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PRIME MINISTER

NHS REVIEW: CENTRAL MANAGEMENT OF THE NHS

I attach the detailed paper on the central management of the NHS for which you asked.

2. You will see from the paper that I am well content with the title of Management Executive that you suggested.

3. I make only one general point. It is that whatever we decide on central management and accountability should be consistent for the United Kingdom as a whole.

4. I am copying this minute and the paper to the Chancellor, the Secretaries of State for Wales, Scotland, Northern Ireland, the Chief Secretary, the Minister for Health, Sir Robin Butler, Mr Wilson (Cabinet Office) and Mr Whitehead (Policy Unit)

23 January 1989

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NHS REVIEW: CENTRAL MANAGEMENT OF THE NHS

Note by the Secretary of State for Health

I attach summary notes setting out:

- the functions, structure and management of the Department of Health (DH) (Annex 1)
- staff numbers in DH (Annex 2)
- the management of the NHS by the Management Board (Annex 3)

2. We have three broad objectives:

first, to put in place an effective chain of command to implement and carry forward our proposed reforms.

second to make clear the distinction between policy advice and operational responsibilities at the centre and the relationship between the managerial chain of command and the Department.

third, to ensure that the Government are only answerable in Parliament for those matters for which they can sensibly be held to account.

Future arrangements for central management of NHS

3. There is a range of options. They begin with the present arrangements then move progressively further from that. In order they are:

1. Management Board (MB), as now

   The MB has a distinct role within the Department, but is essentially part of it. We are agreed we must move beyond this.

2. Management Executive (ME), with a separate and defined status under the Secretary of State for Health

   This would put the ME on a quite different basis from the MB and, for the reasons set out below, is my preferred option.

3. English Health Authority (EHA), a body with separate legal status.

   A new body, between the Secretary of State and the NHS with a Chairman as well as a Chief Executive. Unlike now, Regional Health Authorities (RHAs) would be statutorily responsible to the EHA, rather than the Secretary of State. The simplest model would be a health authority model.

4. Health Service Corporation (HSC), a public corporation with separate legal status.

   The HSC would operate like a nationalised industry,

with direct management control. It could be a unitary model or a devolved model. With a unitary model, the NHS would become a single unified organisation with central, regional and local boards. But the regional and local boards would have no separate legal identity as health authorities have now. With a devolved model, regional and local boards could become more independent bodies. So the Northern Region for example could develop its own character, rather like the NHS has developed its own character in Scotland, Wales and Northern Ireland.

4. Starting with the far end of the spectrum, a Health Service Corporation as in Option 4 would provide a clear separation of the Government from the management of the NHS. The unitary model would provide a streamlined, direct chain of command. The devolved model would provide a visible buffer between the centre and local management, enabling the latter to get on with its job.

5. But I am not aware of any precedent for a public corporation running a public service funded almost entirely (97%) from taxation (81%) and National Insurance contributions (16%) and with virtually no independent income of its own. Even those nationalised industries that have been grant aided have had profit and loss accounts to which they have taken their income from charges or trading. Detailed accountability to Parliament would certainly be much less than now - but to an extent which we would not find easy to defend. We would also have to deal with allegations that the public corporation was a first step to privatisation. And, most important of all, an independent public corporation with a high profile Chairman and funded through taxation would become a powerful, and very visible, lobby for extra resources.

6. Unlike the public corporation model, the English Health Authority envisaged by option 3 would be recognisably in the NHS mould by building on the existing NHS structure. It would provide a separation between the Government and the management of the NHS, though not as sharply as option 4. It would provide an extra link in the chain of command between the centre and regions which matched that between regions and districts.

7. This option still presents us with two of the significant obstacles which apply to option 4, a public corporation. First the EHA would not be part of central government. The Accounting Officer would have to be in DH, as he would be if we went for option 4. And inevitably, the temptation for the EHA would always be to attribute failings to the lack of resources or other constraints imposed by Government. Of course, we would maintain some disciplines through contractual obligations and direct lines of accountability to me from the EHA and its senior management. But the EHA would come under permanent pressure from many of the health authorities below it to become a powerful and visible lobby for more resources. That indeed would be seen as its only quality by people in the NHS who would otherwise look on it as another layer of bureaucracy between them and Ministers. Second, if we are to adopt this option, or option 4, we should have to look again at the arrangements in Scotland, Wales and Northern Ireland.

