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SECRET

PRIME MINISTER

NHS REVIEW: CENTRAL MANAGEMENT OF THE NHS

We have now revised the paragraphs of the draft White Paper that deal with the central management of the NHS in the light of yesterday's discussion. I attach the new version.

2. You said yesterday, and I entirely agree, that while the text of the White Paper does not need to go into detail, we ourselves must be clear about the details before the White Paper is published and the issues are debated publicly. This is the object of my minute.

3. We did not resolve yesterday whether we should have a Management Board or Committee. For convenience, I use the term "Board" in this minute. I still prefer it because to my mind "Board" underlines the importance we attach to its role. A change to "Committee" would mistakenly be taken to signal a reduction in its functions and status.

4. There are four main points to settle:

first, the relationship of the Secretary of State and the Policy Board to the Chief Executive and the Management Board.

second, the constitutional position of the Management Board and its relationship to the Department.

third, the relationship between the Management Board and Regional Health Authorities.

fourth, accountability to Parliament.

5. On the first point, we are agreed that the Secretary of State is responsible for strategy and policy on the NHS and, as part of the exercise of this responsibility, will chair the Policy Board. The Policy Board's remit will be to determine the strategy, objectives and finances of the NHS and to set objectives for the Management Board and monitor whether they are satisfactorily achieved.

6. All operational and managerial issues will be the responsibility of the Chief Executive and the Management Board which he will chair. The Management Board will be accountable to the Policy Board for the delivery of the objectives set by the Policy Board. This is an important and new separation of their respective responsibilities.

[illegible] ? role of Cabinet in policy [illegible].

7. On the second point, the Management Board will have a separate line of accountability from that of the Department, clearly marked by the fact that the Chief Executive will report directly to the Secretary of State on all operational and management matters. The Chief Executive will also be accounting officer for all expenditure on the hospital and community health services.

8. For administrative purposes the Management Board will be located within the Department of Health. I fully accept that the work of the Management Board will be separate from the work of officials whose responsibility is to advise me.

9. It will take time and require careful political handling to establish the Management Board with the separate and accepted identity of its own that I certainly intend it to have. To take a particularly difficult but very important example, it is a long standing practice for the British Medical Association to have direct access to the Secretary of State. I have long felt that it is a nonsense that the employment and management of doctors has become part of the political process, and not simply part of the management of the Service. The BMA feel equally strongly that this is a part of the understanding on which the NHS rests. We need to move to a position where they accept it is normal practice to meet and deal with the Chief Executive on operational matters such as the management of consultants' contracts. I intend to move towards that as quickly as possible.

10. On the third point, I will continue to maintain contact with and to consult Regional Chairmen, who are appointed by the Secretary of State and regard themselves as charged with the delivery of Government policy in their Regions. In future, however, the General Managers of the Regional Health Authorities will be accountable to the Chief Executive who will set objectives for them. It is not clear accountable to their own chairman.

11. The overall effect of these changes will be to introduce for the first time a clear and effective chain of command running from Districts through Regions to the Chief Executive and from there to the Secretary of State.

12. On the fourth point, the normal Accounting Officer rules will apply to the Chief Executive. I shall expect him to take a prominent role in dealing with Select Committees and the like.

13. So far as Ministerial responsibility to Parliament is concerned, we shall follow the line set out in para 2.4 of the draft White Paper. This will require us all to take a robust stance. Realistically we must expect considerable pressure from backbenchers on both sides for Health Ministers to continue to answer on any operational issues which are in the public eye or which are seen as major constituency concerns. This will be so whether or not such issues have been delegated to the Management Board. It is very important that we maintain a common line on this in Scotland, Wales and Northern Ireland.

14. I intend to operate the Department on the basis that I have set out in this minute. It is an important part of the way in which I expect to see our reforms implemented. I trust that the form of words attached for the White Paper backed up by this minute clearly express our new approach.

