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Holding On While Letting Go

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A Report on the Relationship between Directly Managed Units and DHAs

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KING'S FUND COLLEGE

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INTRODUCTION

'Working for Patients' aims to separate responsibility for purchasing health care and providing services. But complete separation will take a number of years to achieve. For some time to come, DHAs will retain responsibility for the management of units providing services and this will go hand in hand with their purchasing role.

In this situation, DHAs need to establish management arrangements in which the purchaser and provider functions are clearly distinguished. If this is not done, those responsible for purchasing may not be able to act with sufficient independence in deciding which services to buy for their residents. Equally, those responsible for providing services may not be able to develop the management capacity needed to run their services efficiently. Only where there is a clear separation of functions within districts will purchasers and providers be in a position to carry out their new responsibilities in an effective manner.

Separation cannot be taken too far, however, because DHAs will retain responsibility for directly managed units (DMUs) keeping within cash limits. Also, if a major incident occurs within a DMU, such as an outbreak of food poisoning, then the DHA will be held ultimately responsible. A further complication is that DMUs cannot negotiate a contract with purchasers of services other than their own health authority without the authority (as the corporate body responsible for the DMU) formally signing the contract. For all of these reasons, the health authority and some of its top managers will need to be involved in both the purchaser and provider functions.

Against this background, the NHS Management Executive commissioned the King's Fund College to undertake a short study of how management thinking and practice on these issues was developing in different parts of the NHS. The study, which was undertaken between March and May 1990, was intended to complement work on the purchasing role of DHAs, summarised in the Department of Health's report 'Developing Districts'. The issues addressed in the study included the separation of purchaser and provider responsibilities in DHAs, the role of the DGM in relation to purchasing and provision, devolution of functions to DMUs, and the role of non-executive directors in the work of DMUs. A full list of the questions which provided the template for the study is given in Annex 1.

At an early stage, these questions were discussed and refined at a meeting of the King's Fund College learning network on the role of DHAs. Visits were then made to six districts which were known to have given some consideration to the questions. The districts were: Eastbourne, Frenchay, Northumberland, North Warwickshire, Southampton & South West Hampshire, and Riverside.

The information gained from these districts was supplemented by intelligence gathered from a number of other authorities through personal contacts and telephone discussions, and from a review of the health services literature. The emerging results were tested at two workshops held at the King's Fund College, and at a meeting of the Department of Health's Project 26 steering group. Additional data were gathered at a joint King's Fund College/NAHA conference on DMUs held in May 1990.

This report summarises the conclusions of the study. It begins with a description of the various organisational models that have emerged so far. This is followed by an assessment of what has been done to develop the purchaser and provider functions. The report then discusses the management processes that will be needed to make the new structures work. This includes devolving responsibilities to units, thinking through relationships between DGMs and UGMs, and examining the role of non-executive directors. The penultimate section of the report comments on a number of other issues that have emerged during the study, such as the need to build on the strengths of the people involved and the challenge of managing the transition to the new arrangements. Finally, the various strands of the analysis are brought together in the conclusion.

The principal aim of the report is to help authorities work through DHA/DMU relationships in their own localities. In pursuing this aim, the report both describes management arrangements in the districts included in the study and evaluates their strengths and weaknesses. It does not advocate a single approach but rather seeks to move thinking forward by identifying and discussing the issues that need to be considered in 'holding on while letting go'. Annex 3 contains a checklist of questions for use by authorities in working on these issues.

THE STUDY

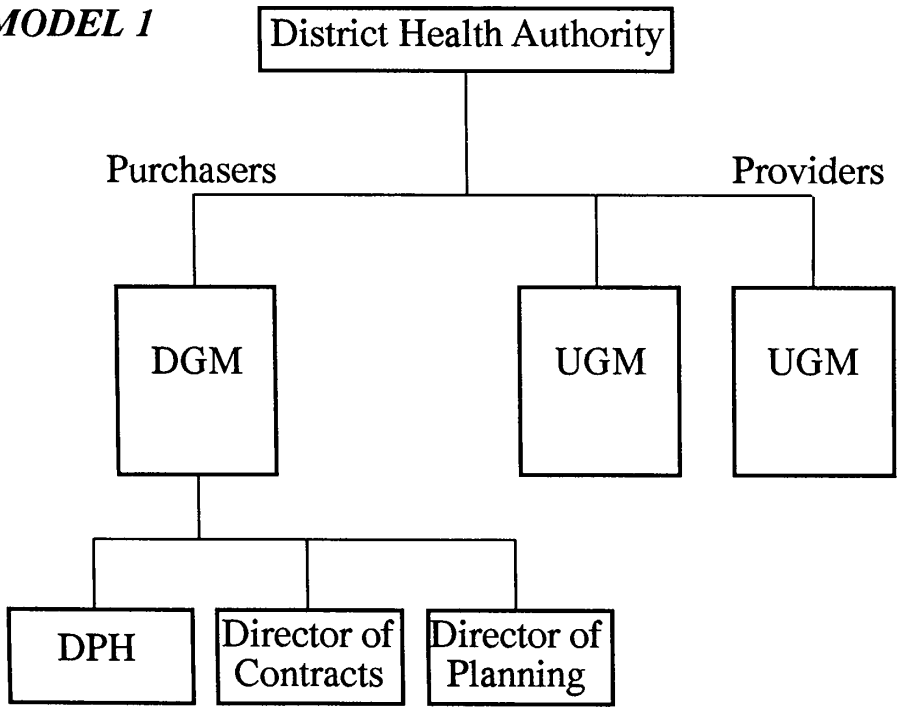
Separation of Roles: Organisational Models

A number of organisational models have emerged in recent months. These models are illustrated in the text. In Model 1, responsibility for purchasing rests with the DGM and a purchasing team. UGMs are responsible for service provision in DMUs and are accountable directly to the DHA (not the DGM) for their performance.

