additional payment, authorities should bear in mind that the effect of the flexibility of job description envisaged in this circular will be to place greater responsibilities on some general managers than on others. Differences may arise not only in comparing the different tiers of management (region, district and unit) but also in comparing general managers in the same tier of management. The time judged necessary to perform this role may also vary between posts and be relevant to the level of remuneration that is appropriate. It is to be expected therefore that these differences will be reflected in the amount of additional allowance paid.

14. In order to achieve some consistency in this respect, all DHAs, when submitting a job description to the RHA, should link with it their proposals for the size of the additional allowance. RHAs and hospital SHAs should do the same in their submission to the Secretary of State in respect of their own arrangements. All such additional allowances require the Secretary of State's specific approval under the NHS remuneration statutes.

Outside appointments

15. An authority may propose to seek a general manager from outside those people normally eligible (see paragraphs 9-11). For procedural reasons at this early stage, authorities must first submit such proposals to the Department for prior approval. DHA proposals should be submitted via the RHA. As soon as possible, arrangements will be made to allow authorities to proceed without direct reference to the Department.

Tenure

16. Authorities should identify general managers on a period basis, with an initial fixed-term contract for 3-5 years. After that, the general manager's employment may be extended on the basis of yearly fixed-term contracts. All contracts should contain an agreement to exclude any claims under Section 54 of the Employment Protection (Consolidation) Act 1978. At no stage should the contract be allowed to run beyond the due date, since this may be held to have created a new contract without limit of time.

Costs

17. The full costs of the general management function must not be met at the expense of services to patients. The total cost of the general management function should be therefore specified in the authority's proposals, with details of how it is intended to contain the cost within existing provision for management.

CONFIDENTIAL

Await RtA and Tsy

Appts

PRIME MINISTER

PERSONNEL DIRECTOR OF NHS MANAGEMENT BOARD

One of the key recommendations of the Griffiths report on NHS management was the appointment to the NHS Management Board within my Department of a Personnel Director. Improved personnel management and more responsibility for managers in personnel matters (including greater freedom to motivate, discipline and reward) are central objectives in our strategy for improving the management of the NHS. In order to achieve these objectives it would be the Personnel Director's task - as a part of his responsibility for those personnel functions which are appropriate to the Department - to carry out a number of wide-ranging reviews into existing NHS personnel arrangements. He would aim to do this so as to secure the maximum possible devolution of responsibility to local management.

Roy Griffiths believed that the necessary experience and skills for this task might best be found outside the Civil Service and the NHS, and I agree with that. I believe, therefore, that we should now recruit the Personnel Director. We have discussed with the Treasury and Cabinet Office a job specification, which I attach. This emphasises that the main initial task will be to carry through these reviews and it represents an agreed basis for recruitment (though the text of any advertisement might well be different). I am therefore seeking your agreement to the creation of a post of Personnel Director in the Senior Open Structure of the Department. My view is that this ought to be graded at Deputy Secretary level, hence my seeking your approval. But it is the salary, not the grade, which is important and we may need to be flexible about that. I propose to recruit by open competition and advertisement, using the same executive search firm as we are using for the appointment of the Chairman of the NHS Management Board.

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

19 May 1984

N F

CONFIDENTIAL

JOB SPECIFICATION FOR NHS PERSONNEL DIRECTOR

Context

1. The appointment will be to a new post in the DHSS, at Deputy Secretary level, as NHS Personnel Director. The creation of such a post was recommended by the Inquiry into the Management of the NHS headed by Mr Roy Griffiths. The Personnel Director will be a member of the NHS Management Board and will be accountable to the Chairman of the Management Board, and through him to Ministers. He will carry the lead responsibility at official level within the DHSS for the discharge of the Secretary of State's responsibilities in respect of the personnel function in relation to NHS staff.

2. Although the Secretary of State for Social Services discharges his statutory responsibilities for the provision of health services in England mainly through statutory health authorities, who employ NHS staff or contract with independent practitioners for the provision of services, important personnel functions are discharged at a national level. These include at present the determination centrally of pay and conditions of service for NHS staff and the formulation of personnel policies for implementation by health authorities. Pay for doctors, dentists, nurses and related groups, is the subject of recommendations by independent Review Bodies. Pay and conditions of service for other staff are negotiated in the NHS Whitley Councils; the DHSS services, and is represented on, the Management Sides of these Councils. Review Body recommendations and Whitley Council agreements require the approval of Ministers before implementation. The NHS employs over 800,000 staff in England.

Responsibilities

3. The NHS is highly labour intensive - about 70% of its current expenditure goes on staffing. The delivery of health care involves an extremely wide range of professional, scientific, technical,

administrative and ancillary staff who have to work together efficiently and effectively. The personnel management function is accordingly of critical importance at all levels of the service. At the centre, within the Department, the Personnel Director will have a key role in supporting the Chairman of the NHS Management Board in his primary task of improving the general management performance of the NHS, through developing appropriate personnel policies and practices. He will be concerned especially in promoting a framework in which:-

: good management practice is encouraged and rewarded and remedial action is taken where performance in this respect is unsatisfactory;

: there is a maximum degree of delegation and devolution in personnel matters to give local management more freedom to manage compatible with overall cost effectiveness and the Secretary of State's ultimate responsibility for NHS pay and conditions of service.

4. With those objectives in mind the Personnel Director will be expected to give priority to setting and carrying through to implementation wide ranging reviews of existing NHS personnel arrangements (including Whitley agreements on pay structure, and terms and conditions of service) with a view, outside the clinical field, to:

(a) developing systems for improving the incentives to staff for good performance and for providing management with more effective means of taking remedial action to tackle problems where the performance of staff falls below required standards;

(b) in support of (a) and of improving the management process generally, developing arrangements for more systematic performance appraisal and review against agreed objectives;

(c) ensuring that decisions in personnel matters are as far as possible taken by local management (within an agreed national framework), so that control of the management function is to the maximum extent integrated at that level;

(d) ensuring that the arrangements for management training and career development are attuned to and operate in support of the drive for improved managerial performance.

The Personnel Director will be expected as an early task to draw up proposals, including timetables for the conduct of these reviews.

5. Apart from these specific tasks, the Personnel Director will be expected to participate, at very senior levels in Government, in consideration of pay and other personnel policies for the public sector and then to achieve the implementation of such policies as are approved by Ministers for the NHS.

6. He will also be responsible, under the Chairman of the Management Board, for the continuing discharge of the Department's personnel functions in respect of pay and terms and conditions of service for NHS staff; industrial relations, training and career development; and non-medical manpower supply planning. These duties include:-

i. advising Ministers on, and securing the implementation of, pay policies for the NHS; personnel and industrial relations policies in the NHS; and the scope for improving the arrangements for determining pay and conditions of service in the NHS.

ii. representing the Secretary of State on, and servicing the Management Sides of the NHS Whitley Councils;

iii. negotiation of terms and conditions of service for hospital doctors and dentists;

iv. co-ordinating and presenting the Government's evidence to the Doctors' and Dentists' Review Body and the Review Body on Nurses, Midwives and Professions Allied to Medicine;

v. developing and assisting in the use of techniques for manpower supply planning (including manpower utilisation);

vi. oversight of the NHS Training Authority which has important responsibilities (for which it is accountable to the Secretary of State) for training and career development of NHS staff. In the case of the major health care professions there are independent statutory and other bodies responsible for setting standards and prescribing educational and training requirements.

7. The utilisation of manpower is a key factor in the operation of the NHS. The Personnel Director will be responsible for carrying forward current work on optimum nurse manpower levels and on determining manpower levels generally, taking account of service needs and plans save that responsibility for work on medical manpower will, in whole or in part, continue under medical direction within the Management Board. The Chief Medical Officer will retain responsibility for seeking advice and views from the profession, and professional bodies at national level outside the Department, concerning medical manpower matters. The Personnel Director will act in support of line management in health authorities who will be responsible for applying manpower planning techniques.

Relationships within the DHSS

8. The Chairman of the Management Board, as Second Permanent Secretary, will be the Secretary of State's senior adviser on Departmental responsibilities for the management of the NHS. He will chair the multi-disciplinary NHS Management Board which will draw together the senior officials within the Department concerned with NHS Management.

