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CENTRAL MANAGEMENT OF THE NHS

SUMMARY

These papers propose a structure and method of operation for the NHS Management Executive and consider its relationships with both the NHS Policy Board and health authorities. They also discuss the implications for the organisation of the centre and for handling Parliamentary business.

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2. "Working for Patients" makes clear that the central management of the NHS must reflect the distinction between strategy and operations. It states (paragraph 2.4):

> "Responsibility for strategy will be for an NHS Policy Board chaired by the Secretary of State for Health. Responsibility for all operational matters will be for an NHS Management Executive chaired by a Chief Executive. The Management Executive will be accountable to the Policy Board for the management of the NHS within the strategy and objectives set by the Policy Board."

3. Ministers have decided that there is to be:

- a Management Executive, located within the Department of Health; but with

- a separate and defined status under the Secretary of State for Health; dealing with

- all central operational and management work on the NHS (including the FPS) carried out in the Department, including - so far as possible - related Parliamentary business; and resting on

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- a written statement covering the relationship between the Secretary of State for Health and the Chief Executive; and also covering

- the powers, responsibilities and function of the Chief (and Management) Executive in relation to the Policy Board, the Department and the NHS.

Finally, the structure and membership of the Management Executive needs to be settled in the light of the conclusions reached on these other matters.

THE APPROACH

4. The Annexes to this paper set out in detail the work which has been done to give effect to these objectives. This work points strongly to the virtues of a two-stage approach. First, we should implement immediately the changes summarised in paragraph 3, along the lines proposed in paragraph 5 below and the Annexes. Secondly, once our wider reforms begin to bite, and in particular as we begin to see substantially greater delegation within the NHS, we should take additional steps both to distance Ministers from accountability for operational matters and further to slim down the central organisation. The scope for this is explored further in paragraph 6.

I: IMMEDIATE ACTION

5. The immediate measures proposed in the Annexes are as follows:

i. a properly structured and defined relationship between the Management Executive on the one hand and Ministers and the Policy Board on the other. This is set out in detail in Annex A. This relationship will rest on two documents:

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- a written statement of the role, functions and accountability of the Management (and Chief Executive); and

- an annual Business Plan - perhaps derived from a rolling five-year strategy - setting out key policy aims and specific objectives. This Business Plan would be issued by the Policy Board to the Management Executive and form the basis for assessing the latter's performance. Both of these documents would be made public.

In addition, it is proposed to implement a programme of work which links the business of the Policy Board to that of the Management Executive in a sensible and structured fashion.

ii. a range of changes in practice and procedure designed to strengthen the line management authority of the Chief Executive, to raise his profile in relation to the NHS and the public and to put even more "clear water" between the centre and the increasingly devolved NHS. Annex B sets out these proposals, which would govern the relationship between the Management Executive and the NHS.

iii. a central organisation which encompasses a more clear-cut division of staff and responsibilities as between the Management Executive and the rest of the Department (although a few senior officials will need to work for the Management Executive on some issues and the Department on others if a costly and unproductive total separation is to be avoided). The preferred approach gives a central role to the Policy Board, which will act to some extent like a 'holding company' in relation to the Management Executive's operational role. It will be the forum within which the separate streams of advice - from DH on policy formulation and the Management Executive on its implementation (and on operational policies such as personnel) - will be assessed, and Ministers' policies translated into clear objectives for the Management Executive and thence for the NHS as a whole.

iv. a central organisation which concentrates only on matters which need to be handled at that level. Functions which - for the time being at least - need to be discharged at a national level in order to obtain significant economies of scale, such as procurement, would be carried out at arm's length from the Department. Such an arrangement would make it easier to draw on commercial and NHS expertise. Annex C deals with the future size and structure of the central organisation.

v. a structure and membership of the Management Executive which reflects the need for a more business-like Health Service, managed at the centre by a Management Executive which is smaller and more focussed than the NHSMB. The proposed membership is at Annex D.

vi. much more rigorous enforcement of the current arrangements for directing Parliamentary business to Regional and District Health Authorities and FPCs, coupled with a progressive devolution from Ministers to the Chief Executive of any such business which continues to need handling at the centre. This is discussed further at Annex E.

II: THE SECOND STAGE

6. Once the NHS Reform legislation is in place and the more fully devolved NHS takes shape, including the exercise of their powers by self-governing hospitals and GP budget holders, we can then move to the second stage, which will entail:

i. less Ministerial - and Parliamentary - involvement in operational matters. The pre-eminent example here is changes of use of NHS facilities, including closures, which involve Ministers and the Department in a great deal of Parliamentary activity, often over relatively trivial changes in the pattern of services. Paragraphs 7-9 of Annex E suggest a number of ways in which this might be achieved. Any such changes in practice should be greatly assisted by the existence of formal public documents establishing the responsibilities and objectives of the Management Executive.

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What is needed is a progressive development whereby MPs come to realise - as with social security matters - that it is to their advantage to pursue detailed operational matters with those primarily concerned with managing the NHS, namely the Chief Executive or appropriate health authority. Of course those seeking to make political capital out of the NHS will no doubt continue to press Ministers on "management matters" and continuous political judgement will be needed as to how far such approaches should be referred elsewhere.

ii. A slimming-down of the central organisation as a consequence of achieving the White Paper objectives. But those objectives will be much harder to achieve if the complex process of White Paper implementation is not managed positively and actively from the centre.

SIR ROY GRIFFITHS

SIR CHRISTOPHER FRANCE

19 APRIL 1989

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ANNEX A

# RESPONSIBILITIES AT THE CENTRE

## INTRODUCTION

1. This paper defines the role and operation of the NHS Policy Board and the NHS Management Executive and their relationship.

## KEY PRINCIPLES

2. The Policy Board has always been seen as an internal body advising the Secretary of State, who will chair it. Nor will the Management Executive have a separate statutory basis. Accordingly, it is imperative to secure maximum clarity as to their respective roles and functions, particularly as both of their remits will focus only on the NHS.

3. A number of key principles should govern the allocation of responsibilities:

- the Policy Board should maintain strategic oversight of the NHS. It should not concern itself with operational detail;
- there should be maximum delegation of operational and management responsibilities from the Secretary of State (advised by the Policy Board) to the Management Executive, and thence to the NHS;
- the work of both bodies should be mutually supportive and 'add value' to decision-making.