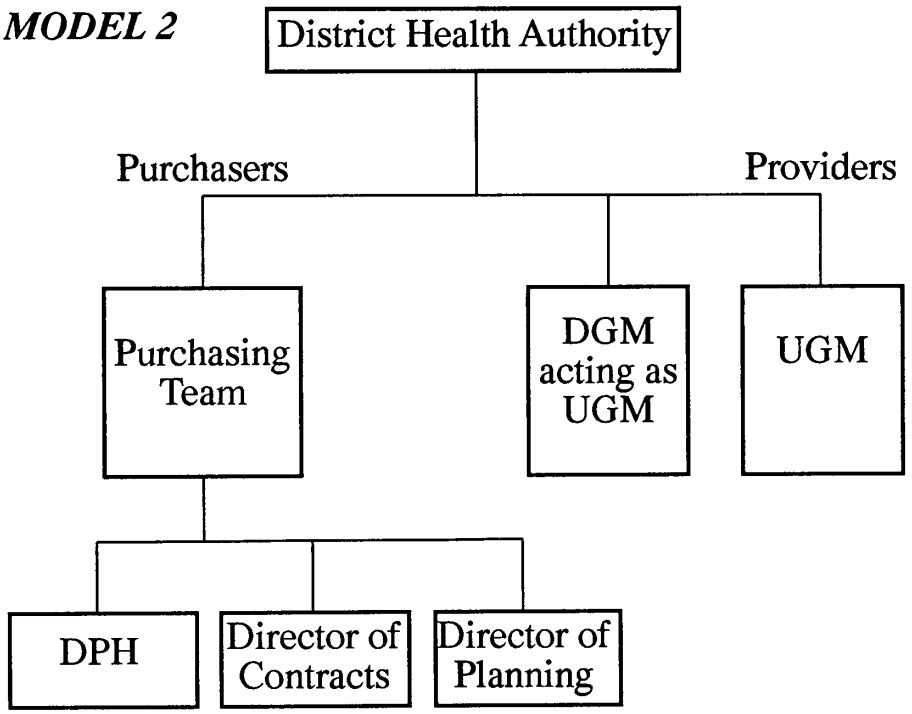
The DGM is able to focus attention on the new purchasing role of DHAs and the UGMs are expected to run their units as if they were NHS trusts. The DHA oversees the work of both purchasers and providers and the authority chairman is a key figure in this process. It is the chairman - not the DGM - who conducts IPR of the UGMs, and it is the chairman's job to ensure that the district as a whole is properly managed.

This model is heavily dependent on the existence of experienced and able UGMs who can assume greater responsibility for the management of their units. If this condition is not met, then these management arrangements would have to be revised. This would probably entail the DGM becoming involved again in the provider function as well as leading the purchaser function. The model also depends on the chairman being able to take on more of an executive role as the DGM moves away from a line management relationship with the UGMs.

MODEL 1



MODEL 2



In Model 2, responsibility for purchasing rests with the purchasing team led by a director of purchasing. Service provision is in the hands of the general managers, including the district general manager who has assumed a leadership role in relation to one of the units. This is a mirror image of Model 1 in that the purchaser and provider functions have been separated but with the DGM identified as a provider.

In practice, the DGM is unable to relinquish entirely his involvement in purchaser issues, and is drawn back in when difficult questions arise at district level. This can cause conflicts of interest, as when the DGM has to play a part in deciding on the funding of units. For these reasons, Model 2 is seen as a temporary expedient, pending the early establishment of NHS trusts and the complete separation of purchaser and provider functions.

In Model 3, the purchaser and provider functions are separated below the DGM. Responsibility for service provision rests with UGMs who remain managerially accountable to the DGM. Responsibility for purchasing rests with a purchasing team whose senior members will form the executive directors of the new DHA. The DGM, who will also be a member of the DHA, sits over and above the purchaser and provider functions.

Each of these models has strengths and weaknesses. Model 1 forces managers to work through the implications of the purchaser/provider split at an early stage. In so doing, the model encourages learning by

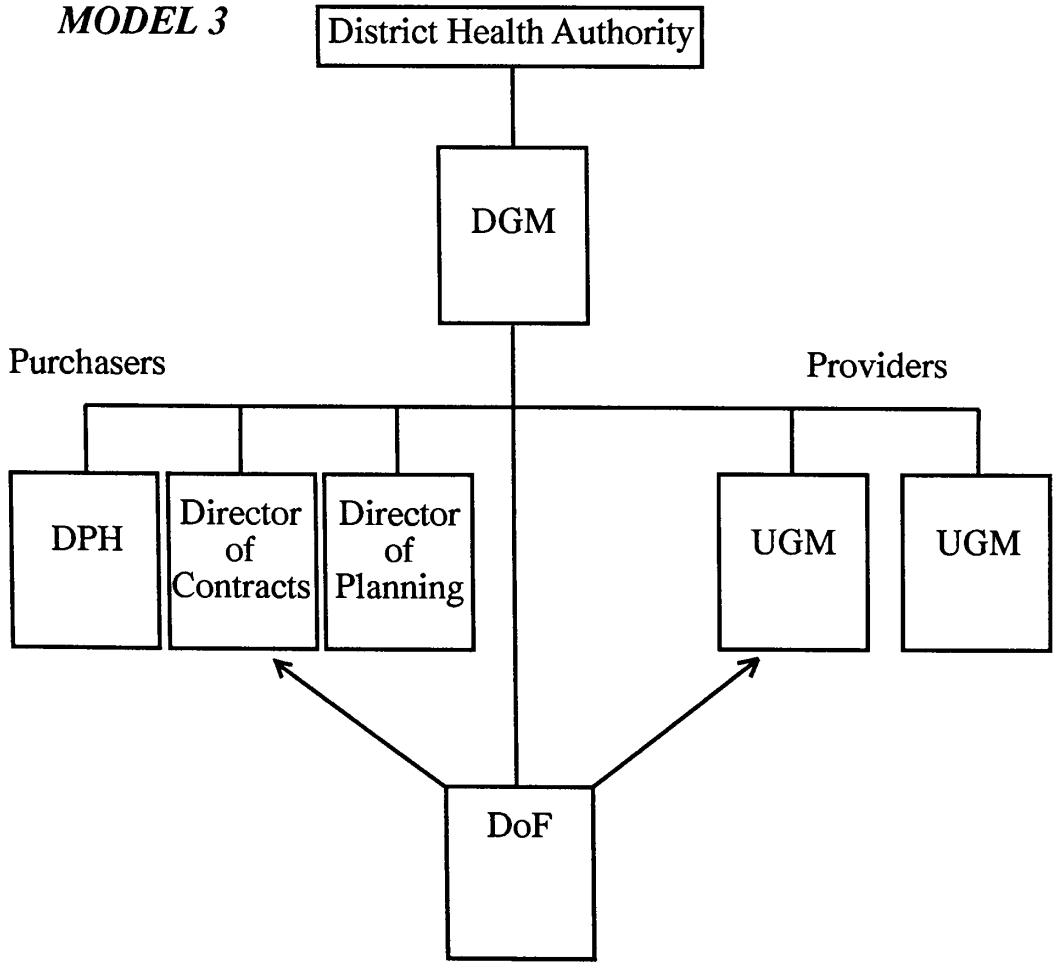
doing, with purchasers having the opportunity to take on responsibilities largely new to the NHS, and providers able to understand more clearly what is likely to be involved in trust status. Against this, a heavy onus is placed on the authority chairman, who in effect becomes the general manager for the district as a whole. Also, by removing the DGM from a line management relationship with UGMs, there is a risk that the authority may lose control of the financial and managerial performance of units.