15. I am copying this to the Chancellor of the Exchequer, the Secretaries of State for Wales, Scotland and Northern Ireland, the Chief Secretary, the Minister for Health, Sir Robin Butler, Mr Brian Griffiths and Mr Richard Wilson.

AJM

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(Approved by the Secretary of State and signed in his absence)

DELEGATING RESPONSIBILITY

Central Management of the NHS

2.4 The NHS will continue to be funded by the Government mainly from tax revenues. Ministers must be accountable to Parliament and to the public for the spending of these huge sums of money. But Ministers cannot, and in future will not, be directly involved in the decisions taken locally by operational units. On the contrary, the oversight of those decisions ought to be the responsibility of the Chief Executive of the NHS Management Board. Ministers must however remain responsible for policy and strategy.

2.5 The central management of the NHS must reflect this division of responsibilities. The Government proposes that responsibility for strategy will be for a Policy Board chaired by the Secretary of State for Health. Responsibility for all operational matters will be for a Management Board chaired by a Chief Executive. The Management Board will be accountable to the Policy Board for the management of the NHS within the strategy and objectives set by the Policy Board.

2.6 The specific proposals are:

* a new Policy Board, chaired and appointed by the Secreatary of State, will consider all strategic issues for the NHS in the light of Government policy. It will replace the former Health Service Supervisory Board and will include non-executive members drawn from inside and outside the NHS;

* the Management Board will be chaired by the Chief Executive and appointed by the Secretary of State in consultation with the Chief Executive. It will deal with all operational matters within the strategy and objectives set by the Policy Board;

* responsibility for the management of family practitioner services will be brought under the Management Board. The better integration of primary care and hospital services is an important objective.

2.7 The overall effect of these changes will be to introduce for the first time a clear and effective chain of management command running from Districts through Regions to the Chief Executive and from there to the Secretary of State.

The role of regions

2.8 The Management Board could not directly exercise effective authority over the current 190 District Health Authorities (DHAs) which have a total expenditure of nearly £14 billion (nearly £19 billion with family practitioner services). Regional Health Authorities (RHAs) will therefore continue to ensure that Government policies are properly carried out within their regions. To be effective they will need to concentrate their efforts on their essential tasks. These include monitoring the performance of the health service, evaluating its effectiveness and keeping the state of health of the people of the region under review. They will have a key role to play in managing the wider programme of changes that are set out in the White Paper.

2.9 In addition, RHAs have traditionally provided a range of operational and management services. These include distribution centres, ambulance and blood transfusion services which could not be provided economically in every District. They also include legal, information and management services to Districts themselves. Following the introduction of general management and the re-organisation of regional headquarters, many RHAs have reviewed the provision of these services. As a result, some services have already been

streamlined, delegated to Districts or contracted out to the private sector.

2.10 There remains, however, a wide variation in the size of each Region's operations. The Government believes that there is still considerable scope for reductions in the number of staff directly employed by RHAs on these operations. The Management Board will therefore review the provision of all regionally managed services. It will only approve the retention of services at the regional level if it is cost-effective to do so. As part of this exercise, Districts will be asked whether they can provide more of these services themselves or purchase them from the private sector.

The role of districts and hospitals

2.11 The Government also believes that there is further scope for delegating decision-making from DHAs to hospitals and their associated management units. Many large hospitals already have a significant degree of self-determination. RHAs should now satisfy themselves that, whenever possible, all DHAs delegate operational functions to their hospitals, taking account of the availability of staff in key disciplines and the need to ensure that, overall, the management of services remains cost-effective.

2.12 The Government's objective is to create an organisation in which those who are actually providing the services are also responsible for day-to-day decisions about operational matters. Like RHAs, DHAs can then concentrate on ensuring that the health needs of the population for which they are responsible are met; that there are effective services for the prevention and control of diseases and the promotion of health; that their population has access to a comprehensive range of high quality, value for money services; and on setting targets for and monitoring the performance of those

management units for which they continue to have responsibility.