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UNIT MANAGEMENT IN CONTEXT

King's Fund Centre
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A project paper compiled as a result of workshops and Conferences held at the King's Fund College and King's Fund Centre, February 1980 - February 1982

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FOREWORD

Unit management has been a topic for increasingly urgent debate ever since the Government issued circular HC 80(8) announcing the ground rules for the 1982 reorganisation of the National Health Service. In the King's Fund we responded by arranging workshops, seminars and conferences to help people explore the topic: we did not have any preconceived solutions but had no doubt about its importance. Virtually all these occasions were heavily oversubscribed and we had to organise additional dates. The demand from the NHS was overwhelming.

John Ranken's project paper synthesises the material from this series of workshops and conferences, drawing on the work of key participants. Much of the apparent urgency may shortly evaporate, when DHAs have defined their initial unit structures. We are nevertheless publishing the paper, not merely for its immediate relevance but because of the directions in which it points.

So far as the immediate questions of structure are concerned, the paper suggests that there are no universal nor perfect solutions. It is all too easy to oversimplify the complicated underlying issues. In truth, however, at least four facets of health services organisation will always need to be held in balance, namely the

institutional
geographic
client group
functional or specialist.

The 1974 reorganisation mistakenly downgraded the first of these. Today the pendulum has swung and the emphasis is heavily on the institutional component. But the other three facets are important also and there will always be some tension among them all.

In settling their unit structures DHAs may find it helpful to consider the following criteria:-

Do the proposals preserve as much flexibility as possible to adjust structures in light of future learning?

Do they fit with the DHAs strategy, in the sense of facilitating and not obstructing the general lines of intended development?

Do they seem workable for all the main professions and for all four of the organisational facets mentioned above (institutional, geographic, client group, functional specialisation)?

Do they make sense in the local context (i.e. do they pass the test of common sense and of minimum unnecessary disruption)?

Do they represent value for money compared with other possible solutions?

Once the initial choices have been made about structures, DHAs will turn their attention to other urgent problems. But that is only the beginning of stronger unit management, not the end. As the project paper indicates, the following questions are at least as important as those of structures:-

How will the units and the district work together in the fields of financial management (chapter 8), personnel management (chapter 6), nursing management (chapter 9), works and other shared functions (chapter 10) and planning and information systems (chapter 5)?

How will the various disciplines work together for management purposes within units (chapter 7)?

What skills will be required, individually and collectively, and how can these be developed (chapter 11)?

Each district should have a broad strategy for tackling these questions and should review progress regularly with units, adjusting policies and procedures in light of experience. This is the idea behind the audit approach briefly described in chapter 11.

The paper also emphasises (in chapter 2) the important implications for district management teams of working with strong management at unit level. The job of strategic management has been grossly neglected in the NHS. There is an opportunity for DMTs to grasp and a need for them to grasp it. In the long run the test of unit management should be what DHAs and DMTs do with their effort and resources, as well as what happens within the units.

R.J.M.

1 INTRODUCTION - CHALLENGES AND OPPORTUNITIES

Reorganisation sets a number of specific objectives to change the structure of the National Health Service. It also offers health authorities an opportunity to think afresh about managerial performance and ways in which health services can better meet local circumstances. When in 1980 the Secretary of State introduced his consultative paper "Patients First" he made the following statement in the Commons:-

'The main purpose of the change is to provide a health service which is better and more efficiently managed.'

This combination of national strategy and opportunity to review local management gives the opportunity for a fresh approach. At the level of the district management team a more strategic style of management may eventually make a more significant new impact on a local health service than the effects likely to be achieved by the more widely publicised concept of stronger unit management.

Reorganisation provides the ideal opportunity to carry through the principle of delegation down to unit and departmental level, and allow chief officers to use their seniority and expertise to effect those organisation changes which may be hard to achieve but are necessary to provide a well-balanced service. The NHS hitherto has been unduly lethargic, or preoccupied with short-term tasks to grapple with many of the more complex but vital tasks necessary to change the face of each community's local health service. Many examples can be cited: inadequate primary care in London, a slow response in improving the provision of services for the mentally handicapped, an uncoordinated approach over the care of the elderly, and half-hearted attempts to develop community and preventive services. These need to become management tasks for DMTs and district health authorities. At unit level the challenge is different. It comprises such things as improving efficiency, monitoring standards, simplifying decision-making processes and carrying out good personnel practice. It requires skills of leadership and administrative coordination, and the principle of delegation must not stop with the director of nursing services and the unit administrator. These are just a few of the issues discussed in this paper.

It is important that operational services in the NHS are well managed. The complexity of this task is well recognised, and there is an increasing recognition that there are no simple solutions. There is a recognition, however, of the need to have some simplification of operational management such that units of management can be clearly identified, that there can be clear cut managerial accountability within them, and that staff can feel that they are working together within a common unit to provide services to their clients in which they can have some pride.

The Grey Book of 1974 stressed the importance of bringing together in a coordinated way three dimensions of organisation, namely:-

- Services to patients or clients
- Professional groups and staff who provide those services
- The places or institutions within which those services are provided.

In 1982, hopefully, there will be an opportunity to produce more cohesive organisations centred on units of management, and for DMTs in taking up their responsibilities for corporate management to play a much more positive role in conceiving, creating and developing effective organisations.

1982 gives much more scope for local initiative in setting up units of management. This is welcomed by many as an opportunity to 'get it right' for their local situation, but it also entails hard thinking about principles of organisational design, managerial systems and working methods. There is a renewed interest in such things as the Brunel work on organisational analysis, the application of organisational development theories, and a search for guidance and ideas on how to cope with the complexities of NHS organisation.

During 1981 there were various conferences, workshops, articles, working papers, statements by professional bodies to supplement the relative lack of central guidance on how to establish new management structures. The King's Fund became involved early in this activity through a series of workshops and conferences, as follows:-

- Workshop for Sector and Unit Administrators
  February 1980
- Workshop on Functional Management
  January 1981
- Workshop on Budgeting and Team Management
  March 1981
- Working Group on Unit Management Structures
  May 1981
- Working Group on District/Unit Relationships
  July 1981
- Five One-Day Seminars on Unit Management
  October 1981 - February 1982

In addition, case studies and training exercises have been developed for use on college courses, concerned with the development of unit

structures and management arrangements. An essential feature of this activity has been the involvement of NHS managers in clarifying problems, seeking solutions and identifying appropriate action to be taken. Much of the activity reflects an 'administrative' outlook, as the first workshops were held in response to a request from the Institute of Health Service Administrators to help to clarify problems being faced by sector and unit administrators and to identify training and development needs associated with those problems. It was felt right that initially administrators should try to sort out some of their own problems, but that increasingly these should be considered in a multidisciplinary context.

This project paper attempts to draw together a number of the issues which have emerged from these discussions and present them to a wider audience. It is important to recognise these issues for what they are - ideas developed and clarified through discussion and debate rather than as a result of detailed research; ideas 'in progress', which means that the discussion needs to continue as units are established and begin to operate; ideas presented almost as 'check lists', by no means exhaustive, to help managers think about their own situations.

Individual contributors to this project paper have been substantially involved in the King's Fund workshops and conferences, and the ideas presented remain their own. There is no attempt to produce a 'King's Fund' solution or definitive answer to many of the issues considered. Our concern has been to stimulate thought rather than to be prescriptive.

Some parts of the Project Paper contain more material than others; where there are gaps it is because issues were not discussed in detail, not that they were felt to be unimportant. It is hoped that this set of papers will be of use mainly during the first year or two of the restructured service as units are established and begin to work. It should be then apparent that there are still many issues to be discussed and initiatives to be taken if units are to fulfil the high hopes which are placed in them.

2 THE DISTRICT ROLE

The structural re-organisation of the NHS is intended to involve minimal "turbulence" and is founded on simple organisational principles. These were detailed in a series of speeches by the shadow secretary of state, Mr Patrick Jenkin, in the two years preceding the 1979 general election. His achievement at that time was gradually to win a broad based consensus within the NHS for his concept of structure, without allowing its framework to be significantly changed or made more complex.

"Patients First", when it was published in 1980, produced reactions ranging from incredulity at its simplicity, compared with the complexities of the 1974 "Grey Book", to grudging respect for the consistency of the format. Its key principles were clearly stated. They included the concept of units of management within districts, to which there was to be maximum delegation of the responsibilities of operational management, and a release from central prescription of management structures. Flexibility was the central theme, though HC(80)8 produced clearly stated guidelines to ensure the commitment to effective units. The provision of unit budgets was judged to be "an essential element in increasing local responsibility and accountability" (para. 30 of HC(80)8) and wherever possible staff working within units in nonclinical support functions (works, catering, domestic services, medical records and personnel) were to be accountable to the unit administrator rather than to district level managers (para. 31 of HC(80)8).

However clearly expressed was the message, it is nevertheless a characteristic of the process of organisational design at district level, that analysis of the district role often begins and ends with little more than an apology for failing to implement the concept of units as detailed in "Patients First", HC(80)8, and subsequent circulars. But if flexibility is indeed the central theme, then ministers can scarcely complain, though it remains to be seen how stringently the regional health authorities will exercise their monitoring role in ensuring that management structures do give effect to the unit philosophy.

If there is one conclusion that emerges from the 1980/81 King's Fund seminars and workshops which addressed themselves to this issue, it is that there can be no prescriptive solutions.

A much more fundamental issue stems from an analysis of what are the optional roles available to the district management team. The outcome of that analysis in each district will be critical in determining the character of district level activity and the level of delegated responsibility to unit managers.

To undertake this critical analysis, the DMT needs to identify the tasks of management which the district organisation as a whole has to handle. A distinction can be made between the processes of administration and operational management (maintaining, servicing, controlling, monitoring, directing, consulting, planning etc), and the task of strategic management or the management of change.

The forces of management within the NHS (authorities, DMTs, administrators, managers generally) for the most part cope with the first activity with moderate effectivenes - though it would be ill-advised to imply complacency - but the response to the second activity has been lacking both in conviction and in effect.

The criteria against which performance in relation to strategic management can be judged are easily identified, because they constitute objectives for which there is a high degree of political consensus. These objectives have been common to statements of policy from successive governments and are enshrined in regional and area strategic plans and operational guidelines. They include:-

a) The response to the maldistribution of resources of the NHS between regions, within regions, and between specialities.

b) The development of the "cinderella" services - primary care, mental handicap, mental illness, physically handicapped, the elderly.

c) The fostering of a more "community" orientated, non-institutional approach to health care.

d) The expansion of services for the elderly to take into account the increasing proportion of elderly persons within the community, particularly those over the age of seventy five.

e) The control of doctor initiated expenditure (drugs, laboratory tests, scans etc.) with the challenge of establishing conscious, rather than ad hoc rationing systems for health care.

Judged by these criteria the NHS has failed. In different ways, the 'Black Report' (1) and the Heywood and Alaszewski book 'Crisis in the NHS' (2) describe this failure and detail the evidence. It is important to emphasise, however, that this failure is no reflection on NHS managerial performance in relation to the processes of administration and operational management. It is a failure of management in relation to the task of strategic management.

