file ECL

10 DOWNING STREET

From the Principal Private Secretary

7 June 1984

Thank you for your letter of 4 June and for sending me the impressive documents about the implementation of the Griffiths Report in the NHS. I particularly liked the brochure and will keep it handy to show to the Prime Minister at a suitable opportunity.

While I am writing can I thank you also for sending me the two articles from "Pulse". These are useful background.

E.E.R. BUTLER

Sir Kenneth Stowe KCB CVO

TH

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

F E R Butler Esq
Principal Private Secretary
10 Downing Street
London SW1

18 May 1984

Dear Robin

I enclose photocopies of two articles from a recent edition of the magazine "Pulse" which is aimed at General Medical Practitioners. They illustrate very well a fundamental characteristic of the Family Practitioner Services which we have mentioned before. General Practitioners can set about maximising their income (and our costs) in a whole variety of "legitimate" ways. Not only does this make forecasting for us very difficult but it shows that General Practitioners can, and do, tailor the service they provide to meet a "demand" that they can help to create. These are difficult waters. We want to see General Practitioners doing more to help treat patients outside expensive hospitals. But some of this has the undoubted flavour of playing the system for all it is worth.

No reply needed: this is just background to the paper which Robert Armstrong is putting up about Doctors etc pay - and the need to add an "efficiency rider" to the Review Body terms of reference.

Yours ever,
Ken.

Pulse 5/5/84.

Hay fever can help cash flow

As the glorious Easter weather banished winter flu, it also ushered in the hay fever season. Last year produced an exceptional demand on GPs and among the most distressed were those sitting examinations.

GPs may resort to a depot steroid preparation, in addition to the normal armamentarium, to ease the worst sufferers through this vital time.

The most organised will have already purchased directly from manufacturers – at a large discount – sufficient bulk of their particular favourite preparation, and will dispense it personally under the Red Book, paragraph 44–13, claiming a dispensing fee on cost allowance.

The amount of income that this engenders is not considerable, but it may help practice cash flow.

If those who do this find that it works, why not consider a similar approach for parenteral products and coils?

Pulse is published
Morgan-Grampiar
Morgan-Grampiar
30 Calderwood S
London SE18 6Q
Tel: 01-855 777

Editor
Howard Griffiths

Deputy Editor
Nigel Duncan

Consultant Medical Edi
Dr Patrick Kerrigan

Associate Editor
Jane Cameron

News Editor
Jenny Sims

Money Pulse Editor
Sue Russell

Science Editor
Ian Mason Ph. D.

Pulse Reference Editor
Lesley Colgate

Chief Sub Editor
Gerald Buckley

Designer
Terry Hedges

Medical Adviser
Dr Robert Bowles

Publisher

Edited by Sue Russell

PULSE 5/8/84

How GPs woke up to extra money under their noses

Doctors are claiming under paragraph 44.13 of the Red Book with great effect, reports Sue Russell.

GPs seem to have mastered the Red Book to their advantage with great effect in the last two years.

A row that has been simmering with the pharmacists for some time has now boiled over again – all because GPs have woken up to the potential of paragraph 44.13 of the statement of fees and allowances.

This enables all GPs – not just dispensing doctors – to claim payment for items which are personnally administered. This includes flu vaccines, IUCDs, and suture material.

The pharmacists have been alerted by the latest report of the Prescription Pricing Authority, which showed substantial increases in the number of personally-administered prescriptions.

In the year 1973–4, there were 6,729 personally administered prescriptions. By 1981–2 this had risen to 734,402, but the really staggering increase came just a year later.

In 1982–3, a total of 1,049,488 items of service were claimed for, representing a rise of just over 30 per cent.

In dispensing fees alone this represents about £619,197, or roughly £20 per GP in the country. But added to this is reimbursement of the net ingredient cost of the item as listed in the drug tariff, plus an 'on-cost' allowance of 10.5 per cent of that cost, plus a container allowance of 2.8p.

Dr John Lewis: says it is perfectly legal for GPs to administer items personally to patients.

And, of course, not every GP in the country does claim under this paragraph – so the difference in income to those GPs who do can be enormous.

One practice received almost £2,300 from dispensing fees last year – without counting the other allowances. But as an example of what can be done if the practice tries, this was 500 more fees claimed on a list size that was 11,000 patients fewer because the practice had split in two.

And utilising this paragraph helped another practice increase its item-of-service remuneration from 5 per cent of total income to 21 per cent.

GPs were given a boost last year when suture material was added to the drug tariff, and so to the list of items that could be claimed for under paragraph 44.13. But even so, Dr Michael Wilson, deputy chairman of the general medical services committee, believes this was only a small factor in helping to increase the extent of GPs claims.

The first practice was claiming for flu vaccine; measles, tetanus, whooping cough, and diphtheria inoculations; gold treatments for rheumatoid arthritis; Depo Provera; chlorpromazine for schizophrenia and Jectofer for acute anaemia.

A conscious effort was made to boost income, and all patients were told that the practice was holding immunisation clinics.

The practice was also able to buy supplies from the local chemist wholesale – so the discounts produced another useful saving as the items are reimbursed according to the normal drug tariff price.

The pharmacists have been grumbling to various health ministers about this loss of income for some years, but this recent massive increase – coupled with the fact that if the doctor supplies and administers the drug, patients are now exempt from prescription charges – seems to have exacerbated their discontent.

The pharmacists' letter to Social Services Secretary Norman Fowler will argue that the Exchequer is losing out on prescription charges.

But Dr John Lewis, chairman of the rural practices subcommittee, says the law is quite clear, and GPs are doing nothing illegal by administering these items themselves.

And Dr Wilson argues that by prescribing and administering vaccines themselves GPs are also boosting preventive medicine and providing more efficient health care.

Most of the patients would be exempt from prescription charges anyway, so the loss to the Exchequer is minimal.