8. Having reexamined the case for options 3 and 4, I have concluded that option 2, a Management Executive, is to be preferred. Annex 1 explains how the Management Board operates within the Department of Health. As my minute of 18 January made clear, I fully recognise both the enhanced role we see for the new ME which will replace the Management Board and the need for us to mark out its new status clearly. I

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propose a number of important steps to achieve this:

First, all central operational and management work on the NHS would come under the ME.

Second, staff working for the ME would have a clearly defined responsibility to the ME. If necessary, this could be incorporated in letters of appointment. I also expect that in future a greater proportion of ME staff will be seconded from the NHS.

Third, all operational and management work on the family practitioner services, including negotiations with the contractor professions, will in future be the responsibility of the ME. The Chief Executive will become Accounting Officer for this block of work too. My officials are discussing with the Treasury the implications of this for the present Vote structure.

Fourth, as I said in my minute of 18 January, the Chief Executive will report to me direct on all NHS operational and management matters.

Fifth, the Chief Executive will have his own budget for the operation of the ME. The precise accounting arrangements, which could draw on the Next Steps Agency model, would need to be worked out.

Sixth, as I have also already said, the Chief Executive will take a prominent role in dealing with Select Committees.

Finally, I envisage that the ME will operate on the basis of policy and resource directives issued by the Policy Board which I chair.

9. Taken together, these steps will both underline and underpin the new and separate status of the ME. They will not however - nor should they - lead to a situation where policy and strategy on the one hand and operations and management on the other become artificially separated. The ME will not be excluded from offering me policy advice; and of course the Chief Executive will be on the Policy Board. Similarly, I will not expect the Department to frame its policy advice without taking account of operational and management factors. And some senior officials will need to offer me advice on both fronts. The crucial point is that it will be clear where the advice comes from, the Department or the ME. It will be like advice on fiscal matters to the Chancellor, some of which comes from the Treasury's Fiscal Policy Division and some from the Inland Revenue

The Secretary of State, the ME and the RHAs

10. There are two lines of communication now between the centre and regions. One is between the Secretary of State and the Chairman, who are appointed by him. The other is between the Chief Executive and the Regional General Managers. This is less messy and more practical than it sounds. The line to Chairman from me is essentially political; the management line is from the Chief Executive to the Regional General Managers. The same arrangement applies between Regions and Districts. If a Regional General Manager spots any different emphasis between the messages he is getting from the Chief Executive and his Chairman it is quickly sorted out in practice.

11. In future the management line will be reinforced by my intention (mentioned in my minute of 18 January) that Regional General Managers will be accountable to the Chief Executive who will set objectives for them. I intend that the Chief Executive will be responsible for monitoring the

performance of Regional General Managers against objectives set for Regions by the ME.

12. It is important, however, that we retain the separate links to Chairmen who, as I have said, regard themselves as charged with the delivery of Government policy in their Regions. This will help us considerably in carrying through our reforms. But it may be even more important in achieving our aims on accountability. Regional Chairmen, as Chairmen of public authorities, have a personal position and standing of their own. This enables them to act as political firebreaks, in resolving or halting issues so that they do not automatically reach Ministers and Parliament.

Accountability

13. My approach to the Management Executive will enable us to establish a new basis for Ministerial accountability to Parliament. Operational and management matters will be for NHS Management rather than Ministers. National management issues will be for the ME to handle and more detailed issues for Regions, Districts and local management to handle as appropriate. I envisage that, when our legislation is implemented, we should normally refer Members who write or ask Questions to the relevant level of the NHS.

14. I do not expect us to get to our final goal overnight. We must move towards it steadily, as part of the implementation of our reforms. It would not be helpful in carrying through our proposed legislation if we were to appear to present Parliament with a fait accompli which meant an immediate and major shift in the present conventions on accountability. In any event I would not want health authorities as at present constituted before our legislative changes to be given this opportunity to attack the Government when pressed on their local problems.

15. I should reiterate the point that we can only change Parliamentary expectations on accountability if we maintain a common line in all four countries. Otherwise my position, and that of the Prime Minister, would not be tenable.

DH 23 January 1989

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ANNEX 1

THE DEPARTMENT OF HEALTH

Functions

The Department has two main functions:-

a. to inform, advise and serve the Secretary of State and other Ministers across the whole range of their responsibilities for health and personal social services, including:

i. supporting Ministers in their, and the Department's duty of informing and accounting to Parliament.

ii. developing policy in response to the requirements of the Secretary of State and of Parliament, consulting the relevant statutory authorities and others as appropriate.

iii. co-ordination and close collaboration with the Cabinet Office, Treasury and other Government departments in carrying forward the business of the Government as a whole.

b. to support the Secretary of State in the implementation of the legislation for which he is responsible, including the efficient and effective delivery of services costing £23 billion in 1989/90 and employing directly and indirectly over a million people.