9. The Management Board will have no corporate status but will be a forum for collective discussion of issues relating to NHS management and their determination. As a member of the Board, the Personnel Director will be accountable to the Chairman for the discharge of his functions. The Personnel Director will have a line management responsibility for a group of DHSS staff, currently numbering around 400, whose duties broadly cover the functions outlined at para 2 above: any professional members of this staff will look for guidance as necessary to their head of profession. The Personnel Director will need to work closely with professional colleagues on the Management Board concerned with professional personnel matters.

Relationships with the NHS

10. The Personnel Director must provide strong personal leadership in the development of staff morale and attitudes, and will be expected to develop close personal working relationships both with senior NHS staff and with those representatives of NHS management involved in the negotiation of pay and conditions of service. He will not exercise line management control over NHS personnel staff, but he will be expected to consult closely with them and to give professional leadership and direction to the personnel function in the NHS.

Requirements for the post

11. The qualities and experience required for the post of Personnel Director should therefore include:-

i. a record of successful personnel management experience at a top level in very large scale organisations;

ii. experience and proven ability in such organisations in the formulation of personnel policy and in its negotiation and implementation.

Experience of dealing with professional groups and of operating in a public sector environment would be an advantage.

Terms of Employment

12. The post will be graded Deputy Secretary and the post holder will be a Civil Servant for the period of his appointment. He or she will not be able to retain any outside appointments requiring a significant amount of time or which might cause a conflict of interest to arise.

13. The period of the contract will be limited in the first instance but will be subject to extension for the successful post holder. Arrangements for the secondment of a suitable candidate from his existing employer would be considered.

14. The salary will be not less than the equivalent of that for a Deputy secretary. However, the salary and other conditions of service will be negotiable and would have regard to all relevant factors including the successful applicant's current conditions of service and the superannuation arrangements proposed (on which see para 15). The salary will be reviewed periodically and adjusted to reflect any percentage change in the pay of a Deputy Secretary.

15. The post will be pensionable. Normally, the post holder will be covered by the Principal Civil Service Pension Scheme but alternative arrangements (eg continued membership of a previous employer's pension scheme or a personal annuity contract) might be possible, depending on the circumstances and the terms of appointment of the successful candidate. Secondment will normally involve continuation of existing superannuation arrangements, with DHSS paying the seconding employer's share of superannuation contributions.

16. The post will be located in London. Assistance with relocation expenses may be available.

DHSS
May 1984

TH

DEPARTMENT OF HEALTH & SOCIAL SECURITY

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Telephone 01-407 5522 ext 6981

From the Permanent Secretary

Sir Kenneth Stowe KCB CVO

F E R Butler Esq
Principal Private Secretary
10 Downing Street
London SW1

18 May 1984

Dear Robin

I enclose photocopies of two articles from a recent edition of the magazine "Pulse" which is aimed at General Medical Practitioners. They illustrate very well a fundamental characteristic of the Family Practitioner Services which we have mentioned before. General Practitioners can set about maximising their income (and our costs) in a whole variety of "legitimate" ways. Not only does this make forecasting for us very difficult but it shows that General Practitioners can, and do, tailor the service they provide to meet a "demand" that they can help to create. These are difficult waters. We want to see General Practitioners doing more to help treat patients outside expensive hospitals. But some of this has the undoubted flavour of playing the system for all it is worth.

No reply needed: this is just background to the paper which Robert Armstrong is putting up about Doctors etc pay - and the need to add an "efficiency rider" to the Review Body terms of reference.

Yours ever,
Ken.

Pulse 5/5/84.

Hay fever can help cash flow

As the glorious Easter weather banished winter flu, it also ushered in the hay fever season. Last year produced an exceptional demand on GPs and among the most distressed were those sitting examinations.

GPs may resort to a depot steroid preparation, in addition to the normal armamentarium, to ease the worst sufferers through this vital time.

The most organised will have already purchased directly from manufacturers – at a large discount – sufficient bulk of their particular favourite preparation, and will dispense it personally under the Red Book, paragraph 44–13, claiming a dispensing fee on cost allowance.

The amount of income that this engenders is not considerable, but it may help practice cash flow.

If those who do this find that it works, why not consider a similar approach for parenteral products and coils?

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PULSE 5/8/84

How GPs woke up to extra money under their noses

Doctors are claiming under paragraph 44.13 of the Red Book with great effect, reports Sue Russell.

GPs seem to have mastered the Red Book to their advantage with great effect in the last two years.

A row that has been simmering with the pharmacists for some time has now boiled over again – all because GPs have woken up to the potential of paragraph 44.13 of the statement of fees and allowances.

This enables all GPs – not just dispensing doctors – to claim payment for items which are personnally administered. This includes flu vaccines, IUCDs, and suture material.

The pharmacists have been alerted by the latest report of the Prescription Pricing Authority, which showed substantial increases in the number of personally-administered prescriptions.

In the year 1973–4, there were 6,729 personally administered prescriptions. By 1981–2 this had risen to 734,402, but the really staggering increase came just a year later.

In 1982–3, a total of 1,049,488 items of service were claimed for, representing a rise of just over 30 per cent.

In dispensing fees alone this represents about £619,197, or roughly £20 per GP in the country. But added to this is reimbursement of the net ingredient cost of the item as listed in the drug tariff, plus an 'on-cost' allowance of 10.5 per cent of that cost, plus a container allowance of 2.8p.

Dr John Lewis: says it is perfectly legal for GPs to administer items personally to patients.

And, of course, not every GP in the country does claim under this paragraph – so the difference in income to those GPs who do can be enormous.

One practice received almost £2,300 from dispensing fees last year – without counting the other allowances. But as an example of what can be done if the practice tries, this was 500 more fees claimed on a list size that was 11,000 patients fewer because the practice had split in two.

And utilising this paragraph helped another practice increase its item-of-service remuneration from 5 per cent of total income to 21 per cent.

GPs were given a boost last year when suture material was added to the drug tariff, and so to the list of items that could be claimed for under paragraph 44.13. But even so, Dr Michael Wilson, deputy chairman of the general medical services committee, believes this was only a small factor in helping to increase the extent of GPs claims.

The first practice was claiming for flu vaccine; measles, tetanus, whooping cough, and diphtheria inoculations; gold treatments for rheumatoid arthritis; Depo Provera; chlorpromazine for schizophrenia and Jectofer for acute anaemia.

A conscious effort was made to boost income, and all patients were told that the practice was holding immunisation clinics.

The practice was also able to buy supplies from the local chemist wholesale – so the discounts produced another useful saving as the items are reimbursed according to the normal drug tariff price.

The pharmacists have been grumbling to various health ministers about this loss of income for some years, but this recent massive increase – coupled with the fact that if the doctor supplies and administers the drug, patients are now exempt from prescription charges – seems to have exacerbated their discontent.

The pharmacists' letter to Social Services Secretary Norman Fowler will argue that the Exchequer is losing out on prescription charges.

But Dr John Lewis, chairman of the rural practices subcommittee, says the law is quite clear, and GPs are doing nothing illegal by administering these items themselves.

And Dr Wilson argues that by prescribing and administering vaccines themselves GPs are also boosting preventive medicine and providing more efficient health care.

Most of the patients would be exempt from prescription charges anyway, so the loss to the Exchequer is minimal.

As Dr Lewis said, in using this paragraph GPs are complying with their terms of service and the regulations of the statement of fees and allowances.

Council spends out to 'rehouse' doctors

Three GPs currently practising in council flats are to be 'rehoused' in a new £530,000 health centre which will be financed not by the district health authority but by the local coun-

WHAT CAN YOU SAY TO SOMEONE ONCE YOU'VE DIAGNOSED MULTIPLE SCLEROSIS?

The first thing a patient has to face with Multiple Sclerosis is the distressing list of possible symptoms.

At the same time, you have the difficult job of telling them that the disease can be progressive and is, as yet, incurable.

Just at the time when the patient most needs hope, and help.