As Dr Lewis said, in using this paragraph GPs are complying with their terms of service and the regulations of the statement of fees and allowances.

Council spends out to 'rehouse' doctors

Three GPs currently practising in council flats are to be 'rehoused' in a new £530,000 health centre which will be financed not by the district health authority but by the local coun-

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

F E R Butler Esq
10 Downing Street
LONDON
SW1

4 June 1984

Dear Robin

You may be interested to see the attached documents which show how we are implementing the Griffiths Report in the NHS. In themselves they represent a change in management style - a sharp emphasis on getting things done, a clearly signalled determination to monitor performance actively and an attempt to communicate management's stance to all members of staff. The latter is best shown by the brochure (a "first" in our parish) - which is backed up by a presentational video.

Yours ever

Ken.

LMT

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY

Telephone 01-407 5522

From the Secretary of State for Social Services

To all Regional, District and
Special Health Authority Chairman

June 4th 1984.

Dear Chairman.

Last October I asked your Authority and the other key management and professional interests concerned for their comments on my proposals for taking action on the Griffiths Report. We have delayed reaching final decisions so that we could take account of the views of the House of Commons Social Services Committee and of Parliament itself. I enclose a circular which announces the Government's decisions.

Authorities are required to start work straightaway to establish the general management function and to identify individual general managers at Authority and unit levels. The circular provides considerable flexibility to take account of local circumstances. It requires regional authorities to make their proposals by the end of September but allows district authorities until the end of 1985 to complete action at unit level. There will be a good deal of careful work for each Authority in thinking through what to do. I am looking to you to take the same personal responsibility for ensuring that the necessary action is taken by your Authority as I shall be doing at the Department.

As part of the new management style we need to establish, I attach particular importance to ensuring that authority members and staff at all levels have an early opportunity to learn what is proposed and the likely effects at local level. The Department and the NHS Training Authority have prepared material to help you in this, which I hope you will find useful.

Yours Sincerely.

NORMAN FOWLER

ENC

HEALTH CIRCULAR HC(84)13

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

To:
- Regional Health Authorities
- District Health Authorities
- Special Health Authorities for London Postgraduate Teaching Hospitals

for action

- Family Practitioner Committees
- Community Health Councils
- Special Health Authorities other than for London Postgraduate Teaching Hospitals

for information

June 1984

HEALTH SERVICES MANAGEMENT

IMPLEMENTATION OF THE NHS MANAGEMENT INQUIRY REPORT

SUMMARY

This circular amplifies the Government's response to the NHS Management Inquiry Report, published in October 1983, and sets out action now required of health authorities.

THE NHS MANAGEMENT INQUIRY REPORT - THE GOVERNMENT'S VIEW

1. The Government's overriding concern is to see that the National Health Service provides the best possible service to patients within the available resources. We are seeking to ensure that the expenditure devoted to the Service - currently £13 billion a year in England - does reach its target: improvement in the physical and mental health of the people and in the prevention, diagnosis and treatment of illness. We have, with health authorities, already established a programme to improve the effectiveness and efficiency of the NHS which is summarised in Annex A. The most important features are the establishment of systems for planning, for annual review of performance against agreed objectives, and for Regional Health Authorities to draw together their plans for services, manpower and the estate within their resource allocations; the pilot projects for management budgets; and improved audit procedures. These initiatives are designed to promote the more efficient use of what must always be limited resources; they are also steps towards the Government's broader aim to ensure that the management of the health service is geared primarily to the interests of patients.

2. The Management Inquiry Report endorsed our view of the management task and stated: "It cannot be said too often that the National Health Service is about delivering services to people. It is not about organising systems for their own sake ... the driving force behind our advice is the concern to secure the best motivation for staff. As a caring, quality service, the NHS has to balance the interests of the patient, the community, the taxpayer and the employees."

3. The report recommended, for this purpose, a further programme of management action which is summarised in Annex B. Many of the Report's recommendations call for continued action on the initiatives already underway, such as the further development of management budgets. We agree with the Report's call for urgent action to begin implementing all its recommendations, while recognising that there must be different timescales for the results of this action. In the short term, further improvements in the management arrangements of the NHS can be achieved through the establishment of the general management function. In the longer term, steps taken now to develop management tools and to strengthen management training, especially for clinicians - doctors and nurses, will enhance the management potential already existing in the health service. This will enable the clinical professions to play a more active role in management, particularly at unit level.

THE GENERAL MANAGEMENT FUNCTION

4. The Management Inquiry Report identified the importance of a clearly defined general management function - which draws together responsibility for planning, implementation and control of performance - as the key to achieving the management drive necessary to ensure that the standards and range of care provided in the health service are the best possible within available resources. After consultation with health authorities, and taking account of the Report of the Social Services Committee of the House of Commons and the Parliamentary

debates, we accept that the lack of a clearly defined general management function is a weakness in present management arrangements at all levels. We have, therefore, decided that health authorities should now begin to make the necessary arrangements to establish the general management function. The simple aim in establishing the general management function is to ensure that the concern shared by all in the health service for the quality and efficiency of services delivered to patients is translated into action. This means developing present arrangements carefully to secure effective management which has the requirement and capability to plan, guide and implement strategies for improvement and development.

5. The Management Inquiry Team recommended that the general management function should be clearly vested in one person (at each level) who would take personal responsibility for securing action. We accept this view; and believe that the establishment of a personal and visible responsibility for the general management function is essential to obtain a guaranteed commitment throughout the health service for improvement in services and concern for the well-being of every individual patient. In reaching this conclusion, we do not undervalue the importance of consensus in a multi-professional organisation like the NHS. But we share the Report's view that consensus, as a management style, will not alone secure effective and timely management action, nor does it necessarily initiate the kind of dynamic approach needed in the health service to ensure the best quality of care and value for money for patients. We have decided that in order to begin to bring about the improvements in the NHS through the various initiatives already established or recommended in the Management Inquiry Report a general manager will be identified for each RHA, DHA, hospital SHA and unit to take responsibility for the general management function, as detailed in Annex C.