(1) 'Inequalities in Health' - DHSS 1980
(2) 'Crisis in the NHS' - S Heywood & A Alaszewski - Croom Helm 1980

The task of strategic management is complex and requires distinct managerial skills. Unfortunately, most existing chief officers in the NHS have acquired their posts on the basis of proven competence inthe processes of administration and operational management. Their capacity to exercise the skills of strategic management is uncertain and unspecified. It is scarcely surprising that senior managers in the NHS and the overwhelming majority of DMTs remain rooted in the tasks of administration and operational management. Strategic management activity is either peripheral to their professional concerns, or is ignored. The consequence is a managerial bias in favour of the status quo, or to that analysis of strategic issues which derives not from NHS organisational objectives, but from the influence of dominant power blocks or vested interests at the local level.

Reorganisation, however, creates the opportunity for a new response from the forces of management within the NHS. In particular there is a need for DMTs to make a conscious effort to delegate administration and operational management matters, and devote significantly increased time, commitment and enthusiasm to issues of strategic management. If DMTs adopt this approach, it will automatically determine the character and scale of district level activity and make necessary the construction of units, for which managers can effectively undertake the tasks of operational management and service planning.

Describing the processes of administration and operational management in an NHS context is not difficult. The well defined hierarchies, and the established roles of health authorities, are easily explained, and there is a high degree of uniformity throughout the NHS. The centrist characteristic of the NHS as an organisation of bureaucracy is nowhere better illustrated. It is a reflection of organisational convenience and managerial inertia that it should be so, and it serves its purpose moderately well.

The problem as it relates to issues of strategic management is that these well tuned systems do not seem to be effective as the vehicles for change. Progress to the achievement of clearly identified objectives for which there is a high degree of consensus within the NHS and amongst those who can claim to be representative of the community as a whole (MPs, local authorities, health authorities, CHCs) is slow and by no means solely to be blamed on financial restrictions.

In project work arising from the King's Fund seminars and workshops during 1980/81, two factors were identified which go some way to explaining this managerial failure and offer some guidance to district authorities and district teams who wish to be more responsive to NHS objectives.

First it is relatively exceptional for existing DMTs to determine the agenda of strategic change and its subsequent implementation. It is

an activity largely peripheral to the on-going tasks of administration and operational management.
Secondly, there is within health districts an inherant resistance to fundamental changes in the nature and direction of health care delivery. The pressures within districts are to develop existing services incrementally, without any analysis of the general direction of health policy.

The opportunity now exists for district management teams to organise themselves to work with their authority to establish strategic objectives and means of implementing them. This will create considerable pressure on team members. They will direct the process of the negotiation of change within the district and this will inevitably involve conflict and stress. The absorption of these pressures will dictate that there be genuine and effective delegation of the tasks of administration and operational management to the unit level.

The issue is not at what level these tasks can be undertaken most effectively. It is rather that by commitment to the unit principle, there is the opportunity for DMTs to re-direct their energies to crucial activity in relation to strategic management. This is potentially the most significant benefit which will result from the current structural reorganisation.

So far as detailed management responsibilities of districts are concerned, these include the following:-

a) Strategic Management

i) To develop medium and long term proposals for health care within the district, initiating and developing action to ensure the implementation of plans.

ii) To evaluate progress towards these goals on a regular basis.

iii) To provide resources within the total district budget to enable units to provide the best possible standards of care and prevention within the resources.

iv) To liaise with bodies with an interest or influence on health care in the district and adjacent areas.

v) To assess standards of quality of care, and where necessary, consider alternative methods of resource, organisation and management.

vi) To service the work of the chairman and members of the authority.

b) Administration and Operational Management

i) To build and maintain an organisation which can deal with operational management with a minimum of involvement from the DMT.

ii) To allocate resources to enable essential services to be maintained district wide.

iii) To service the authority and a number of other bodies or groups - planning, liaison with other bodies including local authority services.

iv) To provide a degree of control, direction and innovation from the top.

v) To monitor and control (quality assessment). This is an important function at every level and has been one of the most neglected activities.

vi) To consult on major policies and priorities (particularly plans and budgets) at formulation stage as well as to consult with staff on district wide arrangements and with associated bodies such as CHCs, LAs, adjacent DHAs, RHA and DHSS.

vii) To provide advisory roles in certain areas, i.e. para medical, catering, personnel and works.

All the above activities are undertaken at district, unit and within units. The appropriate level for each activity needs to be clarified and be in the best interests of increased efficiency and job satisfaction.

3 THE UNIT - FUNCTION AND DEFINITION

It is perhaps inevitable that newly appointed district management teams and district health authorities should wish to proceed with the process of re-structuring as quickly as is feasible. This accords with the interests of managers throughout the service for whom it is a period of personal anxiety and apprehension, which must, in many instances, have a negative impact on current managerial performance.

Yet it would be unfortunate if chief officers limited their organisational design thinking and activity to management structures, and approached the task without any pre-determined framework of principles within which to evaluate it.

A The Purpose of the Unit

There needs to be some definition of what the unit exists to do, and its nature as a competent part of the structure of the district as a whole. Much of this will be considered when discussing the criteria for defining units, but there are certain broad principles to take into account in determining the purpose of a unit. These may include such elements as:-

a) To provide the best possible patient facilities including equipment and estate within the resources available.

b) To undertake some form of quality assessment.

c) To identify future needs both very short term and for the longer term.

d) To provide a platform for the coordination of all services.

e) To integrate health care between the hospital and community services.

f) To provide the support services to enable clinical services to function to maximum effect.

g) To identify and assist with training needs and to provide an environment in which staff are able and encouraged to make the maximum contribution to the organisation and at the same time obtain job satisfaction and develop their own career.

B Organisational Principles

It can be helpful to reconsider certain general principles of organisation which have been found useful in designing and reviewing organisational structures. These include:-

a) Span of Control (Henri Fayol 1911)

The number of managers accountable to any one manager is limited if the organisation is to be effective. Depending on the complexity of the issues raised between managers in individual circumstances, a suggested maximum is six accountable to any one.

b) Number of Levels of Management (Elliott Jaques 1978)

The number of levels of management must be limited if each level is to have the freedom from interference from above to allow it to manage effectively and not feel constrained.

c) Cross Over Points (Ralph Rowbotham 1970)

There is a need for cross-over points at district and operational (unit) level to allow effective coordination and control.

d) Acting Up

Whilst deputising has become unfashionable since the Salmon Report of 1965, there is a need for all essential line managers (although perhaps not staff officers) to have someone who can act up for them in their temporary absence to sickness, holidays, training courses, etc.

e) Full Occupation of Officers

For the whole organisation to have high morale everyone should be fully occupied if not fully stretched. Advisers or managers in particular functions (catering, domestic and pharmacy for example) may be needed to give advice at district (and regional) level, but the extent to which their advice is needed may not justify the whole time employment of a specialist officer.

f) Clear Accountablity and Simplicity of Organisational Structure

Organisational structures must be easily understood by staff at all levels. (Some organisational concepts, e.g. those involving matrix organisations and relationships other than simple accountability may not be understood by a large proportion of the staff).

g) Expert Advice from Practising Specialists

On balance it is an advantage if expert advice, as an input to policy decisions, is seen to come from officers who at least for part of the time are managing at operational level.

h) Line and Staff

The military concep of line and staff officers may have value in utilising those officers with imaginative, intellectual planning talents but who need to feed their plans and proposals to line managers before they can be effectively introduced and sustained.

i) Economies of Scale

Many functions can be carried out more effectively on a large scale (e.g. laundry production) although there may be compensating difficulties, some of which may be overcome by organisational means (e.g. local uniform exchanges and issuing points for laundry).

j) Consumer Liaison

If service giving functions are centralised to achieve economies of scale there will be a need to ensure sensitive liaison with consumers and also innovations of new equipment.

k) Development of Managers

There may be a need for sharing duties, including e.g. committee work, and perhaps having rotating jobs to help manager's development.

l) Communication

Structure will not in itself solve problems, although the converse is true that inappropriate structure will hamper efficency.

m) Budgets

The preparation and control of budgets whilst undertaken by budget holders must be overseen at the crossover points of coordination i.e. district and unit.

n) Mirroring of Nursing Services

Wherever possible the administrative organisation should mirror the nursing organisational structure whether geographical or specialty determined.

o) Accountability to DHA through DMT

All accountability of officers in whatever function should be through the appropriate member of the DMT, the district administrator in the case of unit administrators and any district functional managers, and then through the DMT to the authority.

p) Management and Planning

Management and planning must go together and it is inappropriate to divorce the two as they interact.

C Elements of Organisational Design

Managerial arrangements at the district level need to be reviewed to ensure that their purpose is well defined, that their operation is effective, and that there is total cohesion and balance.

This review should include assessment and analysis of:

a) The Role of the Authority. This includes the formally designated tasks of the authority as an employing body, including responsibilities as managers of mental illness hospitals under the Mental Health Act and the hearing of grievance and disciplinary issues.

That members, managers and staff should be clear what constitutes these tasks is undeniably important. But there is a more fundamental and difficult analysis and that relates to the collective view of authority members as to the direction in which the organisation is to be led. The process of determining conscious leadership direction to the organisation is a role which has been largely neglected. Strategic management within the district is unlikely to be effective if the authority itself has no clear perception of its organisational objectives.

b) The Re-design of Medical Committee Structures. DHSS guidance has been subject to much criticism not least because it does not confirm the requirement for a district medical committee with the 1974 reorganisation constitution of equal numbers of consultants and GPs. This criticism emanates more from threatened self interest than idealism. What has been made available is flexibility at district level and this offers opportunity for rigorous evaluation of the component parts of the existing medical committee structures in terms of purpose and constitution.

This is not to imply that district medical committees should be discarded. but rather that all medical committees are geared to organisational needs and objectives. This is an analysis which requires DMT and authority involvement as well as that of the doctors.

c) The Re-negotiation of Joint Staff Committees. The bulk of existing JSCs were negotiated in the 1974/76 period when their main purpose was to facilitate consultation between management and staff organisations. While that requirement remains, it is now equally important that they should be the means of effective negotiation. Additionally the new framework of

management, involving substantial delegation to units will require the re-construction of existing JSC mechanisms.

d) The Integration of Primary Care. This is for the most part, a neglected aspect of organisational design within districts. The formally constituted Joint Consultative Committee links the health and local authorities, and there are usually sufficient joint planning initiatives to give the illusion of an organisation that cares about integration of its non institutional services. The reality is more often that primary care is almost as segmented as it was before 1974. General practitioners operate within their own organisation framework. Achieving genuinely effective integration that is sufficiently robust to overcome organisational barriers has been too low a priority for the most senior NHS managers.

e) The Management Structure.

D Framework for Designing Management Structures

There are few senior NHS managers who do not feel capable of producing on the mythical back of an envelope a comprehensive management structure for their district which matches their perceptions of management realities and matches their own prejudices. Such structures tend to be 'people' rather than 'objective' orientated. Problems begin to occur when it is acknowledged that management structures have to incorporate different perceptions of DMT members and must be the subject of wide consultation within the district. At that stage it is useful to have a common framework within which the process of designing the management structure can be undertaken. This would minimally include:

a) Knowledge of the district. For many chief officers appointed to posts closely correlating with their previous posts, this presents no difficulty. However, there are some chief officers who will clearly be at a considerable disadvantage in preparing management structures before they have acquired a deep understanding of the district.

   In these cases, the availability of district profiles plus a heavy reliance on existing managers are obvious means of minimising the disadvantage.

b) Acknowledgement by the authority of the validity in the local situation of national NHS objectives. The NHS is fortunate in that not only are its national objectives clearly stated, but it is evident that they are largely common to all the major political parties and indeed have been the subject of formal publication by successive governments.

c) The establishment by the authority of local organisational objectives which give a sense of direction and leadership to the health district.

d) The conversion of these objectives into specific managerial activities.