However, there is still one positive course of action you can take. Refer your patient to the Multiple Sclerosis

21 MAY 1984

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EFFICIENCY UNIT

70 WHITEHALL, LONDON SW1A 2AS
Enquiries : 01-233 8412
Direct line : 01-233 7359

17 May 1984

The Rt Hon Peter Rees QC MP
Chief Secretary to the Treasury

Dear Peter,

SOCIAL SERVICES INSPECTORATE (SSI)

Thank you for copying to me your letter of 26 April to Norman Fowler about the proposal to establish a Social Services Inspectorate to replace the existing Social Work Service. I have also seen the earlier correspondence, including Norman Fowler's letter of 10 March.

I do not have any specific experience in this field but I am suspicious of professional inspectorates. My experience is that they can be greatly concerned with standards and regulation which do not address key issues of value for money - cost and service to customers. There is a real risk that they can turn into pressure groups for the profession.

On the other hand I am impressed by what Norman Fowler is doing to improve efficiency in a range of areas. And I value a capacity to improve value for money by promoting best practice, by setting standards and by making comparisons. It may be that re-creating the Social Work Service (SWS) as an Inspectorate will aid these aspects because the inspectors will be more acceptable to local authorities than DHSS officials of the SWS. I cannot judge on the basis of the information available to me. But I note that the main additional activity is to be dependent on the "voluntary co-operation and goodwill of staff in the inspected authorities".

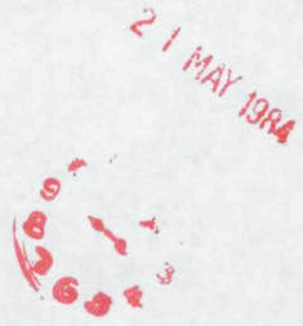
I wonder, therefore, whether a good way forward would be to test the proposed arrangements informally by piloting investigations of the type envisaged without adopting the rigidities of an inspectorate at this stage. An important aim might be to establish the notion of increasing value for money year by year before institutionalising the arrangements as an Inspectorate.

I am copying this to recipients of yours.

Yours ever,

ROBIN IBBS

Nat Health. Efficiency Pt 3



SECRET

FILE
3 da

10 DOWNING STREET

From the Private Secretary 8 May 1984

Abuse of the NHS

The Prime Minister saw over the weekend your Secretary of State's minute of 3 May about two instances of abuse of the NHS, and has noted its contents.

I am sending copies of this letter to Janet Lewis-Jones (Lord President's Office), John Graham (Scottish Office) and Colin Jones (Welsh Office).

David Barclay

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

SECRET

SECRET

PRIME MINISTER

ABUSE OF THE NHS

1. You ought to be aware of two instances of abuse of the NHS by consultants, which will attract considerable political interest. At one hospital in England our auditors' investigations, now in the hands of the police, showed that some consultants were failing to pay the health authority for the use of NHS facilities by private patients. A similar case has arisen in Wales and there may be a small number of others. The trial also began recently of an NHS consultant alleged to have stolen and sold blood.

2. We cannot comment on these cases until investigations are complete. The abuse of private patients' charges will, however, undoubtedly fuel an attack on our policy in relation to private care. I therefore intend to take swift and positive action as follows:

(i) Our guidance on the handling of private patients' charges is comprehensive and detailed, and has been reissued several times asking authorities to bring it to the attention of all the staff involved. I shall, however, be asking all Health Authority Chairmen to review their arrangements for recovering charges, and to ensure that they comply with the guidance.

(ii) A special study of the arrangements for handling private patients' charges at a sample of hospitals will be carried out in the next few weeks. In the light of the results, I will consider whether any further action is needed.

I intend to make a written statement outlining this action next week.

As regards the supply of blood, action has already been taken to prevent such abuses recurring, as part of steps to improve cost-consciousness and stock control.

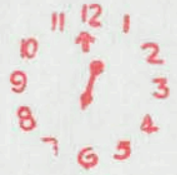
Copies of this go to Willie Whitelaw, Nicholas Edwards and George Younger.

3 May 1984

NF

SECRET

3 - Mai 1984



CONFIDENTIAL

CHIEF SECRETARY TO THE TREASURY

Treasury Chambers, Parliament Street, SW1P 3AG

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

26 April 1984

Dear Norman

SOCIAL SERVICES INSPECTORATE (SSI)

Thank you for your letter of 10 March. I am grateful to you for setting out your intentions for the SSI in greater detail.

I appreciate that your objective is to improve the efficiency and effectiveness of the personal social services and I welcome your explicit statement of the proposed Inspectorate's concern with achieving value for money within existing resources. However, I remain in some doubt as to whether your proposed extension of the SWS's functions is likely to be the most effective way of achieving your objective. Your rejection of definite targets for the Inspectorate, even as something to aim at when considering costs, standards and provision, increases my unease. I would welcome Robin Ibbs's views on what is proposed for the Inspectorate and it may be that he can set my mind at rest.

In any case, I hope we can avoid making a public statement on the SSI for the present. I share Patrick Jenkin's anxiety that this is not a good time to be announcing anything which, in places where better services are thought to equal higher spending, will inevitably be publicised as an example of Government double dealing when we are calling for restraint. Like Patrick, I would also welcome a further sight of the joint statement when you know the Association's views, though I should add that the redraft attached to your letter seems to me a great improvement.

I am copying this letter to the recipients of yours.

Yours ever Peter

CONFIDENTIAL

PETER REES

Nat Health Agency
A3

DEPARTMENT OF CLINICAL PHYSIOLOGY

NATIONAL HEART HOSPITAL

MI[redacted]ONALD LONGMORE

WESTMORELAND STREET, LONDON, W1M 8BA
TELEPHONE 01-486 4433

Our Ref. DL/SMB

Your Ref.

16 April 1984

Handed to me by Sir H. Laing. Pl. file with papers about the NMR scanner and Mr. Longmore.

FERB 4.5.

Sir Hector Laing
Chairman
United Biscuits
Syon Lane
Isleworth
Middx

Dear Hector

If you are to be talking to the Prime Minister during the Easter recess about any medical matters, it would be most helpful if you could suggest to her that there are extremely powerful reasons for her opening the National Heart and Chest Hospitals' CORDA Non-Invasive Magnetic Resonance (NMR) Unit. In addition to all that you already know, perhaps the following points could be made in favour of this use of her precious time:-

1) This is an outstanding example of private enterprise and personal effort on behalf of a number of people joining together with the hospital group to provide something important which the NHS cannot afford itself.

2) The NMR Research Group funded jointly by the National Heart and Chest Hospitals and CORDA are collaborating intensively to help GEC, the parent company which owns Picker Marketing British Technology in the USA.

3) The team we have put together includes Sir Godfrey Hounsfield, whose Nobel prize was for the mathematics which made the first CAT scanning and now NMR imaging possible. Dr Ian Young, of GEC, a brilliant physicist and his group, who have made the machines work. My own team of doctors and scientists, capable of advancing the technology. Behind us are an outstanding group of clinicians from the National Heart and Chest Hospitals. There can be few institutions in the world which could put together high technology, high finance, high ideals and outstanding people in this way. The Prime Minister has visited the Brompton Hospital and will be well aware of the high standards.

4) We have a comprehensive achievable research plan which should help to maintain the vital British lead in this complicated subject.

5) The Unit is not aimed at diagnosing end stage disease but at preventive medicine (I am sure the Prime Minister will be aware that large numbers of dentists are now having difficulty making a living because of the effects of fluoride). I hope we can do the same to expensive cardiac surgery.

6) NMR will be able to detect impending coronary and stroke at a much earlier stage, essential for monitoring the efficacy of treatments to control the disease process, now on trial.

I will of course be available to answer any questions on the telephone to supplement this letter. I am also prepared to submit to whom the Prime Minister might wish, a document which explains the background of the project, how NMR works and the basis of our research plan.

I expect the formal request for her to open the Unit will come from the Board of Governors of the National Heart and Chest Hospitals and the CORDA Charity jointly. I am sure however, that your putting the case personally to the Prime Minister is the best way of explaining the importance of this prestigious project to the country.

I do hope that Mr Dennis Thatcher would also be able to come. I know that he does not like hospital visits. This, however, is a preventive exercise, with no hospital ambience.

All good wishes.

Yours sincerely

Donald.