ESTABLISHING THE GENERAL MANAGEMENT FUNCTION

The Unit

6. The initiatives already taken following the publication of "Patients First" and the Report's recommendations are fundamentally about providing better health services for patients. This means looking for improvements at the point where the patient receives a service - in hospital and in the community. The primary objective for health authorities in implementing the Report's recommendations must therefore be to achieve changes at unit level and below. If there were no observable improvement in services at that level, in the eyes of patients and the community, within three to five years, then there would have been no point in making changes at DHA level or above.

7. There can be no sustainable improvement at unit level if it does not rest upon the fullest involvement and commitment of all the professions concerned with the delivery of health care, particularly the doctors and nurses.

8. It is most important that the implementation of the Management Inquiry Report's recommendations at unit level should develop from the 1982 reorganisation. Developments already in train or planned in this way, are:

- the preparation of regional outline strategies, and regional and district strategic plans and short-term programmes (drawing together money, manpower, service development, and the estate and containing substantial proposals for cost-improvement) in accordance with HC(84)2;

- the development and implementation of management budgets, taking account of the expressed requirements of professional staff;

- the overall strengthening and development of the professional advisory machinery to ensure that there are effective arrangements for the advice of doctors and nurses to inform managerial decisions at unit as well as district and regional levels.

9. The key to further progress at the unit is to establish a responsibility for the general management function. It will require careful preparation and consultation. We envisage that a period of up to 18 months - to the end of 1985 - will be needed to develop and introduce proposals for the establishment of the general management function at unit level.

Clinicians in management

10. We strongly endorse the Report's view that clinicians should be both encouraged and enabled to play a more active role in management and especially unit management. In practice, it is clinicians who determine the way many of the health service's resources are used by the decisions they take about the clinical care of individual patients. At the same time, resources available for health care are not unlimited, and the way resources are allocated will affect the range of decisions open to clinicians in the individual treatments they prescribe. To ensure that available resources are deployed where they are most needed, it is important that decisions about the management of resources take full account of the priorities of patient care and the advice of clinicians. In order that clinicians can play an enhanced role in management, they need access to relevant and timely information; adequate administrative support; and a reduction in time spent on unnecessary bureaucracy and committee work. Health authorities should seek to stimulate action to meet these needs. Further management training for clinicians is also needed and from the earliest possible stage of training. The results of these changes will not be fully realised for some time; but, with the active support of clinicians, a significant start can be made now, concurrently with the establishment of the general management function in units.

Health Authorities and DHSS

11. While authorities are developing their proposals for the units, to secure the establishment of the general management function and the closer involvement of clinicians in management, they and the Department will continue to make the changes in their organisations necessary to support and sustain improvements in health services at unit level:

- we will continue to develop, within DHSS and the existing statutory framework, the Health Services Supervisory Board to help us to establish policies and priorities, and will set up the National Health Service Management Board, as soon as a Chairman has been appointed - meanwhile a multi-disciplinary Management Group has been set up with responsibility for the NHS management programme;

- RHAs and DHAs will begin the process of establishing the general management function and identifying a general manager at regional and district level.

PROCEDURE

12. The Inquiry Team emphasised that, once clear directions had been given by the centre, authorities should be allowed the maximum flexibility in making their own management arrangements. In keeping with this, we accept that:

- there should be some latitude in the timescale in which authorities should be required to establish the general management function and identify general managers;

- authorities should have adequate scope to take due account of local management needs and potential;

- authorities will, therefore, proceed at different speeds but the general management function should first be established at RHA, then at DHA within each region and at unit level only thereafter - the pace will consequently vary as between DHAs/units within a region.

13. We now require health authorities to establish a general management function, drawing on the recommendations in the NHS Management Inquiry Report - paragraphs 14-16 in particular - and following the procedural guidance set out in Annex C. RHAs and DHAs must identify a general manager - at region, district and unit level - to take personal and visible responsibility for carrying out the general management function, in accordance with DHSS guidance as supplemented by RHA and DHA requirements. Hospital SHAs must similarly identify a general manager.

ENQUIRIES

14. Enquiries about this Circular should be addressed to:

Miss A M Williams
Room D918
Alexander Fleming House
Elephant and Castle
LONDON SE1 6BY
Tel. 01-407-5522 Ext 6866

ACTION

15. Health authorities are required:

15.1 to establish the general management function and identify general managers in accordance with the procedural requirements in Annex C;

15.2 to carry forward the further programme of management action identified in Annex B, within the context of the action already in hand and planned in Annex A.

From:

Regional Liaison Division
Alexander Fleming House
Elephant and Castle
LONDON
SE1 6BY

Tel. 01-407-5522 Ext 6866

MNE 22

Further copies of this Circular may be obtained from DHSS Store, Health Publications Unit, No 2 Site, Manchester Road, Heywood, Lancs OL10 2PZ quoting code and serial number appearing at top right-hand corner.

ANNEX A
(HC(84)13)

IMPROVEMENTS IN NHS MANAGEMENT

Since 1979 the Government has taken the following steps to improve management in the health service.