Chief officers need to distinguish critical from less significant managerial activity, so that investment of managerial resources can be determined on a rational basis. At a time of constraints on management costs, the need for that framework for determining the deployment of the management resource, is even more important.

E Key Elements of the Management Structure

During 1981, a training exercise was frequently used at seminars and with working groups to determine the management structure of a fictional health district. Experience with this exercise showed that two fundamental issues had to be resolved.

a) The determination of the role of district and particularly the key tasks of the DMT. An earlier section of this book suggests that DMTs must occupy to a greater extent than previously the ground of strategic management, with the consequence that roles relating to administration, operational management and service planning would be primarily the task of unit managers. If this model was adopted, then the DMT would, in its management structure, seek to ensure that district based functions unrelated to that strategic task, were minimised. Determining the fundamental character of DMT work would, in effect, dictate subsequent decisions about district functions and the delegation of responsibilities to unit level.

F Definition of Units

Much has been made of the fact that HC(80)8 allows, and almost encourages, three separate, and sometimes conflicting, bases on which units might be determined; institutional, geographical and client care. Experience with the training exercise confirms that separate disciplines tend to bring quite different perceptions of how units should be defined. Doctors, especially in district general hospitals, are clear that units mean separate hospitals. Administrators tend to favour a geographical or functional grouping of hospitals to achieve economics of scale in management, particularly in relation to support services. Nurses believe that a client care grouping of services is the logical means of approaching this problem.

The most interesting outcome, is that when faced with the necessity to negotiate a solution in a multi-disciplinary situation (i.e. in line with the reality of the DMT) there is a willingness to think constructively about the problems of the alternative solutions, and there have been some significant shifts in points of view by administrators and nurses. What usually emerged from the multi-disciplinary analysis can be described as a limited client care approach. Limited, in that two units have almost invariably been

defined on an essentially institutional principle - the DGH and the 'community'. With the addition of units for the mental illness, obstetric and mental handicap services, these have usually formed the basis of the solution, with the occasional emergence of separately identified units for services for child health and the elderly.

In addition to this training exercise, one of the King's Fund workshops identified a list of factors which were relevant in considering the definition of units:-

a) Type of district - size and distribution of population and services.

b) Clinical profile of institutions.

c) District plans and priorities.

d) Size and management complexity of institutions.

e) Historical patterns and local feelings.

f) Cost limits and grades available.

g) Ability to control a unit budget.

h) Ability to make timely and effective decisions.

i) Staff available.

j) Ability to manage support services.

k) Proximity and relationships with other units.

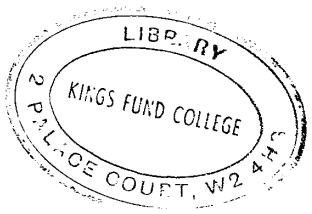
l) The need to balance stability with flexibility.

m) Sense of identity.

n) Defined catchment area or client group.

o) Management considerations e.g. span of control.

p) Realities of power.



In devising any management structure, it is important to take all these factors into consideration, but different emphasis will be given in different situations.

G Size of Units

The DHSS guidance in relation to the size of units creates a dilemma. It is urged that units should, in other than exceptional circumstances, be no larger than, and usually smaller than, existing

sectors and divisions. However, it is also envisaged that the unit administrator and the director of nursing services, working with a medical representative, will not only control a unit budget, but will undertake the essential tasks of operational and service planning. The difficulty is that a viable unit for service planning will often be larger than the 'norm' for unit size, as applied to administration and operational management.

There may be few districts where it is possible to divide the acute services into more than one unit and then realistically expect the key unit manager to undertake service planning. Service planning of acute services in the district will need to take into account services provided throughout the district. The point is valid also in relation to other clinical services.

In this connection, it is perhaps useful to distinguish two elements of the task of management which would be part of the unit function. The first is institutional and support service management and the second is service management and service planning. For these responsibilities to be held at unit level will require some units to be substantially larger than envisaged in DHSS guidance.
If districts decide not to test the flexibility of the guidance or if RHAs are wedded to the view that units must be no larger than existing sectors, then there may be a division of these tasks with units handling institutional and support service management, and the process of service management and including service planning, being dealt with at district. The consequence of this could be a regrettable undermining of the fundamental philosophy of this reorganisation and, might re-enforce a reluctance by the DMT to come to terms with the strategic tasks of management.

H Defining Units to Meet Priority Needs

One of the challenges of reorganisation is to ensure that management arrangements, including not only unit structures but also the decisions about district managed or district advisory services, match the needs of the community served by each authority.

For example, if services and management in a large long stay hospital need to be radically improved, the management structure can facilitate this. Alternatively, if it is felt integration between secondary and primary care needs to be developed, the solution of establishing client care groups is available. Similarly, the choice between establishing some district managed services or decentralising, will depend on local objectives, and the economic advantages of the two options.

I Built-In Flexibility

It is important that whatever unit structures are created, a capability should be built into the organisation to adjust structures in the light of experience. This would be particularly important if an element of experiment is attempted, or if there are strongly divided views in the district about the merits of alternative solutions.

4 MANAGEMENT OF THE UNIT - A FRAMEWORK

The strength of an organisation's structure depends on several different components all being securely welded together. This is illustrated in figure 1. The framework shows that unit management will not succeed if only certain parts of the organisation are given attention. For example, clear accountable management and delegation to departmental managers will not in itself produce good decisions unless the professional advisory and joint staff consultative machinery is well constructed. Similarly the organisation will not work well unless its personnel practices are based on good foundations and professional personnel expertise is available to advise on industrial relations or organise management training. The diagram shows how in one cohesive organisation, four elements are brought together: standards of service, structure, staff management and systems.

A Agreed Standards

To achieve quality of service it will be necessary to strengthen the quality of departmental management. This may require more delegation downwards, greater dependence on managers to resolve their own interdepartmental problems and more management training. In turn, managers themselves may need to do more to provide inservice training for their own staff.

B Structure

The executive structure and representative machinery of the organisation needs to be clearly defined with the following objectives achieved:-

a) 'Grey areas' of managerial accountability need to be eliminated. The management of accident departments, secretarial staff and residences are good examples where final responsibility is not always explicit.

b) Once managerial roles are clearly defined, their own 'line' relationships with principal officers need to be equally clear.

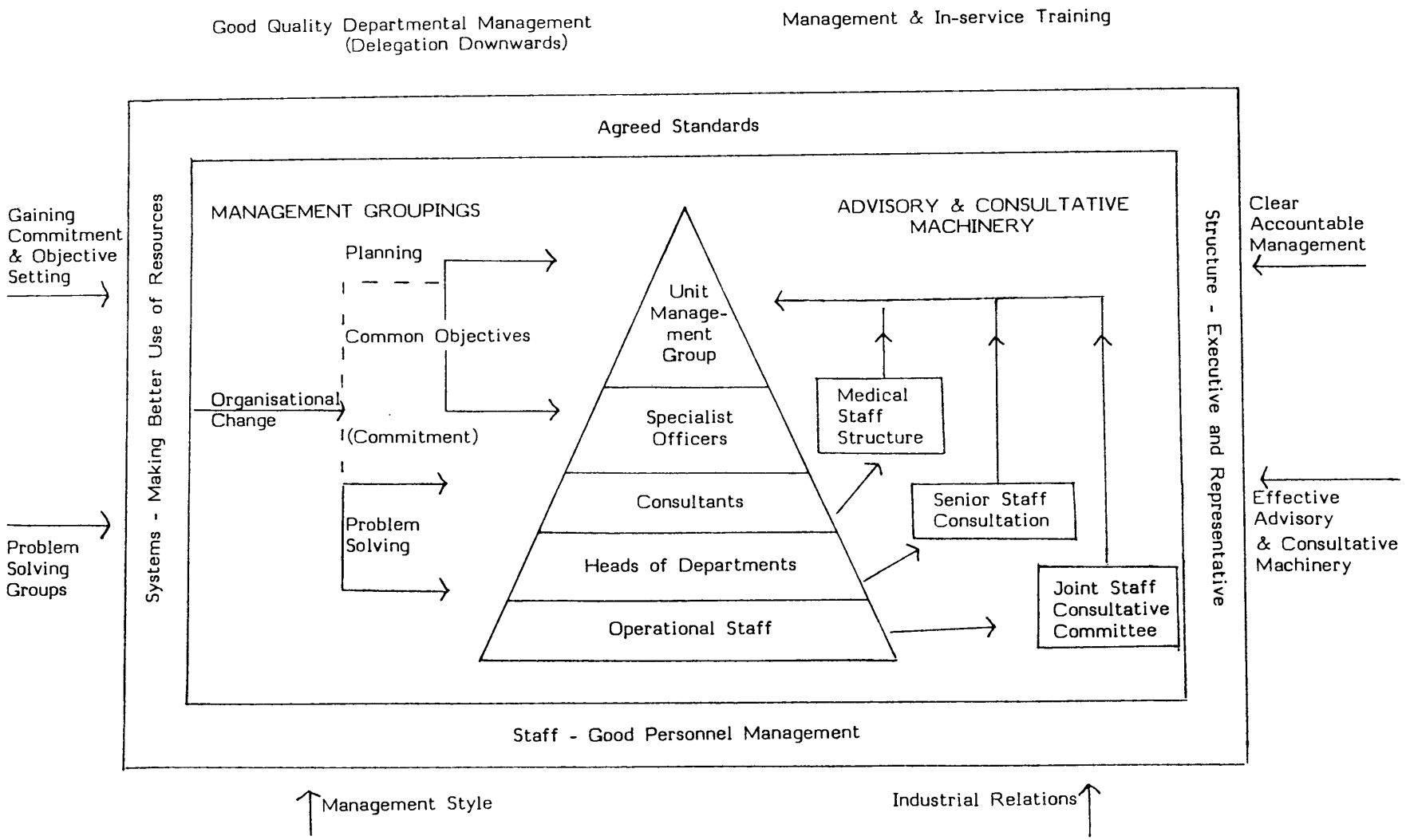
c) Joint staff consultative machinery not only needs to be established, its effectiveness needs to be nurtured by hard work on the part of management and staff representatives alike.

d) The professional advisory machinery for medical staff may require an overhaul in the light of the proposals contained in the chief medical officer's report on the subject.* For large hospital units, an effective representative system for consultants provides the only means of gaining commitment to planning strategies and tackling some of the more difficult issues over the use of resources.

*Joint Working Group on Medical Advisory and Representative Machinery - Report on District Management arrangements. December 1980.

Figure 1

A FRAMEWORK FOR EFFECTIVE UNIT MANAGEMENT



C Staff Management

The requisite management style for a unit is difficult to describe. In many cases, different styles may be equally effective. Good personnel management pays dividends, but this does not happen automatically. Leadership by principal officers and expertise from personnel specialists both have a vital part to play.

D Systems

Bad systems in an organisation are more often the cause of waste, inefficiency and frustration than inadequacies of people themselves. Changing bad systems for better ones can often overcome the difficulties experienced by patients or give rise to a means of saving money. Setting objectives to review and improve systems therefore provides another cornerstone for effective unit management.