D Longmore FRCS

copy to
1) Parliament PT 12 Legislation
2) National Health PT 3
w/e box
Expenditure + Efficiency

PRIME MINISTER (2)

Pt agenda 9/4

MG

H Committee

At its meeting last week, H Committee considered two topics: fluoridation, and NHS recruitment advertising. Their conclusions ~~agreed~~ coincided with your views on both subjects, i.e., a power and not a duty to add fluoride, and an approach to the professional journals to try to persuade them to reduce advertising costs. The Committee agreed that if the latter tactic failed, the Secretary of State for Social Services should pursue the option of a national jobs register which would be put out to competitive tender among private publishing firms.

More parental influence over schools

At their meeting next week the Committee will be considering detailed proposals from the Education Secretary for increasing parental influence over schools. There are two main themes in his paper, a copy of which is at Flag A:-

(i) Giving parents the right to elect a majority of governors from among their number.

(ii) Legislating to define the respective roles of governing body, head teacher and LEA. Existing arrangements for church schools would not be affected.

If the Committee agrees, Sir Keith Joseph plans to publish his proposal as a Green paper in May with a view to legislation in 1985/8

Education support grants

The Committee will also be considering a paper summarising the Secretary of State's proposals for allocating education support

/ grants.

grants. He has £30 million to allocate. Nearly half would go towards the purchase of micro-computers and related staff training. Other main items will be the improvement of mathematics teaching, experiments in recording achievement for school leavers, and the provision of micro-electronic aids for handicapped children. Further details are in his paper at Flag B.

DMS

5 April, 1984.

LCC ND

SECRETARY OF STATE FOR THE ENVIRONMENT

CONFIDENTIAL

2 MARSHAM STREET
LONDON SW1P 3EB
01-212 3434

abpm Daub 4/4

My ref:

Your ref:

4 April 1984

Dear Norman,

SOCIAL SERVICES INSPECTORATE

Thank you for sending me a copy of your letter of 10 March to Peter Rees.

I was glad to see your assurances that the proposed Inspectorate would be constrained to act within national economic policy objectives, that it would concentrate on value for money and the most effective use of existing resources, and that it would act as a complement to the Audit Commission rather than duplicating any studies that the Commission may carry out in the Personal Social Services field.

I have no objection to your pursuing your consultations with the local authority associations on the terms of the joint statement. But I remain unhappy about the timing of any announcement at a time when we are trying to get the Rates Bill through Parliament. Whatever the terms of the announcement, the new initiative is bound to be seen by some in local government as Government pressure for increased PSS spending by some authorities. Indeed I doubt if the Associations would be so happy with the proposal if they thought that the Inspectorate's main thrust was to be a specialist arm of the Audit Commission. Opponents of the Rates Bill are certain to misinterpret the proposal, wilfully or not - indeed, with the new terms of reference it might be cited as an example of increased centralism!

Subject to colleagues' views, therefore, I should prefer no commitment at all to be given about timing at the moment; and I should like the chance to comment again, both on the terms of the announcement and on its timing, when you have had the Associations' views on the revised joint statement.

I am copying this letter to Peter Rees and the other recipients of your letter.

Yours ever
Pat

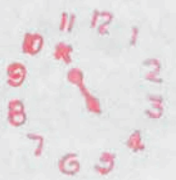
PATRICK JENKIN

CONFIDENTIAL

The Rt Hon Norman Fowler MP

Nat Health: Expenditure Pt 3.

-4 APR 1984



CONFIDENTIAL

NMPM AT 6/4 CC NO

PRIVY COUNCIL OFFICE
WHITEHALL, LONDON SW1A 2AT

4 April 1984

Dear Norman

HOME AND SOCIAL AFFAIRS COMMITTEE: FAMILY PRACTITIONER SERVICES

Thank you for your letter of 21 March suggesting that the Binder Hamlyn Report on Financial Control in the Family Practitioner Services would best be released in the context of a Green Paper setting out the Government's strategy for development of FPS generally.

I share your view which I note reflects agreement with George Younger, Nick Edwards and Peter Rees that the Binder Hamlyn proposals are best released publicly in the context of such a strategy document. In the absence of dissent from other members of H Committee you may take it that you have our agreement to that approach provided you let members have an opportunity to comment on the draft of the Green Paper before you publish. However, in my capacity as Chairman of QL Committee, I must draw attention to its possible consequences for the preparation and content of your Health and Social Security Bill for next Session. Paragraph 5 of the enclosure to your letter suggests publication of the Green Paper in June and argues that it would be possible for the response to the document to "feed into" decisions on the legislative programme. At the time of consideration by QL Committee I expressed my anxiety about the timetable for preparation of your Bill, and I can only say that it has now increased. If you publish a Green Paper on FPS in June, how long are you proposing to allow for comment and then for taking subsequent policy decisions about the content of that part of your Bill? Once time is also allowed for drafting of the necessary provisions, I do not see how you can keep to your target of introduction at or near the beginning of

The Rt Hon Norman Fowler MP

CONFIDENTIAL

the Session. I am very concerned about the Bill as a whole, and I should be grateful if you would let me know what timetable you now have in mind for preparation of this and other parts of the Bill.

I am sending copies of this letter to the Prime Minister, to other members of H and QL Committees, to First Parliamentary Counsel and to Sir Robert Armstrong.

COND

DEPARTMENT OF TRADE AND INDUSTRY
1-19 VICTORIA STREET
LONDON SW1H 0ET
TELEPHONE DIRECT LINE 01-215 3972
SWITCHBOARD 01-215 7877

Sir Brian Hayes KCB
Joint Permanent Secretary

2 April 1984

F E R Butler Esq
10 Downing Street
LONDON SW1

Dear Robin [FERB]

ROYAL MARSDEN HOSPITAL - NMR SCANNER

Ken Stowe copied to me his letter of 22 March to you about the Royal Marsden scanner.

The proposed purchase of a Siemens NMR Scanner for the research programme at the Marsden was known to both DTI and DHSS. As far as I can see we have no basis on which to challenge the decision (yet to be finalised) which evidently has been made on a combination of technical and price considerations. In the circumstances the Picker offer regrettably fell short of the user's requirements. I too am satisfied that nothing more can be done.

I am copying this letter to Ken Stowe and Antony Acland.

Yours ever,

Brian

BRIAN HAYES

National Health pt 3

NHS Expenditure

-3 APR 1984

CONFIDENTIAL

SECRETARY OF STATE
FOR
NORTHERN IRELAND

NORTHERN IRELAND OFFICE
WHITEHALL
LONDON SW1A 2AZ

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

30 March 1984

Dear Norman

HOME AND SOCIAL AFFAIRS COMMITTEE: FAMILY PRACTITIONER SERVICES

Thank you for sending me a copy of your letter of 21 March to Willie Whitelaw about strengthening financial control of the Family Practitioner Services.

I agree that this matter can now best be taken forward as you suggest through the publication of a Green Paper on the development of the Family Practitioner Services as a whole. I am content that further discussion in H Committee is unnecessary and that you should proceed with the preparation of the Green Paper on the lines set out in the Annex to your letter. Whilst the proposed Green Paper will relate only to Great Britain I should of course wish to consider its implications for Northern Ireland so that we can as far as possible maintain parity with the rest of of United Kingdom, and I look forward therefore to seeing a draft in due course.

I am copying this letter to other members of H Committee, the Prime Minister and Sir Robert Armstrong.

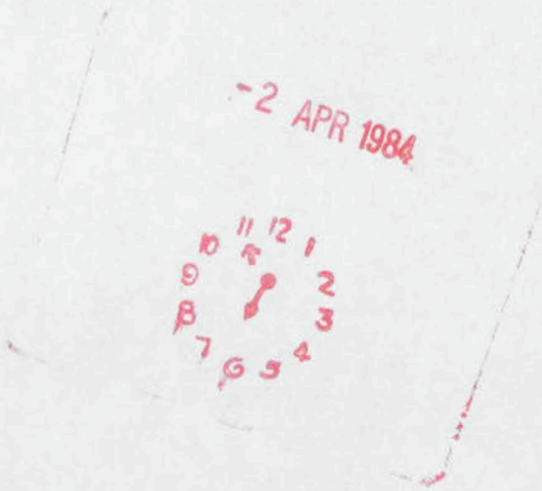
Yours

Jim

CONFIDENTIAL

KL

NAT HEALTH: EEP
Pt 3



CONFIDENTIAL

(1) Press Office
(2) NBPM

PRIVY COUNCIL OFFICE
WHITEHALL. LONDON SW1A 2AT

26 March 1984

Dear Norman — with AT
It not will signal
it required.