- In 1982 the structure of health authorities was simplified by the removal of two levels of management - Area and Sector. Nos?
- District Health Authorities were established generally serving smaller local populations.
- More responsibility was devolved to hospital and community services at unit level.
- Accountability has been strengthened with the introduction of annual reviews led by Ministers of performance against agreed objectives.
- The review cycle has been established for RHAs and DHAs: it is being extended to units this year.
- Family Practitioner Committees are to be made separately accountable.
- A range of statistical indicators of performance (covering clinical services, manpower and estate management) has been developed: in 1983, all health authorities were sent data on their own performance and that of other authorities.
- Work is under way to improve and extend the range of performance indicators.
- NHS management's need for information has been comprehensively reviewed and improved information systems will be introduced over the next few years.
- More effective monitoring of NHS manpower numbers has been introduced: manpower limits have been settled, complementing authorities' cash limits.
- The Rayner Scrutiny technique has been extended to the NHS with a programme of nine studies by NHS officers covering areas such as transport services and recruitment advertising.
- Health authorities have been required to test the cost effectiveness of laundry, catering and cleaning services by seeking competitive tenders.
- Health authorities have reviewed arrangements for the control of items in stock and in use, following the advice of the Health Service Supply Council.
- A value-for-money audit programme has been introduced.
- HC(84)2 required all health authorities to initiate cost improvement programmes.
- Health authorities will have to show how their cost improvement programmes have released resources for the development of services to patients.

- The development of management budgets has begun with the start of several demonstration projects.

- The NHS Training Authority has been established.

- A study of the administration of FPCs has been undertaken by outside consultants.

- A study of the current flow of communications between the Department and health authorities is being led by a Regional Administrator.

- A study of the responsibilities of the Department in relation to the financial management of health authorities is being led by a Regional Treasurer.

- The Health Services Supervisory Board has been established to advise the Secretary of State on the objectives and direction of health services.

- The NHS Management Board is to be established within the Department as soon as its Chairman has been appointed; an NHS Management Group is already working in preparation for the NHS Management Board.

- Manpower in DHSS HQ has been reduced by 20 per cent since 1 April 1979 following a reduction in the central role.

ANNEX B
(HC(84)13)

FURTHER PROGRAMME OF MANAGEMENT ACTION

The NHS Management Inquiry set out its recommendations in the form of a programme of management action to be taken both at the centre and by health authorities. The recommended programme is:

1. Policy of accountability for performance against agreed objectives should be maintained and developed.	(para 6)
2. Accountability reviews should be extended to units.	(para 6)
3. The management function should be developed	
(a) inside the Department	(paras 1-5)
(b) in the NHS.	(para 6)
4. Pilot projects in management budget techniques should be continued with the aim that they be extended to all health authorities in about 2/3 years.	(para 8.6)
5. 11 specific topics should be studied or reviewed	
- the need for functional management structures at RHA/DHA	(para 6.6)
- the role of clinicians in management, in six hospitals	(para 8.2)
- the arrangements for remuneration etc	(para 9.2)
- the assessment of management training	(para 9.4)
- the procedures for appointments etc	(para 9.5)
- nurse manpower levels	(para 9.6)
- other manpower levels	(para 9.7)
- the procedures on capital schemes	(para 10.2)
- the works function	(para 10.3)
- levels of decision-taking	(para 11.0)
- consultation arrangements	(para 12.0)
6. The roles of members and officers in relation to their authorities should be clarified.	(paras 6.4 and 17)

7. The agenda and the procedures for health authority meetings should be clarified and the nature of the reports required by the authority in managing its services should be made explicit.	(para 6.5)
8. Major cost-improvement programmes should be initiated in each health authority	(para 6.7)
9. Each unit should have a total budget and have management accountant support	(paras 8.4 and 8.5)

ANNEX C
(HC(84)13)

REQUIREMENTS FOR ESTABLISHING THE GENERAL MANAGEMENT FUNCTION AND IDENTIFYING MANAGERS

PROGRAMME

1. The general management function should be established by each health authority as soon as possible, and in any event by the end of 1985, under the following procedure, which is intended to give authorities the maximum freedom to develop proposals which best suit local requirements whilst enabling Ministers to monitor their arrangements.

1.1 Not later than the end of September 1984, each Regional Health Authority and Special Health Authority for London Postgraduate Teaching Hospitals must inform the Secretary of State how it proposes to establish the general management function. It should submit a job description for its general manager, and its proposals for identifying a suitable person to carry responsibility for the function and the name of the individual proposed if already identified. This will allow the Secretary of State to perform his role of monitoring health authorities: he will not be attempting to take over the role of the authority itself or to standardise job descriptions to a national pattern. In examining these proposals, the Secretary of State will wish to satisfy himself that the authority has formulated a job description for the manager, which accords with the Secretary of State's management changes within the DHSS; that any additional costs have been suitably offset within the existing provision for management (see paragraph 17) without damaging present and planned provision for direct patient care; and that the general manager as and when identified has the capacity to undertake the general management function. The Secretary of State will arrange a meeting with the RHA Chairman to discuss the proposals and to confirm that he is content for the RHA to proceed to formal decision. Once satisfied, the Secretary of State will approve an interim rate of remuneration for the general manager.

1.2 When the RHA has completed consultation with the Secretary of State, the RHA will ask each District Health Authority similarly to inform the RHA about its proposals for establishing the general management function at District level. Each DHA should submit to its RHA a job description for the District general manager, its proposals for identifying a suitable person to carry personal responsibility for the function and the name of the individual proposedif already idenfified. The RHA should forward to the Secretary of State its recommendations for action. In making their recommendations, RHAs should demonstrate that they have checked their DHAs' proposals in an equivalent manner to the Secretary of State's scrutiny of RHA proposals ie bearing in mind similar factors, but transposed as appropriate to the regional situation. In addition, RHAs will need to check that their DHAs' proposals fit in with the management changes finalised for the RHA, add up to an acceptable management pattern taking the region as a whole and that the suitability of individual general managers, as and when identified, takes into account an assessment of their ability to command the confidence of the representative members of the Management Team. The RHA Chairman will arrange a meeting with each DHA Chairman to discuss the proposals and to confirm that he is content for the DHA to proceed to formal decision, taking account of any views expressed by the Secretary of State. If the RHA Chairman and the DHA Chairman are unable to agree how to proceed, the RHA Chairman should consult the Secretary of State before the DHA proceeds to formal decision. The Secretary of State's approval will be required for the interim remuneration proposed for all general managers.