Model 2 also encourages learning by doing. Like Model 1, it requires managers to decide whether they are providers or purchasers, and it appears to have found favour in those districts where units are moving rapidly to become NHS trusts in the first wave. However, difficulties have arisen in the transitional period, especially in the divided loyalties of the DGM. Also, the identification of the DGM with the provider function creates problems in giving equal status to the purchaser role in the authority.

Model 3 seeks to adapt existing management arrangements to the requirements of the White Paper. The strength of this approach is in enabling the purchaser and provider functions to be developed within the district under the guidance and leadership of the DGM. In this way, the top manager is able to ensure that these functions are separated and that providers are organised in an arm's length relationship with the authority.

The main weakness is that the model runs the risk of maintaining existing relationships and not taking advantage of the opportunities offered by the White Paper. Clearly, much depends on the spirit in which Model 3 is implemented and whether the intention is to bring about real change or merely to give the impression that things are different.

These three models do not exhaust the options available to health authorities. There are variations of each approach, reflecting local circumstances and the



preferences of managers and their authorities. Model 3 has found most favour in the districts included in this study and it would seem easier to adapt this model to the new-style authorities.

In particular, the inclusion of general managers and other executive directors on DHAs in future will make it difficult for the DGM to avoid involvement in both the purchaser and provider functions where DMUs continue to exist. The distinction between Model 1 and Model 3 in practice is therefore likely to be one of emphasis rather than substance. In both cases, DGMs will be involved in purchasing and provision, the main difference being that in Model 1 it is the purchasing function of the DGM which is pre-eminent. The appointment of other executive directors to the new DHAs will also reflect the purchasing role of authorities. Indeed, authorities have been advised by the Department of Health that UGMs and other managers in provider units are barred from serving on authorities.

In view of this, model 2 is not tenable under the new arrangements. The DGM in this situation will have to determine quickly whether to become chief executive designate of an NHS trust or to continue as DGM. If he or she decides to move to the trust, the authority will need to appoint a replacement to lead the purchasing function and to supervise the management of any remaining DMUs. As these comments indicate, Model 3 appears to be the most robust of these options as the White Paper is taken forward.

In summary, while DHAs continue to manage units, the separation of purchasing and provision will be incomplete. All the approaches developed so far have potential weaknesses and it will not be possible in the immediate future to establish a 'pure' purchasing role. DHAs and their top managers must monitor the performance of their units and ensure that effective management arrangements are in place while building up their purchasing capability.

The Purchaser Function

While there are important differences between the organisational models developed so far, in all districts studied there is a large measure of agreement on the nature of the purchaser function and the skills needed to support it. High priority has been given to the appointment of staff with expertise in public health, contracting and quality, finance and planning. A core group with these skills has been put in place and work is now starting on making a reality of the purchaser role. This includes drawing up service specifications and establishing contracts with DMUs and other provider units.

The number of staff needed for purchasing purposes is likely to be considerably less than the number currently employed in management roles at district headquarters. The reason for this is that many of the responsibilities of headquarters staff will in future be devolved to units. This in turn will enable district managers to concentrate on the purchasing role. Despite this, it has not always been easy to recruit people to staff the purchasing function.

As a consequence, some districts have started to explore how they might establish partnership or consortium arrangements with other DHAs. In most cases, the consortia that are being established involve districts coming together informally to share scarce skills and tackle tasks jointly. One exception is in South East London where three DHAs have been discussing the establishment of a commissioning agency on a formal basis. The agency would have delegated power from the districts to negotiate contracts, and eventually it would develop into a health authority covering the area served by the districts.

In other parts of the NHS, steps have been taken to consider district mergers where opportunities arise. An example would be where all or most of the services provided by a district intend to move to trust status in 1991 enabling an adjacent authority to take on purchasing responsibility for the district. In the longer term, the establishment of fewer, larger DHAs should enable each district to attract the critical mass of staff needed for the purchasing function. As 'Working for Patients' indicated, mergers will be a natural by-product of the development of NHS trusts.

The Provider Function

All districts are actively devolving management responsibilities to units. The extent of devolution varies considerably, some authorities having a tradition of district control, others having taken the opportunity created by the introduction of general management to build up the managerial capacity of units. As authorities concentrate on the purchasing role, those responsibilities which remain at district headquarters and which are not essential to that role have come under critical scrutiny.