## ROLE OF THE NHS POLICY BOARD

4. In the light of these principles, the functions of the Policy Board will be to:

- support Ministers by bringing a range of different perspectives to bear on the formulation of policy objectives for the NHS;
- advise Ministers on the determination of the strategy within which the Management Executive will operate;
- advise Ministers on the desirability and feasibility of specific objectives proposed for the Management Executive;
- advise Ministers on resource needs and distribution;
- monitor the Management Executive's stewardship and performance.

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ROLE OF THE NHS MANAGEMENT EXECUTIVE

5. By contrast with the strategic Policy Board, the Management Executive will focus on:

- taking central responsibility for the operation and management of the NHS within Ministers' overall policy framework, eg.

  a. resource needs and distribution;

  b. operational policy issues, such as pay and personnel;

  c. management aspects of other policy issues, eg resource and personnel aspects of mental illness policy;

  d. management matters which need Ministerial consideration, eg appointments.

- setting objectives for NHS authorities, in line with overall Ministerial priorities, and monitoring their achievement;

- leading NHS management in working towards major objectives and providing a professional lead to the main management functions - finance, personnel, etc;

- carrying out certain functions or services at a national level as a support to the NHS, for as long as there is no practicable or realistic alternative to retaining such work at the centre.

- taking a high profile in presenting the achievements of the NHS.

6. The Chief Executive will be a member of the Policy Board and will advise it as appropriate.

MANAGING THE RELATIONSHIP

7. Action to establish the respective roles of the Policy Board and Management Executive and ensure their effective working will have three main elements:

I. Promulgation of a public written statement setting out the powers and responsibilities of the Management Executive;

II. Issue of an annual Business Plan of policies and priorities - perhaps derived from a rolling five-year strategy - which the Policy Board would issue to the Management Executive and which would also be made public; and

III. An annual work programme designed to ensure that the work of the Policy Board and Management Executive moves in parallel. This would be an internal document.

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I: THE WRITTEN STATEMENT

8. A public written statement of the powers and responsibilities of the Management Executive would serve three main purposes:

- for Ministers: it would establish the limits of their accountability for detailed operational management at local level. This would be an important line of defence if some Parliamentary business is to be passed to the Chief Executive;

- for the Management Executive: it would define its key areas of responsibility;

- for Parliament and the NHS: it would constitute a clear statement of intent and serve to establish the leadership roles of the Management (and Chief) Executive.

9. Appendix A1 is an illustrative outline of such a document. The nearest analogues are the 'framework documents' produced for 'Next Steps' executive agencies, although it is not proposed to turn the Management Executive itself into such an agency - see Annex C.

10. 'Next Steps' frameworks also include a description of internal organisational, staffing and financial arrangements. This may be helpful in precisely defining the relationship between the Management Executive and the rest of DH - see Annex C - but it need not form part of an initial public statement establishing the Management Executive.

II: THE BUSINESS PLAN

11. A key Policy Board task is advising Ministers on the desirability and feasibility of objectives for the Management Executive and monitoring their achievement. So, to complement any long-term policy reviews (see para 14 below), there needs to be a short-term cycle built around key operational events, particularly resource allocation, agreement of Regions' objectives for the year ahead and out-turn reports on health authority performance.

12. This should lead to the annual production of a Business Plan for the Management Executive. This would not be a comprehensive circular setting out the direction of policy across the full range of NHS activity but rather a succinct statement of key policy directions and specific objectives for the Management Executive, timetabled and quantified wherever possible. Appendix A2 is a draft of such a document. The Management Executive would convey this to the NHS and use it to set objectives for each Region.

III: THE WORK PROGRAMME

13. A co-ordinated work programme between the Policy Board and Management Executive will be needed to ensure that their work is handled in an orderly fashion. The Policy Board's work programme might comprise:

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(i) Policy appraisals

14. The Policy Board will need to keep policy under review across its whole remit. A cycle of periodic appraisals of individual policy areas might be helpful in assisting the Policy Board to:

- satisfy itself that Ministers' policies were achieving the results intended at the cost predicted;

- review the relative priority given to individual policies and the need for policy changes and the setting of new objectives.

But the Policy Board should seek to avoid the imposition of new pressures on the NHS in mid-year.

(ii) Directorate reviews

15. Regular scrutiny of individual Management Executive Directorates, eg finance, might also be useful if kept at a strategic level, concentrating on policy outcomes and the adequacy of the Management Executive's systems for guaranteeing delivery. This would ensure that all Management Executive functions received regular Ministerial scrutiny, without over-concentration on operational detail.

(iii) Progress reports

16. In addition, the Policy Board may want regular progress reports in key areas. Implementation of the White Paper is the most obvious example, but there will be others, such as Project 2000, pay and personnel policy, medical manpower policy, etc.

THE COMPLETE PROGRAMME

17. Appendix A3 offers a possible programme for the Policy Board in 1990, showing how the longer-term cycle of policy and Directorate reviews will move in step with the shorter-term 'business agenda' and feed into production of the Business Plan for the Management Executive. Appendix B1 indicates how this work programme will also be co-ordinated with the way the Management Executive handles its formal business with the NHS.

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APPENDIX A1

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A STATEMENT OF THE ROLE AND RESPONSIBILITIES OF THE NHS MANAGEMENT EXECUTIVE

INTRODUCTION

1. The NHS Management Executive is an organisation within the Department of Health which shall carry out such of the functions of the Secretary of State for Health relating to the management of the NHS as he shall specify. This document describes the role of the Management Executive in more detail and sets out its functions and accountability.

ROLE OF THE MANAGEMENT EXECUTIVE

2. The Management Executive's role is to:

- take central responsibility on behalf of Ministers for the operation and management of the NHS;
- set objectives for NHS authorities in line with overall Ministerial priorities and within the resources allocated to it, and monitor their performance;
- provide leadership to NHS management;
- advise Ministers and the NHS Policy Board on the operation and management of the NHS;
- where appropriate, carry out certain services at a national level in support of NHS authorities;
- present the achievements of the NHS within the Service and to the general public.

