Griffiths: Challenge and Response

by

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King Edward's Hospital Fund for London

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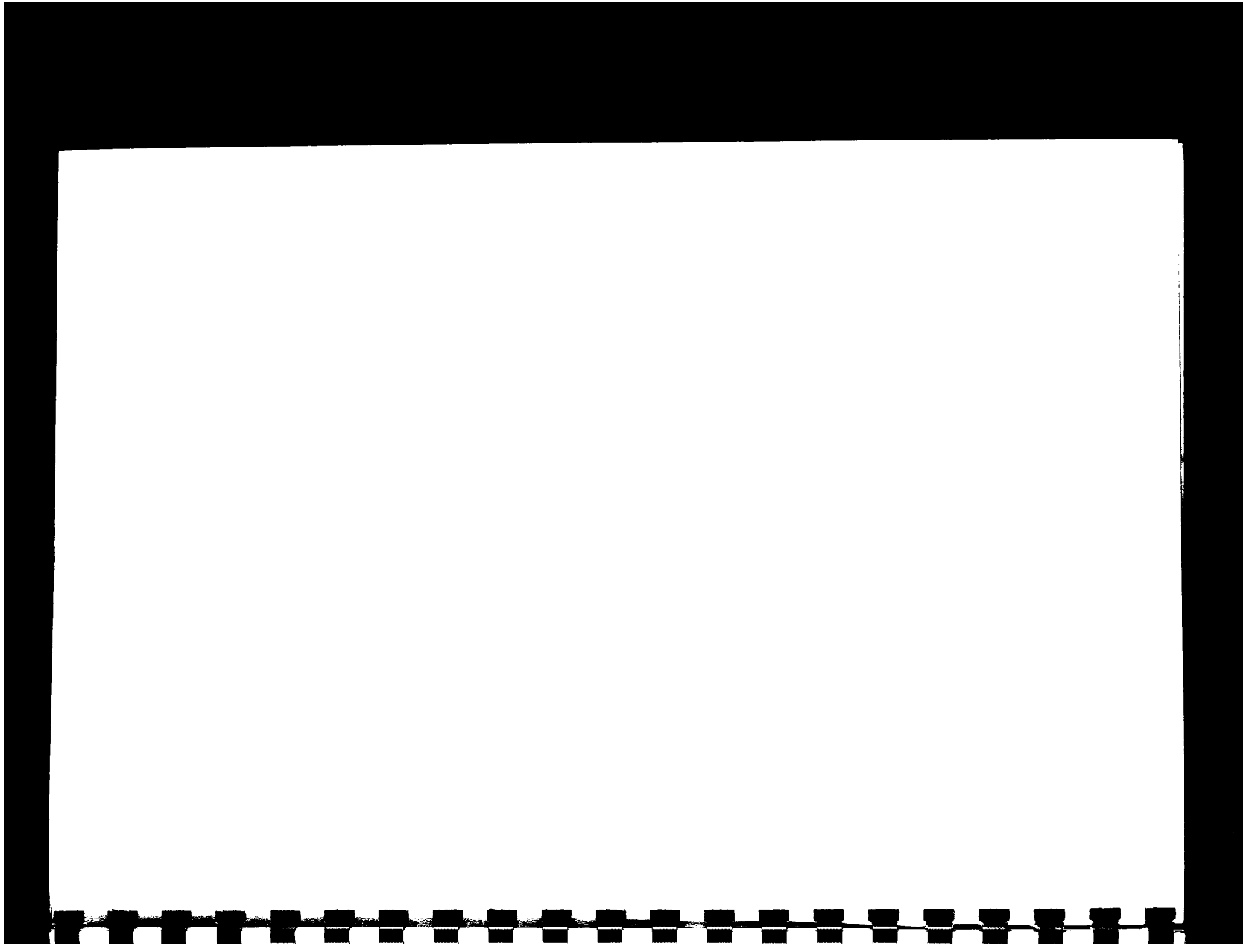
GRIFFITHS: CHALLENGE AND RESPONSE

The widely differing reactions to Griffiths, ranging from total acceptance to almost total rejection, are not simply a normal reflection of political controversy. They also stem from the basic characteristics of the report itself, which is starkly unlike most such documents in both its weaknesses and its strengths. It is consciously impressionistic, reflecting the perceptions of a team of businessmen, who have examined the way that the National Health Service is run and have made recommendations based on their own experience as managers in other fields. Almost no facts are produced to support the team's diagnoses, and the evidence, such as it is, is anecdotal. There is little explanation of the reasoning behind the proposals, which (despite the Secretary of State's disclaimer) call for fundamental change.