1.3 After the RHA has assembled the DHA proposals and completed consultation with the Secretary of State, each DHA should be asked to inform the RHA how it proposes to establish the general management function at unit level, of the job descriptions for its unit general managers and its proposals for identifying suitable people to carry personal responsibility for the general management function, including the names of the individuals proposed, where already identified. DHAs will need to demonstrate that job descriptions fit in with the changes already agreed for the DHA itself; that any additional costs have been suitably offset within the provision for management without damaging present and planned provision for direct patient care; that the individual general managers as and when identified are suitable, taking into account an assessment of their ability to command the confidence of the representative members of the Management Team; and, that the individual unit proposals add up to an acceptable management pattern taking the district as a whole. The RHA Chairman should arrange a meeting with each DHA Chairman to discuss their unit proposals and confirm that he is content for the DHA to proceed to formal decision. Action should be completed at unit level by the end of 1985.

2. Where an authority wishes a general manager to be drawn from outside the range of those listed below as normally eligible, the authority should clearly indicate the arrangements proposed to fulfil the requirements of paragraphs 1.1-1.3 above.

THE FUNCTION

3. The essence of the general management function is the bringing together at each level of organisation, responsibility for the planning, implementation and control of the authority's or unit's performance. The general manager will carry personal responsibility for this, and be personally accountable to the authority for its discharge. The authority in its turn must be seen clearly at all times to give full support and backing to the general manager.

4. The general manager's broad areas of responsibility must include as a minimum:

4.1 direct accountability to the authority, or in the case of units to the district general manager, for the general management function within the undertaking;

4.2 direct responsibility and accountability for the managerial performance within the authority or unit;

4.3 leadership of the authority's management team, or unit equivalent, and accountability for the performance of the team as a whole in developing policies and possible courses of action and ensuring the provision of proper advice;

4.4 ensuring that management and administrative practices enable the care of patients to be constantly to the fore;

and to these ends he should -

4.5 ensure that the authority or unit is provided with the range of advice and information it needs to formulate policies, decide priorities, set objectives, and monitor progress;

4.6 ensure that full weight is given to clinical priorities in the light of advice from nurses and doctors;

4.7 ensure that timely decisions are reached;

4.8 ensure that objectives are achieved;

4.9 provide the necessary leadership to stimulate initiative, urgency and vitality in management eg in ensuring a constant search for constructive change and cost-improvement;

4.10 co-ordinate activities, functions and personnel as necessary;

4.11 ensure that responsibility, including the management budgeting responsibility, is delegated to the point where action can be taken effectively;

4.12 secure effective motivation of staff.

MANAGERIAL RELATIONSHIPS

5. The general manager at RHA and DHA will in each case be accountable only to his authority ie not to a general manager at a higher level. The unit general manager will be accountable to the district general manager.

6. Existing guidance on managerial relationships at district and unit level in HC(80)8 is amended by this circular which provides the general framework within which authorities will develop their proposals for revised management arrangements.

7. Professional chief officers are appointed by the authority and will continue to be directly accountable, and have a right of access, to the authority on the provision and quality of professional advice. On matters relating to the fulfilment of the general manager's responsibility, they will be accountable to the general manager for the day-to-day performance of their management functions. The representative members of the District Management Team will also continue to have direct access to the authority.

THE JOB DESCRIPTION

8. A job description should be drawn up for each general manager which should include, as a minimum, details of his function, his relationship to the other chief officers and of the proposed terms of tenure and remuneration. The broad areas of responsibility which should be covered in job descriptions are set out in paras 3-4 above. Although authorities may need to adapt and expand these to suit local needs and constraints, as well as the different requirements at RHA, DHA, hospital SHA or unit, they will be expected to keep within this framework

ELIGIBILITY

9. It is for the authority to identify the general manager, having satisfied itself that the individual has the management capacity to undertake the general management function, including the ability to command the confidence of the representative members of the Management Team. It is expected that regional and district general managers will be identified in the first place from members of the Regional Team of Officers and District Management Team respectively. Authorities may, however, propose instead to seek a general manager either from elsewhere in the NHS or from outside (see also paragraph 15).

10. At regional and district levels, general managers will take full responsibility for the general management task. This does not preclude the discharge of other responsibilities in exceptional cases, but it is essential that the general management function should be performed effectively and therefore it must be given top priority. Where an existing member of the RTO or DMT is identified as general manager, authorities will need to ensure that appropriate steps are taken to secure the proper discharge of his existing responsibilities. Where it is proposed to identify a clinician, authorities will need to be satisfied that such clinical responsibilities as he may retain are consistent with his effective performance as general manager.

11. At unit level, it is expected that the general management function may be combined with other responsibilities but, as at regional and district levels, the general management function must be given top priority. In the first place, those eligible to undertake the function at unit level will be any DHA employee, consultant or general medical practitioner who works within the district. DHAs wishing to make other proposals for identifying a unit general manager should follow the guidance in paragraph 15.

TERMS OF SERVICE

Remuneration

12. In the interim period before long-term arrangments for remunerating general managers have been established, they should be awarded a fixed rate annual payment not exceeding £3,000 in recognition of their extra responsibilities. The detailed method of paying such an allowance to consultants or general practitioners is under consideration and authorities wishing to make such an appointment should therefore consult the Department.

13. In exercising their judgement on what is the appropriate additional payment, authorities should bear in mind that the effect of the flexibility of job description envisaged in this circular will be to place greater responsibilities on some general managers than on others. Differences may arise not only in comparing the different tiers of management (region, district and unit) but also in comparing general managers in the same tier of management. The time judged necessary to perform this role may also vary between posts and be relevant to the level of remuneration that is appropriate. It is to be expected therefore that these differences will be reflected in the amount of additional allowance paid.