The services concerned are principally finance, estates and personnel. Functions such as planning and information are also affected. In each case, districts are examining the degree to which these services should be retained at district level. Units have often looked to district headquarters for support in these services in the past but increasingly this is seen as incompatible with the purchasing role. Although there is a strong presumption in favour of devolution to enable districts to focus on their core purchasing responsibilities and to enable each unit to be as self sufficient as possible, there are different ways of achieving these objectives.

One option is for districts to focus principally on the purchasing function and to employ a small number of other staff to enable statutory responsibilities in relation to financial control and viability to be discharged. Where this is done, units become self sufficient at an early stage.

Another option is to devolve some services to units but to retain others at district to take advantage of economies of scale. In this option, those services that remain at district may become the responsibility of individual district directors, or they may be brought together under a common services agency. In both cases, budgets are usually devolved to units and UGMs negotiate service agreements with the relevant district director for the provision of these services. A further possibility is to devolve services to one or more of the units and for the UGM(s) to sell these services on a service agreement basis to district headquarters and the other units.

As districts have considered devolution, so the number and configuration of units has come under review. Often, this process started well before publication of the White Paper, but it assumed new significance as authorities were encouraged to establish self sufficient provider units. In all districts in the study, this has resulted in a reduction or a planned reduction in the number of units with the aim of creating units better placed to run their own affairs. While it is important to avoid organisational change for its own sake, it is clear that a review of unit structures will often be helpful.

From a unit perspective, achieving greater independence is likely to mean going beyond having an enhanced capacity in relation to finance, personnel and other functions. In particular, it will be important to develop a management culture in which units are able to run their own affairs with minimal interference from district. If this is to become a reality, DHAs will have to establish a coherent policy and management framework and hold units accountable within this framework.

Put another way, the aim should be to develop a loose-tight relationship which allows unit managers considerable freedom to manage their business provided that they deliver the objectives set by the district and keep within district-wide parameters. Greater delegation and control through objectives will allow DMUs to operate in a similar way to NHS trusts. As discussed below, this calls for explicit understandings on the circumstances in which DGMs will be expected to become involved in the work of units.

The DGM's Role

One of the most important and at the same time most difficult issues to emerge in discussion of DHA/DMU relationships has been the role of the DGM. In a few places, DGMs have taken a clear and early decision that their future lies either in purchasing or in service provision. More typically, DGMs have not yet made such a decision and have sought to retain involvement in both areas. Where this has happened, Model 3 has usually been adopted, leaving the DGM at the apex of the district, standing over and above the purchasing and providing roles.

A key influence here is the fact that most DGMs have pursued a career in operational management. There is therefore a natural and understandable inclination for managers to gravitate towards provider units, or at least to resist the notion that they should give up entirely their involvement in service provision. Model 3 enables DGMs to retain a link with providers, albeit at greater distance than in the past. Depending on the extent to which district services have been or are being devolved to units, Model 3 allows DGMs and their authorities to adapt gradually to the new arrangements.

In view of the aim of 'Working for Patients', it is important that the continuing responsibility of

DHAs/DGMs for the performance of their units is not used to maintain existing management relationships largely intact. In particular, DHAs should retain only those services or functions which are central to the purchasing role and cannot be carried out more effectively within units. As one of the districts involved in this study stated in its proposals on the future role of the health authority:

The key to the relationship is to recognise that the purchaser and the provider are mutually dependent on one another, and that both have the same objective, namely the cost effective provision of high quality health care to the public. Within this context the responsibilities of the units are to be clearly defined and maximum autonomy delegated to them to perform against their tasks and objectives. It follows that the operational services which will remain at district level will be those that are best performed collectively for reasons of economy and efficiency, and these will be organised on an agency basis to provide a service to the units. The principal district establishment will be concerned with the purchasing function, not with supervision or support of the operational management of the units, and whilst some advice will continue to be available from district professional staff this will be ancillary to their main roles.

The process of devolution may take time in some cases but the direction of change should be firmly established at an early stage. This should include considering the scope for some services to be contracted in from the private sector (eg legal advice) or from health authority consortia (eg payroll). If DHAs do not look rigorously at the services they themselves need to provide, then it will take longer than necessary to build up effective purchaser and provider organisations.

DGMs have a key role in forcing the pace of devolution and in ensuring that change occurs in an orderly fashion. Where DMUs continue to play a part in service provision, DGMs will have to promote and encourage the purchaser role as well as oversee the performance of units. In this situation, the essential role of the DGM is to lead, guide and support managers who have specified responsibility for either purchasing or provision and to provide general management leadership for the district as a whole.

UGM/DGM Relationships

Where the DGM stands over and above the purchaser and provider roles, then UGMs continue to be accountable to the DGM. However, the nature of accountability is likely to change. In particular, DGMs will want to focus increasingly on approving and monitoring unit business plans and objectives. As one of the districts involved in the study has stated:

The relationship should come closer to the model of a commercial corporation managing subsidiary companies. The DGM will want to approve business plans and strategies, to set targets for the year and to monitor performance, using agreed key indicators - these should be enshrined in service agreements or contracts wherever possible. There should be less detailed monthly monitoring of costs and input.

In thinking through these issues, it is important to distinguish between the role of the DHA as a purchaser of a unit's services and the role of the DHA as the body ultimately responsible for overall performance in the unit. Acting as a purchaser, the DHA, through the DGM, will monitor performance against the contract or service agreement. Contract monitoring will enable the DGM to ensure that the unit is meeting agreed standards in relation to quality, volume, and other factors.

This is distinct from the authority's responsibility for financial control and management performance. Acting in this capacity, the DHA will want to ensure that the unit is on a sound financial footing and that services are provided in a way which is consistent with district policies and priorities. This includes implementing planned changes in services as well as promoting national and regional policy objectives in areas such as cost improvement programmes and quality management. The business plan for the unit will play an important part in this process. The DGM and his senior colleagues will work closely with the UGM in negotiating and agreeing the business plan, and in monitoring performance against the plan.