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Services

2. The services in England for which the Secretary of State is responsible can be grouped broadly as follows:-

a. Hospital and Community Health Services, delivered through the agency of 14 Regional Health Authorities, 191 District Health Authorities and 10 Special Health Authorities governing the London post-graduate teaching hospitals, the Health Education Authority and the Disablement Services Authority and managed by the NHS Management Board.

b. Family Practitioner Services: Services are provided on the Secretary of State's behalf by 62,000 independent contractors. Their contracts are negotiated centrally by the Department with representatives of the professions concerned; and are administered locally by 90 Family Practitioner Committees which were established in 1985 as separate bodies directly accountable to the Secretary of State.

c. 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

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inquiry, inspection and action in default) and responsibilities (eg in relation to social work training) but not the same measure of resource allocation and performance monitoring as for the health services

d. an extensive range of wider health and social responsibilities some of which derive from specific statutes and others from his general statutory duty to safeguard public health. They include direct executive responsibilities for Special Hospitals, public and environmental health measures, public health laboratories, health education and preventive health measures, relations with the private health sector, licensing medicines, evaluating health care equipment, sponsoring the pharmaceutical and medical equipment industries, grants to voluntary bodies, sponsoring research, monitoring the professions' self regulation and international work.

Structure and Management

3. Support to the Secretary of State for the two main functions is provided at Headquarters. Management developments have been based on the following specific guidelines:-

i. No work should be done in the Department that could be done more cost-effectively outside it.

ii. Work should be delegated to the lowest competent level, subject to monitoring by higher management;

iii. There should be clear lines of accountability at all levels; and

iv. Managers at all levels should be held accountable for performance against agreed objectives.

Where the Department has responsibility for the implementation of policy, directly or indirectly, management bodies dedicated to the particular service have been established some with external advice. By contrast, the Department maintains responsibility of the integrated formulation of policy over the whole field of the Secretary of State's responsibility for health and personal social services, in liaison with the relevant statutory authorities. The Department is developing new management information systems to reflect the varying communications needs of the main businesses.

4. Most recently possible candidates as Next Steps Agencies have been identified with a view to improving the efficiency and effectiveness of delivery of services to customers when it has seemed inappropriate to delegate responsibility for delivery outside the Department.

5. The analysis of DH Headquarters staff numbers at Annex [2] illustrates this trend: Medicines Division (227 staff) is about to become a self-financing Agency within the Department; the Special Hospitals (3,220 in the hospitals themselves) are due to become a Special Health Authority within the NHS this year; NHS Statutory Audit (220) will be transferred to the Audit Commission; the Disablement Services Authority (1,080) is already a Special Health Authority, though for the moment mainly staffed by DH officials; the Dental Reference Service (62) is being transferred to a Special Health Authority and NHS Superannuation (800), Youth Treatment Centres (190) and the Social Services Inspectorate (192) are possible candidates for Next Steps Agencies. Thus the size of the DH is in the process of being more than halved; and a further 1,400 staff are already being transferred or are being examined for transfer into different forms of Agency.

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ANNEX 2

DEPARTMENT OF HEALTH

Approximate Staff Numbers, January 1989

A. HEADQUARTERS (London based)

				Total
(i)	NHSMB support			
	(a) Information, Performance Indicators, Planning, IT		64	
	(b) Health Authority Finance, Financial Management, Management Services, Income Generation		82	
	(c) Regional Liaison		87	
	(d) Health Building		103	
	(e) Procurement		157	
	(f) Personnel		115	
	(g) Estate and Property Management		25	
			633	633
(ii)	Family Practitioner Services			166
(iii)	Health & Personal Social Services Policy			353
(iv)	Medicines Division (Licensing & regulation of pharmaceuticals) (NOTE 1)			227
(v)	Professional Groups (including administrative support)			
	(a) Medical		234	
	(b) Dentists		10	
	(c) Nurses		65	
	(d) Social Services Inspectorate HQ (NOTE 2)		66	
	(e) Analytical and statistical		266	
	(f) Legal		28	
			669	669
(vi)	Finance and internal audit			139
(vii)	Personnel Management and Central Account			203
(viii)	Private Offices and Information Division			83
(ix)	Office Services (typing, messengers, security etc)			420
	Total			2893

NOTE 1: About to become a self-financing Agency within the Department with externally recruited director.

NOTE 2: These are HQ numbers; see B5(a) for the field force.