Thus the report lacks the merits of solidity of evidence and exposition of many documents stemming from previous inquiries. Since it denied itself these advantages in the form it takes, it stands primarily as a critique. In that it is pertinent and timely. Its diagnosis of the reactive nature of most NHS and DHSS management, and of the lack of management data on consumer views, is useful and suggestive. Not surprisingly, the team is less convincing in its prescriptions than in its basic diagnosis, for it is not always sensitive to the ways in which the health service is genuinely different, nor has it been able to resist entirely the pressure to present instant solutions.

Whether the report is "good" or "bad" depends entirely on how it is used by the NHS and by Government. We suspect that Roy Griffiths would himself welcome that verdict, for what he set out to do was not to write a report of great weight and elegance, but to help in the real world. If it is well used, this could prove to be



the most helpful document yet written about the management of the National Health Service.

Thus the report should not be dismissed for its weaknesses, real as these are. Still less should it be adopted as an instant panacea, for that way lies disillusion and yet another discrediting of management in the NHS. Indeed Roy Griffiths' diagnosis would be only too clearly confirmed if the best the NHS can do with his report is first to bicker over it, and then to be pushed into a stereotyped course of action by it. It needs to be used imaginatively, intelligently and purposefully by all those responsible for running the service.

To do this requires forming a view about the relative importance of the various recommendations in the report, and also differentiating between what requires immediate action and what is necessarily evolutionary. For much of the report is actually about changes in attitude, understanding and expectations - about the style of management - which can be facilitated by some action now, but also depend on coherent strategies for change over time. The Griffiths' critique of the passiveness and lack of vision of the way the service has been managed is not the less powerful for being intangible, and resistent to gimmicky solutions.

To date most of the controversy about Griffiths has centred on the appointment of general managers at the District and Unit levels. In our opinion, that is a mistaken focus for three reasons, which are more fully developed in later sections of this memorandum. First, the recommendations about the centre - particularly the proposed Management Board - are actually far more radical, and more important in developmental terms, than most commentators have recognised. Second, the acrimonious disputes about likely winners and losers in the general management stakes are much less vital than the implied shift in style from passive to active. Third, the

relatively decentralised structure of the National Health Service requires that health authorities should themselves choose, within reason, the formula for general management most appropriate to their circumstances, and the path by which they will move towards it. These views are interrelated. Provided that there is an effective Management Board, including a Director General of substance, one of the Board's key tasks in its early years will be to develop the general management strand at all levels in the NHS. Without that sustained commitment, there is simply no chance that the revolution that Griffiths seeks will take place.

Apart from anything else, the idea that the NHS is overmanaged is a myth that has to be dispelled before much progress can be made. If most managers in the NHS are barely coping with day to day events, the reasons lie largely in the real difficulty of their jobs and the chronic lack of sufficient investment in management recruitment and development in the Service. Probably the members of the Inquiry Team recognised this. If so, it is a pity that they did not say so in their report. Otherwise the criticism of NHS management sounds slick and patronising.

The Team undoubtedly discussed with many people the crucial issue of professional clinical autonomy, and the extent to which that does or does not shape the general management task in the NHS. Roy Griffiths and his colleagues apparently concluded that in essence the NHS was no different in this regard than any other organization containing substantial professional components within it, such as large professional partnerships. We believe that they underestimated the problems posed by the need to meld the key professional groups - particularly medical and nursing - into general management. Each group has its own tasks, skills,

discipline and organization. The current management arrangements (whatever their faults) recognise these differences and seek to cope with them through representation of profressional groups within the management structure. As Patricia Day and Rudolf Klein have well identified (1) the Griffiths' model differs fundamentally and in effect makes the resolution of professional differences a task for general managers. That is an approach taken in health services in several parts of the world (and, incidentally, in many private sector health organizations). What nobody should assume, however, is that that actually alters the fundamental need to understand, work with, and gain trust from the health professions at every general management level in any health system.

Our own impression of the state of management in the NHS and the DHSS - coming, as we have done, like Roy Griffiths and his colleagues from outside the NHS - is that there are larger and more subtle difficulties than the Inquiry Team's report recognises. Nevertheless, as we have already said, the report's critique is useful and suggestive in two particular ways. It seems to us absolutely right in calling attention to the lack of awareness of consumer views; and it is largely correct in saying that from DHSS downwards the management function behaves as though it is content with keeping the Service together somehow from day to day. Both those criticisms have substantial elements of truth and to raise performance in these respects will be enormously worthwhile.