In districts where the DHA is the principal purchaser of a unit's services, monitoring through the contract and through the business plan will be closely linked. On the other hand, where a unit relies heavily on contracts with other purchasers, the DHA will need to pay close attention to the business plan and to the ability of the unit to meet financial and policy objectives. Monitoring performance against the plan will help to identify problems in DMUs which may call for intervention by the DGM. These problems will usually be dealt with by

appropriate management action and ultimately it must be possible for the DGM to replace the UGM if the situation demands.

Monitoring must take place in the spirit of a loose-tight relationship. One of the districts involved in the study has expressed the position as follows:

As long as local management is delivering against the contract, involvement or control from the centre will be very loose. If, however, performance starts to slip the relationship becomes tighter: the boss starts to ask rather penetrating questions; people from headquarters may appear to investigate; and eventually if things don't improve the management will be changed. Crucially, the response to underperformance is not to issue increasingly prescriptive orders from the centre, or to claw back the autonomy and delegated authority, taking away from management the freedom to manage. Instead it is to redefine targets, to insist upon performance, and even to exercise the right in the last resort to replace non-achievers.

One means of giving practical effect to this approach has been developed in the Mid Downs Health Authority where explicit intervention rules have been established to regulate the relationship between the DGM and UGMs. The rules are based on key indicators of performance covering finance, activity, waiting lists and other factors. If a unit's performance moves outside the acceptable range then the DGM intervenes to discuss the reason with the UGM. Various stages of management action follow until the indicator is brought back within the acceptable range.

Put another way, the DGM will be involved in units increasingly on an exception basis. As long as units are meeting their financial and other targets, there should be no reason for DGMs to intervene in unit affairs. Clearly, UGMs will want to inform DGMs if issues of political or public sensitivity arise, but UGMs should be allowed to manage their services on an arm's length basis within the framework established by the DHA.

In the case of issues which arise outside the authority, the presumption should again be that UGMs will deal with these issues in most cases. Exceptions will include communications down the line from the NHS Management Executive and RHAs, and major issues of public concern initiated by MPs and organisations like CHCs. In these cases, it will be difficult for the DGM and the authority to avoid involvement. Indeed, DGMs will be expected to play a continuing part in ensuring that national and regional objectives and priorities receive attention in units. As suggested above, the business plan will be an important vehicle for achieving this.

The corollary is that the DHA may find it useful to have direct access to UGMs on some issues. In the case of executive directors, it is likely that DGMs will develop management arrangements in which they work closely with UGMs, albeit at arm's length. As far as the chairman and non-executive directors are concerned, a number of possibilities exist, including the establishment of a DMU board involving non-executives (see below), the attachment of non-executives to units on an informal basis, and DHA meetings at which UGMs are present and report to the full authority.

One specific aspect of UGM/DGM relationships requires careful handling, namely the negotiation of contracts by DMUs with purchasers other than the DHA. In formal terms, only health authorities are able to sign contracts, and so there needs to be an agreed procedure for the authority to endorse contracts before they are concluded. This procedure should give as much freedom as possible to UGMs without threatening the financial viability of the units or their ability to meet the terms of the contracts negotiated with the host authority.

To a considerable extent, how these matters are handled is a matter for local determination, taking account of the financial position of the unit, including its dependence on 'external' contracts for its funding, and the experience and ability of the UGMs. One approach to these issues is illustrated by Southampton and South West Hampshire Health Authority which for some years has provided services on a contract basis to health authorities on the Channel Islands. Units in the district make all the detailed preparation for the contracts which are then passed to district headquarters for assessment. Once finalised, the authority chairman and DGM sign the contracts. As this process has evolved, UGMs have come to play the major part in contract negotiation, leaving the DHA to endorse contracts on a formal basis.

Financial Issues

Many of the issues involved in DHA/DMU relationships are illustrated by the position of the director of finance. DHAs have a statutory responsibility to keep within their cash limits and finance directors are personally responsible for the conduct of the authority's financial affairs. Devolution to units has to be implemented in a way which enables the finance director to exercise this responsibility.

At the same time, the director will be expected to take on new functions in relation to the purchasing role and to control purchasing expenditure through contracts. This includes holding reserves to pay for services provided outside contracts. The finance director will play a key part in establishing and planning the use of these reserves.

Finance directors, like DGMs, should be involved in both purchasing and providing. Although operational financial functions can be delegated to units, the director will need to monitor financial performance in the units and maintain overall financial control on behalf of the DHA. This calls for effective reporting systems and the ability of finance directors to draw the attention of the authority at an early stage to any problems which are emerging.

In carrying out this responsibility, finance directors will need to ensure that units break even in terms of income and expenditure. The challenge facing finance directors will be particularly exacting where a DMU relies heavily on contracts with purchasers of services other than the host DHA. This underlines the importance of DGMs and finance directors playing a part in the approval of contracts negotiated by DMUs with purchasers other than the DHA. If these negotiations are left entirely to the UGM, then the DHA may not be able to guarantee the financial viability of units.

It will also be necessary to develop a culture in which the finance director as purchaser does not act in a way which conflicts with his overall responsibility for providers. For example, a decision to place contracts outside the district may make sense from a purchaser's perspective if there are quality or efficiency gains to be achieved, but this may undermine the financial viability of directly managed units in the district. It is difficult to avoid these dilemmas while directly managed units continue to be the main service providers. In practice, it is unlikely that there will be significant changes in where services are provided in the immediate future and so the occasions when finance directors will face an internal conflict of this sort will be limited.

The Role of Non-Executives

In the new-style DHAs, non-executives will perform a number of functions. Annex 2 sets out the statement on the role of non-executive directors produced by the Frenchay Health Authority. As the statement suggests, two major contributions of non-executives will be to ensure that the authority focuses on corporate aims and strategy, and to monitor performance.