Thank you for your letter of 17 March about the closure of Thornton View Hospital in Bradford.

I am grateful to you for letting me know of the forthcoming announcement, which is bound to cause some difficulty. I understand that your officials are keeping in close touch with the No 10 Press Office and will seek to ensure that the case for closure and for the use of the proposed alternative accommodation is presentetd as positively as possible.

I am sending copies of this letter to the Prime Minister, to members of H Committee and to Sir Robert Armstrong.

Yours
John

The Rt Hon Norman Fowler MP

CONFIDENTIAL

27 FEB 1984

FLE 54

cc: LPO
LCO
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DES
NIO
SO
WO
DSE
LPSO
CDLO
D/Emp
CSD
D/Trans.
CWO
Lord Denham
CO

18

bc John Redwood.

10 DOWNING STREET

From the Private Secretary

26 March, 1984

Home and Social Affairs Committee:
Family Practitioner Services

The Prime Minister has seen your Secretary of State's letter to the Lord President of 21 March. She agrees with the suggestion that a Green Paper should be published alongside the Binder Hamlyn Report.

She hopes that the timetable for receiving comments and for responding to them will be brisk enough to feed into decisions in the next PES round.

I am copying this letter to Private Secretaries to members of H Committee and to Richard Hatfield (Cabinet Office).

ANDREW TURNBULL

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

CONFIDENTIAL

JC

FILE

10 DOWNING STREET

From the Principal Private Secretary 23 March, 1984

ROYAL MARSDEN HOSPITAL - NMR SCANNER

Many thanks for your letter of 22 March and for warning us about this matter. I will make sure that the Prime Minister knows in case she gets a telephone call from Lord Weinstock.

E E R BUTLER

Sir Kenneth Stowe, KCB CVO

SECRET

bc JR.

10 DOWNING STREET

From the Private Secretary

23 March 1984

SOCIAL POLICY REVIEWS

The Prime Minister has seen your Secretary of State's minute of 20 March. She welcomes the comprehensive set of policy reviews which will cover a large part of the social security system. She is content that, in the week beginning 2 April, he should announce the establishment of reviews into supplementary benefits and benefits for children and young people; and the way these reviews, including the one into housing benefit, should be staffed.

I am copying this letter to Janet Lewis-Jones (Lord President's Office), John Ballard (Department of the Environment), Elizabeth Hodkinson (Department of Education and Science), David Normington (Department of Employment), David Heyhoe (Lord Privy Seal's Office), John Gieve (Chief Secretary's Office) and Richard Hatfield (Cabinet Office).

(ANDREW TURNBULL)

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

SH.

JMc

2

Prime Minister

To be aware in case you get a telephone call from Lord Weinstock.

FERB

23.3.

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

F E R Butler Esq
10 Downing Street
LONDON
SW1

22 March, 1984

Dear Robin.

ROYAL MARSDEN HOSPITAL - NMR SCANNER

You should be aware that there may be some protest from GEC that the Royal Marsden Hospital is proposing to buy a new NMR (nuclear magnetic resonance) scanner from Siemens of Germany in preference to one from Picker International, a GEC-owned company, which manufactures these scanners at Wembley.

We have checked with the hospital their reasons for choosing the Siemens scanner. While some of the technical reasons might be challenged, there is no answer to the price differential - £¾ million for the Siemens against £1¼ million for the Picker.

Siemens are clearly determined to buy their way into the UK and Picker, who have sold six scanners in this country and are themselves using similar methods to buy their way into prestigious institutions overseas, cannot compete with their terms. This leaves us with nothing to do but grin and bear it, disagreeable though it is.

I am copying this to Brian Hayes and Anthony Acland.

Yours ever.

Ken.

CONFIDENTIAL

22 March 1984

file

MR TURNBULL

SOCIAL SECURITY POLICY REVIEWS

I am writing to say we are quite happy with the idea of announcing three new reviews of social security policies publicly. The press briefing should be robust and purposeful, but should not imply that the end result of it will be an overall increase in the amount of money going on these areas.

I have told DHSS that I myself would like to sit on the co-ordinating committee.

JOHN REDWOOD

CONFIDENTIAL

22 March 1984

MR TURNBULL

Prime Minister (1)
Agree issue of a Green Paper on Binder Hamlyn.
AT 24/3

FAMILY PRACTITIONER SERVICES

I have read Norman Fowler's letter to Willie Whitelaw, and think it makes a great deal of sense.

Our two caveats are that the timetable should be brisk enough to ensure that financial control in the Family Practitioner Services is strengthened prior to the next PESC round, and that the publication of the Green Paper should not stop preparation of the necessary policy work to ensure delivery of more for less.

JOHN REDWOOD

CONFIDENTIAL

CCNO

DEPARTMENT OF HEALTH & SOCIAL SECURITY

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

Telephone 01-407 5522

From the Secretary of State for Social Services

The Rt Hon Viscount Whitelaw PC CH MC
Lord President of the Council
68 Whitehall
LONDON
SW1

21 March 1984

Dear Willie.

Minutes with AT.

HOME AND SOCIAL AFFAIRS COMMITTEE: FAMILY PRACTITIONER SERVICES

At the meeting on 1 February, I was invited to discuss with the Secretaries of State for Scotland and Wales and the Chief Secretary how we might move ahead in strengthening financial control of the Family Practitioner Services. I am writing to report our conclusions.

H Committee's main concern was that, if the Binder Hamlyn Report were published without any indication of the Government's views, it might provoke so much hostility that it would be even more difficult to make progress afterwards. That is a view which we all now accept. However, we also think it necessary to go wider than the simple question of the Binder Hamlyn Report and the Government's views on it. We have concluded that the best way to win the argument about the need to control costs within the Family Practitioner Service is to set it in the context of the Government's commitment to effective primary care and of a positive strategy for controlled development of Family Practitioner Services. The objective would be to undermine the assumption that control of cost is inconsistent with development of services to meet patients' needs; to bring out the financial implications of trends in expenditure in the light of the Government's financial policies; and to create a sensible climate in which discussions can proceed with the contractor professions and the drug industry about cost control.

We have concluded that this can best be done by means of a Green Paper on the development of the Family Practitioner Services as a whole. It would review briefly the growth in expenditure and developments in services over recent years - for which we can take full credit. It would bring out the financial implications of trends in expenditure and the important distinction between increases

E.R.

in expenditure arising from the system itself and those which relate to specific policy developments. And it would seek to define the Government's objectives in terms of services to be provided and the needs of patients as much as the need to control costs.

The Binder Hamlyn Report would, on this presentation, be an input to the discussion rather than a prescription on which the Government had to make a specific set of decisions. I am sure that this approach will leave the Government in a stronger position to determine the nature of the debate which ensues.

As George Younger, Nick Edwards, Peter Rees and I are in agreement about the way to proceed, I doubt if further discussion in H Committee is necessary. We are agreed that the Green Paper should cover Great Britain and that I should arrange for a draft to be prepared in consultation with the other Departments. If you and other colleagues are content, I will set the work in hand on the lines of the enclosed note.

I am copying this letter to the other members of H Committee, to the Prime Minister and to Sir Robert Armstrong.

Yours ever. Norman

NORMAN FOWLER

ANNEX 1

GREEN PAPER ON FAMILY PRACTITIONER SERVICES

1. Purpose

The purpose of the Green Paper would be:-

i. To present achievements in and progress of primary health care services. (The document would focus on family practitioner services, but would need to deal also with the community health services provided by District Health Authorities, and would outline the overall strategy for primary health care.)

ii. To promote discussion of the prospects for these services over the next five years, opportunities and problems and broad options for the development and financing of the services. The broad theme would be controlled development of the family practitioner services.

iii. To provide a context for the publication of the Binder Hamlyn report and possibly of the report of the Advisory Committee on Medical Manpower.

iv. To prepare the ground for measures to control the development of the services and increase charges to help financing.

v. To set the context for continuing negotiations with professions and pharmaceutical industry.

