AM458

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From the Secretary of State for Health

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22 May 1990

Dear Barry

NHS REVIEW: CENTRAL MANAGEMENT OF THE NHS

I wrote to Paul Gray on 20 July last year with a paper setting out proposals for the central management of the NHS. Paul confirmed in his letter of 11 September that the Prime Minister was content for the Department to proceed on the basis set out in the paper, but had asked to be kept in touch with the exercise and to see a detailed progress report in May 1990.

That report is now attached. It has been prepared by Sir Christopher France and Duncan Nichol, and approved by my Secretary of State and Sir Roy Griffiths.

It is, as was requested, a report on work still in progress. Within the Department, the essential structures have been put in place and close working relationships have been established. And the NHS Management Executive has been developing its managment relationship with the health service in the context of progress towards implementing the NHS reforms. But all these relationships must continue to be refined and developed - not least, in response to the Management Executive's relocation to Leeds in 1992. The report aims both to set out what has been achieved and to indicate the direction in which the Management Executive and the Department as a whole are now moving forward.

I am copying this letter and the report to the Private Secretaries to the Chancellor of the Exchequer and the Chief Secretary, and to Sir Robin Butler.

Yours

Andy

A J McKeon
Principal Private Secretary

CENTRAL MANAGEMENT OF THE NHS

1. The Prime Minister asked to be kept informed of progress made by the Department on the practical implementation of Ministers' decisions on the central management of the NHS.

THE NHS MANAGEMENT EXECUTIVE (NHSME) AND THE DEPARTMENT

2. The Department has recently undertaken a study of its functions and structure in the light of the recent series of major decisions affecting its work - the split of the DHSS, the NHS Review and the decision to relocate the NHSME and its supporting staffs (some 1200 posts) to Leeds. The study concentrated in particular on the respective roles of the NHSME and the rest of the Department, and the relationship between them. The executive summary of the study report is attached at Annex A.

3. The report makes clear the role of the NHSME as a strong and distinct management body responsible to Ministers and the NHS Policy Board for the operation and management of the NHS in the framing and delivery of health care. To strengthen further this role, the report recommends that functions not currently assigned to the NHSME, but concerned solely with operational policy for the NHS, be transferred to the NHSME. This is likely to involve some 20 posts.

4. At the same time the report recognises that there are subjects which involve the NHS but also extend beyond it (eg community care, health promotion). To avoid double-banking of expertise the report concludes there must be only one centre of expertise on any subject. This must be readily available to <u>all</u> parts of the Department, to support them in the discharge of their respective responsibilities. On policy matters which range wider than the specific responsibilities of the NHSME, the report recommends that expertise should generally be located within the Health and Social Services Divisions (see Para 8 of Annex A)

NHS Management Executive

8. The NHSME has worked closely with the Policy Board on the strategic issues outlined above, and has dealt independently with a number of significant short-term operational issues. Examples of such issues are:

i) revenue and capital allocations to RHAs for 1990/91;

ii) the monitoring of quarterly income and expenditure returns from RHAs, and of management action to ensure balance between financial and service levels;

iii) the management implications of the Community Care White Paper;

iv) the transfer of responsibility for FPCs (FHSAs) to RHAs;

v) the management and funding of waiting lists.

The NHSME is currently preparing a corporate response to Regions' short term programmes for 1990/91, approving or challenging their objectives as appropriate.

Chief Executive's Powers and Budgets

9. Ministers agreed that the Chief Executive must have the powers and budgets to enable him to discharge his responsibility for operational matters in the NHS. This is achieved primarily through NHS programme expenditure for which he is Vote Accounting Officer. The changes to Accounting Officer responsibilities proposed last year have now been implemented and further strengthen his position. In addition, responsibility for the NHS Superannuation Vote (which rests currently with the Permanent Secretary rather than the Chief Executive) is to be reviewed in

ANNEX

DEPARTMENT OF HEALTH
(Approximate staff numbers, March 1990, (a))

