TALKING POINT

Griffiths inquiry: a personal perspective

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One frustration of writing a personal view of the Griffiths report is that there is no actual report as such. Mr Roy Griffiths himself, in his letter to the Secretary of State of 6 October 1983, indicated, "that we had not been asked to prepare a report, but that we should go straight for recommendations on management action."¹

Griffiths refers to the results of his inquiry as a letter in two parts, "first, the recommendations which are self-standing and provide the basis for the necessary action; the second part makes some general observations and sets out the reasoning behind the recommendations."¹ These general observations are very limited and can in no sense be regarded as an analysis from which his recommendations may be logically deduced. For example, the recommendation to appoint general managers, which is arguably the most important and the most contentious of all, follows from a rejection of consensus management teams that is based not on analysis but on a simple statement of the popular cliché that they lead to "lowest common denominator decisions." The results of this inquiry, therefore, are a set of quite dramatic recommendations coupled with a few tantalising glimpses of the reasoning behind them, and I can sympathise with Day and Klein in their constant references to having to decode Griffiths.²

Mr Griffiths is a successful businessman who wants to see action as a result of the time he has invested in the NHS. What better way of achieving that action than a fairly bold statement of recommendations, coupled with strong pressure for speedy decisions because "the Health Service can ill afford to indulge in any lengthy self-imposed Hamlet-like soliloquy as a precursor or alternative to the required action."¹ Griffiths has judged that the more we know of his reasons the easier it will be to criticise the recommendations and that the more the recommendations are criticised the less likely is the action. I am sure that in that particular analysis of the NHS he was very much on target. Unfortunately, this leaves reviewers of his famous

letter with very real problems. Either they interpret the few clues that are provided or they supply their own reasoning, which carries the temptation to argue backwards from predetermined conclusions.

Two key issues

In this paper I have accepted the Secretary of State's view that the two key issues are those of the general manager and the involvement of clinicians in management, and I have added a section on the personnel director. Within that framework I will attempt to give a personal view on the decoding of Griffiths.

Griffiths argues that a more effective management process would allow the same level of care to be delivered at lower cost or a superior level of care to be delivered for the same cost. He suggests that the present modest level of cost improvements required by the Secretary of State could be achieved without any serious damage to the level of service and that to argue the contrary is almost a denial of the management process. Arguing that at present change is not carried through with the necessary speed and vigour, Griffiths claims that the labyrinthine consultation processes of the NHS act as a powerful disincentive to the initiators of change. One does not have to disagree with this analysis of current failings within the NHS to be sceptical of the remedy of general managers. Ultimately, the Secretary of State has to judge what he believes general managers will achieve in practice, measure this against alternative courses of action, and judge whether the potential achievements of this particular remedy are worth the inevitable cost. The inquiry is not much help in this respect, for it virtually denies the existence of a cost and is completely silent on the question of alternatives.

Like all newcomers to the health service, Griffiths is dismissive of the differences between the NHS and private industry, arguing that they can be greatly overstated. This is a view that all newcomers eventually modify in a greater or lesser period of time, depending on their personal learning curve, and it accounts for the frustrations of many of the new chairmen of district health authorities.

The NHS does not have a simple pyramidal structure with one unchallenged source of leadership, whether the top of the pyramid is seen as parliament, the Secretary of State, or the district management team. Such a structure could not be achieved unless the government overturned the concordat agreed with the medical profession when the NHS was established, and even then there would be other major obstacles. In fairness, Griffiths is not suggesting such a step, and yet it is his failure to recognise the importance of clinical freedom and his dismissive attitude to the question of where consultants' contracts are held that makes me doubt his remedy of general managers. The medical profession did not fight long and hard to achieve contracts at regional level because the outcome "did not matter."¹ Every administrator and

nurse manager has to operate within a framework that is constrained by the existence of clinical freedom and in which the constraints change at least as frequently as do the consultants. Clinical freedom creates a political dimension that is outside any normal managerial framework.

Infinite demand means rationing

If we accept that the demand for health care is infinite then all health care systems are methods of rationing its delivery. A state system that is provided out of taxation attempts to ration by need rather than price and results in a queue—or, more correctly, a series of queues—for different forms of treatment. As quickly as long established queues are reduced medical science opens up new ones. When queues are growing there is political pressure on the government to increase the funding for health care, and this pressure grows over time because of society's growing reluctance to accept queues anyway.