5 POLICY; PLANNING AND DEVELOPMENT; SYSTEMS

In the same way that a more 'strategic management' approach to the work of DMT officers is emphasised, it is equally important that well graded unit administrators and directors of nursing service 'lift' their managerial performance to an appropriate level. To achieve this, the unit team (if one materialises) and its individual members need to concentrate attention on a number of fundamental elements of good management performance. The following checklist may be useful:

a) Objectives of the unit to be re-defined and agreed.

b) Medical policy and organisation to be determined.

c) Financial objectives to be set, including redistributing resources where appropriate.

d) The role of specialists to be defined, e.g. the district personnel officer and any district officer providing advice rather than having 'line' responsibility, should be clear about accountability.

e) Centralisation policies (where it pays to do so) versus decentralisation.

f) Management information: define what is needed and arrange for it to be provided.

g) External relationships including public relations, the press and liaison with local authority services.

h) Planning role at unit level: appropriate machinery to be established.

i) Personnel policies and organisation.

j) Nursing organisation.

k) Methods of communication.

l) Representative machinery.

m) Use of working groups and other meetings (committees) to support the unit team.

n) Methods of delegation and monitoring throughout the unit.

o) If a unit management team is established, determine its role and method of working.

p) Means of systematically reviewing and updating policies.

The emphasis on efficient management at unit level might easily persuade some observers of the NHS administrative system to suggest that planning activity ought to be transferred to higher levels of management. A crude distinction between day to day administration and longer term planning might soon be divided into the two principal tasks for unit and district officers respectively. If this were to happen, the new structure would get the worst of both worlds; a two tier system with district officers losing too much contact with operational management and unit managers disinterested in the development of their organisation. It is important therefore that principal officers and departmental heads at unit level fully contribute to the NHS planning system, and that their counterparts at district level ensure that this happens. The mechanism for achieving this will vary, but without the commitment of managers and consultants at unit level, operational planning is unlikely to be a dynamic process. At worst organisational change will be frustrated; at best the units will provide the impetus for development and remedies for long standing problems.

Health care planning teams have proved to be a useful means of generating planning proposals for particular health services. Where units are based on 'service' criteria, it should be relatively easy to relate the work of such teams to the management arrangements, but where units are not based on services, it may be necessary to have planning teams which operate across a number of units. It then becomes important that when a plan is agreed, responsibilities for implementing different aspects of the plan are clearly allocated to the appropriate units. In the same way that plans are made for services, it is equally important that each unit has its own plan, so that all who work within the unit can know its priorities, and how it is intended to develop in the future.

When commissioning a new hospital, nobody questions the value of preparing operational systems, yet in an established hospital or in the organisation of community health services, the way systems actually operate often continues unquestioned. Yet it is these systems which determine efficiency both within and between the different departments. The follow up immunisation appointments for children in community clinics, procedures for planning discharge arrangements for the elderly, major accident procedures, movement of x-rays between wards and departments, planned maintenance systems and so on, all of these require monitoring. Inevitably many will benefit from a complete overhaul.

Similarly the efficiency of a unit will be reduced if interdepartmental communications are allowed to falter. It was said in the past that too many problems remained unresolved until either crises occurred, or the administration was called in to arbitrate between two departments, one requesting a service, the other failing to provide it. The 1974 structure of the NHS built in several safeguards by trying to prevent inefficiency through monitoring. Much of this monitoring may disappear, as supporting structures are pruned and become less top heavy.

Greater responsibility will, therefore, need be devolved to heads of departments to monitor their own systems and services, and communicate with other colleagues to resolve difficulties rather than push problems up the line for others to sort out.

6 PERSONNEL MANAGEMENT

Personnel is one of the departments that cannot escape the effects of reorganisation, especially where specialist departments have been established at area headquarters. There are also questions of career structure related to whether personnel becomes a more or less specialised part of general administration. A third factor is the fundamental question whether an integrated personnel department serving all grades of staff is acceptable, desirable or essential.

Whatever the answers may be, all of these factors need to be considered in the context of unit organisation. It might therefore be useful to determine what personnel priorities lie ahead. The following list is suggested:-

a) Greater responsibility for heads of departments will require continuing efforts to provide suitable management training, both at principal and deputy level.

b) Greater emphasis on efficiency will require a more systematic approach to in-service training.

c) Joint staff consultation is growing in significance, both as sound practice and in response to staff wanting to participate more than used to be the case.

d) Although everybody believes in good communication, results, particularly in large hospital units, are not always as good as they ought to be, or as good as managers believe they are! The answer is to test them, identify deficiencies and then strengthen the systems.

e) Good industrial relations are largely dependent on the quality of departmental management. Whereas the personnel specialist will continue to have a leadership role, personnel practices within departments and the style of management hold most of the keys to success.

f) Induction of new staff, a staff health service and an imaginative approach towards providing those employee services that are appropriate for each particular unit all have a part to play.

Taking all of these together, it soon becomes apparent that leadership of good personnel practice, together with specialist help on training and industrial relations, requires a well thought out organisational solution. The determining factor will normally be the size of the workforce. In a large unit, there would certainly be a strong case in favour of establishing a small personnel section.

It could be under the charge of a specially trained personnel officer, or be regarded as a principal responsibility of the second-in-line unit administrator. It would be up to each unit to decide whether to persevere with an integrated department, to include nursing, or create two quite distinct sections. In either case, close cooperation would be needed with personnel policies which were consistent for all groups of staff. Management training and advice on industrial relations both lend themselves to a district based service: the size of the district and the priority its DHA allocates to these functions will therefore largely determine whether or not full time district officers are appointed to carry these out.

Whilst steering clear of any prescription with regard to personnel, a delegated presence of expertise at unit level, and an emphasis on management training being organised within each district is recommended. As with other specialist management functions, each district needs to determine what aspects of personnel management are to be carried out at district and which at unit level. As a theoretical exercise in one of the King's Fund workshops this resulted in the following breakdown:

Tasks to be Done at District

- Manage District Personnel Department
- Establishment Overview
- Manpower Planning and Information
- Whitley Advice
- Policies: Industrial Relations
  Health & Safety
  Appraisal
  Occupational Health
- Staff Handbooks
- Training: Coordination
  Information
- Image/Identity

Tasks to be Done at Unit

- Recruitment
- Leave Procedures (D)
- Discipline/Grievance
- Terminations
- Staffing Control & Records (D)
- Bonus Schemes
- Industrial Relations
- Joint Consultation
- Safety Systems
- Induction (D)
- Appraisal

(D = shared with department heads)

7 UNIT MANAGEMENT TEAMS

One of the most important concepts of the reorganisation which the health service will embark on in 1982 is that of maximum delegation of responsibility to units. The appropriate paragraph (12a) in "Patients First" reads: "There should be a maximum delegation of responsibility to hospital and community services level. For each major hospital, or group of hospitals, and associated community services, there should be an administrator and a nurse of appropriate seniority to discharge an individual responsibility in conjunction with the medical staff."

This concept is at least of as much importance to the future well-being of the NHS as the abolition of area health authorities. One of the major criticisms of the organisation of the health service since 1974, particularly from the medical staff at both local and national level, has been the difficulty in obtaining important decisions at hospital and community services level. This groundswell of frustation was a major impetus to the political pressure the medical profession brought to bear in an effort to rectify the mistakes of the 1974 reorganisation.

Assuming therefore that the new district health authorities (DHAs) will do more than just pay lip-service to this concept of delegation, it is of paramount importance that the management arrangements at unit level are carefully planned.

The decision on whether management teams should be used or whether the management responsibilities at unit level should rest with a defined group of staff working in a looser affiliation is to some extent an argument over semantics.

Any management structure arrived at for units will necessitate 'formal' meetings of managers with agendas and minutes if only on those occasions when the team is undertaking its planning or policy making role. These tasks will be too complex to leave to a system of informal discussions amongst senior managers at ad-hoc meetings. It will be important to have a record of decisions taken plus some documentation which will help ensure consistency when decisions are made. This can be particularly important to preserve continuity as the holders of the unit administrator and director of nursing post may well change and the medical representative may change even more frequently through rotation. It would be expecting too much of the unit administrator, director of nursing and the medical representative to have sufficient background knowledge of all those areas which will need joint discussion and decisions to enable them to do without such aids as working papers. Therefore some bureaucracy is inevitable at unit level.

However, the senior managers should ensure that this is kept to a minimum and the day-to-day management of the unit should be left to the appropriate individuals. Should problems arise which need discussions across the professions these could be organised promptly, without waiting the next 'team' meeting, and will not need the formal trappings of agendas and minutes. Indeed it is to be hoped that the 'triumvirate' as outlined in "Patients First" would meet on a regular informal basis to exchange relevant information.

It will be important to identify the place of the team within the management process in the unit. There must be no confusion over the collective responsibilities of the team and individual managerial responsibilities of members of the team. The aims of the team should be clearly defined, as should the parameters of its authority, and the rules under which it operates. For example, will decisions be made by concensus or will it be by majority vote? If there are to be medical members of the team how will they be chosen, how long will they serve, what will be the extent of their managerial responsibility, how will they be held accountable for their managerial performance?

As these points are decided the management group will become more of a management team. It will repay DMTs to consider the disadvantages and advantages of teams in managing health units so that all senior managers will be aware of the strength and weaknesses of the managerial system under which they are operating.

In order to stimulate thought and discussion on this topic, some of the advantages and disadvantages which have been encountered by a multidisciplinary team managing an integrated sector since 1974 are outlined below.

Advantages

a) In the context of an integrated sector the team concept encourages general practitioners to become involved in management at unit level. This not only enables the general practitioners to participate in the setting of priorities and the allocation of resources, but it also aids the professional dialogue between the GPs and hospital-based consultant staff. This in turn helps to promote a better mutual understanding of the problems faced by both groups.

b) In managing such a complex organisation as the health service, the use of a multidisciplinary team should in theory lead to appropriate decisions being made. In practice this will only be the case if the managerial competence of the individual members of the team is of a sufficiently high standard. The team concept certainly acquaints medical staff with some of the constraints under which managers in the health service work.

c) Decisions made by a multidisciplinary team are more likely to prove acceptable to the wide variety of professions and other occupational groups of which the health service is composed. This is particularly true in today's climate where there has been a marked increase in the growth of many occupational groups in the health service seeking a significant degree of professional autonomy. The concept of a single executive figure has been rejected for regions and districts (para 11 "Patients First" refers) because of the professional independence required by the wide range of staff employed in the service. Instead teams are being established. To a lesser degree the same reasoning holds good for units.

d) The team provides a focus for the rest of the organisation when decisions are needed on questions which affect the whole of the organisation, such as the allocation of resources. If a number of different individuals have the responsibility for making a range of major decisions for the unit there may well be confusion and duplication.

e) The team concept improves coordination between the disciplines working within the unit.

f) Provided there is a regular rotation of consultants and GPs on to the unit team, it will help to increase the medical staff's awareness of how the service is managed and hopefully enhance its commitment to the system of management. The difficult balance to achieve is that of ensuring that the length of time each medical member serves on the unit team is long enough for each to understand how the system works and to make an effective contribution to the team, while at the same time ensuring that it is not so long that busy clinicians are dissuaded from serving on the team.

g) A team system of management must be more democratic than a single individual having sole managerial responsibility for the unit if for no other reason than that there are more disciplines participating in the management of the unit and representing a wider variety of views. It is, of course, arguable whether this is an advantage or a disadvantage to efficient management!

h) Once the concept of medical involvement in the management of the unit has been accepted, it is obviously important to ensure that the medical contribution is both effective and constructive. The team framework enforces a certain discipline on the medical representative in that the team will meet on a regular basis with the medical member hopefully committed to attending and being party to all the team's discussion and decision-making.