4. Central Resource Management Divisions

Finance. (FPS, CFS & Administration)		150
Economic Analysts (b)		16
Operational Research (b)		15
Statistics & Management Information		
Statisticians	41	
Support Staff	147	
	188	188
Legal (b)		31
Research Management (b)		46
Information Division (b)		43
Departmental Personnel		125
Central Resource Management		31
Office Services Management		64
Messengers		84
Security Officers		25
Paper & Office Keepers		35
Typing & Reprographics		150
Telephonists		3
Information & IT Directorate		
Admin	62	
Statisticians	2	
Computer	53	
Library	32	
	149	149
		1155

5. Other Authorities/Gps Accountable to the Secretary of State

NHS Superannuation	596
Youth Treatment Centres (c)	185
NHS Statutory Audit	226
Social Services Inspectorate	133
Regional Medical Service	200
Mental Health Act Commission & Review Tribunals	51
National Development Team for the Mentally Handicapped	7
Health Advisory Service	9
Medicines Control Agency	256
Disablement Service Authority	720
	2383

GRAND TOTAL 5225

(a) Based on staff-in-post returns for 1 March 1990

(b) Numbers in Sections 2-4 include professional as well as administrative staff.

(c) Admin and care staff only

the context of agency proposals.

10. Ministers also agreed that the Chief Executive must have effective control over the appointment and dismissal of key staff and be able to make his own key appointments, subject to clearance with the Permanent Secretary and the Secretary of State in the case of the most senior ones. In implementing this decision it has been agreed that the Chief Executive shall have at his disposal a package of 11 key posts at Grades 2-4 which he may deploy as he sees fit. £1 million was added to the Departmental Administration Vote in 1990-91 to be at his disposal to pay for these posts; and for some 15-20 posts at lower levels for which he has similar delegated authority within the Department. The Chief Executive may offer those whom he appoints to these posts either Civil Service or NHS rates of pay as appropriate. He has maximum flexibility in making his appointments (and where necessary dismissals and changes in appointments) subject only to an element of competition to ensure that the best person is, and is seen to be, selected for the job.

11. The NHSME has recently been strengthened using these arrangements by the appointment of a Deputy Chief Executive from the NHS and a new Director of Personnel appointed after open competition. This brings to five the numbers of Directors who have joined the NHSME since the Autumn and, given a total membership of Chief Executive, eight Directors and a part-time Property Adviser, means that there is substantially a new team. There will be one addition to the team later this year, as Ministers have agreed that the duties of the new Director of Research and Development (yet to be appointed) should include membership of the NHSME.

12. Within the Departmental Management (DM) Division, which deals with personnel matters for the Department, there is now a dedicated section handling NHSME personnel matters on behalf of the Chief Executive. This will form the nucleus of the DM team that will move in due course to Leeds in support of the NHSME. The Chief Executive will continue to have his own budget within the single Departmental Administration Vote.

Relationship with the NHS: Accountability and Devolved Responsibilities

13. Lines of Accountability There now exists a strong line of management and control from the Secretary of State to the Chief Executive and from the Chief Executive through Regions and Districts to Units and ultimately wards. This line of accountability is maintained through the Chief Executive's annual reviews of each of the 14 RHAs. Each year the Chief Executive meets with the Regional Chairman and Regional General Manager, reviews the performance of the Region over the previous 12 months and compares it with the objectives that were agreed for the year. At the same time the Chief Executive reviews the objectives, plans and resources of the Region for the following 12 months and agrees the key objectives for the Region and how they are to be measured. This agreement is set out formally in a letter from the Chief Executive to the Regional General Manager and becomes a contract of Regional performance. Objectives for 1990/91 focus largely on key management areas relating to the NHS reforms (eg the identification of first wave NHS Trust candidates, developing the new commissioning functions of DHAs), and on balancing Regions' books financially: each Region is now committed to bringing DHAs with deficits into balance by agreed target dates. This review process is replicated down the management line.

