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DEPARTMENT OF HEALTH & SOCIAL SECURITY
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Telephone 01-407 5522
From the Secretary of State for Social Services

Michael Scholar Esq
Private Secretary
10 Downing Street

27 July 1983

Dear Michael

NHS MANPOWER

You should know that the new manpower targets for the NHS are now being communicated to Regional Health Authorities, although on the basis that each Region is only being given its own figures. We have also made public the overall reduction which we are expecting of $^3/_4$ - 1 per cent between 1 April 1983 and 31 March 1984. This amounts to a reduction of some 6,000 - 8,000 staff. Because of the redistribution of resources between regions which is still taking place, the absolute reductions in numbers required will be greatest in the Thames Regions while some regions in other parts of the country will still be able to increase their staffing to cope with new developments. We do not propose to comment on individual regional figures which are indicative at this stage and subject to discussion between the Department and the Regions.

I attach brief speaking notes both on the overall reductions and the particular question of the reductions in numbers of nurses. The latter came up several times at Question Time on Tuesday when the Minister for Health refused to be drawn although it is certainly the case that the number of nurses will have to be reduced in some parts of the country.

Yours
Steve

S A Godber
Private Secretary

NOTES FOR THE PRIME MINISTER

REDUCTIONS IN NHS STAFF

We want to make the NHS more efficient and to get the best value for money from it. That means also making the best possible use of staff. To promote this, my rt hon Friend has asked Health Authorities to revise their plans for this year to achieve an overall reduction in manpower of between $^{3}/_{4}$ and 1 per cent in 1983/84. The saving will be greatest among staff not involved in direct patient care. In total, we expect the NHS to be employing 6,000 - 8,000 fewer staff by the end of the year. That is by no means an unreasonable target for Health Authorities to meet.

REDUCTIONS IN NUMBERS OF NURSES

We have to look for greater productivity from all NHS staff. Health Authorities should be reviewing their use of nursing manpower along with other groups. Indeed some authorities have already been planning to reduce the number of nurses they employ. It is not for me to predict what the right answer will be; that needs to be worked out locally.

KR

Mr. Scholar

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From the Permanent Secretary

Sir Kenneth Stowe KCB CVO

Robin Butler Esq
10 Downing Street

26 July, 1983

Dear Robin.

I enclose an article on the Griffiths Inquiry which you may find interesting. It sets out his approach very well; first, you must say what it is you need to do to achieve your aims and only then can you decide both how many staff you require and how they should be organised. I think he has a lot to tell us.

Yours ever.

Ken.

For the first time since the NHS management inquiry was set up its chairman has spoken extensively about the team's progress. In an exclusive interview with Roy Griffiths, Stephen Halpern reports on the themes of the inquiry — general management, clinical budgeting and the delivery of care to the patient

I shld send a copy to Robin B. KW

The quality quiz

The Griffiths inquiry is not about instituting a tier of chief executives throughout the NHS or general managers or full time chairmen. It is about tracking down responsibility. While the NHS management inquiry set up earlier this year could end up recommending any of the numerous solutions already suggested by previous reports, it is at the moment still at the stage of asking questions rather than supplying answers.

Inquiry chairman Roy Griffiths is very careful to steer clear of the concept that he and his team are said to have taken on board. 'I've not talked specifically about the concept of a chief executive. But, he adds, his primary form of inquiry is 'to trace executive responsibility throughout the NHS — not simply executive responsibility but general management responsibility, that is who is bringing together all the factors which bear on any course of action'.

While Mr Griffiths and his team will be tracing the whole length of decision making in the NHS they appear to be concentrating on specific areas, namely at DHSS level and at hospital level, where the bulk of resources are spent.

At hospital level Mr Griffiths wants to develop a general management concept to establish who is exercising the overall responsibility for matching resources to the results which are trying to be achieved.

'I'm not interested in reorganisation'

But whatever changes his inquiry may bring Mr Griffiths says there will not be another structural reorganisation. 'I'm not interested in reorganisation,' he points out, adding: 'I believe that reorganisations should only be done rarely and then they should be done superbly well'.

'In the first place I'm talking about the spelling out of responsibilities and I think there are certain questions one has to ask as to whether responsibilities need to be reshaped. But I think it would be unacceptable to start making a lot of new appointments within the NHS — at least at hospital level.

Cliff Graham secretary to the management inquiry (left), and its chairman Roy Griffiths.