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B. DEPARTMENT OF HEALTH SERVICES

			Total
(i)	Special Hospitals	(NOTE 3) 3220	
(ii)	NHS Superannuation	(NOTE 4) 800	
(iii)	Youth Treatment Centres	(NOTE 4) 190	
(iv)	NHS Statutory Audit	(NOTE 5) 220	
(v)	Miscellaneous services (outside London)		
	(a) Social Services Inspectorate (NOTE 4)	126	
	(b) Dental Reference Service (NOTE 6)	62	
	(c) Regional Medical Service	219	
	(d) Mental Health Act Commission and Review Tribunals	47	
		4884	4884

C. DISABLEMENT SERVICES AUTHORITY (NOTE 7) 1080

GRAND TOTAL	A. Headquarters	2893	
	B. DH Services	4884	
	C. DSA	1080	
		8857	8857

NOTE 3: Planned to become a Special Health Authority within the NHS during 1989

NOTE 4: Possible candidates for Next Steps Agencies

NOTE 5: To be transferred to the Audit Commission on 1.4.91

NOTE 6: To be transferred to the Dental Estimates Board (an SHA) on 1.9.89.

NOTE 7: Became a Special Health Authority in July 1987 tasked with arranging full transfer to the NHS by 1.4.91. Included in the Department only because the Authority is, for the present, staffed mainly by DH officials.

ANNEX 3

THE MANAGEMENT OF THE NHS BY THE MANAGEMENT BOARD

The NHS Management Board (MB) currently manages the NHS through a series of formal systems and informal relationships. Ministers are heavily involved in many of these systems and relationships. The following notes describe the main elements.

2. The MB's Director of Finance leads the Department's work on establishing the financial needs of the NHS in PES. Once Ministers have agreed the outcome, the Finance Director advises Ministers on the allocations to individual Regions and other health authorities, and is responsible for the release of funds to individual authorities, for monitoring expenditure against cash limits and for ensuring delivery of the cash limit by the NHS as a whole. The MB's Director of Financial Management monitors the income and expenditure position of RHAs and their Districts in order to ensure that the NHS spends at a level which can be afforded.

3. Health authorities are required to draw up short term programmes (ie annual operating plans) before every financial year. These show what services they intend to provide (including new developments), what manpower will be employed and how they will be funded. The STPs must be framed to respond to policy guide-lines from the Department eg as to the development of particular services. The STPs must also contain proposals for

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cost improvement and income generation. These STPs are vetted for ambition, coherence and soundness by the revelant MB Directors (Planning, Financial Management, Operations and Personnel), before approval. Implementation is monitored by the MB.

4. The performance of each RHA is thoroughly reviewed every year. The MB examines, inter alia, the execution of a series of special tasks agreed with the RHA at the previous year's review (the Action Plan); the RHA's financial position; and its achievement of a range of policy or other objectives eg the improvement of vaccination rates, the implementation of energy conservation measures,the better use of beds the reduction of waiting times. Having carried out their review, the MB Directors then support a Minister to who carries out Ministerial Review, at which the key issues are thrased out with the RHA Chairman.

5. Capital investment in the NHS is controlled through the requirement on RHAs to submit major building schemes for approval - schemes of over £10m have to go to the Treasury, - and through the monitoring of RHA performance on schemes (eg time and cost over-run).

6. RHAs are obliged to submit disputed hospital closures for Ministerial decision. Such closures often cause political

difficulties and considerable work for the health authorities, Ministers and officials.

7. The pay and conditions of NHS staff are tightly controlled through their central determination by Ministers, whether on the advice of Review Bodies or Whitley Councils.

8. RHAs, and DHA Chairmen, are appointed by Ministers. Ministers now enjoy very close relations with Regional Chairmen. Ministers meet them regularly; frequently consult them on policy and management issues; and expect (and receive) considerable personal loyalty in carrying out Ministers' policies.

9. The MB Chief Executive and his fellow Directors enjoy good relations with Chairmen and very close relations with Regional General Managers. The Chief Executive has established himself as "professional" head of general managers in the NHS, and spends much time and effort encouraging the development of management skills and raising management standards in the NHS. Through hundreds of visits and speaking engagements he has become highly visible to the NHS managers. The MB's functional directors (eg Financial Management, Personnel) also act as professional heads of their functions in the NHS.

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10. Paragraph 2-7 above describe some of the formal, regular systems by which Ministers and the MB manage the NHS. In addition, of course, the MB is in frequent touch with Regions and Districts over particular problems or issues. The requirement to answer in Parliament for what happens in the NHS inevitably pulls up, to Departmental level, many issues which would not otherwise require our involvement.