14. It is strengthened by the system of personal performance review and pay related to performance that has been introduced for senior managers in the NHS alongside the 3 year rolling contracts of employment that apply to general managers. For the 14 Regional General Managers this means that their Regional Chairman proposes for ratification by the Chief Executive starting pay according to experience and performance in the previous job, objectives for the year ahead, and performance pay for delivery of the objectives. The Regional General Manager's personal objectives are derived from the objectives set for the Region in the Regional Review. The process of objective

setting, review and pay related to performance is replicated down the senior management chain.

15. Communications Strategy In order to strengthen the management line down to units to gain the commitment of the Service to the objectives of the White Paper reforms, the Chief Executive has initiated in each of the 14 Regions a communications strategy. The programme will develop the skills and commitment of management to good communications particularly at unit level, and will use the channels of communication to convey a few simple key messages. This will assist in giving the whole NHS a sense of direction in supporting change. The purpose of the communications strategy is to develop understanding and commitment to the health service reforms by stressing a commitment to quality and value for money.

16. Management Delivery These developments in lines of accountability and communication are greatly assisting progress towards the implementation of the changes proposed in the White Paper "Working for Patients". The four key principles which underpin this work are:-

separation of finance from provision and the creation of an explicit DHA commissioning role;

capitation funding so that money follows patients;

resource allocation based on contracts with provider units creating provider competition;

maximum devolution of operational decisions.

The NHS has been fully involved in developing the application of these key principles. Eleven District Health Authorities (DHAs) and four Regional Health Authorities (RHAs) have been developing and testing the role of Districts as purchasers; over 25 Districts have been working on the development of contracts; some 80 hospitals and other units are developing their ideas as possible NHS Trusts; and over 850 GP practices have registered

an interest in becoming fund holders.

17. This work is now moving into the implementation phase. All districts are working towards the distinction between the purchaser and provider functions, drawing on the developmental work that has already been done. From 1 April 1991 there will be contracts between purchasers and providers for all services. Responsibility for operational decisions will thus be clearly devolved, with the purchasers (District Health Authorities and GP fund holders) able to concentrate on the amount and quality of services they want for their populations and the providers (both independent trusts and directly managed units) responsible for deciding how to meet these requirements.

18. Devolved responsibilities : Regional role. Regional Health Authorities have reviewed the management and staffing of their core functions: to drive the White Paper changes; monitor the health of their population; develop integrated programmes between DHAs, FHSAs and LAs; set and monitor District/FHSA targets and objectives; allocate resources; and ensure Regional manpower and training needs are met. They have also identified and delegated or contracted out non-core work eg. hospital design, to enable them to concentrate on the core functions. Where good economic and clinical reasons exist for managing some services at Regional level (eg. Blood Transfusion, Ambulances and Procurement) the services have been placed on a business-like footing with an accountable manager who will have annual objectives and a budget against which performance will be measured, with as much freedom as possible for districts to contract for the Regional provision. The Chief Executive has approved each Region's arrangements.

RELOCATION

19. The whole of the work of the NHSME and its immediate support, - on current plans, some 885 NHSME posts and some 350 supporting posts from the Central Resource Management Divisions - is to be relocated from London to Leeds. The first moves are expected to begin in 1992. The relocation decision was taken after thorough research and a detailed assessment of the

Department's responsibilities and working practices. The move to Leeds of the whole of the Executive presents an opportunity to reinforce a clear identity for the Executive within the Department and to improve the management of both the Department and the NHS. This relocation of a major part of the Department, with posts at all levels, means that most staff will have the opportunity to pursue a full career in either location.

SIZE OF THE DEPARTMENT

20. The Department is continuing to review all its work to ensure that it is both necessary and appropriately discharged. Annex C shows staff numbers for the Department, including those functions which are being transferred to alternative management arrangements. There has been a small, agreed, temporary increase in the central staffing of the Department to handle the 1989-90 legislative programme (the NHS and Community Care Bill, Human Fertilisation and Embryology Bill and - with MAFF - the Food Bill) to manage implementation of "Working for Patients", "Caring for People" and the Children Act 1989, and to prepare for relocation. As implementation proceeds these posts will be cut back.