MANAGEMENT FUNCTIONS

3. The Management Executive will discharge certain specific functions in relation to the management of the NHS, and in the light of Ministerial policies and the availability of resources. These include:

- issue of strategic and operational guidelines to NHS authorities;

- approval of Regional objectives;

- setting performance targets for NHS authorities and reviewing their achievement;

- developing and implementing policies for improved use of resources, including targets for cost improvements, land sales and income generation;

- developing pay and personnel policies to achieve the recruitment, training, retention and motivation of staff for endorsement by Ministers and the NHS Policy Board, and implementing those policies;

- developing and advising on resource allocation policies;

- overseeing the development of medical audit in the NHS;

- developing and implementing accountability arrangements for Regional General Managers, including Individual Performance Review objectives.

ACCOUNTABILITY

4. The Chief Executive of the Management Executive shall be personally accountable to the Secretary of State for Health for the Management Executive's operations and for carrying out the requirements of the Secretary of State, advised as appropriate by the NHS Policy Board.

5. The Secretary of State for Health, advised by the NHS Policy Board, shall issue to the Management Executive:

a. an annual Business Plan, indicating specific objectives for achievement within the resources available;

b. such performance targets, including quality, output and finance, as he thinks fit.

6. The Management Executive shall submit to the Secretary of State and NHS Policy Board:

a. an annual operational programme, rolled forward each year;

b. regular reports to the Policy Board on the discharge of the Business Plan;

c. from time to time, public reports on progress, including health authorities' and FPCs' out-turn;

d. such other advice and reports as Ministers and the NHS Policy Board shall require.

7. The Secretary of State remains answerable to Parliament for policy and for the carrying out of his statutory responsibilities by the Management Executive.

8. The Chief Executive is the Accounting Officer for the Hospital and Community Health Services (HCHS) and for the Family Practitioner Services (FPS). The Chief Executive shall attend the PAC and other Select Committees as required.

REVIEW OF DOCUMENT

9. As determined by the Secretary of State, in consultation with the Chief Executive.

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APPENDIX A2

# ILLUSTRATIVE BUSINESS PLAN FOR 1990/91 *

## INTRODUCTION

1. Ministers expect health authorities to identify the health care needs of their population and ensure these are met by a comprehensive range of high quality, value for money services within allocated resources. The three major service areas in which Ministers wish to see progress are:

- health promotion and disease prevention;

- the effective diagnosis and treatment of illness or injury within times which are both clinically acceptable and reasonable;

- the creation of a range of services to provide care in the setting best suited to the patient's needs and wishes - normally in the community rather than in large institutions for mentally ill, mentally handicapped, elderly and physically disabled people.

Note: Fuller guidance on Ministers' policy aims was given in HC(88)43.

## THE BALANCE BETWEEN SERVICES

2. Ministers believe that, given efficient management of resources (see paragraphs 4-5), it should be possible for Regional Health Authorities to make progress year by year in all three key areas set out above. As a minimum, they should ensure that:

- Districts work towards the achievement of quantified targets to improve the health of their populations, and pursue objectives i and ii set out in paragraph 6;

- acute activity rates (for in-patient and day cases combined) at least keep pace with the Region's demographic change, and that objective iii in paragraph 6 is pursued;

- measurable change is secured in the move from institutional to community care and objective iv in paragraph 6 achieved.

3. Ministers recognise that current levels of provision vary and thus each Region will not necessarily want to advance at the same pace in each service area. Emphasis in developing services - and thus their respective priority - will vary to reflect Regions' differing health needs, current levels of achievement and other circumstances. The overall aim should be to ensure that over-emphasis or ambition in one area does not jeopardise achievement of other objectives. The Management Executive will discuss and agree with each Region their particular objectives for 1990/91.

[NB: * This could be derived from a rolling five-year strategy.]



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RESOURCES

4. Ministers expect authorities to take every step to maximise the efficiency of service delivery, whilst maintaining and improving the quality of services. They will be expected to make substantial efficiency gains (see objective v in paragraph 6); to generate new sources of income; and to ensure the success of the expanded resource management programme.

5. Special attention should be paid to human resources which are a key asset. Authorities should aim to deploy staff flexibly, effectively and efficiently, ensuring a balance between future demand for skilled staff and supply. They should continue to implement 'Achieving a Balance' which aims at improving patient care by improving doctors' career structure.

SERVICE OBJECTIVES

6. In pursuing the general directions set out above Ministers wish all Regions to address these specific objectives:

(i) To ensure that programmes are in place for all eligible women to be called for breast cancer screening within three years of the establishment of the service.

(ii) To improve uptake rates of the main childhood immunisation programmes to 90 per cent of all eligible children.

(iii)To implement a targetted programme so as to ensure the progressive reduction of numbers of patients waiting more than a year for treatment.

(iv) To complete by 1991 the absorption of the artificial limb and wheelchair services currently provided by the Disablement Services Authority into integrated rehabilitation services.

(v) To achieve savings from cash-releasing cost improvements and productivity of at least x per cent.

[DN Other possible objectives might cover:

- Action arising from NHS Review;

- Community care;

- AIDS;

- Mental illness/mental handicap services]

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APPENDIX A3

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## ILLUSTRATIVE NHS POLICY BOARD PROGRAMME FOR 1990

| 1990 | 'Strategic' Policy Agenda | 'Short Term' Business Agenda |
|---|---|---|
| January | # Report on Policy Appraisal (eg Mental Illness policy) | i. Review of progress on NHS Review implementation.<br>ii. Report back from ME on 1989 Regional Review round. |
| February | i. Report on Policy Appraisal (eg health promotion and prevention).<br>ii. Directorate Review - Estate, Supplies. | |
| March | Report on Policy Appraisal (eg terminal care). | Agreement of ME's operational programme for 1990/91. |
| April | Directorate Review - Personnel (including manpower policy, pay strategy, etc). | i. Objectives for PES<br>ii. Review of progress on NHS Review implementation. |
| May | First discussion of Business Plan (see below) | PES bid 1991/92. |

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#. Resources are unlikely to be available to conduct more than 3 major Policy Appraisals each year - the Policy Board could commission a rolling programme.

As well as reports on major Policy Appraisals the Policy Board will also consider from time to time reports from the Management Executive on key service areas which they monitor on an ongoing basis, eg waiting lists. These too will feed into setting the Business Plan.

The Reports on Policy Appraisals are grouped from January to March to leave time for them to feed into the Business Plan (June).