The team concept is also likely to encourage a more consistent medical response to management problems with a clear record being available of decisions taken through the keeping of minutes etc.

Disadvantages

a) The apparently exclusive nature of unit management teams, which represent the major power groupings, may sometimes militate against their effectiveness. Those occupational groups not directly represented on teams may well resent their exclusion and doubt the ability of the team to understand fully the needs and aspirations of the occupational group in question.

b) Confusion may exist internally and externally about the accountability of the team. This applies to the team both collectively and individually. Should the team fail in its managerial responsibilities it is more difficult to take action against a team than it is against individuals. Confusion may also exist over the point where individual responsibilities within the team stop and where the collective responsibilities of the team start. It should be remembered that individuals implement action, rarely teams.

c) There may well be conflict of loyalties within the team. The administrator, the nurse manager and the finance officer are directly accountable to district officers for their managerial performance, while clinical members of the unit team are not responsible to anyone for their managerial performance, with the possible exception of a moral accountability to their peers. Indeed the whole question of the status of the clinicians on the team may well be unclear. Are they delegates or are they representatives of their colleagues and can a team decision taken with the clinical members present bind the medical staff within the unit?

d) Decisions which need to be taken by a team will normally take longer than decisions which are taken by individuals. The length of time it takes to get important decisions made has been one of major criticisms of the health service since 1974. Presumably this is why one of the main thrusts of the reorganisation to be undertaken from 1982 onwards is the attempt to achieve the maximum delegation of responsibility to unit level, with the identification of an administrator and a nurse manager to discharge an individual responsibility. The establishment of unit teams may frustrate this aim.

e) The establishment of teams enables weak or inefficient managers to hide behind the corporate identity of the team. This has been another criticism of the service since 1974. Staff have felt frustrated at not being able to obtain a decision from an individual but have seen instead their requests referred to the team.

f) Decisions which are reached after discussion by a multidisciplinary team are more likely to be swayed by sectional interests, thus undermining a certain element of objectivity in

the decision-making process. However, the reverse side of this particular coin is that the quality of the decision-making should be improved by being based on a wider foundation of specialist knowledge.

g) Undoubtedly a team system of management increases the amount of paper circulating throughout the organisation. It will be necessary to produce background papers for all the important topics to be discussed by the team, if each team member is to play a full part in the management process. Minutes and agendas will invariably be kept and the increase in paper will slow down the speed with which decisions are made, inexorably adding to the bureaucratic image of health service management.

h) The team approach to management of units, with the likely use of agendas and minutes, must lead to a loss of managerial flexibility which is one of the great strengths of management through a single executive figure. It is far more difficult for a team to respond to a rapidly changing set of circumstances which may affect their management decisions, than for one individual to do so.

i) In a service which, over the past few years, has suffered increasingly from cuts in public expenditure, the cost effectiveness of the management system used is obviously of paramount importance. It is more expensive to manage through a multidisciplilnary team but it is by no means axiomatic to claim that such a system is therefore less cost effective than managing the service through individuals.

j) The establishment of management teams at unit level may act as a disincentive to medical staff to play their part, as there is a danger that teams will be seen as being unnecessarily bureaucratic and time-consuming. This may lead to only a select group of medical staff, from those specialities with relatively small clinical workloads, offering to serve on the team, thereby limiting the effectiveness of the team. There are great benefits to be obtained if representatives from all the major specialities can be encouraged to accept nomination to the unit team for an agreed period.

Summary

By their very nature, the above lists of advantages and disadvantages of working through management teams at unit level are subjective. What one person considers an advantage someone else may well consider a disadvantage, and vice versa. Neither are the two lists exhaustive. As indicated earlier, they are based on the experiences of a multidisciplinary team which has managed an integrated sector since 1974, and as such most or all of the points listed may be experienced by those charged with the responsibility of managing units from 1982 onwards.

Possible Collective Responsibilities of the Unit Management Team (UMT)

a) Influence the planning process at district level. This will be a crucial function of the UMT. It will be necessary for the team to have a clear picture of the development needs of the unit and to establish an order of priority for those needs.

The planning process must include an input from all levels of the organisation and the team should therefore ensure that it feeds its plans in at the appropriate stage.

b) Agree which individuals should implement district policy. Once the UMT has fed its priorities into the district planning mechanism, its next function will be to ensure that district policy is implemented. This policy will hopefully reflect the needs of the unit, but the team will still have the responsibility of ensuring its implementation even if the policy runs counter to local priorities.

c) Assist in the coordination of the management of the unit. The team, working through the administrator, will have the responsibility of ensuring that the constituent parts of the unit work within the framework of the district's policy and that the management throughout the unit produces good results.

d) Agree budgets for the unit with the DMT. The team should agree budgets for all departments within the unit after holding discussions with the heads of departments. An important principle for the team to grasp is that the "maximum delegation" talked about in "Patients First" should not stop at the UMT level but work its way down through the entire organisation.

e) Monitor budgetary performance within the unit. It is important to delegate day-to-day responsibility for budgetary control to the appropriate heads of departments. This should enable budget holders to manage their departments effectively without the need to refer every financial and manpower question to the team.

For such a system to work effectively there will be a need to ensure that accurate financial information is available promptly at the end of each month and that the managerial calibre of budget holders is sufficiently high. The poor calibre of health service management has long been used as an excuse for central control of budgets. The best way to break out of this circle is to delegate the control of budgets to a far greater degree than at present. This should then provide a more interesting challenge to local management, which should in turn improve the calibre of staff applying for managerial posts at unit level.

f) Operate virement between budgets at unit level. For the concept of maximum delegation to unit level to be fully realised, the UMT should be given the authority to operate virement between budgets should this prove appropriate or necessary. The DMT will obviously need to agree a limit for such virement and also to ensure that the UMT does not come into conflict with district policy by operating the virement.

g) Monitor the performance of departments, and initiate action where appropriate. To monitor the performance of departments the team will use both financial and patient activity information.

Should a department's performance continually falter, then the team will need to be able to initiate remedial action. This might take the form of either peer group pressure or disciplinary action against the head of department and, as an ultimate sanction, the team should reserve the right to close services if all else has failed. Once again it would be necessary to ensure that such drastic action did not conflict with the needs of the rest of the district.

h) Agree operational plans in so far as they affect the patients. The team will need to agree such policies as meal times for patients, visiting of patients, out-patient appointment systems, indeed all policies which affect the pattern of the in-patients's day and the service offered to out-patients.

i) Agree all other hospital and community policies within the overall framework of district policies. Policies covering personnel, industrial relations, transport, supplies, communications etc which have implications throughout the unit will need to be reviewed by the team. Some of these will be policies which have been agreed at district or even regional level, others will be district policies which have been adapted to take account of local circumstances, and others may be local policies with no relevance to other parts of the district.

j) Ensure good communications. For the team to fulfil all these functions it will be necessary for it to ensure that an efficient system of communication is established both internally and externally. A failure in communication often results in frustration, or more damagingly, in ignorance. The overall performance of the unit will suffer unless this basic but nevertheless vital component is safeguarded.

In summary, the concept of maximum delegation to units can bring real improvements to patient care. DMTs should give prompt and serious thought to how their units are to be managed and clearly outline what the management functions of the units will encompass.

8 FINANCIAL MANAGEMENT

There are financial aspects to most of the subjects discussed in this project paper, but it is convenient to bring them together within this section.

One or two important general financial principles are included, but in the main the paragraphs which follow are of particular relevance to units.

A Budgeting Structure should Reflect, not Determine, the Management Pattern

Budgeting is neutral. The authority should set up its management structure to suit whatever definition of units is adopted. The budgeting structure can then reflect that management pattern, and thus enable unit budgets to be drawn up, and departmental budgets within units.

A word of warning. The budgeting structure will not overcome any failure of the authority and its management to resolve the problems inherent in the different options of defining units; neither will the budgeting structure cope with 'grey areas' of split management and professional responsibility if these are not tackled and resolved. If DMTs actively encourage' grey areas', they should not be surprised if they cannot pin down responsibility (budgetary or otherwise).

B Budgets should Provide for Maximum Delegation

This is a basic principle for budgeting generally and so should cause no problem. Taken with another fundamental principle:-

C Budgets should be Personal and not Collective - It implies that:

a) budget holders will be individuals at unit level, not unit teams

b) budget holders will be people who actually incur expenditure (e.g. signing orders for goods and services, making the decision to appoint staff)

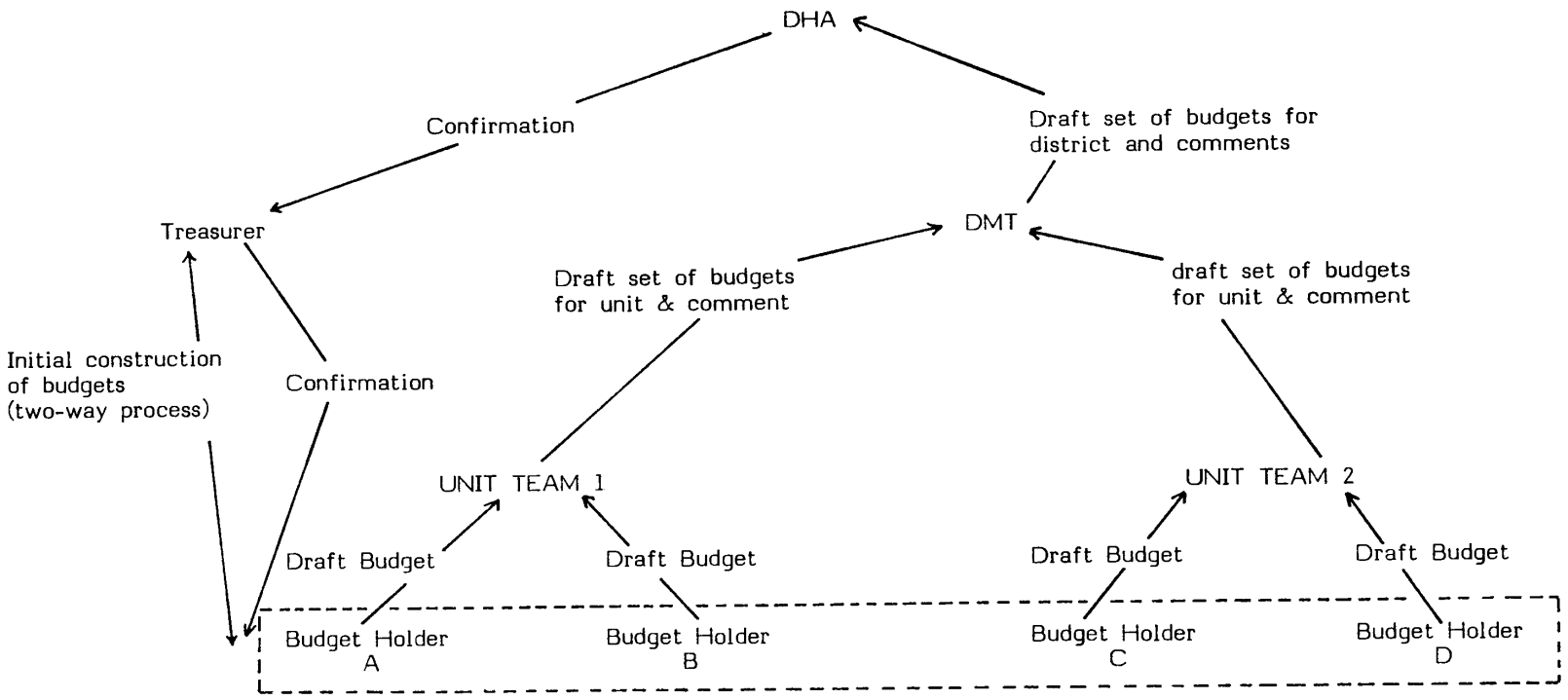
c) budget holders will be responsible to their senior officer for the performance of their budgetary responsibility in the same way as they are responsible for the performance of any other of their duties - no more, no less.