21. Substantial progress is being made in addressing the wider functions of the Department. Since last March 3,200 staff of the Special Hospitals have left the Department to become a Special Health Authority within the NHS. The Dental Reference Service (61 staff) was transferred to the Dental Practice Board in October. NHS Statutory Audit (226 staff) will transfer to the Audit Commission in October. The Disablement Services Authority (now down to 720 DH staff) is being progressively integrated into the NHS and will have disappeared as a separate entity by April 1991. The Regional Medical Service (200 staff) is being transferred in part to the NHS and in part to the DSS in April 1991.

22. These changes will together reduce the total number of staff in the Department of Health from some 8600 in March 1989 to an estimated 4100 by April 1991. And within that latter total are

some 1360 posts in proposed Next Steps Agency candidates: the Medicines Control Agency, NHS Superannuation, the Social Services Inspectorate, Youth Treatment Centres and the Estates Directorate.

23. Alongside the changes already in train, the Department is engaged this year in a number of further scrutinies of its organisation and staffing. An efficiency scrutiny of its Medical Divisions is currently under way and is to be followed by a Senior Open Structure Review of the Department. At the same time the NHSME is reviewing its own functions and structure so as to be able to concentrate on its key tasks once the NHS Review has been implemented.

Conclusion

24. This note is, as requested, an account of work in progress. The developments described in it have together established the management systems needed to deliver the changes Ministers intend. Progress towards implementation of "Working for Patients" is already well under way. But the Department, including the NHSME, do not underestimate the further management effort that will be required, both centrally and at all levels in the NHS, to deliver the improvements in quality and productivity that must now be achieved.

FUNCTIONS AND STRUCTURE OF THE DEPARTMENT OF HEALTH
EXECUTIVE SUMMARY

INTRODUCTION

1. The study of the functions and structure of the Department of Health was set in hand against the background of a series of major changes - the split of the former DHSS, the creation of the NHS Management Executive within the Department, and the decision that the NHSME should relocate to Leeds in 1992. The study was intended to provide an opportunity to take stock of the collective impact of those changes on the future shape of the Department.

2. We were not asked to review or add to the series of major changes that had already occurred or were in train. Rather our remit was to focus on practical proposals that would help all concerned understand and work to best effect within the basic structures we now have. So the accent of our recommendations is on developing a clearer understanding of roles and responsibilities and on establishing clear (though flexible) procedures for ensuring that the Department's business is well co-ordinated. These are not developments that can be brought about instantly - but we recommend a number of practical measures to lay the foundations for further development.

3. We were set a tight timetable. Within this, we have aimed to strike a balance between providing an analysis of the Department's current functions and structure and charting the way forward. This report does not mark the end of the journey. But we hope it will at least enable all those who travel onwards to do so with one and the same map of the Department, and with signposts to help them on their way.

Setting the Scene: The Functions and Structure of the Department of Health

4. We began by examining the statutory foundations of the Department of Health. In Chapter 2 and Volume 2 of our report we identify the full range of the Secretary of State's responsibilities; for health care, for social care and for promoting the health of the nation. We also describe those "machinery of Government" functions which any Department of State must perform in support of its Ministers.

5. We next examined the way in which the Department is currently structured to perform those functions. The basic structure was established by Ministers in the context of the NHS Review. They concluded that the task of managing the NHS required a strong and distinct management body at the centre - the **NHS**

Management Executive - with an effective management chain reaching out to the NHS. But given the realities of a national health service for which the Secretary of State is accountable to Parliament and which is virtually 100% tax-funded to the tune of some £21 bn per annum, the NHSME should be **within the Department of Health,** in close relationship with Ministers and Government.

6. Within that framework, the Department needs so to structure itself as to allow both for the effective management of its individual "businesses" - of which the NHS is but one, albeit much the largest - and for the proper co-ordination of the whole range of its activities in support of Ministers. In Chapter 3 of our report we describe the way in which the Department is currently organised to that end.

The Way Ahead.

7. The Department as we examined it was still in a state of transition following the changes of the past two years. Indeed we found ourselves working in parallel with several studies looking in more detail at the way in which particular Departmental functions were performed. We recognised a need:

i) to clarify roles, responsibilities and relationships within the new Department of Health;

ii) to find ways of sustaining those relationships, particularly following the relocation of the NHSME Divisions to Leeds; and

iii) to identify the implications of recent changes for management and staff, and ensure that these are addressed.