It is natural for governments to seek to reduce this pressure by calling for greater efficiency in the use of existing resources, but to a great extent success depends on the reaction of consultants. Pound for pound an insistence on the highest clinical standards will increase the queue and increase the political pressure on the government: if conditions less than those necessary for the highest clinical standards are accepted the queue becomes less of an embarrassment. I must emphasise that in talking about clinical standards I refer to matters directly under the control of the clinician: the extent of the demand placed on diagnostic departments, the type and duration of nursing care required before discharge, and the preparedness or otherwise to continue operating in isolated theatres in small hospitals without the space and facilities to practise safe, modern surgery, etc.

In all these matters clinical freedom allows consultants to make decisions that directly affect the consumption of resources and the size of the queue. Some consultants can and do pursue clinical excellence knowing that the growth of the queue will put greater political pressure on the government to increase resources for health care. Measured against the resource implications of clinical freedom, the savings achievable through more effective management of non-professional staff are modest, *which is not to say that it is not vital to achieve those savings.*

There could be an interesting debate on whether we should even be trying to persuade consultants to make their clinical demands more modest, but for the sake of the debate about general managers I will assume that we are. Under the rules of clinical freedom consultants have to be persuaded to limit their demands on diagnostic services and nursing services and to continue using antiquated theatres if the queue is to be controlled. The key question for the Secretary of State, therefore, is whether the appointment of general managers at regional, district, and

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unit levels will make this task easier or more difficult.

Key flaw in general management concept

For me the key flaw in the general management concept as proposed by Griffiths is that in relation to clinical freedom the general manager will be something of a toothless tiger, who will be unable to live up to the expectations generated. There is a danger that we will end up creating a title without authority. If clinical freedom is to be reduced to, say, the level at which it exists in many hospitals in the United States consultants' contracts should be held at district with tenure limited to three or five years, renewable only after assessment of clinical performance in relation to resources used. If a general manager is equipped with these tools he could achieve much that would gladden the heart of the Secretary of State. If general managers are established without these tools it will become increasingly obvious that they are necessary, and that in turn will strengthen the demand for them from outside the ranks of the medical profession.

I am sceptical about giving general managers these tools simply because the long and divisive conflict between the administrative and medical professions that will result from direct or indirect attempts to curb clinical freedom will result neither in improved medical care nor in the cheapness that is sought by the government. Griffiths either misunderstood the implications of clinical freedom or he chose to ignore them because of the more immediate necessity of securing medical support for general managers. If consultants can only be moved by persuasion and cannot be moved by instruction then an effective form of consensus management offers a better hope than a toothless tiger.

Those who are unhappy with this analysis may cite Griffiths to demonstrate that his quoted examples of advantages from the appointment of general managers lay outside the immediate issues affected by clinical freedom. Increased efficiency is needed in the use of non-professional resources, and the service has not yet done as much as it should. But these are matters already within the direct managerial control of efficient district and unit administrators. Giving district administrators the title of general managers, the responsibility to break deadlock on consensus issues, and the responsibility to follow through decisions until objectives have been achieved will not enhance their existing authority over non-professional staff. If, for example, ancillary staff are being inefficiently used within the framework of existing national agreements the district administrator is personally responsible for that failure now, and making him general manager will not change that position.

With regard to professional resources, there is a well known concept—strongly championed at Brunel University—that it is possible to divide managerial from professional decision making in health care. If this is valid the administrator general manager could be given final control of managerial decision making in all branches of health care including medicine and nursing, leaving doctors and nurses free to make and implement professional decisions within their respective hierarchies or com-

mittees. If you believe this then the general manager concept makes much more sense. If, like me, you believe that this concept is far less valid in reality and that the exercise of

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professional judgment, if unrestricted, subordinates many "managerial" decisions you must also accept that the attempt to separate the two types of decision making as part of a scheme to introduce general managers will be messy. It will cause endless conflict and friction as nurse managers and consultants attempt to test their degree of professional freedom, and the day to day solutions will not be common throughout the service because of the impact of personalities on local outcomes.

I find it hard to give a judgment on general managers. At one level this is a crude political weapon to start the containment of clinical freedom from which will stem greater cost effectiveness in the delivery of health care. How can I be against greater cost effectiveness? At another, more public, level there is the veneer of managerial philosophy: the Brunel school and the concept of the separation of managerial and professional decision making—decked out in Griffiths with some flattery of the medical profession and aimed at securing short term medical support for the concept. The decision to introduce general managers may become as important in the medical calendar as the concordat with Aneurin Bevan, but with far less satisfactory results for the profession. It is for this reason that my own reaction to general managers is so divided.

