STRICTLY 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

Robin Butler, Esq.,
No. 10 Downing Street,
London SW1

2 December, 1983

Dear Robin.

NHS MANAGEMENT ENQUIRY

It occurs to me that you might find it helpful to have the enclosed copy of a letter and enclosures which I have today sent to Peter Middleton and Robert Armstrong about the re-structuring of DHSS to implement Griffiths in the NHS.

As soon as I have the necessary clearance from the Treasury and MPO, Mr. Fowler will want to report progress and next steps to the Prime Minister. As you will see from the papers, however, we are now embarked upon an urgent and substantial programme along the path that has been firmly laid down by my Secretary of State.

Yours ever.
Ken.

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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

Peter Middleton, Esq., CB,
HM Treasury,
London SW1

2 December, 1983

My dear Peter.

IMPLEMENTATION OF GRIFFITHS REPORT
ON NHS MANAGEMENT

My Secretary of State, with his Ministerial colleagues concerned, has now been able to consider the application of the Griffiths Report to the Department, and its implementation.

Mr. Fowler has already announced, with the Prime Minister's and Chief Secretary's support, that the Government accepts the broad thrust of Griffiths and that he is setting up a Health Services Supervisory Board in the Department, as recommended.

We have now got down to the detailed consideration of implementation in the Department. I enclose a copy of my notes of a presentation to Ministers earlier this week, together with a record of the discussion and the conclusions reached by Ministers. I should be grateful if circulation of these papers could be confined to the necessary minimum of people, since the jobs and careers of many people in this Department may be affected and the proposals will need to be carefully presented here in due course.

I draw your attention especially to what is recorded in the papers about:

a) the importance of speedy and effective implementation;

b) the constraints within which change has to be effected (in particular no erosion of Ministerial responsibility and no increase in Wardale, i.e Open Structure posts); and

c) the timetabled programme which has to be achieved if we are to lead the NHS into implementation of Griffiths

Contd.....

E.R.

MANAGEMENT IN CONFIDENCE

from the start of the next financial year.

We are now setting up a project team to work out in detail for Ministers the nucleus of the NHS management group in the Department as defined in the presentation, so that this can be in place early in the New Year: and above all, so that RHA Chairmen and the NHS can be told in January that this will be in place and will be the new determinant of their relationship with the Department from 1 April 1984.

The immediate purpose of this letter is to seek your and Robert Armstrong's approval in principle for the recruitment from outside the Department of a Chairman of the NHS Management Board. We believe this should be at Second Permanent Secretary level but we shall have to be flexible about salary especially if it is a short-term appointment. This post would, of course, be within the Departmental Open Structure and would, in my judgement be in substitution for an existing administrative Deputy Secretary post (of which there are 3) in the HPSS area of the Department. I envisage that the Chairman would be supported by one of the remaining administrative Deputy Secretary posts, perhaps as Deputy Chairman of the Management Board with the Board itself constituted at Under Secretary level. The third administrative Deputy Secretary post would deal with the other Health and Personal Social Services function outside the NHS Management Group and report to me. I propose no change (nor would my Secretary of State want it) in the responsibilities of the Principal Establishments Officer and Principal Finance Officer who would report to me as at present.

For the purpose of recruiting the Chairman of the Board we shall need to have an agreed job description and the services of head-hunters. Work is in hand on this - Norman Clarke is discussing with Richard Wilding and he has already sent him an outline job description. We shall need to agree a draft job description in sufficient detail (after approval by my Secretary of State) for discussion with the head-hunters. May we have your agreement to the use of head-hunters? I hope we can also agree an outline job description next week.

I am copying this letter and enclosure to Robert Armstrong, whose agreement I also seek.

My Secretary of State will want to report progress to the Prime Minister as soon as possible, so I should be grateful for early replies.

Yours ever

Ken.

MEETING: 29 NOVEMBER 1983

Present: The Secretary of State
Mr Kenneth Clarke (Minister for Health)
Mr John Patten (Parliamentary Under Secretary of State)
Sir Kenneth Stowe
Sir Henry Yellowlees
Sir Geoffrey Otton
Dr Acheson
Mr N E Clarke
Mr Hulme

Subject: Implementation of the Griffiths Report in DHSS

1. Sir Kenneth Stowe referred back to the meeting on 11 November when the Secretary of State had asked how the general manager and the personnel director would be selected and appointed. Sir Kenneth had outlined a series of steps which would have to be undertaken beginning with an analysis of current departmental functions and how they might be restructured. That analysis had been undertaken over the last two weeks and the working papers produced were now before Ministers. The purpose of the meeting was to bring out the issues which have arisen in this work and seek guidance on the direction and timetable for taking it forward.

2. The issues were presented as follows:

Background

(1) The Problem identified in the Griffiths report, as seen by the Permanent Secretary and as reflected in the views of Parliament and of the Health Service had, as the common thread, the absence of a full-time senior focus in the Department for the management of the National Health Service.

(2) The Machinery for Control in the Department showed a sharp contrast between the direct management line for social security operations and that of the health service where there was a clear line of authority from the Secretary of State to the health authorities but a whole series of "dotted line" relationships between them and their officers, the Department and professional bodies. Action to tackle the problems arising was constrained by the statutory provisions for health authorities' functions and the importance of professional bodies who have much control and influence over the way in which treatment to patients is provided

(3) The Management Functions identified in the Griffiths report as required to be done centrally were widely diffused within the organisation of the Department.

(4) The Proportion of Staff involved at Headquarters in NHS management functions varied depending on grade so all of the 18 officials at Under Secretary and above in HPSS administrative divisions had some responsibility for NHS management functions. Below principal the proportion dropped to about 35%.

(5) The Traffic between the Department and the NHS was both heavy and spread amongst a large number of Divisions. The circulars which went to all authorities numbered 590 last year though this was a considerable reduction on 1978/79 when there were 1,200. The less formal traffic was much heavier for example there were an estimated 50,000 incoming calls a year to P2 Division.

Prior Considerations to Action

(6) The Objectives were to respond positively by setting up a clear focus for the management role of the centre with a visible initial impact early in 1984 and a measurable response by March 1985 whilst maintaining the ability to develop and co-ordinate wider health policies. One aspect of the measurable response by March 1985 would be the impact on the pattern and quantity of the traffic between the Department and the NHS.

(7) The Main Constraints were that Ministerial, Regional and District accountability remain unchanged, the numbers of DHSS staff including top management could not increase and the costs of any changes should be kept low. It had been made clear both in the report and accompanying statements that there was no change in the statutory framework but there were those who looked for a separate corporation to run the NHS outside the Department.

(8) Some Guidelines which had emerged from the discussions on implementation were that the general management function should not be overburdened with functions in the initial period; existing sources of advice in support of the Secretary of State's wider functions should not be duplicated; there should be a stronger NHS management input into policy making; the division of functions between the management box and elsewhere should be flexible; and officials who report to the general manager but are part of specialist or professional disciplines should continue to look to their specialist/professional head for professional advice.

Proposals for Action

(9) The Proposal was for Early Establishment of a 'Nucleus' of a stronger management focus. The alternative was to spend more time on a comprehensive plan.

(10) The Nucleus would constitute at the minimum the functions of Regional Liaison Division, Finance Division A and Personnel Division 2, together with professional support, under a unified management.

(11) The Identification of the Nucleus from existing commands would be a substantial task because as demonstrated by the analyses of current functions the responsibilities for NHS management are embedded in Divisions with separate or wider responsibilities. The task was considerably helped however through the existence of the second round of Divisional Management Accounts.

Timetable

(12) The Establishment of a Nucleus to achieve a visible impact by the Spring of 1984 ie to fit in with the timetable for NHS changes would require a crash programme. This would only be justified if Ministers agreed that it was desirable to make progress now whilst taking forward the action required to recruit and appoint the general manager.

(13) The Alternative Approach was to concentrate on defining the role of the general manager, find and appoint the right candidate and only then proceed with the necessary changes within the Department under the direction of the general manager.

Summary

(14) The Programme of Work for the Department and the NHS was strenuous whichever path was taken. The hypothesis put forward was that the prompt establishment of a nucleus of the stronger management focus within the Department was the most practicable way of securing progress but no alternatives had been pre-empted or closed by the work undertaken so far. This reflected the agreement at the previous meeting that Ministers should see the exploratory work and decide the direction to be taken.