Our recommendations on these matters are reproduced in full at the end of this summary; we comment here on the main themes.

The Clarification of Roles and Responsibilities

8. We see the underlying structure of the Department as a tripartite or trefoil relationship, illustrated at Figure 4.1 of the main report, with the following 3 components:

Health and Social Services (HSS) Divisions (the "Policy Group" and associated professional Divisions) responsible for advising Ministers on health care policy and for policy, management and executive action as necessary in respect of the social care and wider health businesses;

NHSME Divisions: responsible for supporting the NHSME on the NHS management and operational matters for which it is answerable to Ministers and the NHS Policy Board;

Central Resource Management (CRM) Divisions: (the "common services"

divisions) responsible for providing support to all parts of the Department.

The roles and responsibilities of these groupings are for the most part clear and undisputed, but we have addressed a number of boundary issues. We concentrate here on the largest single issue, that of the HSS/NHSME Divisions boundary, and then list briefly our recommendations in other areas.

9. The HSS/NHSME Divisions' Boundary Although the essential distinction between the
policy and management responsibilities of the HSS and NHSME Divisions is clear, there is uncertainty about that part of the spectrum where policy development shades into operational and management considerations. We have considered whether clarification could be achieved at a stroke by redefining present boundaries so as to allocate **all** health care responsibilities - policy as well as operational - to the NHSME, or to make it clear that **all** health care policy issues fall outside the NHSME's responsibility. But either of these radical options would undermine the basis of Ministers' decisions on the respective responsibilities of the NHSME and the rest of the Department which underlay "Working for Patients".

10. Some smaller scale changes could be made to give the NHSME Divisions their proper responsibility for certain operational functions - the Waiting List Unit for example - which are currently sited in the HSS Divisions. We **recommend** a special exercise to identify such functions and arrange their transfer. But otherwise, the need is for working arrangements at the boundary area which both ensure a proper input from the NHSME/NHS to the formulation of policy and an input where appropriate from the HSS Divisions to work on the implementation and outcome of health care policies.

11. We see these working arrangements in terms of the staff/line relationship found in business management. The NHSME Divisions have features typical of the line management role; the HSS Divisions have characteristics of the staff support role, both in advising top management (Ministers) on broad policy or on issues spanning more than one business, and in providing expert advice and support as necessary to line management. This relationship reflects the fluid nature of the NHSME/HSS Divisions boundary, where a particular issue - treatment of people with coronary heart disease, for example - might arise either in a management context, requiring an operational solution, or as a more fundamental question requiring detailed analysis and review.

12. One response to this analysis of roles and responsibilities would be the development of matching centres of expertise in both the HSS and NHSME Divisions to discharge their respective "staff" and "line" functions. But that would be a wasteful use of scarce and expensive expertise, involving the sort of double-banking and second-guessing that has been deliberately eschewed in apportioning responsibilities between the NHSME Divisions and other parts of the Department. We therefore recommend that there should continue to be a single

source of expertise in the Department on any one subject. Where that expertise is concerned with health care policy it should generally be located with the HSS Divisions. But the expertise must be equally available to **all** parts of the Department - both "staff" and "line" - in discharging their respective responsibilities in support of the Secretary of State. Those responsibilities mean that it may be appropriate for **either** the HSS **or** the NHSME Divisions to take the lead on action within a single area of expertise, according to the way in which a particular issue arises or the nature of the action required (see the example of coronary heart disease, above). Working arrangements are needed which enable decisions to be taken as necessary on lead responsibility, promote ready access to the Department's expertise, and ensure full consultation across the policy/operations spectrum. We make recommendations as to the way in which such working relationships should develop.