Finally in this overview of the report, the Griffiths Team underestimates just how good the National Health Service actually is. Surprisingly enough this is even true of

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(1) Patricia Day and Rudolf Klein "The mobilisation of consent versus the management of conflict: decoding the Griffiths report"
British Medical Journal 10 December 1983

its management, when compared with other systems. Individual hospitals may not be as well run as in the private sector or North America, but the system as a whole is better adjusted to the key management task of providing value for money on a basis that is moderately fair to all, than any other health system in the world. In responding to Roy Griffiths' critique we should recognise that strength and build upon it.

THE NATIONAL LEVEL

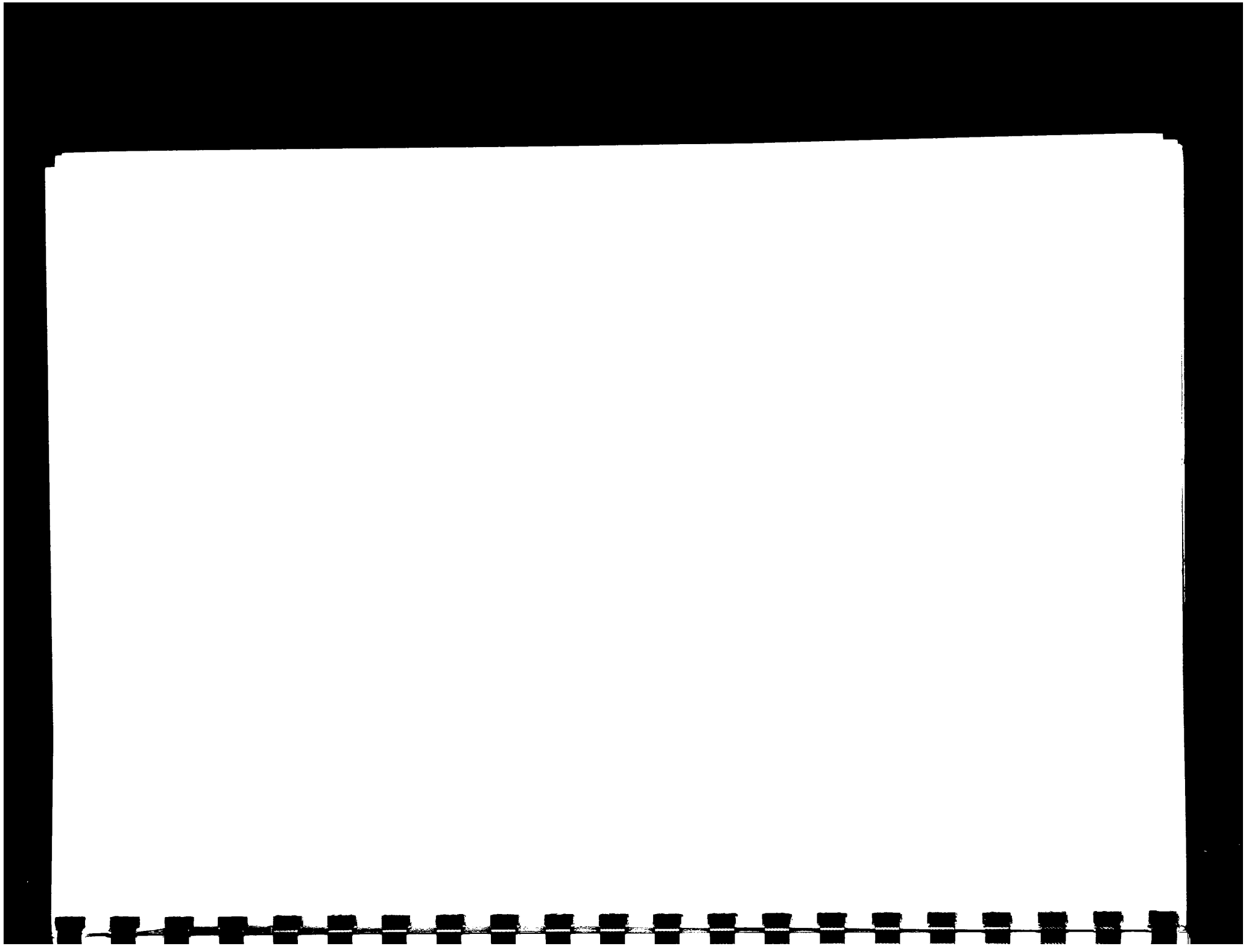
The Supervisory Board, chaired by the Secretary of State, is not a particularly radical concept. The NHS Management Board is. Here the Department's accompanying notes (sent by Mr Fowler to RHA and DHA Chairmen on 25 October 1983) are grossly misleading. If the Management Board means anything, then it must reshape radically the principal relationships at national level. The Director General must be accountable to the Secretary of State (and through him to Parliament and the nation) for the performance of the National Health Service, within the broad framework of legislation, policy guidelines and financial allocations laid down by Government. It follows that the relationship between, for example, Regional Chairmen and the Secretary of State will change. They will no doubt continue to have direct access to him, but the test will come when any Chairman seeks to "appeal against" a decision of the Director General. Similarly the professions will, in many instances, have to do business with the Director General. The Secretary of State will have to be scrupulous not to intervene in the operational management of the National Health Service, however much he may be tempted to do so. The idea of the Management Board also implies a major reassessment of the working and role of some aspects of the DHSS. The new arrangements will only work for good if space is created in which the Management Board can in