3. The Secretary of State said he was grateful for the clear presentation and all the work which must have preceded it. He would like to concentrate intially on the question of whether work should start at once on the initial restructuring of Departmental activity. His strong,inclination was to take that course whilst pressing ahead as quickly as possible with the action required to allow the early selection and appointment of a general manager. It was vital to maintain the momentum of work in both the Department and the NHS. Mr K Clarke and Mr Patten supported the Secretary of State's approach whilst noting that the work undertaken in advance of the appointment of a general manager must not pre-empt the general manager's scope and authority to make changes.

4. The main points then covered in discussion were:

1. The Status of a NHS Management Board. The question was raised as to whether the intention was to create a board which appeared as near as possible to a separate corporation within the current statutory framework. The Secretary of State said that any attempt to present the board as a 'corporation in embryo' would be a fiction and would quickly be identified as such. The objective was to regroup the Department's activities to establish a single clear focus on general management issues in the NHS, accountability, performance review and so on.

2. The Size of the Nucleus. It was agreed that the nucleus should be sufficient to provide a general manager on appointment with a secure working base without limiting his role and leaving flexibility for further changes.

3. Accounting Officer Responsibilities. Sir Kenneth Stowe said that he had an open mind on whether or not the Accounting Officer responsibility for hospital and community health services expenditure should be devolved to the general manager. There were obvious advantages in that course but there were possible disadvantages to be considered too from the general manager's point of view. No final decisions could be reached until the responsibilities of the general manager were clearly defined and could be related to specific votes.

4. Pay and Grading of the General Manager. The Secretary of State said that the terms available for this post and that of the personnel director must allow the option of appointing people of calibre from outside the public service on fixed renewable contract. Officials reported that initial discussions with central Departments had not indicated any insoluble problems. The approach taken with the appointment of the Director of the Operational Strategy provided a helpful model.

5. The Role of Professional Groups. Sir Henry Yellowlees and Dr Acheson drew attention to the potential difficulties of any regrouping of functions for professional groups. Their numbers were relatively small yet a key part of their activity was the capacity to provide immediate authoritative advice to Ministers on professional and wider health issues. It was agreed that the Secretary of State's requirements could only be met by ensuring that he received authoritative professional advice from a single source. The Minister for Health said that the arrangements in the Department for health professional staffs support of the general management function needed to be considered carefully as they would be a signal to how such arrangements should work in the NHS. It was important that aspects of their work such as manpower planning were firmly related to the general management function.

Action

5. It was agreed that action should be put in hand immediately as follows:

1) A small team of officials should be put full-time onto the programme of implementation working to the Permanent Secretary (Mr N E Clarke).

2) Sir Kenneth Stowe to write by 9 December to Sir Robert Armstrong setting out the outline job description of the proposed general manager and seeking approval for arrangements for selection and recruitment.

3) Detailed proposals should be put to Mr Patten and Mr Clarke on the content of the nucleus of a 'management box' and its establishment at a date no later than mid February next year for clearance and submission to the Secretary of State before Christmas (Mr N E Clarke).

D B
PSU

2 December 1983

cc Those present
Members of TOTO

IMPLICATIONS OF THE GRIFFITHS REPORT FOR DHSS HQ

PRESENTATION TO THE SECRETARY OF STATE

November 1983

PSU

THE PROBLEM

a) as stated by Griffiths

"We are convinced that you will need to be supported at the centre, by a small, strong, professional management group, able to devote considerable time to running the NHS through a General Manager seen to be vested with your authority and to be acting on your behalf and as your right-hand man, in ensuring that the statutorily appointed authorities manage the NHS effectively. This appointment would leave undisturbed your clear responsibility for overall policy direction and for the handling of the public and political sensitivities of the service. This will require major changes in the stance and style of management at the centre and in the public and parliamentary requirements of the NHS management process." [Background to Recommendations, paras. 10-12]

"The units and the authorities are being swamped with directives without being given direction."

b) As seen by the Permanent Secretary

Responsibility for the various management functions in relation to the NHS is scattered over many parts of the Department, with no individual below the Permanent Secretary having responsibility for the whole. Moreover, among those having the responsibility, no-one - certainly not the Permanent Secretary - works full time on all those management functions. [See Chart I below]

c) As seen by Parliament

Uncertain whether the Department has the skills, motivation and direction to ensure good management of and in the NHS.

d) As seen by the NHS

Need for greater clarity about priorities, stronger leadership on implementation, and closer partnership on setting management objectives.

MACHINERY OF CONTROL

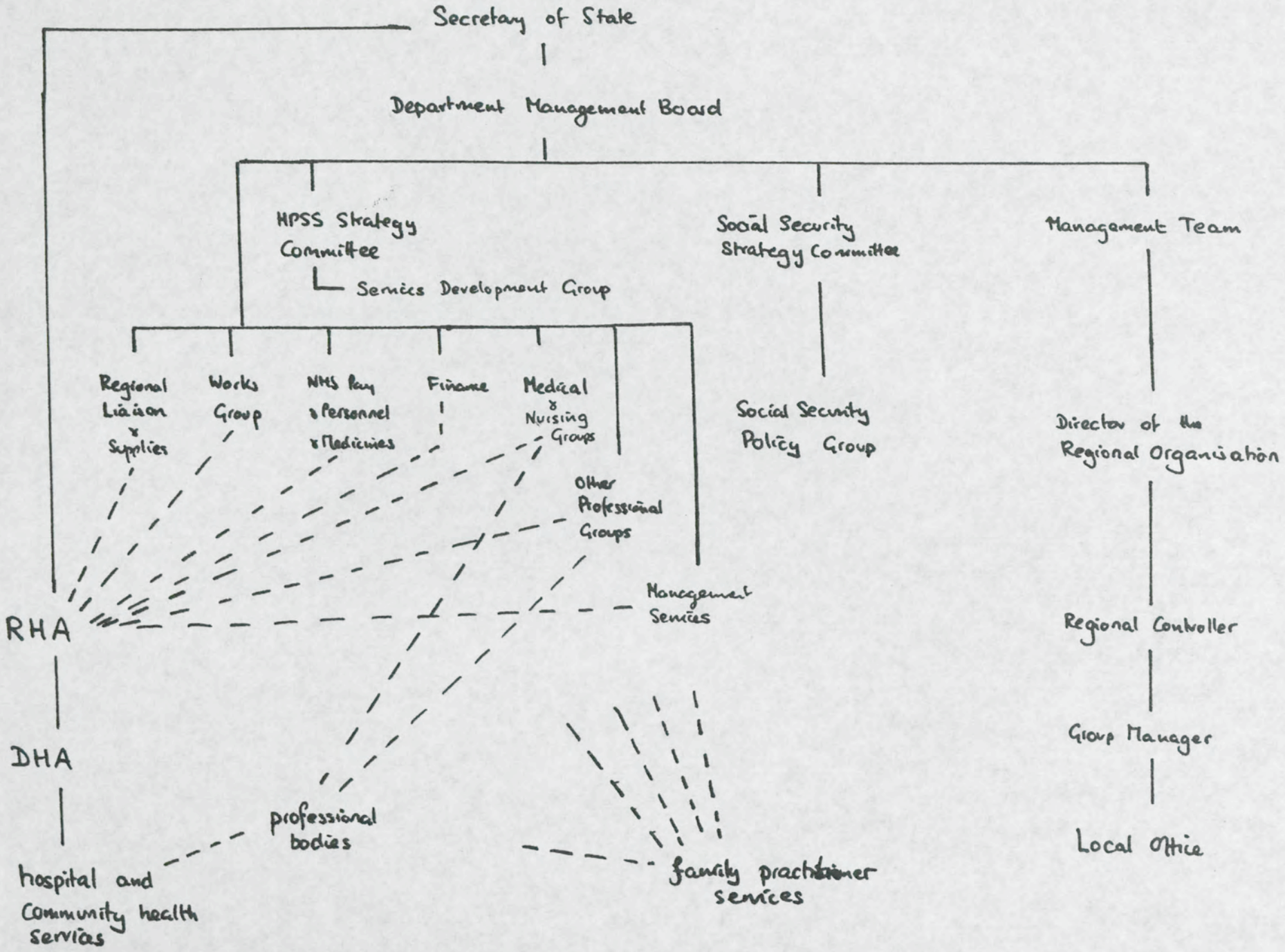

CHART 1

NHS "MANAGEMENT" FUNCTIONS CARRIED OUT IN DHSS AND CENTRAL SHAs ETC

1. General management

   organisation; structure, appointments, accountability; monitoring performance; information.