13. The Family Practitioner Services We conclude that there should be no change for the present in the arrangement whereby the NHSME is responsible for the General Medical Services and the running of FPCs, but not for the other contractor professions. We do not believe that the benefits to be gained from aligning all the FPS responsibilities would justify imposing an additional burden on the NHSME at this stage. We recommend that the arrangements - including Accounting Officer responsibilities - should be reviewed in 1992 once substantial progress has been made in the process of NHS Review implementation, and we make recommendations to clarify responsibilities in the meantime.

14. Finance. We recommend minimal change in **Accounting Officer responsibilities** for the Department's programme expenditure. We have reviewed as requested the decision that there should continue to be a single Administration Vote for the Department, rather than separate Votes for the NHSME and the remainder of the Department. We conclude that given a single Department of Health, with the interlocking structure and the fluid staff/line relationship we describe above, a single Administration Vote remains appropriate and indeed has a constructive part to play in building relationships between the different parts of the Department. Our recommended review of FPS responsibilities would provide an opportunity to take stock also of the way in which the recommeded arrangements for the Administration Vote are working.

15. We recommend changes in the way in which the **Finance Divisions** are structured to support the Accounting Officers: FA and the Financial Management Directorate (FMD) should be amalgamated to form a single NHSME Finance Division under the Director of Finance, and the location of responsibility for PES co-ordination should then be reviewed to see whether the NHSME can be relieved of a task which extends beyond its own responsibilities.

16. Professional Matters We have reviewed responsibilities for professional education and training. We recommend that administrative responsibility should remain as now with the NHSME Divisions (reflecting the NHS role as the major

employer) but that the related professional divisions should provide support also to the Heads of Profession, outside the NHSME, in the exercise of their overarching professional responsibilities.

17. The Central Resource Management Divisions We review the way in which the staff of these Divisions are to be deployed following relocation to provide support to both the Leeds and London HQ locations. We recommend, in particular, that there should be a separate Leeds-based branch of Departmental Management (DM) Division, reporting to the PEO but with delegated responsibilities to be agreed.

Sustaining the New Relationships

18. It is clear to us that there is no simple solution - no single piece of machinery or hard and fast set of rules - that can guarantee effective working relationships across the Department or take the effort out of maintaining both formal consultation and informal contacts. What is needed is an agreed basic framework within which constructive working relationships can then be sustained, particularly following the relocation of the NHSME to Leeds. We make two sets of recommendations to this end.

19. First, we identify the need for agreed procedures for handling individual items of policy development. We outline the stages of the "**policy to implementation" cycle**, identifying the contribution to be made by the HSS and NHSME (and CRM) Divisions at each stage, and flagging up for further attention those stages where working practices need further development. We recommend that this cycle be adopted as the basis for a constructive **"no surprises"** regime.

20. Second, we see the need to develop better means of looking **in aggregate** at all the Department's policy activity as it bears on the NHS, setting this against the NHSME's overall assessment of the NHS's capacity to respond, and working under the guidance of Minsters towards an **agreed agenda**. Ministers will wish to take the advice of the NHS Policy Board on the strategic framework of policy within which they wish the NHSME to work. In support of this, we recommend:

i) **a stronger co-ordinating focus within the HSS Divisions,** able to look across the whole field of HSS interests;

ii) **development of the Departmental Management and Policy Group** (DMPG) as the official forum in which progress towards an agreed agenda can be made;

iii) **development of the Department's own annual business cycle** as the main vehicle for the DMPG's conduct of this business.

21. These arrangements must be supported by effective working links at all levels, able to handle day to day "firefighting" as well as more formal and structured policy business. We do not underestimate the effort that will be needed to maintain such links following relocation. We offer some practical suggestions, but recommend also that further work be done, drawing on outside help as necessary, on the best means of sustaining good communications and understanding across two HQ locations.

Staffing and Management Issues

22. Finally, we have examined the staffing and management issues which flow from the creation of a new Department of Health, a great deal smaller than the former DHSS and in future to be divided across two HQ locations, each with its own distinctive character. We were unable within our study timetable to take these issues forward ourselves. But we found that questions we identified were in many cases already being actively pursued by DM, not least through the PEO's Steering Group on Relocation. We take the opportunity to summarise the issues in our report as a contribution to DM's further work.