truth manage, and can in turn create space for the health authorities to do so. The means far less intervention in detail by Ministers, far less direction by the Department, and far more coherent, sustained leadership by the Director General.

The role of the Management Board is summarised in the Inquiry Team's Report (Para 3) as being "to plan implementation of the policies approved by the Supervisory Board; to give leadership to the management of the NHS; to control performance; and to achieve consistency and drive over the long term." A fundamental task, as we have already implied, will be to create space, opportunity and incentives for managerial growth in the National Health Service. The Board must also redress the balance between short-term directives to the Service (of which there is a surfeit) and sustained concern with the medium and long-term (of which there has been too little).

The Board will need to grapple constructively with the issue of centralisation versus decentralisation, which is as old as the Service itself. It must be able to sponsor innovation; to encourage Regions and Districts to try imaginatively different approaches and compare results; and to emphasise and develop facets of management, such as the assessment of quality of service and of consumer views, in which the NHS is weak. It will have to have a strategy not only for "implementing Griffiths" in the broadest sense, but for sustaining and developing the National Health Service as a whole.

The Management Board is going to have to earn the respect of the National Health Service, while retaining the confidence of the Secretary of State. Its relationships



with the Service must certainly not be directing and controlling in any outdated text-book sense. For example, it will constantly need to encourage, enable and protect, at the same time as guiding, examining and calling to account.

The key figure, obviously enough, will be the Director General. If he is anyone of less than outstanding calibre, or lacks dedication to the National Health Service, the whole idea of a Management Board is much better scrapped. If he comes to the job knowing little about health care, then he is going to have to learn fast, and demonstrate that he is doing so without arrogance.

Roy Griffiths and his colleagues have proposed six other functions within the Management Board (namely personnel, finance, procurement, property, scientific and high technology management and service planning). We do not quarrel with this list, except that all the functions need clearer definition and some development, particularly the last two. Thought must also be given to where suitable recruits can be found, and to the building of the Board as a corporate whole, including within it a balance not only of functions, but of skills and experience, and of executive and non-executive responsibilities.

There must from the start be a balance and comprehensiveness to the way the Board sees its role. Equally it must exercise self-discipline in selecting what it will do, and in what order. For example, it might well decide to move (say) on the personnel function first, even though that meant other members of the Board restraining themselves for the time being. The Board has got to build a track-record of success, which it will not do if it tries to do too much too quickly. Moreover the National Health Service

must have clarity and stability of direction, not another spate of stimuli that lack overall coherence.

Relations with the Secretary of State

The relationship between the Director General and the Secretary of State is always going to be crucial in the Griffiths model - most of all, perhaps, in the early years, until a stable and successful pattern develops. The Director General will have to be responsive to political realities, and must retain the Secretary of State's total confidence, while concentrating on his own particular task of providing overall leadership for an organization of a million people.

For his part, the Secretary of State is going to be in an especially difficult position initially, in having to hold the Service and the professions more at arms length than in the past, to give the Management Board the space to prove itself. He will be investing in the Board collectively and individually, in order to achieve better management of the NHS in the longer term.

