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3(A-6)

PRIME MINISTER

21 April 1989

CENTRAL MANAGEMENT OF THE NHS

The NHS White Paper provided a general framework for the central management of the NHS. Roy Griffiths and Christopher France have now responded to your earlier remit to spell out the detailed options and recommendations. The covering note indicates that Kenneth Clarke and Duncan Nicol are 'content' with the result.

PROPOSAL BY DH

In the short-term:

(1) The role, functions and accountability of the Management Executive would be set out in a formal 'written statement'.

(2) An annual 'business plan' would be issued by the Policy Board to the Management Executive.

(3) As much responsibility as possible would be devolved closer to the patient.

(4) Parliamentary questions will be directed more towards the health authorities and FPCs, where possible.

In the longer-term:

(1) Once the NHS reforms are in place, the central organisation would be slimmed-down.

(2) Less Ministerial - and Parliamentary - involvement in operational matters.

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B

The general approach seems reasonable except for the timing of the central reorganisation. **But the Annexes are far more crucial than the covering note.**

Success or failure will depend on the relationship between the Department of Health (DH) and the Management Executive (ME). If Duncan Nicol is not set free from bureaucratic control we will continue as before. The tension between DH's need to control and ME's desire to loosen the shackles was evident during the extensive discussions on Annex C.

Annex C

Three options were considered:

(1) The autonomous Chief Executive (Duncan Nicol's preference).

(2) The subsidiary agency (DH and Treasury's preference).

(3) The holding company approach (compromise solution).

The main differences between the three relate to the control and accountability of financial budgets.

1

In (1), the Chief Executive of the Management Executive would be the Accounting Officer for most NHS expenditure, except for the Permanent Secretary's policy department and some support services. Crucially, the Chief Executive would hold the budget for his own department.

2

In (2), the Permanent Secretary would hold the purse strings as the Accounting Officer. The Chief Executive would be accountable to the Permanent Secretary ie no change.

C

A compromise was then agreed between Christopher France and Duncan Nicol.

In (3), the Chief Executive would be the Accounting Officer for most NHS expenditure as in (1). But he would not control the budget for his department ie **fudged management**.

MAIN PROBLEMS

1. Management Effectiveness

The debate on community care has highlighted one fundamental truth in management. Power and responsibility must not be divorced. Options (2) and (3) will give responsibility to the Management Executive but without power. And the Department of Health would be given the power without the day-to-day management responsibility. We must avoid this at all cost.

And there is a real danger that Department of Health officials will attempt to hijack the day-to-day management of the NHS. They find it difficult to accept decentralisation. This heavy-handed style emerged in a recent draft circular by the Health Department in the Northern Ireland Office:

> "Boards are asked to submit their proposals to the Department by the end of June. The Department would find it helpful to discuss these proposals with General Managers as they develop. After considering the proposals, the Department will issue further guidelines to enable Boards to implement the agreed management arrangements."

And the paper before us also displays a patent misunderstanding of best management practice or perhaps it hides an underlying Machiavellian streak.

D

In paragraph 6 of Annex C, it suggests that the Chief Executive would have no interest in becoming enmeshed in personnel arrangements.

Surely, the selection and monitoring of senior staff is the most important role of the Chief Executive.

And a 'pain and perks' policy is fundamental. From my own contacts with major corporations at home and abroad, a risk and reward policy will attract the best people. Yet this is anathema to many department officials.

The paper ducks the issue by suggesting key personal changes will need to be cleared with the Chief Executive. Will this really work in practice?

2. Slimming-down the central organisation

Appendix C1 of the paper shows how the 8,623 'health' staff are distributed.

We believe this enormous body of staff should be slimmed down sooner rather than later. Kenneth Clarke should be asked to present a firm timetable of change over the next few years. Particularly worrying are:

	Numbers
Health Building Directorate	107
Procurement Directorate	161
Disablement Services Authority	1057

Is there a need for the first two? And why not privatise the Disablement Services Authority as proposed by Ian McColl? Or create a Next Steps Agency.

3. Parliamentary Accountability

The paper proposes a progressive development whereby MPs increasingly pursue detailed operational matters with the Chief Executive or the appropriate health authorities.

I agree that an immediate declaration of intent in the House would be premature. Progressive devolution will be more effective in the long run.

But this is no excuse for holding on to a large bureaucracy as suggested in the paper. The sooner we slim-down the central organisation, more questions will be asked at a local level. Otherwise, the central bureaucracy will continue to feed off itself.

RECOMMENDATION

- Insist on more autonomy for the Chief Executive. He should be able to hire and fire staff and manage his own administration budget.

- Kenneth Clarke should present a clear timetable for slimming down the numbers of staff at the centre.

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