Annex B

NHS MANAGEMENT EXECUTIVE GOALS AND 1990/91 OPERATIONAL PROGRAMME

ROLE

1. The NHS Management Executive (ME) acts on behalf of Ministers to develop and implement their policies for the management of the NHS. In doing so it provides corporate leadership and direction to the NHS. To achieve its goals it works closely with Regional Health Authorities and the policy arm of the Department of Health (DH).

STRATEGIC GOALS

2. The ME's overall goals are:

a) to secure, through the NHS and within available resources, significant improvements in the health of the population through the delivery of services providing health promotion, prevention and diagnosis of illness, and high quality cure, care and rehabilitation;

b) to ensure that these services are provided effectively, efficiently and economically, in response to identified needs and with regard to the wishes of patients;

c) to ensure that the NHS provides the structure and support for its staff satisfactorily to carry out their jobs and develop their careers.

3. To achieve these goals the ME seeks to:

a) identify the major health care challenges facing the NHS;

b) work within the framework of Ministerial aims and objectives to see that these challenges are addressed through policies which are managerially achievable, coherent and balanced;

c) develop and implement strategies to address major management challenges;

d) strengthen the effectiveness of the NHS organisation by developing and supporting effective local management and promoting devolution;

e) help Secretary of State to assess the financial resources which the NHS needs to achieve its goals, and help the NHS to secure with the money obtained the optimum human and capital resources;

f) develop the scope and quality of training (both clinical and non-clinical) and research.

MEDIUM TERM AIMS

4. In the next 3 to 5 years the ME aims to:

a) ensure that health authorities and general practitioners,through their placing of contracts, maintain and, wherever possible, improve the quantity, quality and effectiveness of health care services;

b) implement the changes to the NHS that flow from the NHS and Community Care Bill and the three recent White Papers "Working for Patients", "Caring for People" and "Promoting Better Health";

c) achieve greater integration of primary and secondary health care;

d) ensure that health authorities retain effective control of their financial and human resources and capital assets;

e) help health authorities to secure a sufficient supply of appropriately skilled staff to achieve service and organisational goals;

f) maintain momentum in the NHS towards increasing the effectiveness, efficiency, economy and consumer responsiveness with which it uses its revenue, capital assets and human resources;

g) determine a strategy for measuring the performance of health care systems in terms of their outcomes for the health of the population;

h) establish and promote its own corporate role within the DH and in relation to the NHS.

1990/91 OPERATIONAL PROGRAMME

5. The Management Executive's operational programme for 1990/91 (below) consists of those tasks corporately agreed to be critical to the success of medium term aims in paragraph 4. As most of these tasks will be achieved more through the ME's management of the NHS than by the Executives's direct and independent action, they are reflected in the objectives in regional short term programmes agreed between the ME and each RHA.

SERVICE PROVISION (see 4a)

6. a) To ensure that the NHS maintains the overall volume of its services and adheres to agreed plans for service delivery.

b) To ensure that the NHS reduces and, if possible, eliminates the overall number of patients waiting for more than a year

for their operations, particularly by increasing the number of day cases.

c) To ensure that health authorities carry out the service objectives published in HC(88)43 (appendix 4) and HC(89)24 (paras 12 and 13).

d) To ensure that, through the GPs' contract, the public have better access to services of an acceptable standard and are able to make an informed choice of doctor.

IMPLEMENTING THE WHITE PAPERS (see 4b)

7. a) To ensure that the purchaser/provider separation will operate effectively from April 1991 by:

i. establishing the methods of operation of the contracting system, including a clear emphasis on specifications of quality and consumer responsiveness;

ii. clarifying and strengthening the purchasing role of DHAs, particularly their role in improving the public health;

iii. clarifying the range of management arrangements for directly managed units;

iv. developing for Ministerial approval approximately 50 NHS Trusts;

v. developing for Ministerial approval up to 400 GP Fund Holding Practices and clarifying their role as purchasers of patient care;

vi. leading the NHS in developing the information systems needed to manage contracts;

vii. establishing a regime of capital charging throughout the NHS.

b) To continue the reforms of the management of primary care by:

i. ensuring that RHAs are properly prepared to take over responsibility for Family Practitioner Service Authorities;

ii. having in place arrangements for indicative prescribing budgets for all GPs.

c) To lead the NHS in identifying and securing the human resources needed to implement the reforms.

d) To clarify the role of the NHS in the implementation of "Caring for People", and to equip the NHS to carry out this role.

