Reference No: E 0705

MR WILSON

Management arrangements for the NHS in Scotland

We were asked for any comments on Mr Rifkind's minute of 31 May to the Prime Minister.

2. We should test Mr Rifkind's proposals against the criteria applied by the Prime Minister to the organisation of the NHS in England. I shall take them one by one.

Separation of policy from management

3. This is of course the most important test. It breaks down into a number of others:

a. Status. The White Paper said that the Management Executive in England would be in the DOH but have "a separate and defined status" under the Secretary of State. DOH proposed to give it such a status by a written public statement of its role, functions and accountability, and by an annual public Business Plan. Mr Rifkind says that the Scottish Chief Executive will operate according to an annual Business Plan, but he does not mention a written statement of his role. His paper suggests that the Management Executive Group in Scotland will have a lower status than its counterpart in England, and be more obviously an internal unit of SHHD. There may therefore be a stronger case for bolstering it by a public statement of responsibilities.

b. Membership of Management Executive. The ME in England will contain, at least at first, three DOH officials from its membership of nine. Mr Rifkind does not say exactly what the membership of the Scottish Management Executive Group will be. But it will be "similar" to that of the existing Policy Group, which apparently consists entirely of SHHD officials, but "augmented" by key NHS personnel and any

additional appointees made on the Chief Executive's recommendation. This is an area which could bear further enquiry.

c. Staff. In the case of England, it became apparent that the DOH's proposals would have allowed some overlap between staff on policy work and staff on management work. Mr Clarke was asked to consider further the position of staff working for both the Executive side and policy side of his Department, and in particular the risk of double banking. Mr Rifkind is again not very explicit on the arrangements to be made in this area in Scotland. He does say that the Chief Executive will be able to assess what pattern of support staff is necessary. But he also says that the Chief Executive will be Vice-Chairman of the Common Services Agency "which provides a wide range of operational and support services on a national basis". Again, more information is clearly needed here.

d. Accounting Officer responsibilities. Mr Rifkind says that the Chief Executive will be the Accounting Officer for programme expenditure. The arrangements for administrative expenditure are not explained, although there is an implication that the SHHD Secretary will remain as Accounting Officer for them. After some discussion, the Prime Minister said she was prepared to accept a similar arrangement for England, so there is unlikely to be an issue here. But in discussions about England the point was thought to be important and the plans for Scotland should be explained properly.

Powers and responsibilities of the Chief Executive

4. The important point here is that at the Prime Minister's meeting on 25 April it was decided that the Chief Executive in England must be able to make his own key appointments subject to clearance with the Permanent Under-Secretary and the Secretary of State in the case of the most senior ones. Mr Rifkind says on

this point only that the Chief Executive in Scotland will "be free to propose adjustments or supplementation to the existing arrangements at senior level" before he formally assumes his responsibilities.

5. The Chief Executive's powers in relation to the Health Boards are also important. For England, DOH proposed that there should be an understanding that "the Chief Executive speaks with the authority of the Secretary of State who has explicitly delegated management issues to him". The Prime Minister's meeting on 25 April decided that the Chief Executive should have sufficient powers delegated to him in relation to Health Authorities, including their Chairman, to enable him to manage operational matters effectively. There seem to be no similar proposals for Scotland and indeed Mr Rifkind says explicitly that the role of the Health Board Chairmen "must not be or appear to be diminished". His only positive proposals are that the Chief Executive should foster a sense of corporate identity among General Managers so that they will in due course come to regard him as the head of their profession, and that the Chief Executive will countersign the annual reports on General Managers.

Devolution with NHS

6. There is no reference in Mr Rifkind's note to this.

Slimming down the Department

7. There is no reference to this either.

Parliamentary accountability

8. Nor to this, which was a subject of particular interest to the Prime Minister.

Conclusion and next steps

9. I do not believe that Mr Rifkind's note can be accepted as it stands. It does not deal at all with some of the questions that most concerned Ministers in considering the NHS in England and where Mr Rifkind does make proposals they apparently fall short

of what the Prime Minister wanted for England.

10. On the other hand, it would clearly be better to avoid a major argument with Mr Rifkind over these issues. Indeed, in some cases at least, a further explanation of his intentions may show that there is less disagreement than now appears. It is also helpful that Mr Rifkind proposes that the new Chief Executive should have an initial three-month period in which to consider how best he can discharge his duties, and what changes he would propose in arrangements at senior level. This provides a reason for not trying to force the issue now.

11. I suggest therefore that the letter from No 10 should:

i. Point out that in England there will be a written statement of the Chief Executive's responsibilities, and ask if Mr Rifkind has any thing similar in mind for Scotland.

ii. Ask for more precise details of the membership of the Management Executive.

iii. Ask for more details about the number of support staff in SHHD on the policy side and the management side, and if Mr Rifkind will consider the possibility of reducing SHHD numbers, perhaps by elimination of double banking.

iv. Ask what is proposed on Accounting Officer responsibilities, especially as regards administration.

v. Mention the decision that in England the Chief Executive should make his own senior appointments, subject to clearance with the Permanent Under-Secretary and Secretary of State in the most senior cases; and invite Mr Rifkind to consider a similar arrangement in Scotland.

vi. Probe further the relationship between the Chief

Executive and Health Boards, and ask whether there should be arrangements to make it clear as in England, that the Chief Executive speaks with the Secretary of State's authority on management matters.

vii. Ask how Mr Rifkind intends to encourage maximum devolution within the Scottish NHS.

viii. Ask what he has in mind on Parliamentary accountability.

ix. Say that the Prime Minister would like a further report on all these matters when the views of the new Chief Executive are known after his preliminary period of consideration, and before final decisions are taken.

12. If this line is agreed, we can if necessary draft a letter accordingly.

G W MONGER

Economic Secretariat
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