2. Personnel

   pay, terms and conditions of service; industrial relations; training; career development; manpower planning and control.

3. Finance

   allocation; funding; monitoring outgo against cash limits; budgeting; financial management systems.

4. Service Planning

   planning guidelines; translation of policies and priorities into service plans; monitoring implementation; areas subject to close central control (eg private practice).

5. Procurement

   purchasing goods and equipment; quality control.

6. Works and Estate Management

   large capital schemes; standards for buildings, maintenance etc; disposal of surplus land.

7. Scientific and High Technology Management

   computer; information technology; supra-regional specialties.

Chart II shows where these functions fit into the present organisation.

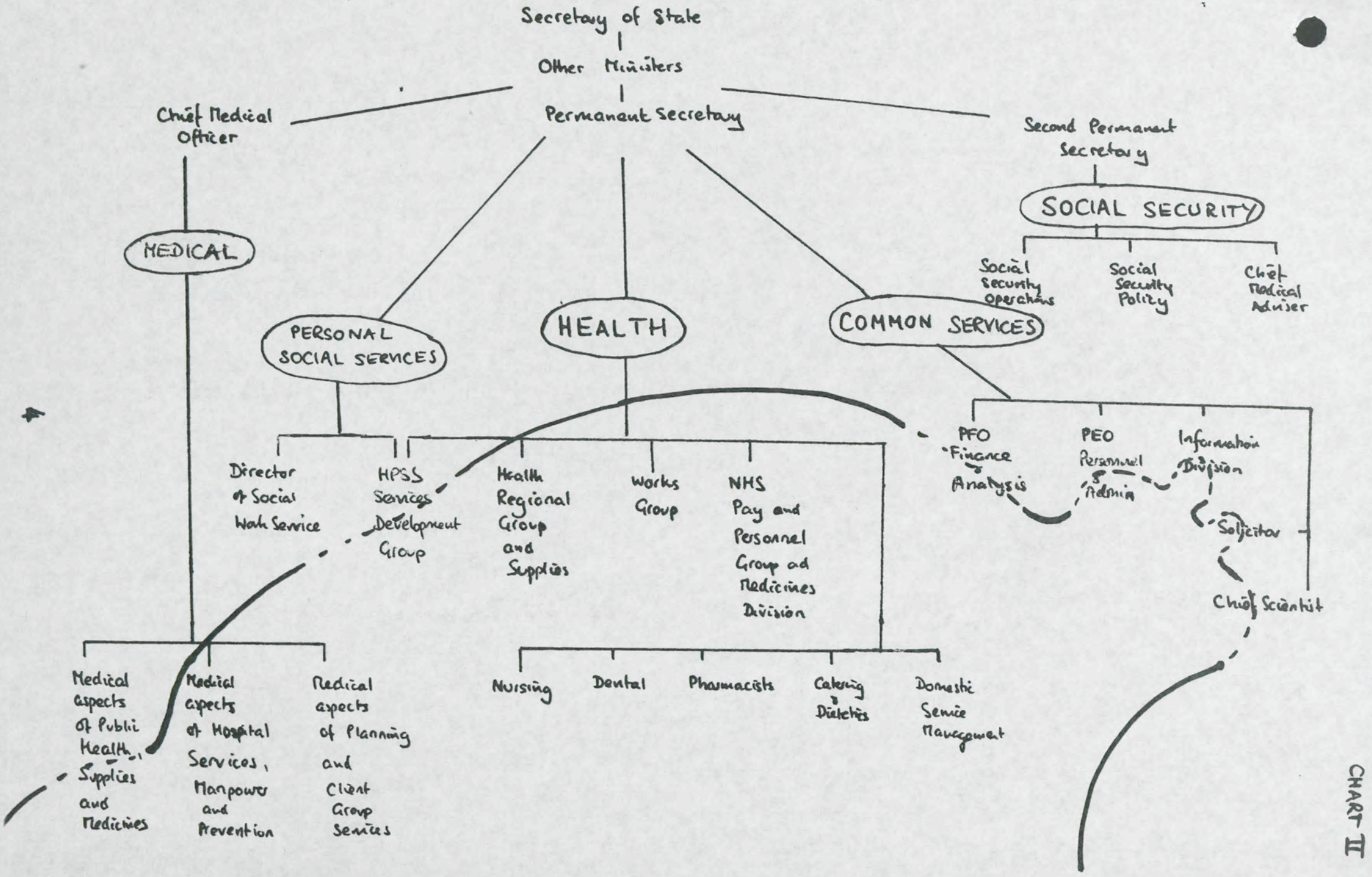
Secretary of State
Other Ministers
Permanent Secretary
Chief Medical Officer
Second Permanent Secretary
MEDICAL
SOCIAL SECURITY
Social Security operations
Social Security Policy
Chief Medical Adviser
PERSONAL SOCIAL SERVICES
HEALTH
COMMON SERVICES
Director of Social Work Service
HPSS Services Development Group
Health Regional Group and Supplies
Works Group
NHS Pay and Personnel Group and Medicines Division
PFO Finance Analysis
PEO Personnel & Admin
Information Division
Solicitor
Chief Scientist
Medical aspects of Public Health, Supplies and Medicines
Medical aspects of Hospital Services, Manpower and Prevention
Medical aspects of Planning and Client Group Services
Nursing
Dental
Pharmacists
Catering & Dietetics
Domestic Service Management

CHART II

FACTS

Manpower involved wholly or in-part in NHS "management" functions

under secretaries and above:	18	
assistant secretaries & S/Prins:	around 30	
principals:	between 70 and 80	
staff:	around 500	
Total	over 600	NB: i) admin only ii) rough guide only

Some Measures of traffic between NHS and Department

Formal, written:	590	"dear administrator" letters, health circulars, hazard notices etc in year ending April 1983.

This covers only letters etc sent to all health authorities. Chart III shows the number of those originating from each group, which shows how diffuse DHSS seems to NHS.

Informal, written: (annual)	3,000	incoming letters to P1 Divisions on hospital doctors' and dentists' pay
	7,000	incoming letters to P2 Division on personnel work.
Face to Face: (annual)	14	regional reviews and 9 SHA reviews.
	6	meetings with regional chairmen.
	about 50	unidisicplinary meeting with regional officers from 15 different disciplines.
	135	Whitley Council meetings in P2 Division alone.
Telephone: (annual)	10,000	incoming calls to P1 Division on hospital doctors' and dentists' pay.
	50,000	incoming calls to P2 Division on personnel work.