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| 1990 | 'Strategic' Policy Agenda | 'Short Term' Business Agenda |
|---|---|---|
| June | Agreement on Business Plan for 1991/92. | Business Plan passed to ME for action and issue, together with resource assumptions. |
| July | Directorate Review - Information | Review of progress on NHS Review implementation. |
| September | | i. Mid-year report on operational programme covering I and E, manpower utilization and key activity markers.*<br>ii. Report from Audit Commission on 1989/90.<br>iii. Pay - discussion of approach to Review Body round. |
| October | Directorate Review - Medical and Nursing (including quality/outcome issues). | i. Report back from ME on 1989/90 outturn.**<br>ii. PES outcome for 1991/92, leading to cash limit for ME for that year.<br>iii. Review of progress on NHS Review implementation. |
| November | Directorate Review - Financial Management. | |
| December | Discussion of any 'national' areas to be explored with all Regions in preparation for Autumn 1991 Regional Reviews. | Resource allocations to Regions. |

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* Manpower utilization could be the subject of a separate Directorate Review.

** This could form basis for any public reports on NHS performance.

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ANNEX B

## THE MANAGEMENT EXECUTIVE AND ITS RELATIONSHIP WITH THE NHS

1. The role of the Management Executive is set out at paragraph 5 of Annex A. This paper sets out what should be the main features of its relationship with the NHS in its exercise of that role, under the headings of:

- strengthening line management (paras 2-4);
- increasing devolution (paras 5-8);
- integrating management systems (paras 9-11);
- communicating with the NHS (paras 12-13).

### Strengthening line management

2. Para 2-6 of "Working for Patients" says that the overall effect of the management 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". This means the Management Executive needs to have clear line management control over Regions and, in turn, Regions over Districts so as to ensure Ministers' policy aims and objectives are carried out.

3. Legally, the line of authority runs from the Secretary of State to RHAs and on to DHAs. Chairmen and general managers have no powers other than those given by their authorities. So we need to create an understanding between all the parties that the Chief Executive speaks with the authority of the Secretary of State who has explicitly delegated management issues to him. RGMs (and on occasion Regional Chairmen) will therefore look to the Chief Executive on management issues. Regional Chairmen will of course continue to have access to Ministers and to have regular meetings with them - focusing mainly on policy and strategic issues - but Ministers will need to refrain from issuing executive instructions to Chairmen.

4. The Chief Executive will wish to develop his own style of leadership in relation to general managers both collectively and individually. An important part of this will be joint working between the Management Executive and the NHS through a 'task force' approach, in which officers of the Management Executive and NHS general managers would form groups to tackle problems identified by the Management Executive.

### Increasing devolution

5. It will be essential to complement the delegation of operational issues to the Chief Executive by ensuring that the Management Executive in turn pushes decisions out to health authorities. This must be a prime objective, because:

i. health authorities are nearer the action;

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ii. as statutory bodies health authorities have a degree of autonomy which can be built on to encourage effective devolution and greater innovation.

6. This overall approach should be pursued by action in specific areas across the board, notably:-

i. pay and conditions of service. Ministers are already familiar with current policies which will:

a. allow self-governing hospitals to opt out of the present arrangements, and

b. give health authorities much greater discretion over the pay and conditions of their staff.

Substantial progress on (b) will be made during 1989, in particular through a flexibility deal for administrative and clerical staff, a pilot scheme for nurses and extension of existing discretion for general and senior managers. The intention is to introduce flexible pay systems for most groups of staff within the next 2 years. A medium term objective is abolition of central bargaining for ancillary staff.

The report of a comprehensive study of conditions of service has just been received. This recommends considerable decentralisation, opening up the possiblity of locally or even individually tailored remuneration packages.

Other intended lines of advance are wider extension of performance related pay (at present confined to senior and general managers and manual staff) and introduction of arrangements for local productivity bargaining.

ii. Crown immunity. Work is under way on proposals for a progressive removal of all Crown immunity for the NHS. Making health authorities subject to the normal legal requirements, including inspection and enforcement procedures, diminishes or removes entirely any need for the Department itself to enforce standards which are enforced by other public agencies. It would also ensure hospitals managed by authorities were on the same footing as self-governing and private hospitals. (There may be a continuing need to produce advice on compliance with the law and to discuss with the proper authorities the resource consequences of their policies and standards).

iii. building schemes. The White Paper announced (para 2.27) that the limits for central approval of schemes are being raised from £5m to £10m. RHAs - as part of their review of their functions - will need to consider again how far non-SGH schemes should be delegated by them to Districts.

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iv. financial limits. Authorities at present have to refer, for example, the payment of compensation and the writing off of losses to the centre according to a schedule of delegated limits. We will be investigating this area with the aim of raising the limits.

Changes in service patterns

7. Contested changes in hospital facilities, especially closures, must under present (non-statutory) guidance come to Ministers for a final decision. This involves them (and the Department) in many detailed and frequently trivial issues, sometimes involving as little as £8,000. Distancing Ministers from small-scale changes (perhaps by introducing an expenditure threshold below which contested changes would go to Regions for final decision) could be a highly effective means of removing Ministers from 'management' matters.

8. But progress in this area will need careful handling and will probably need to await the enactment of the NHS Reform legislation. In any event the procedures for handling contested changes of use and closures will almost certainly need to be revised once contract funding is in operation, since it will be the withdrawal of (or failure to secure) contracts which will become the most frequent "trigger point" for such changes.

Integrating management systems

9. The formal management systems need to be simplified and integrated in order to:

i. reinforce accountability; and

ii. increase devolution.

The esential components of any such systems are the setting of objectives, and identification of individuals who are responsible for achievement of the objectives, monitoring, and the taking of appropriate action where performance is particularly good or bad.

10. A new, streamlined system is needed which would dispense with much of the paper work of the existing system; put the emphasis on management outcomes rather than processes; focus more sharply on essentials; and strengthen accountability. Its main components would be:-

a. a Business Plan, issued by the Policy Board to the Management Executive and thence to the NHS - see Annex A. The Plan will leave plenty of "space" for local management decision and innovation. It would be protected as far as possible from "crisis" additions in-year;

b. each Region would agree annually with the Management Executive its specific objectives for the year;

c. performance against those objectives would be monitored by the Management Executive.