However, although he plans to spell out responsibilities within the existing structure, it is likely that his eventual report will be more than just fine tuning.

'Fine tuning implies that the whole of the music is already there, whereas in some cases I don't believe it is.'

The Griffiths team is also analysing the whole area of management budgeting. Mr Griffiths wants to go 'beyond clinical budgeting' because it tends to be limited just to those costs which relate to direct clinical activity.

He says most hospitals tend to have budgets broken down between functions. One can speculate that Mr Griffiths wants budgetary control to be linked directly to the type of managerial responsibility he wants to see at hospital level. While it would be an injustice to bandy about terms such as medical superintendent, it does appear that the managerial involvement of clinicians in deciding how to spend resources will be upgraded in some form.

Of course one could also speculate that the decision making will shift in an opposite direction and that a general administrator will directly control and manage a hospital or a given part of it. However, the political niceties of the NHS are a bridge that Mr Griffiths has yet to cross.

While the focus of the inquiry team is at the extremities of the chain of command, the regional and district roles will not be neglected. He does not feel it is necessary to take an axe to the intermediate management tiers.

In view of the fact that the NHS has 2,000 hospitals, he said, '14 regions and 190-odd health authorities may sound a lot but not in the context of a business as large as the NHS, particularly when you reflect that any one of those 14 regions would be in the top handful of British companies, in pure cost terms, if they were registered as businesses'.

Of course the one area that springs to mind when talking about the looseness of accountability is the position of authority members and chairmen in relation to officers. The Griffiths eye has already been cast in that direction.

'I don't think the nature of the job is sufficiently clarified,' he said, with regard to 'which decisions are to be retained at district level as distinct from what is being delegated'. He also wanted some clarification of 'the full role of the district chairman.

'Someone or some body of people have to take the general management responsibility for what is going on in the district, he said.

This part of the inquiry has prompted a rash of district chairmen to stand up at various conferences and talk about chief executives. However, this is not to deny the methodology of the Griffiths inquiry. They are still asking questions.

'Is that sufficiently spelt out?'

As Mr Griffiths puts it: 'How you structure that is the second question once you've answered the first which is "Is that sufficiently spelt out?" In order to alter things you you've got to understand the present position and that is by no means clear.

'I think the position of the district chairman in relation to the management team in executive terms isn't clearly spelt out'.

While the inquiry will run parallel to a number of small studies Mr Griffiths says his team has deliberately avoided setting up large working parties and bringing in consultants at an early stage. He says the work done on the NHS over the past 20 years is 'formidable' but, asked whether enough action has been taken over them he replied: 'The question is who was there to take action on the reports and that leads to the very first point of the inquiry which is "Where does the executive responsibility lie?"'

Mr Griffiths also believes management accountability has become less clear over the years. He says that when the NHS was established in 1948 there were clear lines of responsibility

through to the medical superintendent and the board of Governors. He sees the various superstructures set up since then as 'pulling responsibility from the hospitals'. Despite a lot of attention being given to organisation and structure Mr Griffiths feels less has been given to the management role.

He quite firmly wants to put decision making back at hospital level as far as possible and he concedes that there are many decisions which need to be taken outside the hospital but he hints that there are more than are probably necessary

Another theme of the Griffiths inquiry is the patient. He says: 'I see a major need to look at health care from the point of view of the individual patient and to see how things impact on him'.

For example, on matters such as the complexity of the NHS being delivered through several statutory bodies, Mr Griffiths does not believe that the patient would perceive them as such.

'Individual patients do not see the multiplicity of health care organisations. They believe that when they go to the doctor that they are just starting a whole process of medical care for themselves. The fact that it is being provided by a whole variety of different authorities is not wholly understood and perhaps should not be wholly understood by them', he says, adding: 'They simply want to be looked at from the point when they go to the GP to the point when they have finished their treatment'.

The answer lies in market research

The theme of the patient is brought up at every opportunity in the Griffiths inquiry. Mr Griffiths says that on his visits one constant question is: 'How well do you know patients are being looked after?'

The answer to this question, Mr Griffiths believes, lies in market research. He makes it quite clear that by treatment he means both clinical treatment and administrative treatment: how long people have to wait for appointments, the state of outpatient waiting rooms and so on will all be the subject of study.

He obviously feels the NHS has a little way to go in managerial terms if it is to match up to being the largest business in Europe but he is optimistic because of the attitudes he has encountered.