Finally, the Secretary of State must be aware that the early appointment of general managers creates a major problem of timing. More effective budgeting arrangements are required including understandable and manageable clinical budgets. More effective appraisal techniques, both of clinical performance and of general managerial efficiency, are also needed. If these and similar tools are created before the appointment of general managers there will at least be a meaningful scale against which to measure their performance, and the very existence of these tools will give some credibility to the concept. What we are in danger of doing, however, is appointing general managers before they have the tools and we have the evaluation techniques. This is a recipe for the greatest conflict and the least achievement.

Management budgets

The Griffiths proposals on the management of budgets have been much more strongly supported and rightly so. Whether an individual budget for each clinician can be achieved remains to be seen, and I hear that the Griffiths experiments are meeting with difficulty, but effective budgetary responsibility must be brought as near to the individual clinician as possible. The problem is one not of commitment but of finding the most appropriate method, and I hope that the Secretary of State will vigorously support this search. Having said that, I am worried by the reasons put forward by Griffiths to justify investment in this task. He clearly believes that once doctors know the financial implications of their decisions they will, they must, "accept the management responsibility which goes with clinical freedom." A lot will be achieved, but we must not overstate the likely gains. If after a particular procedure the first surgeon requires the patient to be mobilised after 24 hours and sent home within five days and the second requires no mobilisation for five days and no discharge in under 10 days, I am not convinced that the latter will change his clinical practice merely on being informed of the cost differences per patient between himself and his colleague. The existence of accurate financial information is merely one step on the long trail of persuasion, and there are those clinicians who will see the greater investment of resources per patient merely as an improvement in the quality of clinical care and something intrinsically desirable.

I am also concerned about the implication in the Griffiths letter that strengthening unit management is synonymous with strengthening the cogwheel medical advisory machinery.³ The 1982 reorganisation, where it has been effectively carried out, has created some interesting management tensions between unit management teams and cogwheel executives.⁴ The key issue has been the ability or otherwise of unit consultants to take and implement decisions through unit management rather than accept the discipline of the medical executive committee. The purchase of medical equipment out of savings, the allocation or withdrawal of junior doctors' units of medical time, the allocation of theatre time, etc, are all matters that have created tension. That tension will continue to grow with the strengthening of unit and the weakening of detailed control at district level. I support Griffiths in urging the continuation of this trend, but I have no illusions about its implications for cogwheel, the most important of which is a diminution in the power and influence of the medical executive committee unless it can retain its authority by enrolling and working with the medical members of unit management teams.

Personnel management

The recommendations of Griffiths in personnel management and industrial relations and particularly the appointment of a national personnel director from outside the NHS or the Department of Health and Social Security are to be welcomed. With or without the other Griffiths recommendations, it is clear that the health service is about to enter a period of greater change and greater conflict in labour management, and a strengthened personnel function that is dynamic and committed to

achieving management objectives in changing the traditional character of labour relations is essential. The appointment of a national personnel director who shares these objectives and provides a national focus for professional leadership will do much to boost the morale and the status of the personnel function within the service.

The Secretary of State's decision to establish manpower controls, his directives on efficiency savings, and the requirement of competitive tendering, not to mention the reformed and revitalised management side of the Whitley Council's negotiating machinery, all create a challenge for the personnel function within the districts, and to couple this with the appointment of a national personnel director cannot but help the service to achieve its new objectives.

One of the personnel director's responsibilities will be to submit evidence to the pay review bodies, and I will be interested to see how the personnel director interprets this responsibility. Until recently the views of health authorities have tended to carry less weight in the final Civil Service submissions, and this change is likely to lead to greater prominence being given to the wishes of health authorities. In the longer term this could have considerable implications for the recommendations on pay levels, but a lot will depend on the formal arrangements, still to be determined, for allowing various interested parties to contribute to the final submission. I assume that the ultimate political veto will still be retained and that civil servants will still continue to act as the watchdog on the Secretary of State's behalf.

Apprehensive for the future

This commentary on Griffiths has concentrated on three key issues and has been sceptical of only one, the appointment of general managers. Had I commented on every part of the Griffiths letter the balance would have been even more favourable. I am particularly impressed with his view of the ordering of authority business and his urging of greater personal incentives coupled with a weakening of job security for senior managers in all disciplines. Despite that, I feel sad about the proposals and apprehensive for the future of the service. I sense a mood in some quarters of the NHS for a more autocratic style of management, but with our usual penchant for half heartedness and compromise we will deny the tools and fail to insist that our general managers may and often should be stood down. My personal plea to the Secretary of State is therefore either to insist on the appointment of general managers in every district with *real* powers to manage *all* resources (and a contract that will permit their dismissal from the service for failure to achieve that district's targets) or to avoid general managers and achieve most of the Griffiths objectives through the existing structure. Much has been achieved since the 1982 reorganisation in the creation of unit management teams, the establishment of unit budgets, and the handing down of extensive powers of virement. The Secretary of State could require the NHS to take this further, in line with Griffiths, and could ask regional health authorities to push those districts that have dragged their feet on devolution. Much can be achieved this way by a determined

Secretary of State as recent manpower and competitive tendering initiatives have shown.