11. The new system would mean:-

a. detailed Regional Strategic Plans would no longer be produced. Regions would be expected only to produce short statements of their longer term direction and guiding principles;

b. the existing short term planning system would continue, but in simplified form. Only the Region's specific objectives would be approved by the Management Executive. The Management Executive would assess each Region's performance at the year-end;

c. the Individual Performance Review (IPR) of the RGM and his senior colleagues would be linked to the Regional objectives so that success or failure in delivering them would be reflected in their performance ratings and pay;

d. Ministers' involvement in mangement would be reduced. Their main functions would be to issue their policy aims and priorities (linked to resources) for delivery by the Management Executive and the NHS. Ministers would no longer chair the annual review of a Region's performance.

An illustrative timetable for these systems is at Appendix B1. It links with the illustrative Policy Board work programme at Appendix A3 to Annex A.

Communications with and guidance to the NHS.

12. It is vital for the Management Executive to control both the volume and content of the communidations from the centre to the NHS, because:-

i. if too many messages are sent, the important is obscured by the trivial;

ii. only a limited number of objectives can be taken on at any one time; and they must be coherent and achievable within available resources;

iii. the more guidance the Management Executive gives to the NHS, the more it will be expected to police its implementation.

In short, effective devolution and effective accountability require the Management Executive to cut down the flow of "guidance" to the NHS to the absolute minimum.

13. This could best be achieved by ensuring that:-

i. the Management Executive is the channel through which all written guidance issues to the NHS;

ii. guidance generally covers only essential information, and on what the centre wants the NHS to do, not how. There would of couse be a few cases where mandatory guidance on "how" was justified, either because uniform processes needed to be followed for statutory or management purposes (eg standing financial orders) or because the importance of the issue (eg child abuse, legionella) demanded the centre took a lead;

iii. the NHS should no longer look to the centre for the bulk of good practice guidance.

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APPENDIX B1

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## ILLUSTRATIVE TIMETABLE FOR ME/NHS MANAGEMENT SYSTEMS

1990

| | |
|---|---|
| January | Agreement (following PB December 1989 discussion) on any 'national' issues to be pursued with all Regions in run-up to Autumn Regional Reviews. |
| February<br>March | Agreement by ME of each Region's major objectives for 1990/91. |
| April | Discussion between ME and RGMs [and Chairmen] of their ideas for 1991/92 Business Plan, to feed into PB's considerations. |
| May<br><br>June<br>July | i. Issue to NHS of Policy Board's Business Plan for 1991/92, with resource assumptions.<br>ii. Submission to ME by Regions of:<br>(a) reports on their performance in 1989/90; and<br>(b) summaries of their programmes for 1990/91, as a baseline for monitoring achievement in June/July 1991 (not for agreement).<br>iii. Discussion by ME of agenda items for individual Regional Reviews. |
| August | |
| September | Agreement with Regions on Regional Review agendas, in light of ii. and iii. in June/July. |
| October<br>November<br>December | Regional Reviews with each Region, including discussion of their performance in 1989/90; progress in 1990/91; and objectives for 1991/92.<br>(December) Resource allocations to Regions. |

1991

| | |
|---|---|
| January | |
| February<br>March | Agreement of each Region's major objectives for 1991/92. |
| April | |
| May | |
| June<br>July | i. Issue of PB Business Plan for 1992/93.<br>ii. Regions' reports on performance in 1990/91 and programmes for 1991/92 to ME. |

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ANNEX C

RELATIONSHIP BETWEEN THE DEPARTMENT OF HEALTH AND THE NHS MANAGEMENT EXECUTIVE

SUMMARY

This paper discusses the implementation of Ministers' decision that the NHS Management Executive is to be located within the Department of Health but with a separate and clearly-defined status. It should be read in conjunction with the paper at Annex A on the relationship between the Policy Board and the Management Executive. For the purposes of this paper, 'DH' refers to that part of the Department which is not accountable to the Management Executive.

INTRODUCTION

2. The paper starts from three premises. First, that the relationship between DH and the Management Executive must be informed by an understanding of what each actually does. Formulating policy advice relevant to the way the NHS delivers services is only one aspect of the Department's work. It also carries out the tasks of a typical Health Department in a country where there is no 'NHS'. So it is involved, for example, with wider public health issues, including communicable diseases, food safety and environmental health, with the licensing and regulation of pharmaceuticals and with standards of care in both the public and private sectors. It also has policy responsibility for the personal social services, including child care services. So any arrangement must recognise that the DH and the Management Executive are not co-terminous. What is required is an efficient method of relating these two different but overlapping entities.

3. Secondly, DH is not exclusively in the lead on policy development for the NHS. In operational areas, such as advising Ministers on pay and personnel, that lead rests with the Management Executive because it is fundamental to efficient management of the NHS. It will, of course, be for Ministers and the Policy Board to determine the overall negotiating framework, taking account of the available resources.

4. Thirdly, Ministers have already rejected radical options such as an English Health Authority or Health Service Corporation, mainly because of their likely propensity to lobby for additional resources.

5. Accordingly, three options have been considered for structuring the relationship between DH and the Management Executive:

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(i) The autonomous Chief Executive

6. The first would give the Chief Executive an almost complete measure of autonomy in running his operation. He would be solely responsible for supporting the Secretary of State in the Public Expenditure discussions on his Votes - it has already been decided that the Chief Executive will become the Accounting Officer for both the Hospital and Community Health Services and Family Practitioner Services Votes. The Chief Executive would also, under this approach, be responsible for his own Administration Vote, and so would be responsible for ensuring that the Management Executive kept within its budget for running costs, for personnel matters, etc. Although this approach would strengthen the Chief Executive's position, it contains a number of disadvantages:

- it would, in effect, mean turning the Management Executive into a separate Government Department in its own right, a step which Ministers have so far rejected. This would not only mean splitting the Department of Health again, shortly after its separation from the Department of Social Security, it would also create two very small Departments (see Appendix C1 below) with potentially damaging consequences for morale, career development, etc;

- it would force the Chief Executive to become enmeshed in routine HQ management matters such as personnel arrangements and running costs, distracting attention away from NHS management and making a heavy and difficult job even more so;

- it could be costly because, over time, there would be a tendency towards completely separate staffing, as well as "second guessing" of the Management Executive by DH, a much criticised feature of the relationship between sponsoring Departments and nationalised industries.