D The Role of Unit Teams* as Distinct from the Budget Holder

This is evident from the following steps in the budget process (see also figure 2 - "Steps in the Budget Process").

Figure 2

STEPS IN THE BUDGET PROCESS



a) The budget for any function (e.g. unit catering) should be drafted by the management accountant in conjunction with the budget holder.

b) The complete set of budgets for the unit should then be presented to the unit team. They will comment to the DMT as to the balance between budgets and make recommendations as to relative priority for developments - if necessary suggesting areas for reductions in order to finance developments.

c) The DMT will receive draft budgets and exercise co-ordination across units - in a similar way they will suggest the relative priority for developments, but overall; and may make recommendations for cut-backs in one unit to finance developments in another.

d) The DHA will receive the final set of recommended budgets and priorities for development from the DMT.

e) Following the DHA agreement, the budget will be confirmed to the budget holders (and notified to the unit team).

E Virement

The unit team also has another important role - virement. In this context it means switching budget provision from one budget holder to another within the unit, within whatever rules are laid down. Such rules might cover:

a) The position of Nursing
b) Fortuitous vs non fortuitous savings
c) Recurring vs non-recurring
d) Length of time to retain savings

*NB 'unit team' is used as a convenient term to describe the coordinating activity of the administrator, nurse and medical staff member(s). They may or may not actually operate as a formally constituted team.

The rules governing virement will be one of the most important decisions the authority will make. Clearly virement powers cannot be unlimited, otherwise the initial decisions taken by the DMT and DHA could be completely nullified. On the other hand if virement powers are too restrictive it will not allow the unit the freedom to manage, which is the keynote of the re-organisation.

One potential set of rules, included here as a basis for discussion, might be:-

a) Any virement is allowed except where expressly forbidden below.

b) No virement from a non-recurring saving to a recurring purpose may be allowed.

c) No virement from a non-staff saving may be applied to a staff heading without the prior permission of the district treasurer.

d) No virement may exceed £5000 or 2% of the budget, whichever is the greater, without the prior permission of the district treasurer.

e) Fortuitous savings are at the disposal of budget holders in exactly the same way as planned savings. However, as a 'quid pro quo' budget holders will have to recognise that unplanned overspends, regardless of cause, will be expected to be recovered by budget holders.

   If this principle fails, fortuitous savings will not be available for virement.

f) 'Savings' due to timing delays (e.g. late delivery of equipment) are not available for virement since they are needed in the next year.

g) Locally planned savings are 100% available on a recurring basis to the budget holder.

   Savings arising from DMT/DHA policy changes, or in response to an across-the-board DMT imposed cut are not available to the budget holder.

h) No virement can be deemed to have taken place until both budget holders have confirmed their agreement in writing to the district treasurer (so as to protect the 'loser' from being "rail-roaded") and had the change to their budgets confirmed.

i) The DMT may, on occasion, require virement across units.

One cautionary note - virement involves both a loser and a gainer. The high hopes for flexibility and delegation to unit level may still founder, not because of restrictive rules, but because no budget holder is prepared to give up savings to another. A prime job of the management accountant will be to advise the unit team of savings being made and the potential for virement, so that the unit team can exert the necessary pressure.

F Budgetary Control

Having set budgets which, hopefully, reflect the policy of the organisation, it is clearly necessary to control expenditure against the budget. This has the added benefit of controlling costs in total against the total cash limit, which is a statutory duty (section 5 NHS Act 1980).

Budgetary control is by the normal routine interaction of the management accountant and budget holder - reporting variances, investigating reasons and taking corrective action.

The role of the unit team should not be a routine one, otherwise they will be deluged with paper which will divert their energies from taking action. Perhaps the best method is for the treasurer to agree with the teams (unit, DMT and DHA)

a) The level of detail required.

b) The frequency with which it is required.

c) Whether exception reporting (i.e. significant variances only) is better in some cases than full reporting, even in a summary form.

d) Whether prospective systems (e.g. establishments, commitment accounting) offer better prospects for control than retrospective systems.

The policy on carrying-over year-end over or underspends also needs to be clearly laid down well before the year finishes.

G Role of Treasurer

Where there is a unit team, there may be some debate as to whether the treasurer (or his representative) should sit on it, have the right of access to attend it, or should be called in for appropriate items. Any unit team unwise enough to exclude a competent treasurer simply for reasons to do with emphasising team independence and status, will fail to get the best for their unit. Conversely, any treasurer unwise enough to send an incompetent representative to a unit team will fail to command the respect necessary for his advice to be heeded.

Finally, it must be remembered that the treasurer has certain statutory obligations which he must discharge as an individual rather than a team member.

H Which Professions Report Where?

Budgeting, as has been pointed out, reflects the management structure, so this question should have been settled already.

But authorities would do well to ponder two questions:-

a) Is it feasible for the unit nurse to expect to participate in unit decisions, if virement to or from the unit nursing budget is with another unit's nursing budget and not with other functions within the unit?

b) Is it practical to operate a system where para-medical budgets and services are unit-based, but they report to a district member of staff?

I Transfer Pricing

In a functional budgeting system, district-wide services (such as provided from a central pathology lab) usually have one budget.

In a unit budgeting system should they:-

a) continue to run as one budget, based on the unit where they reside? If so, what incentive is there for other units to economise? Who pays if other units expand?

b) 'price' their products (e.g. pathology tests) to the other units, who have the budget provision? If so, should this be at average or marginal cost?

J Points to Ponder

The previous financial paragraphs have dealt with some key issues that have to be tackled to change the service over to a unit basis.

In addition to these there are some things which deserve a mention, even though they apply whether a functional or unit (or indeed any) basis of financial management is being adopted.

a) Budgets should be notified in advance of the financial year. Given parliamentary approval procedures (i.e. a national budget in March) this is often technically impossible. But practically, much can be done using planning assumptions and issuing provisional budgets which can then in the main be confirmed.

b) No secret reserves should be kept. There may be a need for some reserves e.g. for pay and price inflation. But in general,

reserves should be discouraged, and certainly the practice of each level (DMT, unit team, budget holder, plus treasurer keeping them) should be avoided. The 'year-end-spend' which is often observed is usually due to this.

c) The budget holder should only be responsible for those costs which are significantly - not necessarily wholly - controllable by him. The management structure should be designed to maximise the extent to which the organisation's costs are able to be budgeted to a manager with controlling ability. This may mean placing budgets higher in the hierarchy where decisions are made; or decentralising decision-making; or identifying costs more clearly to budgets. Performance reports should clearly identify controllable and non-controllable costs and variances; and price and volume variances.

K Budget Holders

Budget holders should receive regular, prompt and accurate statements of expenditure against their budget; accompanied by appropriate statistical information.

L Job Descriptions

Job descriptions for budget holders should include specific reference to budgetary responsibilities.

M Goal Congruence

There should be goal congruence, i.e. management and budget structures should be such that the incentives in the system for individual budget holders are consistent with the overall goals of the DHA. At the very least perverse incentives (e.g. the incentive for a manager to spend as much as possible when the authority's goal is to minimise spending) should be avoided.

N Reward and Sanction

Management reaction to variances should be swift since the effect of reward or sanction is diminished the longer it is after the variance is incurred.

O Internal Control

There should be good internal control arrangements. In the haste to appoint all powerful individuals who can take decisions, do not forget basic principles to avoid fraud and waste.

P Links With Other Data

Financial information is fairly useless on its own. It needs to be linked with some measure of performance (ideally the same measure

as used in setting the budget). Manpower data (staff in post, paid hours) and patient activity data (in-patient deaths an discharges) provides a good start until more sophisticated data is ready.

Q Planning System

Units should be prepared to feed into the district's plans for the future. They will need resource assumptions otherwise the 'shopping list' or 'blue sky' approach will devalue their efforts.

R Openness

All budgets and named budget holders should be published so that staff can see who is responsible for what items.

S Zero-Based Budget

A change in management arrangements may provide the ideal time to introduce zero based budgeting. It may well be necessary to adopt a modified zero-based approach - identifying areas of saving in order to finance developments.

9 NURSING ISSUES

Nursing has the opportunity to create more radical change than just a different management structure. There have been positive gains in some districts in the attention paid to certain client groups and it is hoped that structures will facilitate such developments. However, in other districts, geography, the siting of institutions and health authorities' decisions willl not make this easy. It is essential that the nursing structure enables senior nurses to have responsibility for services for midwifery, mental handicap, mental illness and the care of the elderly infirm, as well as having an identifiable senior nurse in charge of each hospital. Community services may be best run separately, but where integrated units are established, it is important that they do not become hospital dominated.

The nursing structure below the level of the unit director of nursing remains uncertain. The lack of guidance on grading and salary may cause uncertainty for nurses, but the district team can benefit from it. Management structures should not be determined by the DMT alone, but by them and their appointed unit officers, and therefore a delay may be of benefit to everyone.

The principle aims for nursing, as for other groups, will be to work within the unit structure and management cost limits while producing an improved and simpler structure. In addition, nurses will want to respond to the demand from nurses and others to create clinical posts at a more senior level. The hidden agenda which should not be forgotten is the oft-expressed desire for the return of the matron! The matron's important qualities were those of a clear nursing leader with formidable authority.

In order to achieve a management structure which is better and simpler, it will be necessary for nurses to consider carefully the best structure to support the delivery of nursing. This will require specific and appropriate training of staff working in clinical areas, particularly ward sisters. The King's Fund project into ward-based training of newly appointed sisters provides important lessons in how this can be achieved.

The management structure will need to take account of certain support functions: research, personnel, planning, occupational health, child health, and local authority liaison. Some of these may form part of a management post, some will require support posts at district or unit level. An administrative support post will rarely adequately cover the nursing issues.

The nursing budget is such a large part of any districts's total budget that it interests all staff. For nurses and treasurers the most important issue is control.

Many nurses have worked for years with poor or inaccurate budgets which have used means or averages rather than actual salaries, and have failed to take account of allowances for unsocial hours, increments, leads and on call payments. Once an accurate budget is provided, control is the nurse manager's job, not the treasurer's. Information systems should be designed which facilitate not only control but management decision-making.

The word 'virement' has arrived recently in the NHS vocabulary. It appears to mean 'how to get a share of the nursing budget'. Potential unit administrators are concerned that the major part of the unit's resources will be effectively controlled by the nurse at district level. Virement should be allowed by each district within an overall health authority policy, but this may be on a non-recurring basis. In a situation of limited or no growth most DHAs will only change the service they provide by redirecting nursing money. Where nurses, or other staff, work to create saving they should be able to retain part of the savings.

With the move away from functional administrators, nurses will want to renegotiate their working relationships with administration. At the moment, major areas of patient care are in the hands of administration, particularly the care of the physical environment and the supply of food and clothing. Many nurses have, wrongly, divorced themselves from any responsibility for 'non-nursing duties'. However, a number of these areas have important therapeutic significance. Nurses should use the present changes to accept a shared responsibility with their administrator colleagues and take the lead in ensuring the satisfactory nutritional status of patients, the appropriate physical environment, and the provision of the most suitable furniture and equipment. Together, nurses and administrators should try to make all aspects of their service more customer sensitive. Adminstrators ought to consider which administrative functions need only be provided on a nine to five basis and which need to span longer hours.