2. Audience

i. Parliament, informed opinion among those who use and pay for the services, up-market media (with popular presentation of key messages), consumer bodies.

ii. Service providers, health professions, health authorities, pharmaceutical industry.

3. Presentation

Short, aiming to bring out key issues in punchy way; good visual presentation of key data - format similar to 'Health Care and Its Costs'.

4. Contents

The paper would be in two main halves:-

i. Backward looking: the objectives of the services as set out in legislation and policy statements; progress over the last five years in the context of longer term trends. Key figures on resources used (money, manpower), services delivered (intermediate outputs, evidence on quality and consumer satisfaction, impact on health).

ii. The forward look (over the present PESC period and, more tentatively, beyond):

- trends on present policies - resources required and services delivered;

- opportunities (eg, contribution to more efficient and effective pattern of care) and problems (eg, money available and risks of mismatch between money and manpower);

- options for development and control of services including, for example, growth in and control of prescribing costs; growth in and controls on practitioner numbers, support staff and facilities;

- financing options.

iii. Each half would contain sections on:

- general medical and pharmaceutical services, including PPRS issues, economy in prescribing;

- community nursing services and other forms of support from the district health services;

- general dental services;

- ophthalmic services;

- overall perspective on primary health care.

The forward-looking section would also cover our objectives for the reorganised FPCs and for the future of FPS administration.

iv. We should be drawing mainly on work already done and information already available or shortly to be available. The Green Paper might point up key work in hand or needing to be undertaken. It would draw where relevant on current studies involving Treasury.

5. Timing

Factors to be considered are the extent to which publication of Binder Hamlyn can be delayed, the timing of charging increases, key negotiations with the professions and the drug industry and relationship to the next PESC round and the time necessary to do a proper job. June is tentatively suggested as a target which would be defensible for publication of Binder Hamlyn and, would give a feasible time-table for preparation. It would make it possible for the response to the document to feed into decisions on charging in 1985-86, the next PESC round and decisions on the legislative programme. Final decisions on timing would be taken when work was further advanced, having regard to likely reactions of the professions.

CONFIDENTIAL

Miss Stevens PA

Could you check that DISS tell us in advance 1) Mr Fletcher 2) PM when this announcement is going to be made

DHSS 22/3

DEPARTMENT OF HEALTH & SOCIAL SECURITY
Alexander Fleming House, Elephant & Castle, London SE1 6BY
Telephone 01-407 5522
From the Secretary of State for Social Services

PT 23/3

The Rt Hon Viscount Whitelaw PC CH MC
Lord President of the Council
68 Whitehall
LONDON
SW1

PS 20/3

17 March 1984

1) Mr Fletcher
2) Prime Minister (2) : To note.

Dear Willie.

This closure decision could easily become a "cause célèbre."

DHSS 19/3

CLOSURE OF THORNTON VIEW HOSPITAL, BRADFORD

I am writing to let you know about a difficult announcement which we propose to make shortly.

We have had the task of deciding whether to agree to Bradford Health Authority's proposals to close two hospitals - the Thornton View geriatric hospital and the Shipley GP and pre-convalescent hospital. There are strong service grounds for closing Thornton View: it is an old hill-top workhouse, difficult to reach and ill-suited to modern geriatric practice. Unfortunately one of the several wards which the Authority proposed to use in place of Thornton View was itself not of a good standard. We have, therefore, decided to agree to the closure of Thornton View but not to the use of the unsatisfactory ward. Shipley Hospital will be retained for outpatient use by the local GPs and its beds transferred to geriatric use in place of the ward proposed by the Authority.

Both closure proposals have attracted substantial opposition. In the case of Thornton View the opposition has been sustained, widespread and sometimes violent. At one stage the Chairman, Administrator and Information Officer of the Regional Health Authority were forcibly detained by a large deputation of opponents. Threatening telephone calls have been made. The car of the Chairman of Bradford Health Authority was recently vandalised, in its garage, at a protest. The hospital has been "occupied" since last August - preventing senior management gaining access - and was featured in a recent Labour Party Political Broadcast which showed Mr Meacher visiting the hospital. He is but one of a stream of well-known visitors to the hospital since the occupation began, including Messrs Kinnock, Benn, Livingstone, Scargill, Bickerstaffe, Vanessa Redgrave and Glenda Jackson.

CONFIDENTIAL

E.R.

We intend that the run-down of Thornton View Hospital will be gradual as alternative accommodation is found for the patients. This will avoid the appalling prospect of a mass evacuation of some sixty elderly patients in the face of hostile opposition. In our statement we shall be stressing the improvements which have been and are to be made in services to the elderly, paying tribute to the devoted care given in the past to patients at Thornton View, and encouraging those staff to participate in the improvement of services. At local level the DHA Chairman has a carefully prepared presentation ready for the day of the announcement. This, we hope, will defuse the opposition, but we cannot be confident of this, and there could be strong reactions. Hence this letter to let you know what is afoot.

I am sending copies of this letter to the Prime Minister and to members of H.

Yours ever Norman

NORMAN FOWLER

19 MAR 1984

CONFIDENTIAL

File

14 March 1984

LIVERPOOL HEALTH STRATEGY

Your Secretary of State raised the question of the strategy prepared by the Liverpool District Health Authority at the meeting of Ministers yesterday on Liverpool. The Prime Minister has now seen his minute of 12 March and agrees that he should approve it.

Andrew Turnbull

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

CONFIDENTIAL

Prime Minister (1)

This was mentioned at the Liverpool meeting - Agree X?

AT 13/3

PRIME MINISTER

Yes

LIVERPOOL HEALTH STRATEGY

In view of the sensitivity of the general position in Liverpool, you will wish to be aware that we are now ready to confirm a strategy for the rationalisation of health services in the city. The strategy has been prepared by Liverpool District Health Authority to change the balance of its services in the light of a reducing population in the city itself and the fact that health services in surrounding areas are being built up and will need to depend on Liverpool less in the future.

The strategy has as its objectives to achieve a better balance of service. Liverpool has historically been over-dependant on acute hospitals, which have achieved substantially lower levels of performance than those in many other parts of the country, while community services have been less than adequate. The strategy will aim to reduce, and make more effective, acute services while building up services in the community for the elderly (particularly the elderly severely mentally infirm), the mentally ill and the mentally handicapped. This strategy, which is very much in line with national policy, will require major capital investment but will mean that Liverpool can live within the reduced resource allocation which, because of the demographic changes, it can expect over the next few years. As well as new developments, the strategy will require the eventual closure of two out-of-date hospitals.

The strategy has been the subject of prolonged consultation in Liverpool which did not arouse excessive controversy. It has been approved by the RHA and Kenneth Clarke and I are convinced that it should go ahead. The DHA has been awaiting final approval for some months now and I think we should go ahead as soon as possible. If we delay further we run the risk of demoralising one of our more enterprising DHAs who, having tackled their difficulties and drawn up

E.R.

a policy, are beginning to see themselves as being thwarted by Ministerial indecision. It would also begin to appear that we were delaying a decision precisely because of the position of the City Council. Kenneth Clarke has discussed this with Patrick Jenkin who has agreed that we should go ahead. In presenting the decision, however, I believe it is important that the lead should be taken by the local health authorities rather than by Ministers. Don Wilson and Leslie Pocock are fully conscious of the need for sensitive handling and for emphasising the positive aspects of the strategy - they would base their approach on the attached press notice which was originally drafted for a Ministerial announcement. I am confident that they will handle this well and circumspectly.

12 March 1984

N F

£30 MILLION INVESTMENT IN LIVERPOOL'S HEALTH SERVICES

The Chairman of the Liverpool District Health Authority today announced that the authority's plans to achieve major improvements in Liverpool health services over the next five years had been approved. Mr Pocock said:

"Our plans provide the opportunity to move towards a health care service for Liverpool based on up-to-date hospital facilities and strong community services which will give a better service to patients. Our main objectives are:

- a major capital investment of £30 million to make significant improvements in patient care;

- transferring resources from the acute hospital sector to community nursing, day hospitals and primary care services;

- siting of hospital beds, particularly for the elderly, nearer to the community to minimise travelling and transport costs for both patients and relatives who want to see them;

- major improvements for the elderly severely mentally ill;

- an increase in expenditure per head of population from £174 in 1982/3 to £180 in 1988/89.