CONTROL OF RESOURCES (see 4d)

8. a) To initiate action early in the year to ensure that all DHAs, with a few agreed exceptions, eliminate their underlying deficits by the year end.

   b) To ensure that health authorities maintain firm control of manpower costs and service volume to prevent the recurrence of income and expenditure imbalances.

   c) To settle 1990 pay claims within affordable limits in ways which encourage local pay flexibility.

SUPPLY OF SKILLED MANPOWER (see 4e)

9. a) To carry forward the drive to extend and improve management development, launched by the Chief Executive in March 1990;

   b) To secure the establishment of new mechanisms for determining and funding levels of training for key staff.

EFFECTIVENESS AND EFFICIENCY (see 4f)

10. a) to ensure that all health authorities have communications strategies designed to further the effectiveness of their health care activities.

    b) To ensure that all health authorities have strategies for the rationalisation of their estate consistent with the agreed national strategy.

OUTCOMES MEASUREMENT (see 4g)

11. a) With the policy arm of DH, to boost the work to develop health care outcome indicators;

    b) To establish a central co-ordinating unit and regional network for the collation, processing and dissemination of outcomes assessment work.

THE ME'S CORPORATE ROLE (see 4h)

12. a) To agree and publish a statement of the ME's key values and corporate strategy.

NHSME Secretariat
26 March 1990

ANNEX C

Department of Health: Staff in Post

Summary Table

March 1989			March 1990	April 1991 (estimates)
39	1.	Ministers' Private Offices etc	45	
860	2.	NHSME Divisions	885	
		(includes 128 potential Next Steps agency posts)		
745	3.	Health & Social Services Divisions	757	
		(includes 64 potential Next Steps agency posts)		
1090	4.	Central Resource Management Divs.	1155	
2734		SUB TOTAL	2842	2842
	5.	Other Authorities/Groups accountable to the Secretary of State		
3204	i)	Special Hospitals	*	*
61	ii)	Dental Reference Service	*	*
1057	iii)	Disablement Services Authority	720	*
197	iv)	Regional Medical Service	200	*
213	v)	NHS Statutory Audit	226	*
1096	vi)	Next Steps Agency Candidates	1170	1170
61	vii)	Other	67	67
5889		SUB TOTAL: numbers remaining in the Department	2383	1237
8623		TOTAL: numbers remaining in the Department	5225	4079

* Para 21 of the main report describes the future management arrangements for those groups which are transferring out of the Department.

DEPARTMENT OF HEALTH
(Approximate staff numbers, March 1990, (a))

1. Ministers' Private Office 45
Including Parliamentary and Correspondence Sections

2. Management Executive Divisions

Chief Executive & his Private Office		5
Health Authority Finance		54
Estate Directorate (b)		128
Procurement Directorate (b)		161
Regional Liaison & Planning		99
NHS Trusts Unit		16
Health Service Information		21
NHS Information Technology		57
Health Authority Personnel		107
Financial & Resource Management		44
FPCs & General Practitioner Services		98
Professional Divisions		
Medical	68	
Nursing	27	
	95	95
		885

3. Health and Social Services Divisions

Permanent Secretary & his Private Office		5
CMO & his Private Office (b)		6
Children, Maternity & Prevention Policy		62
Community Services Policy		74
Environmental Health & Food		95
Priority and Health Services		90
AIDS Unit		17
NHS Review Unit		16
Policy Secretariat		8
Commercial & Contractual Family Practitioner Services		61
Social Services Inspectorate		64
Professional Divisions		
Medical	170	
Nursing	32	
Pharmaceutical	13	
Dental	11	
British Pharmacopoeia	33	
	259	259
		757

NAT HEALTH : Expenditure Pt 22