No discussion on nursing issues would be complete without reference to nursing education. The management changes should not affect the posts of those nurses working in shcools of nurisng. The major changes in nursing education will be those currently under discussion by the UK Central Council, the new body with statutory resonsibility for nursing, midwifery and health visiting. The impact of present training programmes varies in different districts, but usually nurse training produces certain constraints and inflexibility in the use of nursing resources. However, training schools are usually the main source of trained staff recruits. Health authorities need to invest more in the education and training of qualified staff and this is likely to become a formal requirement in the future.

Professional nursing advice has to be available to each DHA and it will be up to the authority's nursing officer, in consultation with the nursing profession, to decide how this is to be done.

Nursing and midwifery professional advisory committees have had varying degrees of success, but they have provided a unique opportunity for nurses from all grades and disciplines to meet together to discuss matters of professional concern. Elections were cumbersome and time-consuming and a simpler system will be essential. In multi-district areas the exclusion of district nursing officers made for difficult communications and relationships. Where nursing units match nursing client groups there may be an advantage in having advisory machinery based on units which produce representatives to form a district committee.

Health authority chairmen, usually through their administrators, have expressed concern that advice may be given to the authority by an advisory committee which conflicts with that given by the authority's officer. There seems no evidence that this has been a problem during the past six or seven years. The health authority has to face the reality of differing views held by professionals and the nursing profession has to be mature enough to explain to the authority the reason for differing views.

This change in management arrangements is, for some nurses the third in ten to fifteen years and it will be faced with trepidation. It offers an opportunity to build on the strengths of previous ideas and to learn from the mistakes of the past. The flexibility exists now for nurses, with administrators, to provide a management structure to support and promote the delivery of health care.

10 FUNCTIONAL MANAGEMENT

Functional management in the NHS began in the 1950s as a method of dividing administrative duties in large hospitals. In some hospital management committees and a few teaching hospitals, top administrators devised new structures which allowed themselves, their deputies and assistants to specialise in particular parts of the overall administrative task. The chief administrator would advise the board or committee on overall policy, and maintain relationships with medical and nursing staff and external bodies; his subordinates would share the rest of the work of operational management, support services (sometimes called hotel services) and personnel services. These new structures often arose from the need to re-think management arrangements when new hospitals were commissioned.

For the most part, functional management was seen as a division of duties among administrators on a functional rather than a geographic basis, but at one of the London teaching hospitals there was the beginnings of what was called Fultonism (based on the Fulton report on the civil service) under which administrative areas of work might be headed by a professional specialist instead of an administrator. At St Thomas' Hospital, the director of works under the Woodbine Parish reforms was a works professional.

Reconsideration of management structures at the time of the 1974 reorganisation understandably encouraged most health service professionals to take the opportunity of furthering their professional status and career prospects by pressing for functional managers in various professions at different levels, from district to area. Some professsions had already achieved representation at regional level by the appointment of regional pharmacists and scientific officers and catering and domestic management advisers.

Functional management was one of the key issues at the series of workshops held at the King's Fund College in 1980 to discuss the strengthening of unit administration.

At the first workshop, medical and nursing representatives spoke frankly about the shortcomings of administration since the 1974 reorganisation. While administrators had become more involved in planning an integrated health service, they had neglected their traditional role as hospital managers and consequently depleted resources at hospital level. The administrator was left to be not only a provider of support services, but an overall coordinator and leader and motivator of the whole institution.

Many unit administrators were younger than their medical and nursing counterparts and found it difficult to obtain results promptly from higher graded functional managers at district level. The strengthening of unit management, emphasised in "Patients First",

required functional services such as catering, domestic management and works to be accountable to the unit administrator.
Functional managers stressed the importance of functional management at district level to provide advice to the new DHAs and to ensure that there was professional leadership and high professional standards in each function.

Difficulties associated with functional management included:-

a) Medical and nursing staff demanded that unit administrators should be able to marshall resources in support of clinical colleagues without delay.

b) The quality of functional management, although sometimes excellent, was nevertheless variable.

c) Functional management gave rise to divided accountability and the matrix or service-giving concepts did not always provide an easily understood and effective solution.

d) Functional management produced loyalties to district functions and militated against unit identity.

e) Management costs were inflated by the proliferation of hierarchies.

f) Non-operational functions advisers became increasingly less credible the longer they were at a level remote from operational management.

Professor John Childs* has identified the problems in matrix organisations, which functional management necessitates, as being:-

a) A threat to occupational or organisational identity.

b) Conflict from having more than one superior.

c) Greater administrative costs because of the multiplication of hierarchies.

d) Managerial time devoted to resolution of conflict.

So both practical experience in the field and academic theory combined to bring into sharp focus the doubts about whether functional management should be continued especially if overall management costs had to be reduced.

*CHILDS John - "Organisation - A guide to problems & practice" - Harper & Row

Functional management nevertheless has displayed several advantages including:-

a) Widest use of the best expertise.

b) Ease of comparability of units to performance.

c) Professional leadership.

d) Ready advice to DHAs.

e) More effective and more easily accountable budgetary control.

f) Setting of standards and monitoring performance.

g) Alleged freeing of unit administrators for other tasks.

h) Cost effectiveness.

i) Extended and more attractive career structure.

Some of these advantages can also be realised in alternative management structures.

It is commonly agreed that the tasks of support services, however organised, should be cost effective, of an appropriate quality, properly integrated with other services, well managed and planned and developed according to need.

A number of alternative organisational options for dealing with functional management have been identified as follows:-

a) District functional manager.

b) District adviser.

c) Supra-district adviser.

d) Rotational district adviser, the task rotating between unit functional managers.

e) District adviser in one unit combining advice with operational management.

f) District support services manager.

g) Functional managers in units only.

A general prescription for all districts would clearly be inappropriate, but a possible solution worthy of consideration would be to pursue a middle road, reducing the number of district functional managers but retaining some in functions which do not fit economically or effectively under unit control.

Where functional managers do not remain at district level, the benefits of professional leadership may still be retained in some functions at least by nominating an individual functional manager at unit level with part-time district-wide advisory role. Such district advisers who retained an additional role as unit functional managers would be accountable to the unit administrator. They might be as influential in the future as they were in the past and could be styled district catering leader - for leadership in their calling would best describe their role.

In each district a custom-built solution must be found for example, which depends on management costs to be saved, abilities and availability of officers to fill the posts envisaged and the success or failure of existing management arrangements. A suggested division of functions under the different optional arrangements could be as follows:-

A **Retained District Based Functional Managers**

(Accountable to the district administrator, probably through a second-in-line-officer)

Works (but unit administrators would hold budget allocations and act as clients for Eastmancode category B and D work)

Supplies	Ambulance Services	Residences	Dietetics
Transport	Fire Prevention	Pathology	Pharmacy
CSSD	Security	X-ray	Occupational Therapy
Laundry	Health Education	Physiotherapy	Occupational Health
		Dental Services	

B **Unit Based Functional Managers with Unit Operational Role but also District-Wide Part-Time Advisory Role**

(Accountable to unit administrator of unit where based)

Catering	Speech Therapy	Clinical Pathology
Domestic	Audiology	Medical Engineering
	Chiropody	Medical Physics

Medical records/patient services including medical secretariats.

Para-medical and scientific services such as pathology, x-ray, medical physics, physiotherapy, occupational therapy have been included in the suggested distribution but arrangements for them are more likely to vary with local circumstances.

C **Unit-based functional managers**

(Accountable to unit administrator)

Portering	AppliancesTelephonesEEG
Linen distribution	Cardiography
Supplies Distribution	Opticians
CSSD Distribution	Orthoptists
Postal Services	Operating Department Attendants
Sewing Room	ECG
Refuse Disposal	Medical Photography
Postal Services	Voluntary Services
Library	Social Work Liaison

11 STRENGTHENING UNIT MANAGEMENT - AN EXERCISE IN ORGANISATION DEVELOPMENT

The government's stated policy of achieving significant delegation to units of management within health authorities has the potential of becoming a time consuming charade. The issuing of circulars HC(80)8 and HN(81)34, study days for new chairmen and the avuncular eye of regional health authorities are unlikely to be sufficient to secure a radical change of existing policies. The danger is that the expectations roused in managers, staff and public by the challenge of strengthening unit management will be frustrated by the enormous inertia within existing health authorities. The pressure of conforming with the requirements of national policy may lead to substantial changes in formal structures and rules of the organisation which might quickly become divorced from the day-to-day informal practice as the reluctance to change presses the organisation back towards the status quo. One method of avoiding this potentially destructive state of affairs is to regard the strengthing of unit management as an exercise in organisational development which requires systematic planning and training. This suggests a purposive evolution rather than a radical revolution which will occur on an arbitrary date in 1982.

The political and historical background

One of the most unfortunate results of the national nature of health service organisation is that it is subject to politically attractive fashions which are propounded as universal panaceas to management problems within the service. This tends to overlook the very different characters and needs of individual health authorities and over-simplifies the tradeoffs between advantages and disadvantages that are usually involved in alternative organisational models. The 1974 reorganisation placed emphasis on specialist management, the advantages of centralisation and economies of scale, integrated health care for a community related to other social services, and the importance of corporate planning. Dissatisfaction with some of the inevitable disadvantages associated with this type of organisation coupled with other problems unrelated to the organisational form (such as inflation and the oil crisis) led to a general reaction against the 1974 management structure. This was articulated through the Royal Commission and distilled by the government into two key organisational changes (in addition to simplifying the planning system and reviewing the professional advisory machinery) - unitary health authorities below regional level and strong units of management with considerable delegated powers of decision making. The first of these proposals probably had a very wide measure of support within the service which has only been reduced by its rather erratic implementation. (For example the decision to divide several large cities into separate health authorities).

However, even without support in the service the creation of unitary authorities is readily amenable to implementation through central control and legislation.
On the other hand, the policy of delegating considerable managerial autonomy to units appears to have rather more fickle and patchy support within the service. At the level of generalisation, usually the province of politicians, most senior managers probably approve of 'maximum delegation' rather as they all disapprove of sin. This kind of rhetoric, however, conceals a large measure of disagreement about the desirability of delegation and what this might mean in practice.

The implementation of the general policy of strengthening unit management could either be secured by senior managers being convinced of its value and being motivated to seek its achievement or by close central monitoring and control. There is currently little evidence of spontaneous enthusiasm for the policy within the service and the government's previous record of achieving changes of this kind at the periphery of the NHS by means of central fiat would not encourage much optimism on this front.

The problems of implementation

If the current situation is analysed in terms of power and the pursuit of interests, it is difficult to identify a great deal of influential support for strengthening unit management. It is commonly supposed that the government's policy was influenced by two principal groups. Firstly, the doctors, particularly doctors in acute hospitals, who it is thought wished decision-making to be decentralised so that they would have greater control over the management of the organisation in which they work. Secondly, unit and sector administrators who were able to suggest that many operational management problems stemmed from the reduction in their own authority and the development of specialist functional managers at district level.