Breakdown of the 580 Formal communications to the NHS in the year ending April 1983

(multi-disciplinary circulars matrices are ascribed to RL)

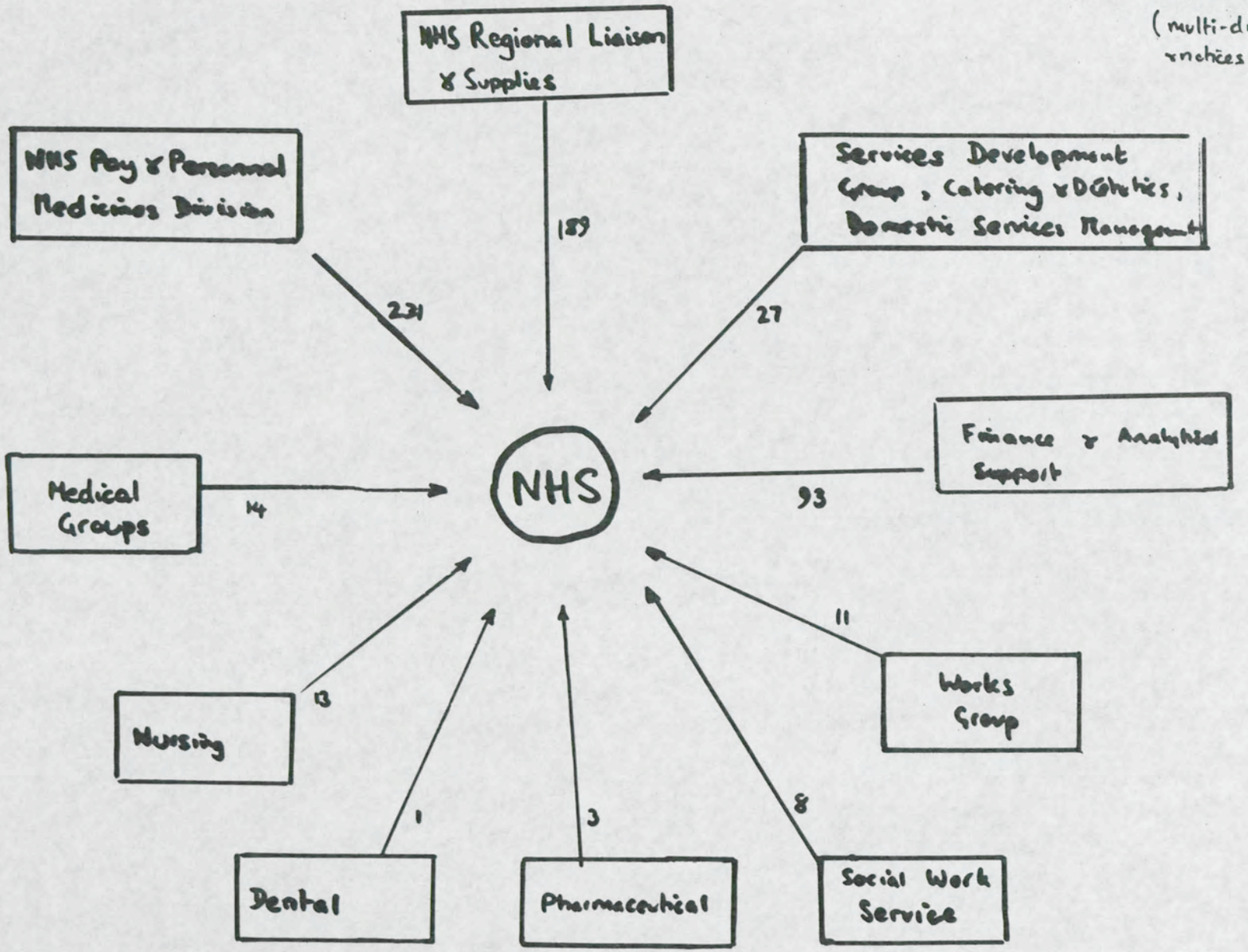

CHART III

PRIOR CONSIDERATIONS

1. Objectives

a) to respond positively to the problem by setting up a clear focus to begin action on what Griffiths saw as the general management role of the centre:

- implementation of policies
- leadership for management in the NHS
- control of performance
- consistency and drive over the long-term.

b) to give initial effect to our response early in 1984 and to achieve measurable response by March 1985.

c) to have some immediate impact, which is visible to the NHS, to Parliament and to the Public.

d) to maintain ability to develop and co-ordinate "wider health" policies.

2. Constraints

a) Ministerial, Regional and District accountability and authority to be unchanged ie within current statutory framework; no corporate status.

b) no increase in DHSS manpower, and within that no increase in posts at under-secretary level and above.

c) low cost.

3. Guidelines

Five broad principles which have emerged from Departmental discussion

a) When in doubt, leave out

In the initial period, the management box is likely to work best if it is not over-burdened with functions which are not essential to its task. Eg: negotiations with opticians, dentists, pharmacists.

b) No duplication

The management box should not duplicate sources of advice or channels of contact which exist to support the Secretary of State in his wider health functions (eg consultation with the Joint Consultants' Committee) and to support him in his Cabinet and Parliamentary activities.

c) Stronger management input into policy making

The Secretary of State's responsibilities for development of health policy (eg smoking), are wider than those of the management box; but the management box should have a strong influence on policy making on order to reflect the NHS "management" viewpoint. EG: switch to community care of the mentally ill and mentally handicapped.

d) Flexibility

Issues may be reallocated into or out of the management box as emphases change over time as between Secretary of State's policy development and management implementation. Eg: primary care (cf pensions).

e) Professional and functional links

Members of the management box should be accountable to the NHS general manager; those who are also part of specialist or professional disciplines should continue to look to their professional head for professional guidance.

ACTION: PHASE 1

Aim: To identify by January 1984 and have effective by March 1984 the nucleus of the management box.

The initial moves must create for the HCHS at least a nucleus under unified management comprising three components, including appropriate professional support:

1. General management for HCHS

   - organisation, structure, appointments
   - communications, information
   - accountability, performance review

2. Personnel for HCHS

   - pay, terms and conditions of service
   - industrial relations, Whitley
   - manpower planning and control

3. Resources and Planning for HCHS

   - financial allocation, funding, monitoring outgo against cash limits.
   - budgeting, financial management systems.

A first analysis of how these components might be constructed from the existing divisions is being undertaken. Chart IV illustrates this process for Finance Division A. The five administrative groups, the medical groups and the nursing group have all beeen analysed in this way and an initial summary prepared for each of them.

CHART IV

ILLUSTRATIVE ANALYSIS OF FINANCE DIVISION 'A'

Responsibilities as shown in DMA

1. Assessment of future needs for resources and cash, taking account of Ministers' policies and priorities and external factors, advice and support to Ministers on public expenditure negotiations.

2. Translation of agreed public expenditure into financial allocations to businesses.

3. Advice to Ministers on sources of finance.

4. Monitoring trends in use of resources, outputs and productivity for HPSS.

5. Overview of longer term costs of service development policies for HPSS.

6. Preparation of evidence to Social Services Committee on financial matters; co-ordination of Department's dealings with this and other Select Committees.

7. Advice to policy branches in SDG, P Group (excluding FPS), Works Group and RL on financial aspects of policy and programme review, including costing, evaluations and availability of resources.

8. Financial control of health authorities, including funding, banking arrangements, monitoring of in-year expenditure to keep within cash limits.

9. With RL colleagues, advice to Ministers on health authority revenue and capital allocations, short term planning guidelines, and long-term resource assumptions. Preparation of HCHS public expenditure forecasts, Parliamentary estimates, and cash limits.

10. Development of better financial management in health authorities, including budgeting, finance aspects of planning and performance review, option appraisal, training and information.

11. Advice to Ministers on financial aspects of Regional reviews, and finance input to SHA reviews.

12. Financial control of, and development of better financial management of fringe bodies and other centrally funded services whose budget holders are in SDG and P Group (excluding FPS), including the UK CC for nursing. NHS training authority, Central Blood Laboratories Authority, NRPB Special Hospitalsgrants to voluntary bodies and welfare milk.

13. Scrutiny and processing of claims for free welfare milk to day nurseries.

14. Advice to Ministers on LA PSS financial matters, including public expenditure, GRE's for PSS, and rate support grant. Chairmanship of PSS Expenditure Steering Grou

15. Casework, PO cases, PQs and briefing for Ministers, PAC, Social Services Committee.

16. Management of FA including FMI implications.

□ = wholly in management box

⬚ = partly in management box

IMPLEMENTATION

Part I - DHSS

1. Put a small team of officials full-time onto this work

   - NOW

2. Define more clearly the three components of the nucleus and settle an operative date [Feb/March] for their establishment

   - BY 2 DECEMBER 1983

3. Seek Treasury/MPO authority to draw up, in consultation with head-hunters, job descriptions for the general manager and personnel director and then recruit

   - BY 9 DECEMBER 1983

4. Resolve unified management and interim reporting arrangements for nucleus, and settle provisional communication lines with NHS (consulting NHS as necessary) and with rest of DHSS

   - BY END DECEMBER 1983

5. Discuss with RHA Chairmen emerging picture

   - 18 JANUARY 1984

6. Set up nucleus, including accommodation changes, and bring into operation.

   - FEB/MARCH 1984

7. Plan second phase - ie completion under the direction of the supervisory board of the complete NHS/management board structure.