In a number of districts, consideration has been given to the involvement of non-executives in the work of DMUs. One view is that non-executives who serve on the DHA should not be formally involved in the work of DMUs. In part, this is because of a concern that non-executives may seek to intervene in areas that are properly the responsibility of unit managers, and in part it stems from the argument that DHA non-executives should concentrate on the purchasing role (as the Department of Health has emphasised) and should not be too closely identified with their own provider units.

As far as the latter point is concerned, some districts have proposed making use of non-executives who do not serve on the new authorities in order to build up the status and identity of units and to create more space between units and the authority.

The Frenchay and Riverside health authorities have developed their ideas on the role of non-executives in relation to DMUs further than most districts. In Frenchay, the authority has suggested the establishment of a monitoring board for each unit. The board will comprise five executive directors, including medical and nursing representation, with the UGM serving as the chief executive. Two non-executive directors of the DHA would also serve on each board, as would the DGM, who in the first instance would take the chair (in a non-executive capacity in this context) in order to maintain a line management relationship with the UGM.

A number of functions have been idenitifed for monitoring boards. These are:

* to approve the unit business plan

* to monitor the performance of the unit against its plan and contract

* to monitor the performance of the service specifications

* to monitor the performance of the unit in implementing the authority's policies.

The board will not manage the unit as this is clearly the responsibility of the UGM. Rather, it will assess progress against agreed targets and exercise overall control of performance through the contract.

A similar monitoring board is planned for the purchasing function, with particular emphasis on the contracting, monitoring and quality assurance aspects. DHA non-executives would serve terms in rotation on each board in order to achieve a personal overview and balance between the purchaser and provider responsibilities.

Development of the Frenchay model may incorporate ideas under discussion elsewhere including the possible addition of three non-executives from outside the authority who would have a longer term commitment to each board. In constitutional terms, the boards would be committees of the authority with some co-opted members. The management arrangements for Frenchay are illustrated in the accompanying figure.

Within this framework, the authority as a whole and the DGM have a lead role in the new task of authorities in identifying the health care needs of the resident population and developing a long term strategy for resource allocation to meet these needs. This should not involve a conflict of interest between purchasers and providers in the authority. Responsibility for implementing the authority's strategy rests with the monitoring boards and it is at this level that separation of functions occurs.

A similar model has been under discussion in the Riverside Health Authority. This also involves the establishment of DMU boards as committees of the authority. The unit general manager would act as chief executive of the unit and would be accountable to the chairman of the board. The chairman would be chosen from among the non-executive directors of the DHA. There would be five non-executives serving on the board with the chairman and these would be drawn from outside the authority. The role of the board would be to agree with the unit general manager the policy and strategy for the unit. The chairman of the board would be accountable to the health authority.

Other Issues

Behind the different approaches reported here are a number of other issues. These are:

People

In all districts it is recognised that management arrangements must build on the strengths of the people involved. As an example, Model 1, in which the UGMs are accountable directly to the DHA, depends on the existence of experienced and able UGMs in whom the authority has confidence. This model also grew out of the enthusiasm of the DGM for the purchasing role. If different people were in post, it would be more difficult to make this arrangement work.

Another example is an authority in which the chairman's business background was influential in shaping the arrangements that have been evolved for the district. At an early stage, the chairman recognised the close similarity between the purchaser/provider split and the way in which large companies organise their affairs. Drawing on his experience of different units in the business trading with each other under the aegis of the main board, the chairman was able to lead thinking in the district on the relationship between purchasers, providers and the DHA as a whole.

If these examples illustrate the importance of people in promoting the implementation of new ideas, there are also districts in which individuals can delay and obstruct change. As an example, in some authorities district directors have been unwilling to let go of the services they have controlled in the past. There are many reasons why this is so, including:

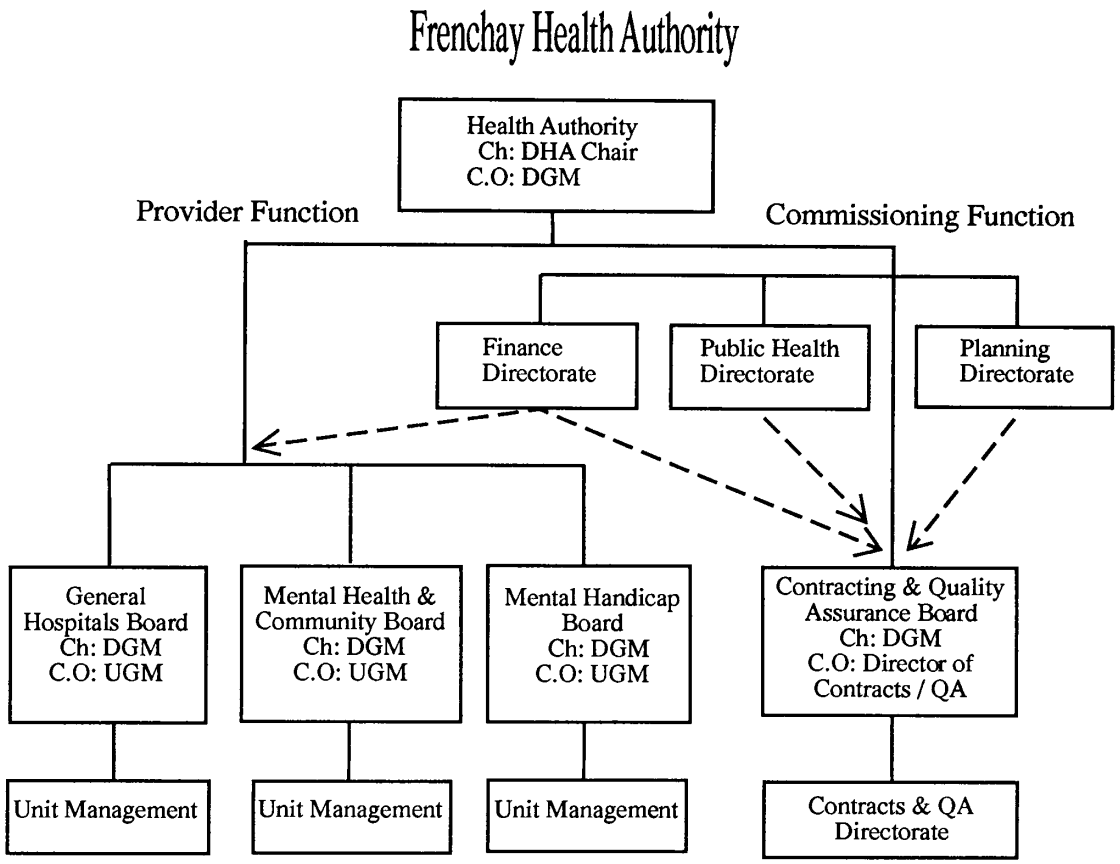
* a history of management failure in the service resulting in managers wanting to avoid repeating past mistakes