Neither of these groups currently represent powerful forces for devolution. The doctors, while often supporting the idea of local management, appear reluctant to back this with any real enthusiasm. Indications are that doctors will not be queueing up to serve on unit management teams and will often devote their political activity to influencing the DMT and the authority. The decision to keep consultant contracts at regional level, with the exception of teaching districts, was a timely reminder of the doctors' propensity to bypass local management when the opportunity arises.

Existing sector and unit administrators, even where their enthusiasm is undimmed by the prospect of managing the catering department, are not in an influential position. They have no guarantee of particular posts in the new structure and depend on the support of the new district administrator for their future.

On the other hand the forces for a centralised, district focus for management are potent. The new district health authorities are in

many cases nearer to the grass roots than their predecessors and members will require considerable willpower if they are to avoid intervention and interest in the minutiae of managing hospitals.

Similarly, the district focus of the community health councils will tend to draw even the most reluctant DMTs in to day-to-day issues.

DMT members themselves are likely to have mixed and contradictory views about delegation. There are treasurers who fear loss of financial control if we move from functional budgets to unit budgets. There are district medical officers who are reluctant to sever managerial connections with the paramedical staff. There are district nursing officers who support the Rcn policy of retaining a whole district nursing budget to allow easier virement between units. There are district administrators who are reluctant to move from the public arena of crisis management.

In most existing districts the senior functional managers are also a powerful force for the status quo. Many have proved professionally effective, raising standards and improving controls, and are seen as virtually indispensable to the organisation.

Medical opinion, which is usually extremely influential in the health service decision making process, is muted. It is possible that this is a combination of apathy and reluctance to commit themselves until the location of real power in the distribution of resources becomes apparent.

Finally, staff organisations will, in many instances, be reluctant to give up the direct relationship with district management which has been painstakingly assembled during the last seven years. Most unions would find it difficult to provide sufficient stewards of calibre to operate effectively in each separate unit.

An exercise in organisational development

If the analysis so far is anywhere near approaching the truth then we are in danger of moving into an era where the formally stated policy of health authorities - maximum delegation to units - will be hopelessly out of line with reality. This would appear to be a recipe for frustration and inefficiency as managers spend their time managing the system rather than improving their performance in the interests of health care for the community.

This suggests the need for an explicit organisational plan for delegation to units which can be phased over a period of time to allow for training and changes in attitude. The capacity of health authorities to change and achieve delegation will be markedly different. It is apparent that there are many health districts who have delegated more authority to units <u>now</u> than others will achieve by April 1983. An organisational development exercise of this complexity demands some form of simple system and documentation if it is to be effective.

The chief officers are in the key position in determining whether positive achievements can be made in organisational arrangements. A simple system which documents intentions in respect of delegation to units is needed if the pressure of other important management tasks is not to push the development of units into a series of ad hoc, ill-coordinated decisions. Communications of ideas is perhaps the other most important reason for a documented plan.

It is vital that chief officers who are formulating ideas on roles and delegation are able to disseminate these views to subordinate staff and other professions. This then allows the organisation as a whole to negotiate and reach a common understanding of the degree of delegation to be achieved - a shared expectation. For example, new district administrators can make their views known to functional managers, existing sector and unit administrators and other professions, particularly nursing. This would enable district nursing officers to gauge compatibility with their own proposals in respect of delegation to directors of nursing services.

There are three distinct phases in such an approach. Firstly, there is the stage of establishing the existing situation - the facts. (Undertaking this exercise in one district caused some surprises; the district administrator said that he had not previously appreciated that what they currently did was to centralise success and decentralise failure!) Secondly, the chief officer can suggest an optimum degree of delegation to units - the ideal. This then provides a negotiating document which can be discussed and considered with authority members, the DMT, other professions, subordinates, trade unions etc. As a result of these discussions the third stage of an organisational policy can be achieved - the plan. This provides a planning document which can be monitored and reviewed after a given time period. The time period would vary from district to district according to the amount of change intended and the local capacity for change.

One such system for planning delegation to units is 'Reviewing the strength of unit administration: an audit approach'.*

This divides the task of unit administration into six key areas:-

a) Setting and monitoring standards
b) Finance
c) Functional management
d) Communications and coordination
e) Personnel and industrial relations
f) Planning and development.

These sections are to some extent arbitrary and are not mutually exclusive but nevertheless provide a convenient classification for analysis of roles. Each of the six areas is divided into a number of key questions designed to highlight the degree of real responsibility for existing and proposed administrative units.

*"Reviewing the strength of unit administration: an audit approach" - C Fewtrell, University of Birmingham - HSMC - Occasional Paper No. 39.

The two papers which relate to personnel and industrial relations are attached by way of illustration (figures 3 & 4). For example, this section asks the question: 'Does the unit administrator have responsibility for dismissal of staff from the unit?' The current situation might be that this is never so, in which case the appropriate box in the existing section would be coded '1'. The district administrator might, however, propose that the ideal is that in all cases the unit administrator should have delegated powers of dismissal. The box in the ideal section would be coded '5' (indicating always or completely responsible).

Following discussions with the district nursing officer, district personnel officer etc, the organisation's policy might be that dismissal should in most cases be a unit decision with some defined exceptions. The plan (or revised objective) section of the document would be marked with a '4' (indicating mostly or majority).

This document is readily adaptable to local needs and a parallel system has been developed with questions which are directed specifically at nursing organisation and roles. However, any system developed locally would serve the purpose equally well as long as it provided a basis on which ideas could be exchanged and an organisational plan negotiated. Having achieved an organisational development plan for delegation to units, the implications for training and changes in policies and systems becomes much more explicit. Training can be specifically geared to those issues where the greatest gap is identified between existing and desired roles.

The greatest danger is that pressure of work and lack of enthusiasm for the development of strong units of management will lead chief officers into generalisations about delegation which are not reflected in training or in actual organisational performance. If this is allowed to happen, then the chaos and frustration which will ensue will leave the health service ripe for yet another reorganisation as the next organisational panacea commends itself to the government. We must avoid the danger of strengthening unit management becoming a charade played out to satisfy national policy, and take the opportunity to treat it as a challenge in organisational development adapted to meet local needs.

Figure 3

STRENGTHENING UNIT MANAGEMENT - E. PERSONNEL AND INDUSTRIAL RELATIONS

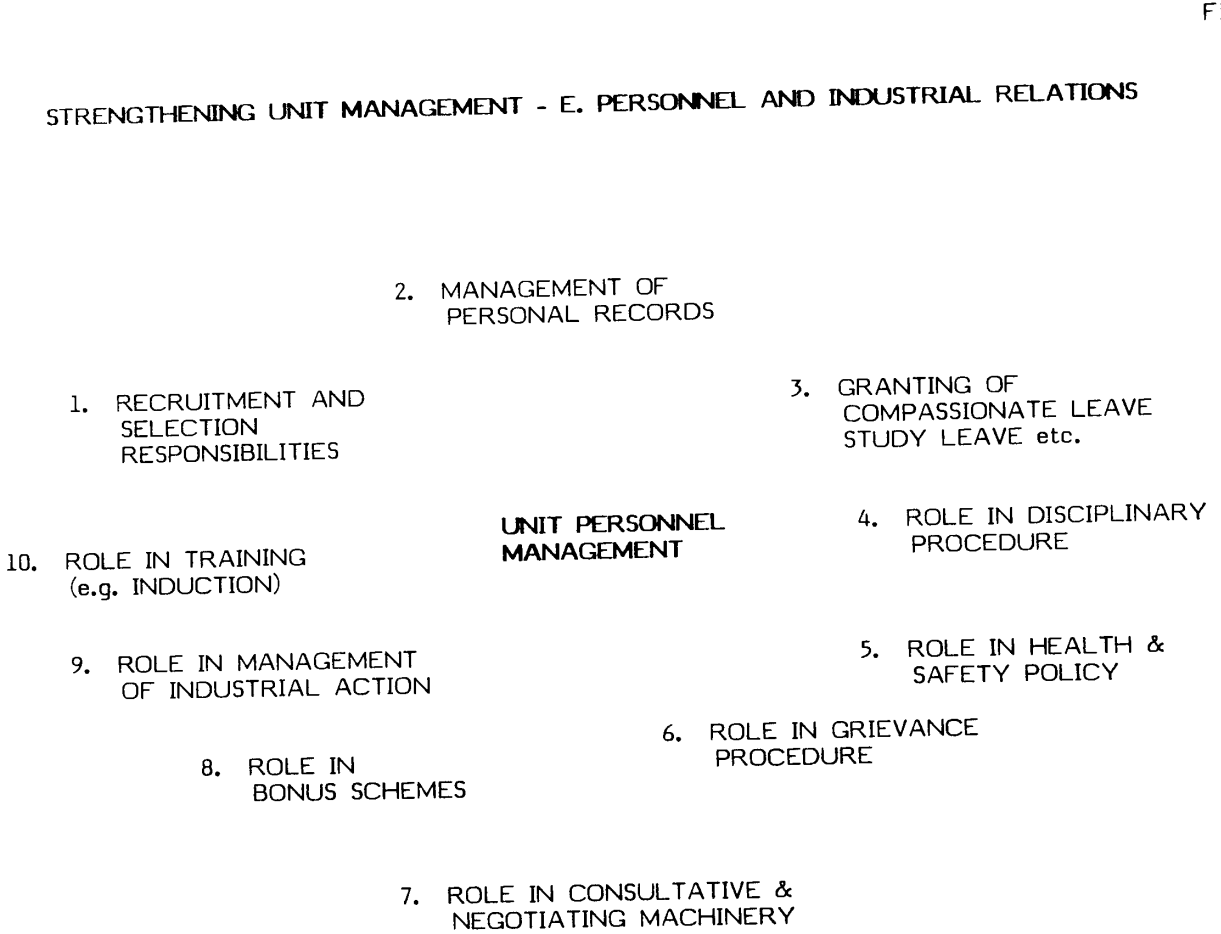


Figure 4 – Personnel and Industrial Relations Responsibilities

Does the Unit Administrator have responsibility for:-	EXISTING 1 2 3 4 5	IDEAL 1 2 3 4 5	REVISED OBJECTIVES 1 2 3 4 5	COMMENTS
1. Recruitment and selecion of senior managers within the unit?				
2. The management of unit staff personal records?				
3. The granting of special leave (e.g. compassionate or study leave?)				
4. The dismissal of staff from the unit?				
5. Issuing final disciplinary warnings to staff from the unit?				
6. Health and safety matters within the unit?				
7. Resolving grievances referred to by unit departmental heads?				
8. Staff consultation and negotiation machinery for the unit?				
9. Agreeing and monitoring incentive bonus schemes within the unit?				
10. Managing and resolving industrial action arising within the unit?				
11. Induction of new staff to the unit?				
12. Training for staff within the unit?				
13. Recognition of trade union representatives within the unit				

12 THE FUTURE

This paper primarily summarises the issues that have emerged from the King's Fund College Workshops and the Centre's series of seminars. Experience will inevitably show different managerial patterns emerging, many being regarded as equally successful. The pace of change will also vary, tardiness sometimes being due to resistance, or it may be attributable to a contrived plan to carry the unit into reorganisation at a pace it can cope with.

Whatever happens, the principal objectives of this reorganisation will take some time to accomplish: 'a better health service and one that is better managed' requires more than just a new structure. Qualities of leadership at unit level, the motivation of departmental managers and their management training, effective machinery to encourage staff participation, and supportive professional advisory machninery are just four of the prerequisites for success. Each of these can take at least two years to develop: if good fortune allows them all to flourish simultaneously, then patients may see good results from reorganisation sooner rather than later.

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