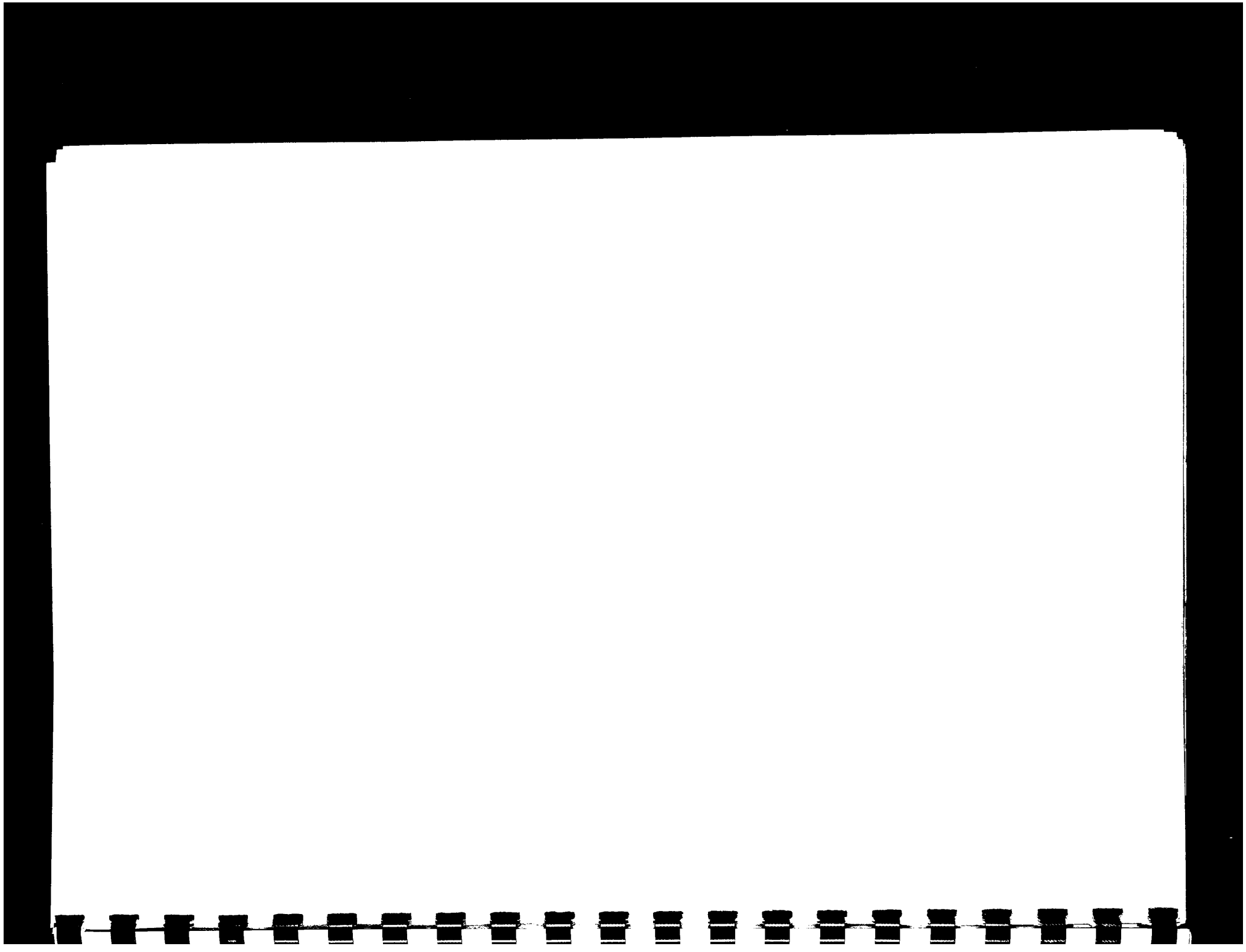
It follows that the Secretary of State will need to be able to justify his "hands-off" stance, to lobbyists and critics within the NHS, and to the public more broadly. This calls for a very clear, if informal, "contract" between the Secretary of State and the Management Board about the Board's responsibilities, aims and mode of operation. Moreover this understanding is not simply a private matter: it has to be explained and justified more publicly than that. The Secretary of State will also need from the Management Board the regular, reliable and up-to-date information on performance without which he cannot possibly sustain a "hands-off" position for long.

Relations with Parliament

The establishment of a Management Board will not, as we see it, alter the need for parliamentary scrutiny, nor its principal modes. It should indeed offer the opportunity to make scrutiny more useful. The Public Accounts Committee has been concerned that the NHS is largely unmanaged by the Department of Health, and has criticised the lack of information available to it, and the weakness of many of the management systems within the Service. The Social Services Committee has drawn attention to the lack of coherent strategy, or of the intelligence (in the sense of information) on which a strategy could sensibly be based. The Management Board will have to demonstrate that it can respond to such criticisms better than the Department was able to do.

Parliamentary questions provide an important means of exercising oversight, and they will undoubtedly continue. Part of the "contract" between the Secretary of State and the Management Board is going to have to cover the way in which these are answered, since Parliament will certainly not be satisfied unless it knows that questions are dealt with scrupulously, and that lessons are learned from them, and action taken when appropriate.