IMPLEMENTATION

Part II - NHS

1. Draft guidance on general management function and involvement of clinicians in management in the light of comments received on the Secretary of State's letter of 18 November

- DECEMBER 1983

2. Complete consultation process - 9 JANUARY 1984

3. Discuss results of consultation and guidance prepared with RHA chairmen

- 18 JANUARY 1984

4. Issue initial guidance on general management function, including timetable for appointments, DHSS management arrangements and future channels of communication

- END FEBRUARY 1984

5. Identify general managers in regions, districts and units

- MARCH ONWARDS

6. Issue further guidance on detailed personnel issues arising from general manager role

- END MARCH

7. Extension of accountability reviews to units

- APRIL ONWARDS

8. Each authority to set in hand a programme of work to:

- APRIL ONWARDS

a. consider organisation of management structure, clarification of roles of chief officers, and of authority members

b. review and reduce need for functional management structures

c. initiate cost improvement programmes

d. follow guidance on involvement of clinicians

e. establish unit budget

f. clarify district financial management processes

g. ascertain acceptability of service output; use as a performance measure.

9. Priority tasks for the NHS general manager and the personnel director on appointments will be:

a. review levels of decision taking (GM)

b. review all consultation arrangements (GM)

c. ensure development of a property function (GM)

d. develope streamlined procedures for major capital schemes (GM)

e. ensure "Review of Works Function" gives priority to requirements of management box (GM)

f. review implications of remuneration system for incentives (PD)

g. assess management training (PD)

h. review of personnel functions and conditions of service (PD)

i. study nursing manpower levels (PD)

j. study of other manpower levels (PD).

ALLOCATION OF FUNCTIONS: THE FINANCE GROUP

Summary

At present the Finance Group has a manpower allocation of 1398.5. Of these 451.5 are in the 2 health divisions FA and FB, 356, are in three specialist groups - Statistics and Research (SR), Economic Advice (EAO), and Operational Research (ORS) - providing services to the whole Department, and 591 are in the division, FC, which deals with social security Finance and the cost of DHSS Administration.

The initial analysis was that FC and the specialist divisions providing common services, SR, EAO and ORS would not be within the remit of the NHS Management Board but might provide some services to it as they do to Headquarters generally. The functions of FA and FB divided roughly 1:3 into functions which must be within the Management Board's remit and those which could fall outside. The allocation is shown in the attached chart (the precise balance depends on the decisions on the issues below).

Key issues are:

- The overall HPSS financial policy and planning and handling of PESC is shown outside the Management Board.

- Financing of the FPS is shown outside the Management Board although general medical services is within it under the proposed allocation of Personnel functions.

- The audit responsibilities of FB4 are shown outside the Management Board and they include the support for the Accounting Officer in responding to the CAG and PAC. This may need to be reconsidered in the light of final decisions on Accounting Officer responsibilities in a new structure and in the balance of workload between Divisions.

- Finance branches liaison duties with HQ policy branches ie financial control, budgetting, monitoring etc are assumed to continue outside the Management Board; their extent depending on the extent of policy work to which they relate.

- The chart assumes a strengthened capacity for improving financial management systems in the NHS - an objective which was stressed by Griffiths and would stand whatever the allocation of functions.

EXISTING FUNCTIONS BY DIVISION

Finance Division A	Possible reallocation of functions
- PES negotiations and procedures for HPSS, analysis and presentation of trends in use of resources, consideration of longer term expenditure needs and sources of finance.	- outside NHS Management Board
- Funding and cash limit control of health authority expenditure; regional allocations & financial planning guidelines; financial management in health authorities, finance aspects of regional reviews, finance liaison work with various policy branches.	- inside NHS Management Board with additional emphasis on financial management systems
- Local authority personal social services; RSG; grants to voluntary bodies; welfare foods; finance liaison.	- outside NHS Management Board
Finance Division B	
- Central accounting for HPSS votes; NHS accounts and costing returns; budgets of centrally financed services (HPSS's finance liaison work).	- outside NHS Management Board except for NHS accounts and costing returns and centrally financed services which are within the Board.
- Family Practitioner Services and related bodies (eg Dental Estimates Board, PPA, Medical practices Committee; hospital and community health doctors and dentists (costs) finance liaison work.	- outside NHS Management Board except for finance work on hospital and community health doctors and dentists; general medical practitioners; and FPCs
- Accountancy and audit for DHSS HQ; statutory audit for certain non-Departmental public bodies; external audit of NHS; training and support for Accounting Officer.	- outside NHS Management Board subject to decisions on accounting officer responsibilities

ALLOCATION OF FUNCTIONS: THE REGIONAL GROUP

Summary

At present the Regional Group has a manpower allocation of 518. Of these, 94 are employed in Regional Liaison Division, 413 in Supply Division (this figure does not include 972 administrative and technical staff stationed at 30 ALAC and other centres), and 6 in the Health Services Information Branch.

An allocation of functions for these two Divisions and the HSIB is shown in the attached chart. Key issues are.

. The Management Board will have to strengthen arrangements for securing implementation and control of Ministers' objectives and policies. This role is not fully reflected in the current functions of Regional Liaison Division although the programme of regional reviews etc has become and increasingly important part of their work. Whilst therefore all the functions of the Divisions are shown within the Management Board these will need to be reviewe by the Board and modified as necessary to reflect new thinking about the way the health service should be managed.

. The exact position of the Supply Council within the aegis of the Management Board remains to be decided. How that question is decided will also influence how Supply Division's functions are treated.

. It for consideration whether services - such as the artificial limb and artificial eye services - which are run and financed directly by the Department should come within the scope of the NHS Management Board. A review of the management of ALACs is pending.

. All the functions of those branches of Supply Division which are concerned with support for health industry and exports are shown outside the Management Board although their work is clearly linked with procurement.

Existing functions by Division	Possible reallocation of functions
1. Regional Liaison Division	- inside NHS Management Board
- Liaison between the NHS and the Department; eg securing implementation of Ministers' service policies; advising Divisions on NHS implications of policies; arranging formal communications; support for Ministers in Parliamentary duties.	
- Advising on issues requiring central decision; eg resource allocations; approval of major capital schemes; hospital closures.	- inside NHS Management Board
- Devising and operating systems for securing, and measuring, effective management; eg accountability reviews and examination of authorities plans; management costs; performance indicators; manpower controls.	- inside NHS Management Board
2. Health Services Information Branch	
- Co-ordination of response to, and advice to Ministers on, reports of Korner Committee on Health Services Information; co-ordination of action arising from Ministers' decisions.	- inside NHS Management Board
3. Supply	
- Staff support to the Supply Council	- inside NHS Management Board
- Procurement of / contracting for: vaccines, hearing aids and environmental controls, aids and appliances for NHS.	- inside NHS Management Board (transfer of some contracts to supply Council under discussion)
- Running Artificial Limb and Artifical Eye services, the procurement and maintenance of wheelchairs, trikes and cars, contracts for surgical appliances and administering Heywood Central store.	- centrally financed services: allocation to be considered

- Promoting strength and export performance of domestic health-care and pharmaceutical industries	- outside NHS Management Board
- Operation and policy on the Pharmaceutical Price Regulation Scheme	- outside NHS Management Board
- Research on / procurement of medical equipment and supplies of adequate standards of safety, efficiency, and economy; includes administrative responsibility for Bioengineering Centre	- outside NHS Management Board

ALLOCATION OF FUNCTIONS: THE PERSONNEL GROUP

Summary

At present the Personnel Group has a manpower allocation of 379. Of them, 260 are in the 3 Personnel Divisions, concerned with the full range of personnel functions in respect of staff groups in the NHS, and 119 are in Medicines Divisions, which deals with the operation of, and policy on, the legislation governing the licensing and control of medicines.

The initial analysis was that Medicines Division would not be within the remit of the NHS Management Board. An allocation of the functions of the remainder of the Personnel Group as between those within the remit of the Board and those outside is attached in chart form. Key issues are:

- Advising Ministers on pay. The strengthened personnel function within the Management Board must play a major role. But NHS pay issues including evidence to Review Bodies is only one aspect, though a very important one, of the overall strategy for public sector pay and public expenditure. It is difficult to judge how much of the pay policy work should be within or outside the Management Board.