(ii) The subsidiary agency

7. Under this model, the Management Executive would be regarded as an executive agency discharging a clear remit from DH. DH would agree a "Next Steps" -type framework of policy and resources with the Management Executive, with the Chief Executive becoming an Agency Accounting Officer and the Permanent Secretary remaining the Accounting Officer. This would make the Management Executive (and its Chief Executive) clearly subordinate to the Department; and so diminish the authority and accountability of the Chief Executive. It also seems incompatible with a Chief Executive who will be directly accountable to Ministers for the operations and management of nearly £19 billion of expenditure. Nor is it acceptable to the Chief Executive himself.

(iii) The 'holding company' approach

8. So neither of these options is recommended. Instead officials recommend an approach whereby policy and resources advice from DH and advice on implementation and management (and some policies) from the Management Executive is considered within the forum of the Policy Board, acting as a type of 'holding company' in relation to the Management Executive's operational role.

9. The advantages of such an approach are that:

- it gives a strong central role to the Policy Board in assisting Ministers to reach decisions based on advice from both DH and the Management Executive;

- the source of advice would normally be clear - either DH on policy or Management Executive on implementation. The management decisions of the Management Executive would not be "second guessed" by DH;

- it would enable economies of scale through common services;

- the close working between DH and Management Executive would enable good formal and informal channels of communications to remain, critical if the policy makers are to seek a management input (as well as being disciplined by resource constraints) and the managers are to remain sensitive to policy and political realities. For example, decisions on resource allocation policy need to be well informed by an operational awareness of health authorities' financial position, as well as by a clear sense of Ministerial priorities.

10. This approach also recognises the need to avoid embroiling the Chief Executive in the Whitehall machine and to ensure he does not become a focus of pressure for more resources. On the other hand, it gives him sufficient independence and "clout" to concentrate on - and deliver - his management tasks.

11. If this approach is agreed, the precise division of Accounting Officer responsibilities between the Permanent Secretary and Chief Executives needs to be finally settled. But the overriding imperative is that the Secretary of State should be properly supported by the Chief Executive and his staff on matters of NHS policy implementation and management, and by the Permanent Secretary and his staff when NHS policy formulation is at issue. A few senior officials in the Management Executive may need to work on separate but related issues to both the Chief Executive and the Permanent Secretary in order to secure economical staffing.

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MANAGEMENT EXECUTIVE STAFFING

12. The Chief Executive is rightly anxious to have as much freedom as possible to recruit - from whatever source including the NHS - people to fill key Directorships and some other senior posts, perhaps totalling 20-30 in all. This in turn means having the ability to offer suitably attractive pay and conditions to obtain the right people. For the reasons set out at paragraph 6 above, it is proposed to retain a common Administration Vote for the whole of the Department of Health, including the Management Executive. The precise allocation of funds is under discussion between the Permanent Secretary and the Chief Executive (who already work jointly on the setting of budgets for their respective parts of the Department.)

13. Under the new arrangements the Chief Executive will need to identify a sum from within his various budgets which he can use to secure the services of some people from outside the present Department, particularly the NHS and the private sector. External recruitment of this kind would be subject to the need for Treasury agreement on a case-by-case basis for remuneration packages significantly out of line with current practice. This builds on the pattern of NHSMB staffing, where Directors were recruited from a variety of sources including the NHS, business and the Civil Service. Personnel changes involving key Management Executive staff not referred to in paragraph 12 above will need to be cleared with the Chief Executive. It will need to be decided whether the Chief Executive should have a separate budget for accommodation, support services and so on, or whether these are best provided, as now, as a common service to both DH and Management Executive.

SIZE OF THE CENTRAL ORGANISATION

14. In serving the Secretary of State the Department of Health:

a. advises the Secretary of State on health policy, public health and the personal social services;

b. acts as the Headquarters of the NHS;

c. manages other Authorities and Groups accountable to the Secretary of State.

15. Appendix C1 shows how the 8,623 'Health' staff are distributed between Management Executive functions, the Policy functions in the rest of the Department and their Departmental support (Sections 2-4); and the other Authorities and Groups accountable to the Secretary of State for carrying out executive functions, including direct services to client groups (Section 5). By far the largest proportion of the staff - 5,953 - are in the last category; and as the Notes to Appendix C1 show, changes of status are in hand to transfer all but a few of them to outside bodies, including the NHS and the Audit Commission, or to turn them into Next Steps Agencies.

16. Sections 2 and 3 of the table attribute those staff which can clearly be so attributed at this stage to Management Executive functions (1,140), the rest of the Department (906), and their joint support (585) - a total of 2,631. As will be seen from the Notes to the table, within the Management Executive and policy areas of the Department, we are examining the possible devolution of:

a. much of the Health Building, Procurement, Estate and Property Management and possibly some NHSIT and Health Services Information functions, either to an NHS Common Services Authority or other Agency;

b. all but a small core of the Social Services Inspectorate Headquarters staff to a Next Steps Agency;

c. the British Pharmacopoeia to an Agency.

17. As parts of the Department continue to be devolved into Agencies, the common services staffs will continue to be reduced in step.

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APPENDIX C1

DEPARTMENT OF HEALTH

(Approximate staff numbers, March 1989)

1. Ministers' Private Offices 39
incl Parliamentary and Correspondence Sections

2. Management Executive functions

| | |
|---|---|
| Chief Executive & his private office | 5 |
| Health Authority Finance | 44 |
| Health Building Directorate (Note 1) | 107 |
| Procurement Directorate (Note 1) | 161 |
| Regional Liaison | 86 |
| Health Service Information (Note 1) | 18 |
| NHS Information Technology (Note 1) | 38 |
| NHS Business strategy | 10 |
| Estate & Property Management (Note 1) | 24 |
| Health Authority Personnel | 115 |
| Financial and Resource Management | 46 |
| Family Practitioner Services | 91 |
| Medical | 59 |
| Nursing | 28 |
| Pharmaceutical | 3 |
| Economic Analysts | 8 |
| Operational Research | 10 |
| Statistics and Management Information | 166 |
| Legal | 12 |
| Finance (FPS, CFS & Administration) | 95 |
| Research Management | 14 |
| | 1140 |

3. Policy & other functions

| | |
|---|---|
| Permanent Secretary & private office | 5 |
| CMO & his private office | 6 |
| Policy on: | |
| Children, Maternity & Prevention | 54 |
| Community Services | 74 |
| Health Services | 94 |
| Priority Care | 90 |
| Aids | 18 |
| NHS Review | 16 |
| Policy Secretariat | 5 |
| Family Practitioner Services | 82 |
| Medical | 168 |
| Nursing | 38 |
| Pharmaceutical | 12 |
| Economic Analysts | 11 |
| Operational Research | 8 |
| Stats and Management Information | 69 |
| Legal | 17 |
| Finance (FPS, CFS & Administration) | 63 |
| Research Management | 32 |
| Dental | 10 |
| British Pharmacopoeia (Note 2) | 34 |
| | 906 |