* concern at the ability of units to assume greater responsibility

* a desire to ensure that the pace of change is sensitive to the ability of managers to adjust their performance

* a personal unwillingness to take on new roles which are unfamiliar and unproven.

Authority chairmen and general managers have a major role to play in working through these 'people' issues and ensuring that the transition to the new management arrangements is conducted smoothly and effectively.



N.B: Ch = Chairman
C.O = Chief Officer

Names and Symbols

The term 'directly managed units' does not help in creating a positive image of the new roles and responsibilities of providers. If the aim is to build up the managerial capacities of units and their ability to act as independently as possible, a different language is required. Possibilities include NHS provider units or self sufficient provider units.

The development of a new vocabulary could be reinforced in other ways. One option, as discussed above, would be to establish a DMU board, involving unit managers and non-executives. The board would assist in establishing a separate identity for units and in creating space between the units and the authority. Another option would be to encourage units to develop their own distinctive symbols or logos. This would help to reinforce their separate existence and identity within the district.

Language is also a problem in describing the future role of DGMs. In this case, District Chief Executive would seem more appropriate. This label would help to distinguish between the traditional role of general managers in which operational responsibilities have been paramount, and the new functions involved in leading and guiding a strategic purchasing body and overseeing the performance of the DMUs.

Timescales

The White Paper will begin to be implemented from 1st April 1991. In preparation for this, authorities are, as we have reported, already in the process of revising their management arrangements. The pace of change will vary depending on the position from which districts start and their plans for NHS trusts.

In a few places, it may be possible to achieve a large measure of separation between purchasers and providers during 1990, including effective devolution to units, as a prelude to complete separation in 1991. More usually, it will take 12 to 18 months to accomplish separation of roles within DHAs, with the establishment of trusts following in 1992 and thereafter. In a few places, the transition may take even longer.

In short, the pace of change will be different in different parts of the country, and will need to be sensitive to local circumstances.

Managing the Transition

Given the magnitude of the changes involved in developing the role of DMUs, there is a major job to be done in managing the transition. DGMs are likely to lead this process. At a minimum, it involves developing a clear vision of the future shape of services, identifying what needs to be done to move from the existing state to the new arrangements, and charting intermediate goals and targets.

In view of what has been said about resistance to change, DGMs will need to develop strategies for overcoming objections and building commitment to future plans. An element of this that is likely to be particularly difficult in some districts is encouraging managers to think and work as purchasers. The purchasing function has no history or tradition in the NHS and much effort will have to go into creating a vision of what is involved in purchasing and the opportunities available to managers who become purchasers.

DGMs will also need to demonstrate leadership in creating a culture in which the separation of purchasing and providing roles is clearly maintained. Sheila Masters, director of finance on the NHS Management Executive, has drawn attention to the role of Chinese walls in this process. A Chinese wall is an invisible, internal barrier within an organisation to ensure confidentiality of information. As was noted above, some top managers, including the DGM and the director of finance, will need to be involved in both purchasing and providing, but otherwise it is likely that responsibilities will be separated within authorities.

The challenge facing DGMs in taking on a new role is arguably greater than that facing other managers. Increasingly, DGMs will be expected to lead and guide the work of their staff and to distance themselves from operational management. As such, they will need to become honest brokers within the organisation and to actively build alliances and networks with other agencies.

Parity

As new organisational arrangements are developed, it may be useful to establish equality of the purchaser and provider functions by ensuring that the general manager of each function is at the same management level within the district. In one authority, this has been achieved by creating a post of director of contracts and quality on the purchasing side of the organisation which does not have a place on the new DHA. The director is directly accountable to the DGM and is equivalent in status to the director of public health and the director of finance but is outside the DHA itself. This ensures parity with the unit general managers who of course will also not be executive members of the authority but who will be accountable to the DGM.

Summary & Conclusion

This study has described the various approaches adopted by some DHAs in separating responsibility for purchasing health care and providing services. The approach that has found most favour involves separating the purchaser and provider functions below the DGM. In this approach, reponsibility for service provision rests with UGMs, and responsibility for purchasing rests with a purchasing team. The DGM sits over and above the purchaser and provider functions and leads the work of the authority as a whole.

The strength of this approach is in enabling the purchaser and provider functions to be developed within the district under the guidance and leadership of the DGM. The potential weakness is the risk that existing relationships will be maintained and change will be superficial. However, it is clear that it is not possible to move immediately to a 'pure' purchasing role. While DMUs continue to play a part in service provision, DHAs and their top managers will have to balance their responsibility to manage units and to develop the new purchasing function.

Districts have made considerable progress in creating a distinctive purchaser function. This includes appointing staff with expertise in public health, contracting and quality, finance and planning. The number of staff needed for purchasing purposes is likely to be less that the number currently employed at district headquarters. Despite this, the shortage of relevant skills has resulted in difficulties in recruiting people to staff the purchasing function. In response, some districts have been exploring the use of partnership arrangements in which skills and staff can be shared. More formal consortium arrangements are also under discussion, most notably in South East London where a commissioning agency is in the process of being established.