- Medical manpower and training. Again this is an important part of the personnel function in the Griffiths structure. The proposed allocation puts linked areas such as PG Medical Education within the Management Board as well but this might be left within whatever medical structure is outside the Board.

- The Family Practitioner Services (FPS) are shown as outside the Management Board, with the exceptions of the General Medical Services (GMS) and of the management of Family Practitioner Committees (FPCs). The essential place of GMS in the integrated delivery of health care argues for their inclusion. This and the advantage of having the pay of all doctors within the same structure might be considered to outweigh the disadvantage of splitting the General Medical Practitioners (GMPs) from other FPS professions (ie dentists, pharmacists, opticians). Although much of FPC's work is routine administration of contracts, they provide a mechanism for achieving drive and direction in the GMS towards integrated health care. This allocation has, however, to be judged against the disadvantage of separating FPCs from the main responsibility for the FPS.

- The community dental service is shown as inside the Management Board's remit. The question arises, however, as to whether it is operationally viable to separate this aspect of dental services from the general dental services, which are shown as outside the Board.

- The arguments on the list, and particularly the second and third issues, are very evenly balanced, and no solution is wholly satisfactory. Some of the decisions should be taken in conjunction with decisions about the arrangements for handling the work of the professional divisions.

Existing functions by Division	Possible reallocation of functions
P1 Division	Inside except possibly general evidence to the Review Body.
Support for Doctors and Dentists Review Body, implementation of reports, negotiations on terms of service for all doctors and hospital dentists and administration of pay systems.	
NHS Superannuation	Outside NHS Management Board
General policy on FPCs including expenditure/manpower forecasting and control, management and administration of FPCs and related policy issues.	Inside NHS Management Board
Disciplinary appeals and representations	Inside NHS Management Board
Medical manpower planning including career structure, improvements in General Medical Services, liaison with UGC, community medicine and overseas doctors.	Inside NHS Management Board
PG medical education vocational training, GP training.	Inside NHS Management Board
Other NHS Training	Inside NHS Management Board
GMC/EC Medical Directives	Outside NHS Management Board
P2 Division	
Pay policy: advising on and implementing pay policies in the NHS.	Inside NHS Management Board (except for general pay policy issues: see summary)
Personnel and industrial relations: advising on and implementing policies.	Inside NHS Management Board
NHS Whitley: improvement of system; servicing and representing Ministers on Management Sides; exercising statutory powers of approval of agreements.	Inside NHS Management Board
Personnel liaison work with policy branches.	Inside NHS Management Board
Training grants in paramedical professions.	Inside NHS Management Board

Existing functions by Division	Possible reallocation of functions
P3 Division	
Family Practitioner Services: functions in respect of general dental practitioners, opticians and retail pharmacists relating to:	
- providing and developing an acceptable service	Outside NHS Management Board
- negotiating remuneration	Outside NHS Management Board (but see summary)
- terms and conditions of service	Outside NHS Management Board
- fixing charge structure and levels	Outside NHS Management Board
- liaison with professional bodies over legislative framework (registration, education, discipline)	Outside NHS Management Board
- EEC questions	Outside NHS Management Board
DEB, PPA, Rural Dispensing Committee	Outside NHS Management Board
Other dental questions: community dental services, manpower planning, post-graduate education.	Inside NHS Management Board
Nurses, midwives and health visitors: pay, manpower planning, agency nurses, education and training.	Inside NHS Management Board (but see summary for pay issue)

ALLOCATION OF FUNCTIONS: THE SERVICE DEVELOPMENT GROUP

Summary

The Service Development Group (administrative Group) has a manpower allocation of 296, in four Divisions: Children, Community Services, Health Services, Mental Health. The titles are approximations eg health education (including adults) is covered in Children's Division. Working closely with NHS are the small Catering and Domestic Services (professional) Branches[16 staff].

Most tasks require joint work with staff in Medical, Nursing and Social Work Service Divisions. Many tasks - but not all - involve policy appraisals running across PSS as well as NHS and, especially where tasks are supportive of work in which professional aspects predominate (eg control of infectious disease outbreaks), look to links with the professional bodies, universities etc. The initial analysis reflects the necessity of maintaining coherent staff support, from administrative and professional divisions, to the Secretary of State in his responsibility for the wider health and social policies, and for local authority social services. However it aims to place within the Management Board functions which are predominantly about implementation of Ministerial policy objectives through NHS management. The allocation is shown in the attached chart. (The precise balance depends on decisions on issues below).

Key issues are:-

(1) The allocation follows the broad principle that work on the formulation and review of strategic objectives - for decision by Ministers, advised as appropriate by the Supervisory Board - would be done outside the Management Board, taking full account of, amongst other factors, NHS management requirements; and that the implementation of strategic objectives would be for the Management Board (in so far as the NHS was concerned). Thus, general social and health policies for the client groups (eg the vulnerable elderly) would be articulated <u>outside</u> the Management Board but the mechanisms for implementation, eg securing reports of NHS performance against objectives and the review process, would be <u>inside</u> the Management Board.

(2) In deciding the initial allocation an element of pragmatism is also necessary, to reflect the current balance between policy and management objectives. Thus primary care, which is coordinated in SDG and of which a major review is proposed for 1984, is shown outside the Management Board but would be closely coordinated with the personnel functions for the general medical services inside the Board. Similarly, the established community care policy for the elderly and mentally ill and handicapped is seen as best substained by staff work including performance review and efficiency measures across the whole of HPSS and is allocated <u>outside</u> the Management Board. On the other hand, hospital development including, acute services and their technical and support services, are placed <u>inside</u> the Management Board as they relate only to the NHS and the current emphasis is on good management, not on policy development. The same consideration explains the suggested allocation of the treatment of overseas visitors, pay beds, and road accident cases <u>inside</u> the Management Board. Where available information - whether from the NHS,

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via the Management Board, from professional bodies, or from elsewhere - suggested that policy review was needed in areas initially allocated to the Management Board because of the current emphasis on management objectives, such review could be carried out in the 'secretariat' outside the Management Board. The 'secretariat' would not necessarily keep all service policy areas under review at all times but could have a general programme review function, the priorities for review being decided by Ministers, making use of the DMA system.

(3) Where the administrative work is closely linked to professional functions, the placing of the latter functions outside (or inside) the Board should be a deciding factor.

(4) The chart assumes that SDG functions relating to patients as consumers (community health councils, complaints, Health Service Commissioner reports, confidentiality of health records) would be within the Management Board, contributing to its (new) function of pressing consumer interests on NHS management. This overrides the argument that these functions of criticism shold be, and be seen to be, independent of management.

(5) The Health Advisory Service and Development Team are not Departmental staff - except for small secretariats. They help to safeguard especially vulnerable patients (long stay, mentally ill, mentally handicapped) by providing objective and independent professional advice to local management. Their future administrative link is provisionally shown inside the Management Board, but their links to wider health and social policy-making, and their tie-up with SWS, must be safeguarded.