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4. Support

| | |
|---|---|
| Information Division | 33 |
| Departmental Personnel | 120 |
| Central Resource Management | 25 |
| Library | 32 |
| Office Services Management | 78 |
| Messengers | 84 |
| Security Officers | 25 |
| Paper and Office Keepers | 35 |
| Typing and Reprographics | 150 |
| Telephonists | 3 |
| | 585 |

5. Other Authorities/Groups accountable to the Secretary of State

| | |
|---|---|
| Special Hospitals (Note 3) | 3204 |
| NHS Superannuation (Note 4) | 520 |
| Youth Treatment Centres (Note 4) | 183 |
| NHS Statutory Audit (Note 5) | 213 |
| Social Services Inspectorate (Note 4) | 187 |
| Dental Reference Service (Note 6) | 61 |
| Regional Medical Service | 197 |
| Mental Health Act Commission and Review Tribunals | 46 |
| National Development Team for the Mentally Handicapped (Note 7) | 5 |
| Health Advisory Service (Note 7) | 10 |
| Medicines Control Agency (Note 8) | 270 |
| Disablement Services Authority (Note 9) | 1057 |
| | 5953 |
| GRAND TOTAL | 8623 |

NOTES

1. Candidates (in whole or part) for an NHS Common Services Authority or other Agency
2. The future status of the British Pharmacopoeia is under active consideration
3. Becomes a Special Health Authority within the NHS during 1989
4. Candidates for Next Steps or other Agencies
5. To be transferred to the Audit Commission on 1 April 1991

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6. To be transferred to the Dental Estimates Board on 1 October 1989

7. Consideration is being given to merging these two bodies and plans are in hand to put them onto a self-financing basis with the possibility of Agency status in the future

8. Became a self-financing agency working within an agreed framework from 1 April 1989

9. Became a Special Health Authority in July 1987 tasked with arranging a full transfer to the NHS by 1 April 1991. Included in the Department only because the Authority is, for the present, staffed mainly by DH officials.

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ANNEX D

MEMBERSHIP AND ORGANISATION OF THE NHS MANAGEMENT EXECUTIVE

An important aspect of the remit is the structure of the Management Executive. Detailed proposals are set out below.

METHOD OF OPERATION

2. The Chief Executive wishes to operate by placing clear responsibilities on individual Directors who will account to him for their performance. While he wishes the Management Executive to have a common purpose, aims, and style, and while individual Directors' actions must be co-ordinated, he does not wish the Management Executive to operate as a corporate decision-taking body. Decisions will be taken as appropriate by Directors or the Chief Executive, after any essential discussion between the people involved. Each Director will have a set of objectives and progress in achieving these will be regularly monitored by the Chief Executive with the Director concerned.

3. The Management Executive will meet fortnightly to discuss strategy, to exchange information and to enable the Chief Executive to deal with any business that needs the input of the top level Directors.

MEMBERSHIP

4. The Management Executive will comprise the Chief Executive and the following eight Directors:-

i. Operations (Deputy Chief Executive)

ii. Information and Review

iii. Finance

iv. Personnel

v. Medical

vi. Nursing

vii. Family Practitioner Services

viii. Estate

5. Of these 9, 5 initially will be from the NHS or private sector - see paragraph 12 below. The main features of the new arrangements are described in the rest of this paper. Some of the functions ascribed to individual Directors may be dealt with in future at arm's length - see Annex C.

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6. The Director of Operations will also act as Deputy Chief Executive. The other ME Directors will report direct to the Chief Executive, but the Director of Operations will act for the Chief Executive in his absence and will undertake specified roles in support of the Chief Executive. These will include:-

i. co-ordinating the implementation of "Working for Patients" in the NHS;

ii. developing a corporate strategy for the Management Executive, including communications with the NHS;

iii. providing the secretariat function for the Management Executive and Policy Board.

7. The Director of Operations will be responsible for day-to-day relations with health authorities, for procurement and for certain duties in relation to building and estates work (see para 14 below).

8. The Director of Information and Review will be responsible for the NHS planning and review system and for information strategy and its implementation throughout the NHS (including the FPS). He will act as customer for the statistical services provided to the Executive by the Department's Statistics and Management Information Division.

9. The Director of Finance will be responsible for the resource management initiative, as well as financial management in the NHS and for leadership of the Executive's relations with the NHS in the area of finance. The separate Director of Health Authority Finance (Grade 3) will report to the Department of Health's Principal Establishments and Finance Officer in relation to overall management of the PES process and to the Chief Executive as Accounting Officer in relation to the rest of his duties.

10. The Director of Personnel will have overall responsibility for manpower planning, pay and conditions of service, and for education and training for all groups of HCHS staff (including doctors). In so far as specific personnel responsibilities fall to the Medical and Nursing Directors, the Director of Personnel will be responsible for overall policy and for co-ordination.

11. The Medical Director will be a Deputy Chief Medical Officer. He will be managerially accountable to the Chief Executive and remain professionally accountable to the CMO of the Department. He will have under his command three medical divisions, namely those dealing with primary care services, with NHS management, planning and organisation and with medical manpower and education.

12. We are actively seeking to recruit a nurse with a strong managerial track record to be the Nursing Director. She will be graded as a Deputy Chief Nursing Officer. She will be managerially accountable to the Chief Executive and professionally accountable to the CNO of the Department. She will have under her command these staff of Nursing Division who deal with NHS management and personnel matters.

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13. The FPS Director will be responsible for the management of Family Practitioner Committees and for the Family Practitioner Services.

14. The Estates Adviser will be a part-time appointment. He will be responsible for all NHS estate matters, including building. He will be supported by a full-time Director at Grade 3 level. Because the Adviser is part-time the Grade 3 Director will also report to the Director of Operations on the management of the Directorate.

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ANNEX E

12

## HANDLING PARLIAMENTARY BUSINESS

1. Paragraph 2.3 of "Working for Patients" states:

> "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 large sums of money. Such accountability does not mean that Ministers should be involved in operational decisions."

