(2)

Prime Minister

To note

LC N.O.

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

MS! MLS 17/5

PRIME MINISTER

NHS MANAGEMENT INQUIRY

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

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

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

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

E.R.

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

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

16 May 1983

N F

CONFIDENTIAL

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

10 DOWNING STREET

From the Private Secretary

16 June, 1983.

NHS Management Inquiry

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

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

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

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

CONFIDENTIAL

(1)

PRIME MINISTER

NHS MANAGEMENT INQUIRY

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

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

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

N.B.

Ferdie Mount agrees with this line.

MCS

15 June 1983

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

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

Nat. Health

(2)

Prime Minister
for
MCS 9/6

Rather wholesome: a rather stultifying work!

CHIEF SECRETARY TO THE TREASURY

PRIME MINISTER

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

NHS MANAGEMENT INQUIRY MCS 13/6

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

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

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

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

J Gieve

for LEON BRITTAN
7 JUNE 1983

[Approved by the Chief Secretary]

Nat Health.
Feb '81. NHS
Manpower Inquiry

FILE RM

B/C NCNEN.

10 DOWNING STREET

From the Private Secretary

18 May, 1983

NHS MANAGEMENT INQUIRY

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

M. C. SCHOLAR

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

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

Telephone: 01 407 5522 X7684/ 6604

Leader of Inquiry:

Roy Griffiths

Team Members:

Michael Bett
Jim Blyth
Sir Brian Bailey

Support Staff:

Cliff Graham
Kay Barton

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

12 May 1983

Dear Secretary of State

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

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

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

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

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

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

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

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

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

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

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

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

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

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

health services information and the "Salmon" report on

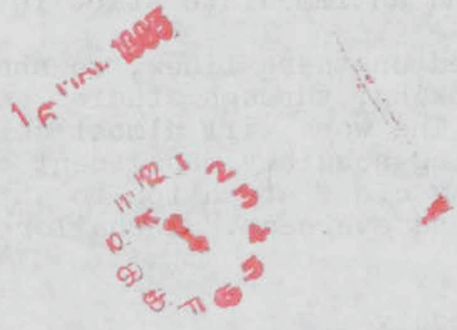
We are confident that further work on the above lines will enable us to formulate more precise recommendations for implementation within the NHS. There can be no doubt that the overall implementation, particularly the strengthening of line management, will be a long and challenging task simply because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

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

Yours sincerely

Roy Griffiths.

E R GRIFFITHS



Personal.

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

4 May.

FRCB

Dear Robin,

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

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

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

I remain enthusiastic.

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

As ever.

Ken.

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

The Managing Director's office

SAINSBURY'S

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01-921 6000

Telex 264241

To Sinclair.

PERSONAL

22nd April, 1983

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

Dear Mr. Fowler,

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

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

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

/ Cont....

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

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

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

Best wishes,

Roy Griffiths

E.R. GRIFFITHS

Enc.

CONFIDENTIAL

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

MAIN TASKS

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

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

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

GENERAL OBSERVATIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

GENERAL MANAGEMENT ACTION

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

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

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

SPECIFIC MANAGEMENT ACTION

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

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

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

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

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

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

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

NEXT STEPS

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