'There is a tremendous commitment to the NHS. People are quite clearly interested in the quality of service . . . and increasingly they are interested in the way reasonably limited resources are used to meet these requirements,' he says.

Mr Griffiths is independent minded enough to report what he feels is right and he has been given a wide brief by Secretary of State Norman Fowler. Nevertheless he is diplomatically polite about the Government over matters such as management cost reductions.

Of course the lack of sophistication in the way that much decision making in the NHS has been made is partly the reason why people like Mr Griffiths have been brought in. He is not unaware of the hostility that surrounded his appointment. 'This is one of the crosses I have to bear throughout the inquiry,' he says, and he admits that there are bound to be differences between running the NHS and a chain of supermarkets. But, he argues, there are certain universal characteristics covering all organisations. 'The NHS is like any other business in that it is seeking to achieve particular ends through the use of particular resources,' he says.

'This feeling that somehow there is a hard-nosed businessman handling private industry when what is required is a much more sensitive individual to handle to the NHS does injustice to both sides. The same process is required', he said.

Mr Griffiths is likely to make some form of recommendation to Mr Fowler in the Autumn and as yet the inquiry is a long way from coming up with detailed answers. 'We are still forming views on it. It would be arrogant after four or five months to suggest otherwise,' he says.

He is also careful to avoid the answers for the present because people will discuss issues such as the chief executive without looking at the whole problem.

While Mr Griffiths is anxious to avoid comments that will further fuel the endless speculation about his team's activities the very nature of his inquiries lend themselves to animated discussion.

While he gives some clues to what he might eventually want to see at hospital level, the same principle of nailing down responsibility becomes even more interesting when applied to what Mr Griffiths describes as the centre.

'This feeling that somehow there is a hard-nosed businessman handling private industry when what is required is a much more sensitive individual to handle the NHS does injustice to both sides. The same process is required.'

If for example the Department is seen as being unable to take executive responsibility for directing the NHS then what replaces it if it is thought there is an executive vacuum at the centre?

Again at health authority level the ridiculous ambiguity of the roles of members and officers has been on the most part cheerfully accepted over the years as being one of the many quaint eccentricities of British public life.

Like most things in the NHS the existing solution has been reached as a compromise between various competing power groups such as local authorities, the professions, central Government and so on. While the solution has possibly left an ineffectual means of executing authority it has achieved some sort of equilibrium between competing groups.

Plurality of interest groups in public sector

Any alteration of that balance could be fraught with difficulty. Perhaps one of the main differences that Mr Griffiths will encounter between the commercial and the public sectors is the plurality of interest groups that are attached to the public sector which could make the type of single mindedness associated with the commercial sector much more difficult to reproduce.

The other aspect of the Griffiths inquiry could sound like music to the ears of some NHS treasurers. At a conference on clinical budgeting some time ago a treasurer described how he had to be restrained from costing down to different specialties details such as the wear and tear on the lino in the corridors. His day may now have come.

Perhaps the ultimate in costing is to do more than present each patient with a nominal bill at the end of his or her treatment. While this would have the benefit of perhaps making people realise the cost of treatment it also has other inherent dangers such as if say a Government in a public expenditure crisis wanted patients to give a small contribution towards the cost of their acute treatment.

But perhaps the most beneficial aspect of the Griffiths inquiry is the emphasis it appears to be placing on the consumer. Possibly the greatest criticism that can be labelled against the NHS is that the comfort of the patient (as opposed to the treatment of the patient) has received too little attention.

Something that should have happened sooner

The market research projects into how patients see the NHS is something that should have happened sooner and should not have been left to CHCs to handle. However Mr Griffiths might do well to look at the CHC role.

What emerges from talking to Roy Griffiths is that he is moving in a fairly definite direction. The publication of *'Patients first'* laid the ground for health authorities to establish the organisation and the structure to devolve decisions downwards. What it did not do was to ensure that those decisions were taken in a sharper way which reflected the activity in a hospital. Who takes the decisions in the hospital is likely to be the hottest part of the inquiry's eventual report.

At the risk of coining yet another management platitude which does not do full justice to the inquiry team's efforts, it seems that the inquiry wants to identify an individual within a hospital who in simple terms is the boss. This is not easy task at the moment. Who they identify as the most appropriate person to take on that role will emerge over the next few months and that is when the fun will really start. □

NOTE FOR FILE

Mr Walker's letter of 20.6.83 to MCS has been returned to Mr Walker at his request.

6.7.83