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Existing Functions by Divisions

	Possible Reallocations of Functions
Children's Division	
- Children in local authority care, adoption; child abuse	Outside NHS Management Board
- Community Health Councils, complaints by patients, Health Service Commissioner, Confidentiality of health records	Inside NHS Management Board
- Control of Infectious Diseases, vaccination policies	Outside NHS Management Board
- Prevention of Illness, Health education, nutrition, smoking, welfare foods	Outside NHS Management Board
- Support for Ministers in developing and assessing cost effective health and social policies for mothers and children, and responsible parenthood. School health. Family planning and abortion matters; child abuse; nurseries; childminding; legislation. Maternity Services Advisory Ctte.	Outside NHS Management Board
- Primary health care and community nursing services, health centres.	Outside NHS Management Board,

Health Services Division

- Hospital scientific and technical services, blood transfusion service, ambulance service	Inside NHS Management Board
- Public Health Laboratory Service, Radiological Protection Service, Toxicology, chemical Health hazards	Outside NHS Management Board
- Specialised services, supra-regional services and special financial arrangements	Inside NHS Management Board
- Private Health Insurers and Hospitals; Nursing Homes; registration and development	Outside NHS Management Board except that control of NHS pay beds and contracting by NHS with the private sector would be inside the Management Board
- Catering and Domestic Services; contracting out of services	Inside NHS Management Board
- Secretariat to Standing Medical and Nursing Advisory Committees and to nurmerous expert advisory committees.	Outside NHS Management Board, except where the expert group relates to a function which is within the Management Board
- Policy on treatment of overseas visitors, road accident cases	Inside NHS Management Board
- Food Hygiene and safety	Outside NHS Management Board
- Rehabilitation of disabled people, aids for the handicapped	Outside NHS Management Board
- Development and performance review of hospital services (other than maternity, mental health, geriatrics and chronically disabled).	Inside NHS Management Board

Mental Health Division

- Management of Broadmoor, Rampton, Moss Side and Park Lane Hospitals (in the case of Rampton Hospital there is a Board with special health authority status)	Outside NHS Management Board (the management of these Special Hospitals is currently under review, which might lead to a different allocation at a future date).
- Mental Health Act Commission and Tribunals; implementing the 1983 Act. Legal aspects of detention and treatment. Liaison with Home Office, prisons, and the Courts	Outside NHS Management Board, except possibly for any continued central support for the Regional Secure Unit programme.
- Support for Ministers in developing and assessing comprehensive policies, including the transfer to community care, for mentally ill and mentally handicapped people, involving local authorities, voluntary bodies, health service management, professional bodies and social security and other Departments in their implementation; by research and pilot projects; and by contributing to setting objectives and performance indicators and to the Review process within NHS management. Framing and staffing implications of the policy.	Outside NHS Management Board except possibly for any central support required by NHS management in the major closures programme.

Community Services Division

- Personal Socal Services, and general responsibility for relations with local authorities and with the voluntary sector	Outside NHS Management Board
- Secretariat to Korner Committee Administrative support of Health Advisory Service Guidance to NHS on planning activities Co-ordination of policy input to Regional Reviews	Inside NHS Management Board
- Framing and reviewing care in the community policies for the elderly and disabled (except mental health); rules for joint finance and central management pilot projects	Outside NHS Management Board, except for specialised NHS items such as hospital bed location (See under key issues).

ALLOCATION OF FUNCTIONS: THE ADMINISTRATION GROUP

The Administration Group is responsible for Departmental manpower and personnel, for social security operations (both at the two Central Offices and in the Regional oranisation), for international relations (HPSS and social security), and for management services and computers.

The initial analysis was that of the areas of responsibility only that concerned with management services and computers in the NHS could be considered as potentially coming within the remit of the NHS Management Board. Three branches (totalling 43 staff) of Management Services and Computers Division (MSC) are concerned. A suggested allocation of their functions is shown in the attached chart. Key issues are:

- The future of the Computer Policy Committee: Griffiths recommended that the Management Board be responsible for computer policy and the allocation of functions attached follows that. The precise relationship between the Board and the Computer Policy Committee would need to be defined. It needs to be borne in mind that if the Management Board, as Griffiths recommended, is composed of DHSS civil servants working full-time on the NHS management matters, this seems to rule out the chairman of the CPC as a member of the Board.

- The advantage of including the small Management Services branch which concentrates on studies related to the health service under the management board has to be weighed against the possibility that the professional expertise of this branch will be weakened in removing them from MSC, the central focal point for management services and computers. This is a point which may need to be considered in the light of the CIRC review, the inter-departmental scrutiny of review and consultancy capabilities.

EXISTING FUNCTIONS BY DIVISION	POSSIBLE RE-ALLOCATION OF FUNCTIONS
Management Services and Computers 2 Branch	
- Management Services in the NHS: carrying out O+M studies in NHS; DHSS/NHS liaison on management services; central O+M training.	- inside NHS Management Board
Management Services and Computers 3A Branch	
- NHS computing: policy; Computer Policy Committee; direction of computer projects.	- inside NHS Management Board
Management Services and Computers 3C Branch	
- Computing aspects of implementing Korner Committee management information systems.	- inside NHS Management Board

ALLOCATION OF FUNCTIONS : THE MEDICAL DIVISIONS

1. This paper is a response by the Medical Divisions to the Secretary of State's wish that the NHS should see the Department give a clear lead to the implementation of the Management Enquiry. In particular it seeks to deal with the most urgent of the eight components of the analysis identified by Sir Kenneth Stowe at the meeting with the Secretary of State held on 11 November. These are:

(a) the identification of those functions which should be under the Management Board irrespective of who currently undertakes them and where they are located (the content of the "executive box");

(b) the identification of other functions ie those parts of DHSS within HPSS which are not within the remit of the Management Board ("secretariat box");

(c) preparation of an organisation chart with

(d) reporting lines.

2. The medical divisions have a number of important functions outside the National Health Service. These embrace international developments which infringe on the public health such as communicable disease control and reciprocal health agreements, the safety of the environment, nutrition, food additives, the safety of medicines and devices, the control of drug abuse and addiction, and health in the schools. Some of these functions come within the responsibilities of the Secretary of State for Health and Social Services while others are the responsibility of the Home Secretary, Secretary of State for Education and Science, and other Government departments. It is essential that following the implementation of the Griffiths proposals lines of accountability remain which ensure that cohesive and credible advice continues to be given by the medical divisions on these and other aspects of health.

3. An analysis of the functions of ten medical divisions (and ALAC) is attached. The functions are classified according to whether they relate predominantly to the Management Board to the Secretariat or to both. Attention is drawn to the large number of functions which have relevance both within the NHS and outside it. This is because the issues which underlie health and disease are extremely broad and because the role of the NHS is predominant in medical care and it also has important functions in preventive medicine and the promotion of health. In relation to its work in "client groups" such as children and the mentally ill, the medical divisions unlike the administrative divisions within the Department, have responsibilities to other Government departments.

4. Any consideration of the implementation of Griffiths by dividing functions between the "executive box" and "secretariat box" should take into account that there are many fields in medicine in which the same expert must advise on policy and management. A topical example is the field of blood transfusion where the same team gives advice both on the development of policy for the control of the AIDS syndrome, self-sufficiency in blood products and effectiveness of local services. In other fields the realities of the manpower position

exert an absolute constraint on re-organisation. Thus in relation to mental handicap in children both policy and management advice are given by a single member of the medical staff who devotes two-thirds of their time to other subjects.

5. The National Health Service in England is clearly also related intimately to the service in Wales and in Scotland. In a number of important fields, eg medical manpower, the career structure for doctors and postgraduate medical education DHSS through the CMO gives a lead to the United Kingdom. This would need to be taken into account in relation to the function of the "personnel member" of the NHS Management Board.

6. The development of strategic policy in relation to the National Health Service inevitably involves wider considerations which relate to the social services function of the DHSS and the other aspects of health mentioned above. For this reason we consider that strategic planning should be a function of the "secretariat box".

Divisions Predominantly Outside The NHS Management Board

7. The Medicines and the Toxicology and Environmental Health Divisions fall most easily into this category. The function of the former is to implement the Medicines Act 1968 and EEC Directives 75/318 and 75/319. The International and Communicable Disease Division may also be categorised here because all of its functions have an element external to the NHS although many of them (see chart) also have obvious relevance within it. Within the Primary Care and Regional Services Division a substantial part of the time of the Regional Medical Officers is taken up with the examination of patients referred to them who are receiving various types of social security benefit (the so called "reference system"). This function is also clearly outside the remit of the NHS Management Board although another portion of the work of these medical officers is clearly within its remit (see below).

Divisions Easily Placed Within The NHS Management Board

8. The most obvious and easily classified is Management Planning and Organisation. Much, though not all, of the Scientific Equipment and Building Division is also exclusively related to the NHS and this should also probably be classified under this heading. At least part of HPS would fit within the executive box eg hospital policy, supra regional policy and some of the hospital specialty work. The Artificial Limb Appliance Service and the Central Blood Laboratories Authority also clearly come under this category. There is a major dilemma about the placing of Primary Care. Without it there is a real risk that the Management Board will underestimate the importance of its function in relation to the community services, lose the capacity to transfer care into this field and come to be seen as a "Hospital Management Board". On the other hand inclusion might well be seen as an infringement of the independent contractor status of the general practitioners. This would be extremely sensitive with the medical profession particularly as the Griffiths Enquiry did not examine the General Practitioner Service or conduct consultations in this field. If it were decided that negotiation of the terms and conditions of service of general practitioners should be conducted through the "secretariat box", that element of the function of the Regional Medical Officers which advises general practitioners on prescriptions, premises etc and exercises some

control on standards and expenditure in this field should be a function of the Management Board. Unfortunately, however, the fragmentation of the Primary Care and Regional Medical Services Division in this way would have serious disadvantages as it would render any co-ordinated management or planning of the Primary Health Care Services in the National Health Service extremely difficult.