14. In order to achieve some consistency in this respect, all DHAs, when submitting a job description to the RHA, should link with it their proposals for the size of the additional allowance. RHAs and hospital SHAs should do the same in their submission to the Secretary of State in respect of their own arrangements. All such additional allowances require the Secretary of State's specific approval under the NHS remuneration statutes.

Outside appointments

15. An authority may propose to seek a general manager from outside those people normally eligible (see paragraphs 9-11). For procedural reasons at this early stage, authorities must first submit such proposals to the Department for prior approval. DHA proposals should be submitted via the RHA. As soon as possible, arrangements will be made to allow authorities to proceed without direct reference to the Department.

Tenure

16. Authorities should identify general managers on a period basis, with an initial fixed-term contract for 3-5 years. After that, the general manager's employment may be extended on the basis of yearly fixed-term contracts. All contracts should contain an agreement to exclude any claims under Section 54 of the Employment Protection (Consolidation) Act 1978. At no stage should the contract be allowed to run beyond the due date, since this may be held to have created a new contract without limit of time.

Costs

17. The full costs of the general management function must not be met at the expense of services to patients. The total cost of the general management function should be therefore specified in the authority's proposals, with details of how it is intended to contain the cost within existing provision for management.

The Next Steps

Management in the Health Service

Better Management in Health Authorities in England

The Inquiry

Many of us – in and outside the NHS – believe that we could make a better job of health care if we had better management. The NHS Management Inquiry team was asked by the Government to review NHS management and come up with proposals.

What the Inquiry team found

The Griffiths team found a lack of effective general management at all levels of the Health Authority structure. The result? Too often, frustrating delays and inaction. The need for better management is widely agreed throughout the Health Service and the House of Commons Social Services Committee found that the Griffiths Report's critique "commands general assent."

The key recommendation of the Griffiths Report is that management in Health Authorities should be strengthened so that the NHS can become yet more effective in providing services to patients. And it provided a welcome restatement of the principle which should guide everybody responsible for Health Services – concern for the individual patient.

Its fundamental message was of the need for a more dynamic management style in Health Authorities: getting things done, rather than deferring action. In short, bring in general management.

What is 'general management'?

'General management' enables an organisation to plan, act on, control and measure its decisions and actions effectively and efficiently; and in a way which brings results. The General Manager is the person responsible, and accountable, for ensuring that these decisions are made and actions taken.

The purpose of general management in Health Authorities

By establishing a general management function in Health Authorities, the concern shared by all working in the Health Service for the quality and efficiency of patient services will be more easily translated into effective action; the available resources will be better used and those working in the Service will obtain greater satisfaction from their work. The patient, the community, the taxpayer and the employee will all benefit.

Managing by consensus – that is, managing by agreement – works well some of the time in business and in Health Authorities. Where consensus is working well, no sensible General Manager will need to lose it.

General management will have most effect where consensus **is not** working well. It will help people to take decisions where and when they are needed – thus improving effectiveness.

Consensus management can fail when difficult, perhaps painful, decisions have to be made. Too often in Health Authorities, the power to veto has meant that nothing happens.

Some problems, of course, solve themselves or go away. But others remain and may get worse. This does not improve patient care and it is depressing for Health Authority staff. Effective management means that such problems are tackled not shelved.

The critics: are they right?

The Griffiths team concluded that the processes of decision-making and consultation in Health Authorities are elaborate and that the machinery for implementing decisions is weak. These are the direct results of a lack of clear management.

Many people, in and out of the Health Service, agree. As the BMA's Secretary has put it:

"The criticisms of the Griffiths Report of NHS management will be readily understood by clinicians who have become increasingly frustrated with the inordinate delays which accompany even relatively unimportant issues in the NHS before any action is taken."

And clinicians are not the only people to feel frustrated. Lots of people would like to see improvements.

By clarifying and strengthening the role of management throughout Health Authorities, we are developing the existing arrangements in a positive way.