2. One key aspect of distancing Ministers from operational matters concerns the handling of Parliamentary business. Given that - as the extract above shows - there is to be no fundamental (or statutory) change in the overall accountability of Ministers to Parliament, achieving the objective will depend on careful handling and timing.

3. Previous attempts to spell out the level at which representations should be addressed (most recently in a PQ in 1987) have had limited success. Many MPs have been unwilling to address questions on clearly local issues to health authorities nor have all Ministers been consistent in adopting an arm's-length approach.

OPTIONS

4. There are several possible options for improving matters. These range from the pragmatic, ie:-

> i. a re-statement of the existing guidelines on issues best handled locally, and more rigorous enforcement thereof;
>
> ii. referring Parliamentary business to the CE;

to more radical departures from existing practice and conventions, such as:

> iii. preparation of a 'declaratory' statement or guidelines for handling Parliamentary business, to be made public and perhaps debated in the House;
>
> iv. a selective approach to distance Ministers from specific issues which generate substantial 'management' business, eg hospital closures and changes of use, by means of changes in guidance or practice.

5. Option i would reinforce the further substantial thrust towards more delegation of authority to health authorities which runs through the White Paper proposals. A re-statement of this kind may also stand a greater chance of success once the formal responsibilities of the Management Executive are published in a written statement. Its impact will, however, depend crucially on political will-power.

6. As for option ii, it may be possible to refer some business, such as MPs' correspondence, to the Chief Executive for answer and to answer matters which cannot be so delegated, such as PQs and

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Adjournment Debates, in terms which make it clear where operational responsibility lies. This would need to be done sensitively given that the Management Executive is to be part of the Department of Health (albeit with a separate status) and therefore within the purview of the Secretary of State's statutory responsibilities.

7. The concept of a declaratory statement - option iii - is not without precedent, notably the Home Office guidelines on the handling of immigration cases. It would be comprehensive and might carry public authority. A possible draft is at Appendix E1. But there are two obvious objections. First, it might not work in practice. MPs who are determined to pursue detailed local issues with Ministers will probably not be deflected by such a statement. Secondly, its production could provoke a major row because of the NHS' high political profile, with Ministers being accused of seeking to evade Parliamentary accountability at a time when a controversial NHS Bill is being steered through the House.

8. As for the selective approach - option iv - this might be worth attempting once the NHS Reform legislation is in place. For example, removing Ministers from taking the final decision in contested hospital closures below a certain expenditure threshold would clearly signal the arrival of a more truly devolved NHS than anything which has been seen before. It would help fix in MPs' minds the notion that Ministers' primary concern was with overall strategy and policy, not with the detail of how policy was implemented on the ground.

9. In any case, as Annex B argues, there will need to be a fresh look at closure procedures once the trigger-point for such closures becomes the failure to secure (or withdrawal of) contracts.

THE UK DIMENSION

10. The Secretary of State for Health has previously expressed concern that his position - and that of the Prime Minister - in seeking to direct operational matters to those responsible for them will become untenable unless mirrored by Scottish, Welsh and Northern Irish Ministers. However, territorial Ministers are unlikely to be able to distance themselves from operational issues for a variety of reasons, notably the absence of a Regional tier to which matters not appropriate for the operational health authority can be directed. The other Health Departments already carry out many of the functions of English Regions. This bolsters the need to await a more devolved and mangerially-mature English NHS before embarking on radical changes in Parliamentary accountability.

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APPENDIX E1

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HANDLING PARLIAMENTARY BUSINESS: POSSIBLE DECLARATORY STATEMENT

Introduction

1. The underlying aim of the White Paper "Working for Patients" is to ensure that the NHS provides the best possible service to patients. The Government believes that the NHS will be best placed to achieve this if greater authority, responsibilities and powers are given to those who actually deliver services. The White Paper therefore sets out as a central principle the maximum delegation of operational authority from the Secretary of State to the Chief Executive of the Management Executive, and from there to Regional and District Health Authorities and on to individual units.

2. It follows from this that information regarding operational issues, such as local performance and the interpretation locally of national policy, will be most readily and accurately available either from health authorities or from the Chief Executive. It is therefore proposed that representations* from Members of Parliament on such matters should, where possible, be addressed in the first instance to the appropriate health authority(ies) or to the Chief Executive. This statement offers guidance on the level at which particular types of representation should be addressed.

3. This proposed delegation of authority is broadly in line with current practice. Many representations on local issues are already referred to health authorities for reply. Ministers will continue, as now, to answer representations on policy issues at national level. The aim of this statement is to extend and strengthen existing arrangements; to explain how they will apply to Parliamentary business in future; and to define the circumstances

* Defined here as PQs, correspondence, local matters which might be raised in Adjournment Debates, and other representations from MPs.

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when Ministers might be expected to answer in detail on local operational issues. The proposals are not intended to detract from Ministers' ultimate accountability to Parliament for the delivery of health care and the use of resources in the NHS.

4. Subjects on which representations will be handled by Ministers

a. Issues arising directly out of national service policies (eg policy on mentally handicapped adults).

b. Overall level of NHS resources.

c. Overall strategy for the NHS.

5. Subjects on which representations will be handled by the Chief Executive of the NHS Management Executive

a. Issues arising directly out of national operational or management policies (eg current pay negotiations in NHS Whitley Councils).

b. Centrally-collected information which cannot be provided by RHAs or DHAs (eg national or pan-regional data).

c. National or pan-regional questions on operational matters - implementation of policy, monitoring of performance, etc.

[6. It is proposed that the Chief Executive should publish a regular digest of answers to representations made by MPs where these are of general interest.]

7. Subjects on which representations will usually be handled by the responsible RHAs, DHAs and FPCs

a. Locally determined policies and priorities.

b. Application locally of national priorities.

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c. Statistics and other information which is locally available (to be provided by DHAs or FPCs or, in the case of information covering a number of DHAs or FPCs in one Region, by RHAs).

d. Operational cases where responsibility rests locally, and where local mechanisms for enquiry have not yet been exhausted.

e. RHAs will handle questions relating to the allocation of resources to DHAs and other funding matters.

Ministers' reserve powers

8. In line with their accountability to Parliament, Ministers will retain the right to intervene in issues concerning locally determined policies or local operational matters where these are of significant public concern, or raise questions about a national policy.