Divisions With Mixed Functions

9. Within the remaining divisions the Nutrition Unit (CDN) and Special Hospitals (MHI) are clearly secretariat functions. Much of the work of the Division concerned with Children and Disablement and that of Mental Health and Illness relates to client groups whose interests straddle the NHS (the elderly within HPS are also in this category) or to areas with wide implications such as alcohol and drug abuse (MHI) and prevention including health education (CDN). Family planning, abortion and private practice are examples with similar implications within HPS, and it should be noted that in relation to abortion the CMO has statutory duties. In a number of these areas there is a responsibility through the CMO to the Home Office or DES. It is suggested that these divisions should be allocated to the secretariat in line with SDG. The CMO's responsibility in relation to the Abortion Act cannot be delegated.

Medical Manpower and Education

10. Doctors, their numbers, distribution, staffing structure, terms of service, education and discipline are obviously of crucial importance to the NHS and are highly sensitive areas both politically and professionally. The development of policies relating to these matters are negotiated at the highest level on a United Kingdom basis with key outside bodies such as the GMC, the Royal Colleges, the UGC, the BMA and other Government departments such as the Home Office (control of overseas doctors, immigration) and DES. It seems essential therefore that policy development as well as the negotiation of these policies as distinct from their implementation should be reserved to the secretariat box. Once policies have been settled the day to day personnel issues arising could be dealt as a management function.

Lines of Accountability

11. The lines of accountability must provide for the following:

(a) cohesive medical advice to the Secretary of State (DHSS) on health matters which go beyond the remit of the NHS;

(b) medical advice to the Chairman of the Management Board on relevant matters;

(c) retain the credibility of the CMO as the principal adviser on health matters to other Government departments;

(d) retain satisfactory lines of communication between the CMO and the General Medical Council, the Medical Research Council, the Royal Colleges;

(e) retain the confidence of the medical profession without whom no effective working of the National Health Service is possible;

(f) avoid at all costs the risk of the Secretary of State receiving conflicting medical advice from the Management Board and from the CMO.

It is submitted that these objects can only be secured if there remains a clear line of accountability of all medical staff to the CMO.

MEDICAL DIVISIONS - LIST OF PRINCIPAL FUNCTIONS

DCMO - DR E L HARRIS

	NHS MB BOX	SECRETARIAT BOX	BOTH
ALAC (Artificial Limb Vehicle and Appliance Service)	+		
SEB (Scientific, Equipment and Building)			
Policy on supplies	+		
Laboratory management	+		
Export supplies		+	
Standards (professional)			+
Blood transfusion	+		+
Hospital pathology services	+		+
PHLS			+
CAMR			+
Dangerous pathogens			+
Radiology	+		
Radiation protection			+
Building	+		
Computers	+		
Cancer services			+
Lasers, collection of pituitaries		+	
IMCD (International, Microbiology of Food, Communicable Diseases)			
WHO			+
Commonwealth relations		+	
European Community			+
Council of Europe		(+)	
Bilaterial Health Agreements			+
Immigration			+
Microbiology of food		+	
Communicable Disease			+
Infection in hospitals control			+
Immunisation			+
Environmental hygiene		+	
MD (Medicines Division)		+	

DCMO - DR E SHORE

	NHS MB BOX	SECRETARIAT BOX	BOTH
CDN (Children, Disablement and Nutrition)			
Nutrition Unit (also MAFF)		+	
Disablement			+
Children (also DES)			+
Prevention (also DoE, MAFF)			+
MHI (Mental Health and Illness)			
Mental Health (also Home Office)			+
Mental Handicap			+
Drugs, Addiction (also Home Office)			+
Alcoholism (also Home Office)			+
Special Hospitals (also Home Office)		+	
Forensic psychiatry (also Home Office)			+
PCR (Primary Care and Regional Services)			
Prescribing	+		
Regional Medical Services referral		+	
visiting	+		
GP terms and conditions		+	
Appeals	+		
Primary care policy			+
MPO (Management, Planning and Organisation of NHS)			
Planning	+		
Performance Indicators	+		
Korner	+		
Medical Audit	+		
Reg Liaison	+		
Data Protection	+		

DCMO - DR G FORD

	NHS MB BOX	SECRETARIAT BOX	BOTH
MME (Medical Manpower and Education)			
Policy		+	
Day to Day Personnel matters	+		
HPS (Hospital Policy and Services)			
Hospital policy	+		
Supra regional	+		
Abortion and foetal abnormality (N.B. CMO's Statutory Duties)			+
Family planning			+
Maternal deaths			+
Private practice			+
Hospital specialty work	+		+
Elderly			+
TEP (Toxicology and Environmental Health			
Toxicology, Environment, Food		+	
Toxicology Unit			+

SUMMARY

DCMO - DR E L HARRIS

ALAC	NHS Management 'Box'
SEB	Mostly NHS Management 'Box' but some work has important implications outside NHS (eg export)
IMCD	Mostly Secretariat 'Box'
MD	Secretariat 'Box'

DCMO - DR E SHORE

CDN	Apart from Nutrition, which is Secretariat 'Box', straddles the two boxes
MHI	Most of these have important aspects within and outside the NHS
PCR	See text
MPO	NHS Management 'Box'

DCMO - DR G FORD

MME	Day to day personnel function in Management 'Box' development and negotiation of policy Secretariat 'Box'
HPS	All have NHS Management implications but many also have external implications
TEP	Secretariat 'Box' except for the Toxicology Unit

Predominantly NHS Management Box	Both	Predominantly Secretariat Box
ALAC		IMCD
SEB	PCR	MD
HPS	MME	TEP
MPO		CDN
		MHI

Branch M6B of Med SS at Norcross, some of whose function is devoted to processing NHS Superannuation claims in which the claimant is seeking early retirement on health grounds is also within the compass of the NHS Management Board.

ALLOCATION OF FUNCTIONS: NURSING DIVISION (SUMMARY REPORT)

At present Nursing Division has a manpower complement of 71. The Chief Nursing Officer is supported by a Deputy, 9 Principal Nursing Officers and 29 Nursing Officers. Administrative and secretarial staff in support total 31.

The initial analysis was that, except in respect of specific professional responsibilities and policies on which Nursing Division was in the lead, the allocation of the functions of the Division would follow general decisions about the distribution of work, based on the allocation of the administrative 'lead'. A suggested allocation is shown in the chart opposite. Key issues are:

- The need to weigh consistency of professional allocations with administrative allocations, which leads to 4 of the 8 functions listed being shown as inside the NHS Management Board, against the need to ensure that the Chief Nursing Officer's position is not weakened in her wider role of support to the Secretary of State across the full range of his HPSS and wider health responsibilities. The underlying issue here is the reporting relationship of professional staff working within the NHS Management Board.

- In a professional division individual officers often have a particular expertise. In the service development field in particular the allocation of functions, and so of the responsibilities of the 3 Principal Nursing Officers and 14 Nursing Officers who work on them, will need to have regard to this factor.

NURSING DIVISION

Existing functions	Possible re-allocation of functions
NHS service development: policy formulation and evaluation	- In general: allocation to follow administrative 'lead' - Specific professional policies and initiatives to be considered individually
Personnel:	
- pay, conditions of service, manpower planning, agency nurses, recruitment	- Inside NHS Management Board
- education and training, including liaison with statutory bodies	- Outside NHS Management Board
Regional liaison functions: professional aspects	- Inside NHS Management Board
Building and supplies	- Inside NHS Management Board (except possibily work on exports - following administrative lead)
Research	- Outside NHS Management Board
Information and computers	- Inside NHS Management Board
International	- Outside NHS Management Board