In addition, more systematic modes of exercising oversight need to be developed - on the aims and strategies being pursued by the NHS, on resource allocation and use, on priorities, and on the quality of services actually given. A casual approach to these matters simply leads to frustration on the part of MPs, defensiveness on the part of the bureaucracy, and no effective oversight over the way the National Health Service is run. An encouraging aspect of the Griffiths proposals is that it would become vital for the Supervisory Board that more systematic and effective approaches to monitoring be developed, and that it



should be able to share the results with Parliament.

Relations with the Department

The DHSS, on the health side, has had to combine the functions that are common to any Department of State (advising its Ministers, formulating legislation and national policy, monitoring services and so on) with the management of an enormous and highly complex service. While under the Griffiths proposals the Management Board and its support staff will be within the framework of the Department, it is important to distinguish these two sides of the Department's activity and to imagine how they will continue. Clearly the first of its functions, that of political administration, is undisturbed by the Griffiths proposals. However, it is important that the second function, that broadly of the corporate management of the NHS, be related directly to the establishment of the Management Board. This has fundamental implications for the role, organization, staffing and modes of operation of large parts of the Department. But if the challenge of clarifying the responsibility and lines of management of these departmental activities is ducked then the legacy for the Management Board and the NHS is unenviable. A shift of this kind has been foreshadowed, some years ago, by the Three Chairmen's Review [2], and will need to be considered once again and carried through into action. Some activities, such as those of Regional Liaison, would need to be incorporated into the support staff of the Management Board. In other cases, such as the complex structure of professional advice (medical, nursing, works), more hybrid solutions may be appropriate. Some of their personnel would be necessary to sustain the corporate function of the Management Board. Others more properly would be located at Region, since it is

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(2) Regional Chairmen's Enquiry into the Working of the DHSS in Relation to Regional Health Authorities (1976)

crucial to the success of the Management Board that its staff remains small and clearly relevant to the conduct of its corporate function. To achieve this it must delegate with greater determination and clarity of role than the Department has been able to do. (This incidentally does not imply criticism of individual Civil Servants who could not be expected to reform their activities in the absence of some basic reshaping of the central management structure, such as is now proposed). Furthermore, some of the people and skills most appropriate to the corporate level may be found amongst those currently in the NHS. The reallocation of work and personnel to corporate and Regional levels should be based on suitability not merely on their current location.

Relations with the Regional Health Authorities

It is inevitable and right that the Chairmen of RHAs should continue to be responsible to the Secretary of State, and continue to have direct personal access to him. It is equally inevitable that if these links are used to undermine the Director General the latter's role will be unsustainable.

To this paradox there is no simple, structural solution. It will require a strong sense of collective purpose and trust among the individuals concerned, and a clear demonstration from the start that the Director General is going to use his authority in substantial measure to allow and encourage RHAs to manage the affairs of their Regions. He will indeed call them to account, but in the clear understanding that he will also give them the elbow-room to do their jobs.

THE DISTRICT AND UNIT LEVELS

Viewed from the District level there is a sense in which the Griffiths report offers a real opportunity. If the Management Board conceives of its role and its duties in the way that we have outlined above, substantial discretion could be delegated to District to analyse its managerial needs and resources and to shape its own strategic approach to the management of its affairs. Such an approach would stimulate innovation in place of what has been a monolithic and often pedestrian approach to management structures and practice. The imposition by the Secretary of State of specific requirements for management arrangements would have the opposite effect.

The most important consideration for Districts is the need to relate and take a coherent view of the several elements identified by Griffiths, namely general management, responsibility at unit level, clinical involvement, concern with effectiveness, budgeting and consumer satisfaction. It is easy, and misleading, to separate this set of issues into specific prescriptions (eg the appointment of general managers) and technical questions of management systems (eg clinical budgeting). The problems of managing a District can never be resolved merely by structural change or by technical innovations. What is required is a strategy for change of attitude and understandings, and for the development of processes within the organisation. We agree with Griffiths that the key to this is the identification and fostering of a general management role, with the responsibility to design and accomplish change throughout the organization. Once again one cannot advance on all fronts at the same time. Strategies for change must be discriminating but coherent and,

must embrace a consistent sense of purpose.

However, if the concept of general management is so central, we must be clear of its meaning and the forms it might take. Griffiths restricts the idea unnecessarily by focussing on the general manager as an individual rather than on general management as a function in the organization. Recognition of 'general management' as the responsibility of the group of senior managers, allows us to avoid the polarisation of individual and team which many have been read into Griffiths' recommendations. Senior management in the modern world is about the effective working of teams, though, of course, not necessarily involving the 'consensus' relationship within the team which characterises the NHS.