The worst outcome for the NHS would be for the Secretary of State to be half hearted and to allow districts a choice on whether or not to appoint general managers. Effective consensus management as we know it cannot properly survive the option to appoint general managers. If some districts appoint and some do not consensus team relations in those that do not will inevitably suffer and so will the quality of consensus management. A district administrator not appointed as a general manager will regard it as a slight on his professional competence and will either seek to reverse the decision or look for general manager posts elsewhere. Good administrators will inevitably strive to join an exclusive general manager club. Small districts will be tempted to offer able administrators general managership as an inducement, and that in turn will create pressure to appoint in the larger districts. This is not a prospect that would be conducive to the effective management of NHS resources. Certainly it is not the easy way out of the choice on general managers, however much it might seem so.

References

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- ² Day R, Klein R. Two views on the Griffiths report. The mobilisation of consent versus the management of conflict: decoding the Griffiths report. *Br Med J* 1983;**287**:1813-8.
- ³ Ministry of Health. *The first report of the joint working party on the organisation of medical work in hospitals*. London: Ministry of Health, 1968. (Cogwheel report.)
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Deputising services

Minister offers talks on restrictions

The Minister of State for Health, Mr Kenneth Clarke, has replied to Dr John Ball's criticism of the government's proposals for restricting the use of deputising services. The letter from Dr Ball, chairman of the General Medical Services Committee, was published on 7 January (p 89). Mr Clarke's letter is reproduced here.

"Thank you for your letter of 22 December about deputising services for general medical practice. I very much welcome the GMSC's desire to improve the quality of deputising services, and the initiatives which you have taken to that end. There is clearly a wide measure of agreement between us on this aspect of the problem and I look forward to receiving your committee's comments on the specific proposals which we have made.

"You identify two matters which are causing you and your colleagues particular concern. I will deal first with your second point: the question of consultation. The release of draft guidance to a range of interested bodies for

comment is a long established consultative procedure which has worked well. Its use in this case was certainly not an attempt to preempt anyone's response to our proposals. I have chosen to consult widely because this is clearly a subject of great public importance and wide concern and I am anxious to canvass a broad spectrum of opinion. I shall, of course, pay particular attention to the views of the GMSC and of the medical profession generally. It was for this reason that I wrote to you personally inviting your comments on our proposals.

"On the question of extensive use of deputising services by family doctors, I am bound to say that in some areas of the country some practitioners have come to rely excessively on this method of providing care to their patients. The replies to my letter of 26 July to family practitioner committee chairmen indicated that there are some committees which allow unrestricted use at night and weekends, despite clear guidance to the contrary. I do not believe that very extensive use of this kind is consistent either with what patients want and have a right to expect or with the type of general practice which governments and the profession have for many years striven to develop.

Doctors cannot remain on call continuously

"I do of course accept that doctors cannot be expected to remain on call continuously, although a minority do in fact choose to do so. On the other hand a certain amount of work during unsocial hours is, as you will agree, an inevitable part of the life of a family doctor. More than half of all doctors arrange their affairs so that they do not use a deputising service at all. Our proposals are designed to strike a balance between the reasonable expectations of patients and doctors, taking account of what is clearly found to be feasible and acceptable by a majority of doctors. The proposals are, however, flexible and recognise the need to take account of particular local circumstances and the problems of individual doctors and practices.

"What we are suggesting involves no amendment to the regulations or terms of service. It is simply intended to guide family practitioner committees in the exercise of the powers which they already have under paragraph 19 of the terms of service. I really do not think that this represents any challenge to independent contractor status, which it is certainly not my intention to change.

"Advice on what represents excessive use was requested by a number of respondents to my July letter, and this is what paragraph 4 of the draft circular is intended to clarify. If you and your colleagues regard the proposals as unduly restrictive, even allowing for the element of flexibility which they include, I shall be happy to consider any alternative proposals, and the arguments in support of them, when you come to comment on the document as a whole.

"I know you will share my hope that in the debate about the area of disagreement we should not lose sight of the basic objectives which we have in common. There is clearly widespread public concern about deputising services, and I believe that we must act promptly together to restore public confidence in a service which is both necessary and can, if effectively regulated, work well and in the interests of patients and doctors alike."