"The strategic plan is based on a sensible and soundly-based reappraisal of Liverpool's needs because of its falling population. It means that by 1988/89 £5½ million a year can be switched to new developments elsewhere in the Mersey Region. The new plan for Liverpool means that there can be a major

rebuilding and upgrading work at Broadgreen Hospital and Alder Hey Children's Hospital which, with the new Royal Liverpool Hospital, will provide a more up-to-date base for the city's acute hospital services. Major improvements will be made for geriatric patients. There will be new day hospitals for the elderly and elderly mentally ill at Broadgreen, Mossley Hill and Park Hospitals, and a community unit for the mentally handicapped at Olive Mount Hospital.

"There will be a redistribution of beds. The number of beds for elderly mentally ill patients will increase from 30 beds to 210 by 1988/89 and in trauma and orthopaedics the increase is from 248 to 280 beds. Mental illness and mental handicap beds allocated to Liverpool patients will decrease as developments in community care take place. There will be reductions in general medical beds (from 634 to 369) but this will be balanced by better geriatric services and community services. Other reductions will take place in general surgery (442 beds to 331) and paediatrics (447 beds to 372) reflecting the general trend to shorter lengths of stay in hospital by patients in these specialities and falling population.

"Regrettably, two out-of-date hospitals, Newsham General and Princes Park, will have to close over the next few years. Both these hospitals are old and would require substantial sums spent on them if they were to continue to provide a satisfactory environment for patient care and their closure will help fund improvements.

"Inevitably in such a comprehensive re-think of health care priorities detailed adjustments to the plans may be needed in the light of experience. But I endorse the general policy aims of Liverpool's proposals towards a more balanced spread of health services, with the special emphasis on community services and provision for priority groups such as the elderly, the mentally handicapped and the mentally ill."

NOTE FOR EDITORS

In detail, the strategy includes:-

- Major developments and rebuilding at Alder Hey Children's Hospital, including the provision of improved facilities for children's heart surgery (capital cost: £10 million +)

- Replacement of five structurally unsound wards at Broadgreen Hospital together with a new dermatology unit - to replace that at Newsham General Hospital - new outpatient facilities and x-ray rooms (£7.3 million)

- Provision of 95 geriatric in-patient beds and a 50 place geriatric day unit at Broadgreen Hospital (£2.9 million)

- Provision of 60 mental illness beds and 25 beds for the elderly mentally ill at Broadgreen Hospital plus a 45 place day unit for the mentally ill (£2.5 million)

- New 50-place day unit for the elderly mentally ill at Park Hospital (£750,000)

- Modernisation of four geriatric wards and provision of a minimal care unit at Sefton General Hospital (£650,000)

- Provision of 30 in-patient beds and a 50 place day unit for elderly mentally ill patients at Mossley Hill Hospital plus a 30 place experiemental long-stay community unit nearby (£2.4 million)

- Upgrading existing accommodation at Park Hospital (£200,000)

- A new 25-place community unit for the mentally handicapped at Olive Mount Hospital (£100,000)

- Closure of Newham General Hospital (480 beds - mainly general medicine and geriatric) by 1990 and the transfer of some services to Broadgreen, Mossley Hill and Rathbone Hospitals and the rundown of others

- Closure of Princes Park Hospital (100 geriatric beds) in 1985/6 and transfer of patients to Sefton General Hospital.

2 PPS.

DEPARTMENT OF HEALTH & SOCIAL SECURITY

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

Telephone 01-407 5522

From the Secretary of State for Social Services

CF: Await reactions from colleagues.

DHS 12/3

The Rt Hon Peter Rees QC MP
Chief Secretary to the Treasury
Treasury Chambers
Parliament Street
London
SW1P 3AG

March 10 1986

Dear Peter.

SOCIAL SERVICES INSPECTORATE (SSI)

attached.

Thank you for your letter of 31 January.

In working out the proposals for the Inspectorate I have from the start had in mind the danger of creating pressures for increased spending and the need to avoid this. Conversely, I have seen the proposed re-orientation of the existing Social Work Service (SWS) as a way in which we could contribute better to the achievement of value for money by social services departments and - as the draft joint statement says - assist authorities in making the most effective use of existing resources. The SSI proposal is, in fact, a major feature of my Department's financial management initiative, and is the way in which we think we can best influence social services spending patterns.

It may be that in previous correspondence we have failed to bring out sufficiently clearly certain key factors of these proposals. I shall hope to allay your concern (and that expressed separately by Patrick Jenkin) by doing so now. And I am enclosing a modified version of the draft joint statement with the Local Authority Associations (not as yet shown to them) which seeks to remove any scope for misunderstanding of our intentions.

I understand, of course, your fears about the traditional propensity of professional inspectorates to advocate improved standards of service without adequate regard to the cost. You point out, however, that when MPs quoted certain established inspectorates in this context during the RSG debate nobody mentioned SWS. I am not surprised: the distinguishing feature is that SWS forms an integral part of the chain of command within my Department. That situation will be in no way altered by the proposed change of nomenclature and the increased emphasis on efficiency work. The new inspectorate will not be a quasi-autonomous unit with form terms of reference. It will operate, through the Chief Inspector, under the control of my Permanent Secretary and within the established policy framework. It will present its reports to me and will be answerable to me for its observance of Government policies and priorities. If

there have been no grounds for complaint about the output of SWS in the past, I see no reason why they should be created by its reconstitution as the SSI on the basis which I propose.

There seems to have been some misunderstanding about the extent to which local authorities will be able to influence the activity of the SSI and about the attachment of local authority staff. I envisage that inspections will be of three main types:-

a. initiated by Ministers and the Department in exercise of my formal powers of inspection;

b. issues of general concern outside formal powers and covering a number of local authorities, by agreement with the authorities concerned, and in accordance with a programme agreed by the local authority associations;

c. requested by individual local authorities to cover specific services or activities.

Of these three, a. and c. will continue as before; and I would expect the activity at c. to be limited in extent and to relate primarily to specific, localised management problems. They key area is b.; and it is through the expansion and redirection of this activity that we would hope to make an impact on the general level of efficiency in delivery of personal social services. As the activity will be entirely extra-statutory we shall be reliant on the voluntary co-operation and goodwill of staff in the inspected local authorities; and this makes it important that the programme should have both the endorsement of the local authority associations and the agreement of the individual authorities involved in any particular instance. But this "steering" function involving the local authority associations will relate solely to the setting up of the annual programme of work. The SSI will report to me and the individual authorities, and not to the steering group; and as I have said, our internal management arrangements will ensure that reports are soundly based on Government policies and priorities. There is no way in which the local authority associations could hijack the Inspectorate and use it in support of their political ends.

In proposing that the SSI should be reinforced - for studies of the b. type - by staff on attachment from local authorities, I have had in mind not so much social services staff - who would normally duplicate the expertise of our own people - as staff from treasurers' departments or central management; similarly attachments from other organisations and disciplines would be, for example, management accountants, experts in information technology or others required to complement the Inspectorate's own skills. Again, there is no scope for local authorities turning the Inspectorate into an instrument of their political ends.

You mentioned the relationship between the Inspectorate and the Audit Commission. I see the two as complementary, and working in close alliance. So far the Audit Commission has been able to devote only limited attention to the personal social services; and their work has been less than definitive. The interests of the Commission are so wide, and so many are the activities of social services departments and so varied the standards of performance by local authorities

that I think it essential to back up the work which the Commission can do in this field with related, more intensive studies which make full use of social services expertise. I hope that the two bodies can co-ordinate their work closely, and we for our part intend to collaborate as fully as we can.

You also mentioned the possibility that the SSI might be set specific targets in terms of savings to be made. With the best will in the world this seems to me quite impracticable. The interactions between the personal social services and the NHS and between them and the voluntary sector vary so much in different areas that targets of that kind would be entirely academic. Nor could they be enforced on individual authorities. I think we must retain a pragmatic approach.