A clear appreciation of this point might enable Districts to avoid the most likely, and unfortunately the most destructive, pathology of the general management idea, namely the loading of all responsibility onto a 'superman' figure and the withdrawal of other senior managers into a more restricted role than they currently fill. This illustrates the importance of thinking through the nature of senior management as a whole as a basis for determining the role of a general manager or CEO. One of us[3] has suggested three possible models:

- nominal - in which one of the existing team is designated as general manager while retaining his existing responsibilities
- supernumary - in which one of the team is appointed to a new post of general manager and is replaced in his old post in the DMT which remains structured as before
- executive board - in which the DMT is changed into an

(3) Tom Evans "Griffiths - The Right Prescription?" CIPFA-AHST 1983

executive board with a CEO and a distribution of responsibilities which reflect management functions rather than professional representation.

In our view, the nominal general manager would be a disaster. We would like to see an evolution from the supernumary general manager to the executive board concept. In every model there is also the crucial question - unaddressed by Griffiths - of how the general management function dovetails with professional structures.

Whatever model is adopted, the important issue is the development of a coherent senior management at District which can plan, guide and implement strategies for changes in attitudes, understandings, involvements and processes throughout the organization. This would give rise to a more purposive and coherent management style embracing units, clinical involvement, budgeting, and so on. We do not believe that these desirable changes could be approached usefully by prescriptions as to unit management, or budgeting mechanisms, or whatever else, from outside the District. Of course, the District managers should be held to account for their performance in achieving real progress in these dimensions.

Though we would emphasise the need for other changes within the District to be the product of an organizational strategy formulated by its senior managers, it may be helpful to offer some comments on some of the associated issues raised by Griffiths.

The King's Fund has recently published a book [4] which discusses approaches to unit management in more detail than we could offer here. In some Districts real progress has already been made towards establishing the unit level

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(4) Iden Wickings (ed) Effective Unit Management (King Edward's Hospital Fund for London, 1983)

as the major discretionary tier of management, not only in the control of operational activity, but also in formulating strategies for change in the means of providing given services, in assessing effectiveness and, potentially, in the control of quality of service. Regrettably this is by no means universally true, but where units are developing momentum it would be tragic if the implementation of Griffiths were to negate it. Elsewhere the stimulus of Griffiths must be used to put pressure on those DMTs which are still controlling all activities within their Districts on a tight rein. Once again this leads us to support the argument for discriminating implementation, in which the needs and potential of the local situation fashion the pace and direction of change.

Of course, discriminating implementation leaves open the possibility of some Districts dragging their heels. To overcome this, Regions should be charged with the responsibility to audit, through their Review mechanism, Districts' analyses of their local situation, their plans for implementation of the Griffiths' principles, and their progress over time towards achievement of those plans.

The involvement of clinicians in management and their accountability for their use of resources is a central element in the managerial revolution in the NHS which could be achieved through the sensible implementation of these proposals. However, the involvement of doctors must not simply be tied to the development of budgeting systems. There is a tendency to think of clinical budgeting as though the challenges were primarily technical, and hence as though what is needed is primarily accountancy tricks of cost recording, cost apportionment or setting internal prices. On the contrary, the greater task is that of persuading and accustoming doctors to

[redacted]

managing resources consciously and deliberately rather than unconsciously, and the development of social processes through which their activities and uses of resources can be evaluated. While there is undeniably growing interest in these issues, the subtleties of successful practice have not yet been widely demonstrated. Moreover, clinical involvement in budgeting cannot be sustained in the long term unless it grows into the areas of budget setting, planning and priorities. All of this will take time, trust, and a great deal of energy. What we should be looking for in the first instance is the strategies of senior management for promoting the involvement of doctors and other professionals in resource management and planning.

Again the emphasis is on the coherence and determination of senior managers in effecting change rather than on specific prescriptions. We ought to expect such coherence and determination, and be prepared to monitor the achievement of change against agreed targets. The capacity of District senior managers to think these issues through, to produce strategies for change and to be held accountable for the achievement of those strategies, would only be inhibited by initial directives from above about unit management, specific prescriptions for budgeting arrangements and so on. The other side of the same coin is that, given the responsibility to plan and manage change in the District, there will be no acceptable excuses for non-achievement.