The Next Step

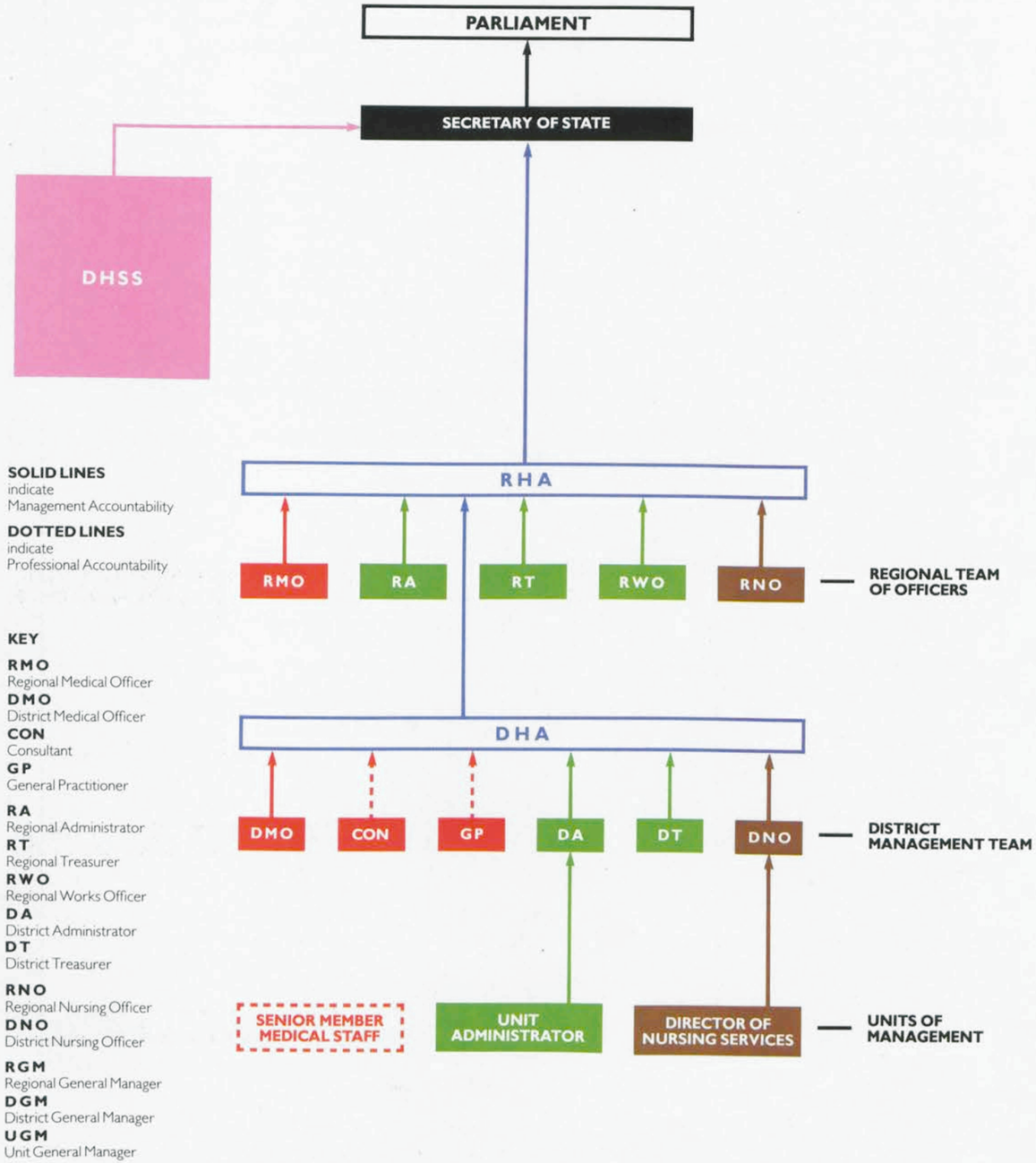
The Government is going to implement the Griffiths Report proposals for general management as the next step in its programme of improving management in Health Authorities.
(See 'What's Going On?')

This is what is happening

- A Health Services Supervisory Board has been set up in the Department to advise the Secretary of State for Social Services on the strategic direction of the Health Service. Members of this Board include the Health Ministers; the Permanent Secretary and Accounting Officer, the Chief Medical Officer, the Chief Nursing Officer; Mr Roy Griffiths and the Chairman of the new NHS Management Board.
- An NHS Management Board is being established within the Department: it will carry out, under the direction of Ministers, those management functions in respect of Health Authorities which the Department must carry out – for example, finance, information and performance review. It will report to the Supervisory Board on Health Authorities' performance; the new Chairman, when appointed, will be a member of that Board.
- Health Authority management is to be strengthened at Regional, District and, later, at Unit level.
- Each Regional and District Health Authority is to identify a General Manager who will then take responsibility – and be accountable to his or her Authority – for the overall managerial performance of the management team and the people under it. When Authorities have done this, District Health Authorities will identify Unit General Managers.
- Regional and District Authorities are being given considerable freedom to propose arrangements which best suit their local requirements, but they and their Units must establish their own general management function and that for their Units, by the end of 1985.
- In line with the intentions of the 1982 reorganisation, decision-making and responsibility is to be devolved wherever possible down the organisation to the Unit, where patient needs are directly met and where the changes must occur to achieve the overall aim of improving services to patients.
- Support for the new and existing management roles is to be provided by the NHS Training Authority through an enhanced management training programme, particularly geared to doctors and nurses.

Health Authority Management – The Present

This is a simplified representation of the main present management relationships in Health Authorities and their links with DHSS, the Secretary of State for Social Services and Parliament.



SOLID LINES
indicate
Management Accountability

DOTTED LINES
indicate
Professional Accountability

KEY

RMO
Regional Medical Officer
DMO
District Medical Officer
CON
Consultant
GP
General Practitioner

RA
Regional Administrator
RT
Regional Treasurer
RWO
Regional Works Officer
DA
District Administrator
DT
District Treasurer