Finally, you raise the question of timing of the establishment of the Inspectorate and suggest delaying it until SWS has been staff inspected. The fact is that contrary to the recollection of your Department SWS were staff inspected in 1972 and 1977 (and since 1977 numbers have been reduced by 30 or almost 25 per cent). They would have been inspected again more recently had it not been for the proposal to establish the Inspectorate. It seems more sensible - and I must say that I still think it makes sense - to delay that inspection until the new pattern of activity was settled, so that the benefit of the effort expended could extend some way ahead.

I should like to be as helpful as I can on timing; but it was April last year when we first canvassed these proposals and November when we reached an understanding with the local authority associations. The Social Services Committee in their Second Report for 1981-82 made an explicit recommendation in favour of an inspectorate based on SWS, and I expect them to question me when next I appear before them on the outcome of the recent consultations. I do not myself believe that early establishment of the Inspectorate would create difficulties for us in the handling of the rate-capping legislation since its first report under the b. heading above could hardly be rendered before the middle of next year. Moreover, I think the availability of the Inspectorate could be very helpful to us in resolving some of the problems which will face us when we come to implement the legislation, for example on derogations. Nevertheless, if Patrick Jenkin or you saw advantage in it I should be ready to confine myself at this stage to announcing that the inspectorate would be set up (on the basis of a revised statement agreed with the local authority associations) at some stated future date - say 1 October next. In that way we could still obtain the advantage to be gained from the early resolution of uncertainty.

I hope that in the light of this fuller explanation of the background to my proposals you will feel that the difficulties you foresaw need not arise. If you would like to discuss any aspect of the proposals I am at your disposal.

I am copying this and the enclosure to the Prime Minister, Willie Whitelaw, Leon Brittan, Patrick Jenkin, Keith Joseph, Nicholas Edwards, George Younger, Jim Prior, Sir Robert Armstrong and Robin Ibbs.

Yours ever Norman

NORMAN FOWLER

JW

4th DRAFT

SOCIAL SERVICES INSPECTORATE: DRAFT JOINT STATEMENT WITH THE LA ASSOCIATIONS

1. In April 1983, the Secretary of State sent to the Chairman of all Social Services Committees a consultative document proposing development of the Department's Social Work Service - which already exercises inspectorial functions - explicitly into an inspectorate for the local authority personal social services. In the light of a wide range of helpful comments on the consultative document, the Government has now reached agreement in principle with the local authority associations on the way forward.

2. The resources available to social services departments are always going to be under heavy pressure. It is therefore necessary to ensure their most efficient and economic use. The aim of the Social Services Inspectorate will be to assist authorities to obtain value for money by making the most effective use of existing professional and other resources, and to spread good practice. Its work will complement that of the Audit Commission for Local Authorities in England and Wales.

3. Inspections will be of 3 main types:-

a. initiated by Ministers and the Department in exercise of the Secretary of State's formal powers of inspection;

b. issues of general concern outside formal powers and covering a number of local authorities, by agreement with the authorities concerned, and in accordance with a programme agreed by the LA associations; and

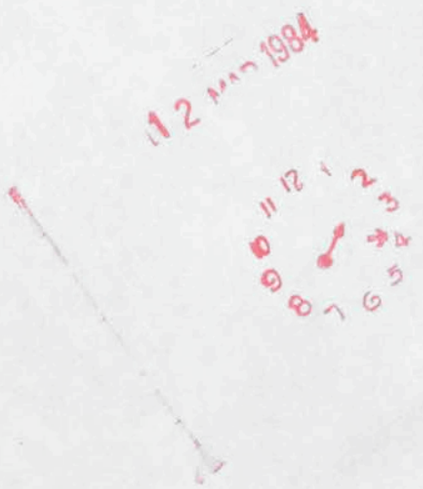
c. requested by individual local authorities to cover specific services or activities.

Reports written as a result of formal inspections would be made in the first instance to the Secretary of State, but all other reports would be concurrently to the authorities concerned for their Social Services Committee to see. Reports would normally be documents of public access.

4. Formally, the existing statutory powers of inspection (which are considered sufficient for the purposes of new Inspectorate) are vested in the Secretary of State, and he will be the Minister responsible for the Inspectorate's management and actions. In practice, however, the programme of work of the Inspectorate

outside formal powers will be a joint concern of central and local government. This will be reflected in a Steering Group of the Government and the local authority associations, whose detailed terms of reference are under discussion with the associations.

5. The staff of the Social Services Inspectorate will consist of members of the existing Social Work Service, supplemented by staff from relevant disciplines on attachment from local authorities and when appropriate from other organisations, including experts in financial management and value for money techniques. The Inspectorate will continue existing collaboration with HM Inspectorate of Schools and the Probation Inspectorate and will work closely alongside the Audit Commission.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PART 3. begins:-

S/S DHSS to CST 10/3/04

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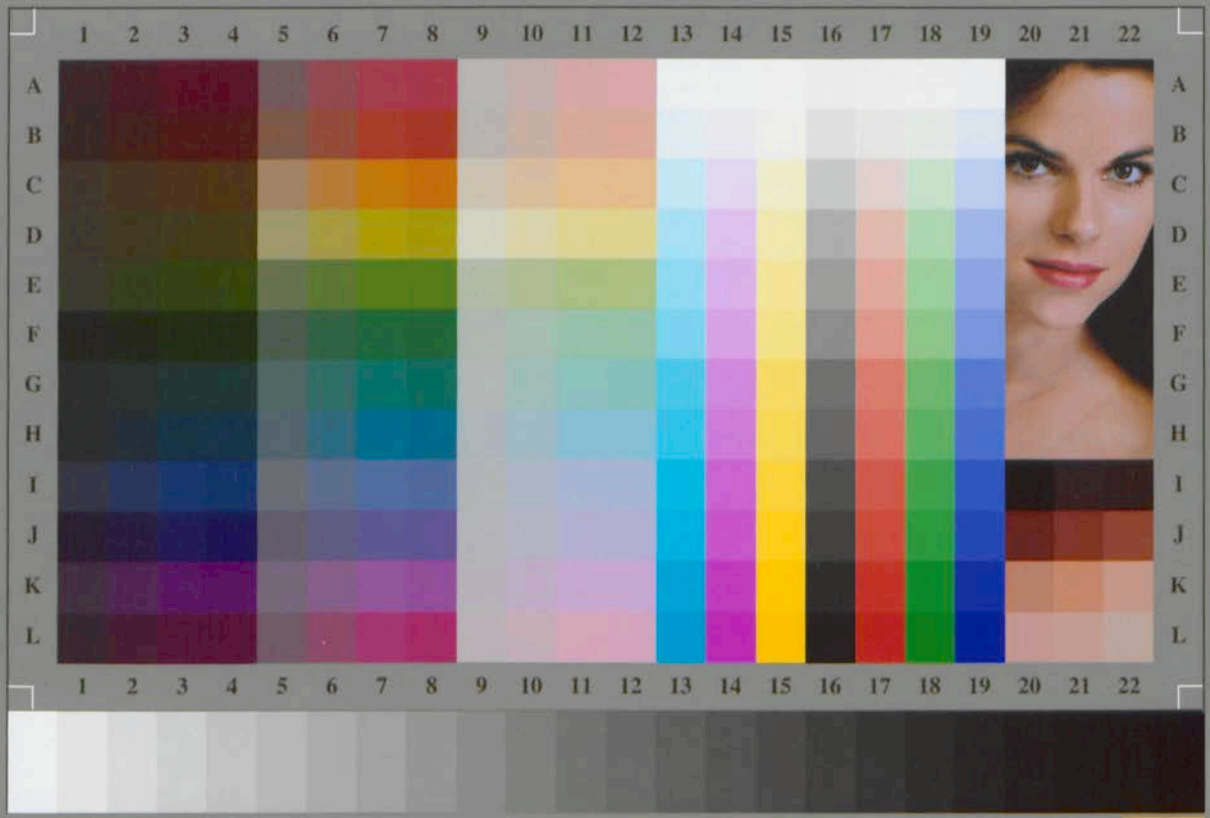

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