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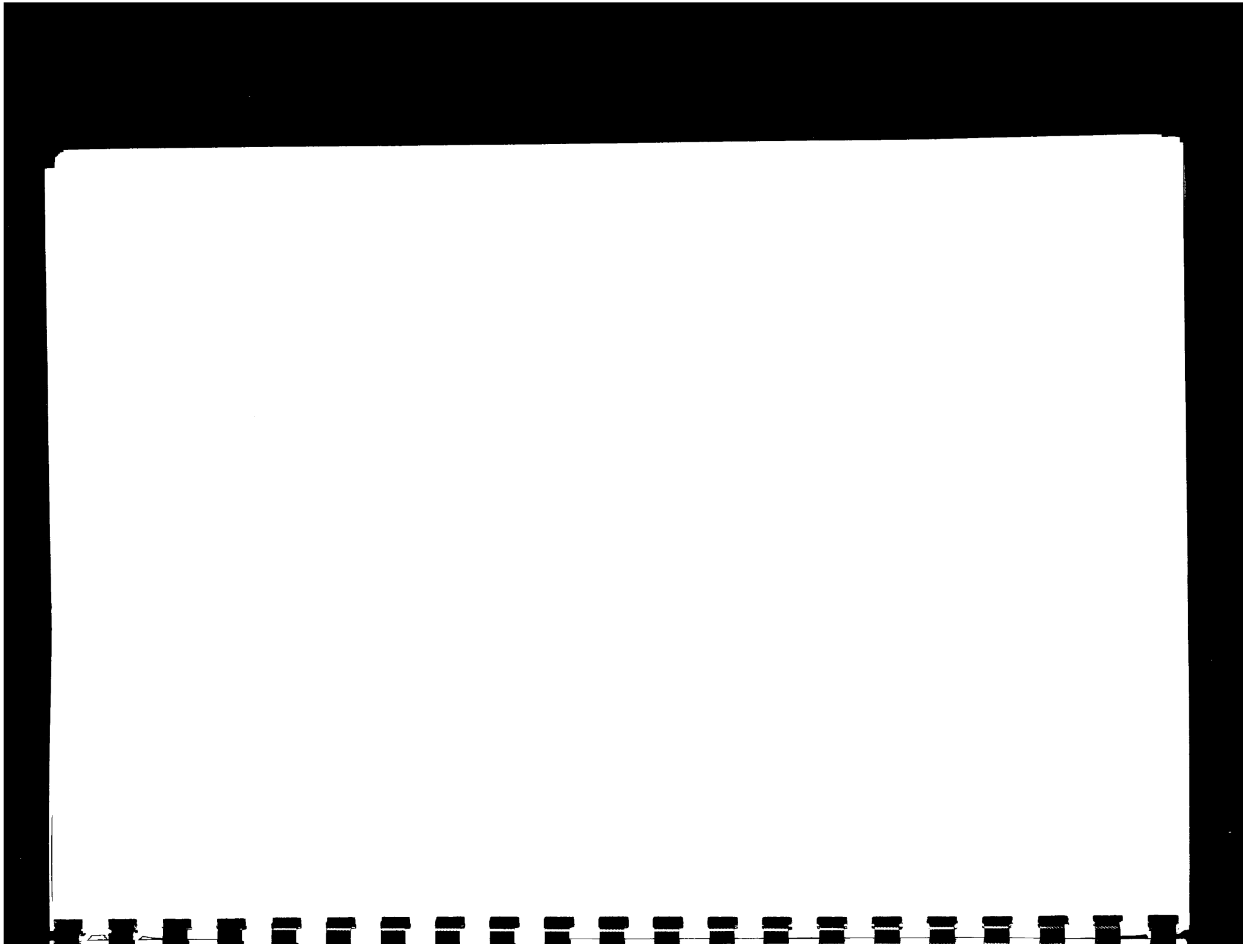
By this time the Select Committee will be only too well aware of the strong reactions aroused by the Griffiths' Report. Those in favour of the Report and those against share at least one thing in common, which is a tendency to take it far too literally. Its greatest strength is,

we believe, as a diagnostic critique. If that critique is accepted, then the responsibility for responding constructively and successfully lies not with Griffiths but with those who hold leadership positions in the Department and the National Health Service.

In the short term there are, we think, two chief priorities. The first is to choose an outstanding Director General and get the Management Board off to a successful start. The second is NOT to inflict upon the NHS a standard, "charts and boxes" appointment of General Managers. Roy Griffiths and his team have provided a report that could ultimately bring great benefit to those served by the NHS and those who work within it - provided it is used well, not followed slavishly.

Tom Evans.

Robert Maxwell

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