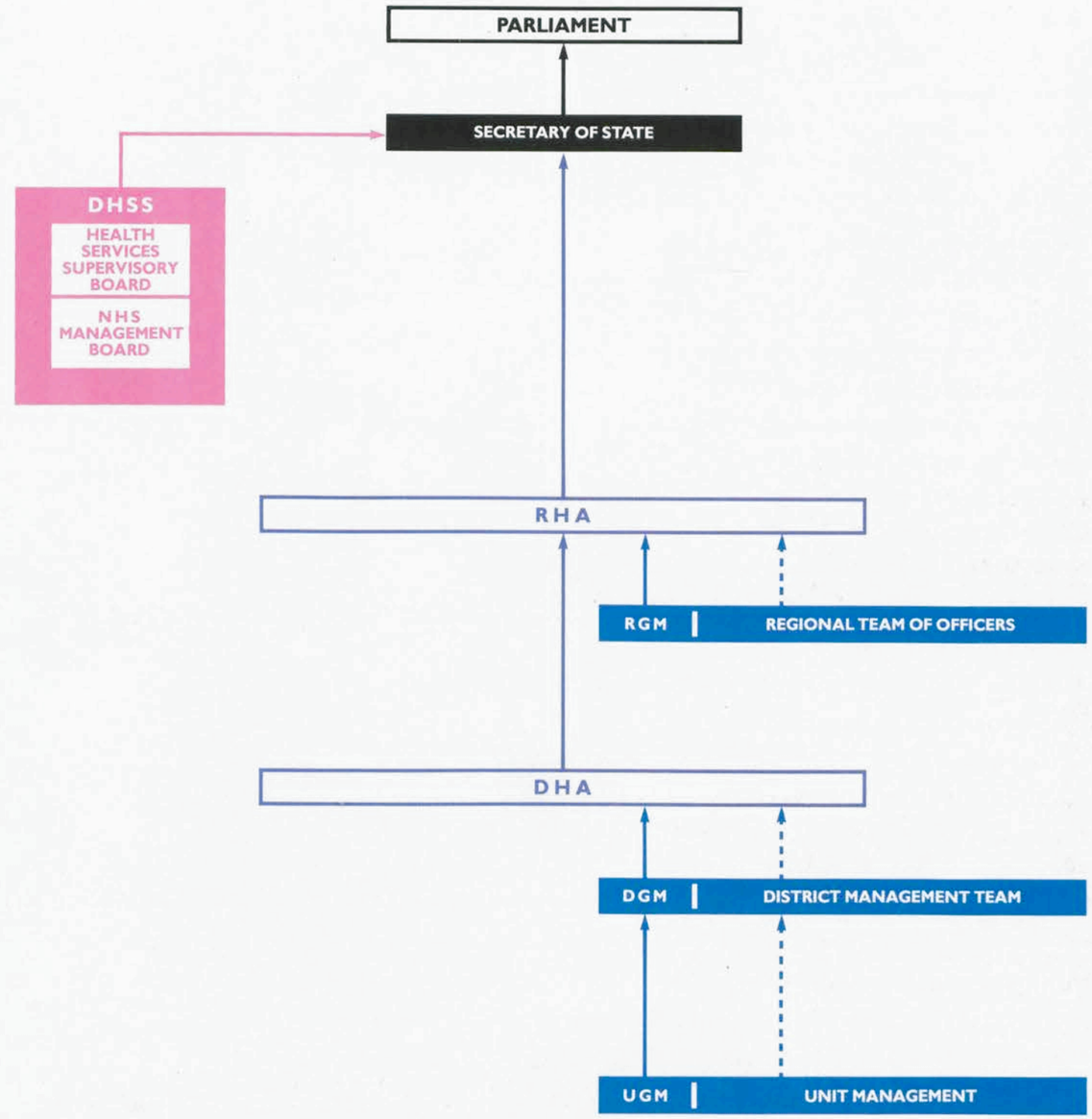
RNO
Regional Nursing Officer
DNO
District Nursing Officer

RGM
Regional General Manager
DGM
District General Manager
UGM
Unit General Manager

Health Authority Management – The Future

This is a simplified representation of the key future management relationships in Health Authorities and DHSS, how they link to each other, to the Secretary of State for Social Services and to Parliament.

These management developments will all take place within the existing accountability arrangements and statutory framework.



What's Going On?

The introduction of general managers in Health Authorities is not being done in isolation. It is part of a national development programme in NHS management: some parts established already, some happening now, some yet to come.

Developments in 1982

Health Service restructured

Rayner-type scrutinies introduced for the Health Service

System of annual accountability reviews established

Annual review by Ministers of Regional Health Authority performance introduced

Annual review by Regional Health Authorities of District performance introduced

Developments in 1983

Annual accountability reviews extended: DHA reviews of Unit performance

Comparative performance indicators applied

Value-for-money audit programme introduced

Manpower planning tightened up

Manpower information now available more quickly and at quarterly intervals

Competitive tendering introduced

NHS Training Authority established

Griffiths Report published

Health Services Supervisory Board set up by Secretary of State

Developments in 1984

Cash limits, manpower targets and service development brought together

Cost-improvement programmes established

DHSS Headquarters manpower target – 20% reduction since 1979 – achieved

Stock control reviewed

Nucleus of new Health Service Management Board created

and now

Griffiths Report implemented and general management function introduced in Health Authorities

Further action planned or in hand:

Chairman of NHS Management Board to be appointed and Management Board established

Management budgets for DHAs being further developed

Works function being reviewed

Introduction of improved information systems (based on the review of Mrs Körner's Working Group)

Review of communications between DHSS and NHS (led by a Regional Administrator)

Review of possible further developments in Health Authorities' financial management (led by a Regional Treasurer)

NHSTA management training programme being introduced

Questions and Answers

Wouldn't it be better for Government simply to put more money into the Health Service?

The Government **is** putting more money into the Health Service. Spending on the NHS has doubled since 1979 from £7¾ billion to £15½ billion, an increase of 18% more than inflation.

But that's not the whole of the argument by any means. No matter how much money is put into the NHS, we will never be in the position where we will be so rich that we could afford to waste money. There is a duty to be efficient. A sensible management system aids the effective use of resources which are inevitably limited. NHS management must have the authority, and take the responsibility, for promoting efficient use of those resources.

Shouldn't we be allowed to settle down from the 1982 reorganisation before we embark on all this?

This new scheme isn't a reorganisation – it is a development of the 1982 structure. Most peoples' jobs will remain much as they are. It is the process of **managing** the 1982 structure which is being improved. 'Settling down' is a luxury which few organisations can afford, since their clients are constantly becoming more demanding about the services they require.

Not only that, but every time an organisation develops a new system – like the 1982 reorganisation – experience soon shows how to make the next set of improvements. All organisations have to adapt to changing circumstance and the NHS can, and must, continue its long history of evolution in order to carry out its tasks in the best possible way.

Will these new general managers have powers to take decisions and promote action?

Yes. They will be responsible for the effective working of their teams and staff. Responsibility **without** power is the role of the scapegoat. If you want effective management, then responsibility and authority have to be matched. That is what these new proposals aim to achieve.

What happens if the doctors or nurses disagree with the General Manager?

If the disagreement is over a management decision, the General Manager must fulfil his responsibility to see that the decision is taken, if necessary by the Authority itself. This is the job the Authority has given him or her.

If the disagreement is over a professional matter, the doctors and nurses will be able to refer to the Authority, as at present.

Designed and Produced by Hawkshead Communications/Sutton Cooper for the DHSS. Printed by DPL, London. June 1984.