In parallel, districts have been devolving management responsibility to units. There are different ways of doing this but whatever the approach the aim is to make units as self sufficient as possible in relation to such functions as finance, personnel and estates. The extent and pace of devolution reflects the different starting point of districts and the need to maintain basic management support at a time of considerable change. As districts have considered devolution, so the configuration of units has come under review, resulting in a reduction in the number of units in many districts with the aim of creating units better placed to run their own affairs.

The role of the DGM will change significantly under the White Paper. In the immediate future the DGM will play a major part in managing the transition to the new arrangements. This includes developing the purchasing function and strengthening the role of DMUs. In the longer term, the DGM will have to decide whether to become a purchaser or provider as an increasing number of DMUs move towards trust status. In view of the fact that most DGMs have pursued a career in operational management, this poses a major personal challenge.

In most districts, UGMs will continue to be accountable to DGMs. In future, this accountability will be discharged by the DGM monitoring performance against business plans and contracts. DGMs will want to be sure that the contracts negotiated by UGMs with other purchasers help to secure the financial viability of units without detriment to the services provided to local residents.

At the crux of DHA/DMU relationships is the continuing responsibility of the authority to keep within cash limits. This means that finance directors will need to monitor financial performance in units and ensure that units balance their budgets. Finance directors will work closely with DGMs in advising the authority on the financial position in the district and will contribute to both the purchaser and provider functions.

The new relationship between DHAs and DMUs is best described as loose-tight. Units will be held accountable for meeting the objectives set by the authority but otherwise should be allowed considerable freedom to run their own affairs. Developing explicit rules of intervention by DGMs in the business of units should help in making a reality of the loose-tight relationship.

There are different views on the role of non-executive directors in DMUs. According to one school of thought, units should be run by UGMs without formal participation by non-executives. An alternative perspective is that each DMU should have a board involving executive and non-executive directors. The non-executives may be drawn from the DHA, they may be appointed from outside the authority, or a combination of insiders and outsiders may be used.

One of the potential advantages of a DMU board is that it would help in creating a separate identity for units. The distinctive role of units might be further enhanced if they were known as NHS provider units rather than DMUs. Units might also establish their own symbols or

logos to reinforce their arm's length relationship with the DHA.

As new management arrangements are developed, it may be useful to establish equality of the purchaser and provider functions by ensuring that the managers who lead each function have parity within the district. Also, the systems that are created must build on the strengths (and weaknesses) of the people involved. The pace of change will vary depending on 'people' issues and the position from which districts start. In some places it may be possible to achieve complete separation of roles in a matter of months. More commonly, the process of transition is likely to take 2 - 3 years or longer.

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Annex 1

The Framework for the Study

How can we develop separate purchaser and provider organisations within the DHA?

Who takes responsibility for purchasing and what are the skills needed?

Who takes responsibility for service provision and what are the skills required?

What is the role of the DGM in relation to purchasing and provision?

What is the role of the DHA in setting a policy framework for DMUs?

How is responsibility for cash limits/financial viability handled?

When a DMU negotiates contracts with purchasers other than the DHA, what is the role of the DHA/DGM in countersigning these contracts?

What is the role of members/non-executives in relation to DMUs?

Should a DMU board be established with non-executives?

If so, should these non-executives overlap with those who sit on the DHA?

Should all functions (personnel, finance etc) be devolved to DMUs or should some be retained on an agency basis?

Annex 2

Frenchay Health Authority: The Role of Non-Executive Members

The Chairman and five non-executive members will have two primary contributions to make to the DHA's business:

A. They must ensure that the DHA focuses appropriately on its corporate aims and strategy, which they will shape and influence.

B. They will monitor the DHA's performance, through consideration of key items and exception reports. Whenever possible, these will reflect outcomes and results.

They will, in addition, be involved in the appointment of the DHA's general manager and its other directors, and have the ultimate responsibility to act on any executive management failures. The chairman has the added role of leadership and a particular responsibility for the DHA's public profile.

The responsibilities of the non-executive directors of the DHA will encompass:

1. Ensuring that the interests of patients remain in the forefront of management thinking and Executive Board deliberations.

2. Ensuring that the District conducts its affairs with proper regard to the overall interests of the service and avoids inappropriate parochialism in its approach.

3. Ensuring that management of the service reflects the interests of the general public and are not biased towards the collective or personal interests of professional management.

4. Contributing personal judgement to the affairs of the Authority, together with any relevant special knowledge or expertise, maintaining an informed external view independent of management or any special interest group.

5. Sharing with executive directors corporate responsibility for the formulation of strategy within the overall policy of the service and fiscal responsibility for managing within allocations.

6. Ensuring that proper ethical standards are set and maintained in the conduct of the service.

7. Supporting and advising the chairman in his/her relationship with management, seeking to constrain him/her if necessary, and in extremis drawing the attention of higher authority to major failings or potential crisis.

8. Drawing out views from executive directors in discussion to ensure that each contributes fully to the corporate work of the authority, properly distinguishing their director responsibilities from their executive duties as subordinates of the general manager.

9. Monitoring the performance of management and the executive directors including advising the chairman on:
Performance of senior individuals, particularly the general manager
Collective performance of management, particularly its cohesion as a team
Management's relations with key interest groups, e.g., patients, suppliers, the press, neighbours and the general public.

10. Advising on and consenting to management structure and senior appointments, and participating in the appointment of Executive Directors and particularly of the general manager.

11. Attending formal authority meetings, making regular visits to hospitals, etc., serving on relevant subcommittees and working groups, and undertaking other practical duties as may reasonably fall to non-executive members.

12. Allocating sufficient time and personal effort to gaining and maintaining knowledge and understanding of the service and facilities, including contact with management, staff and patients to inform all the foregoing responsibilities.

Annex 3

Checklist of questions for DHAs

Has the authority developed an organisational structure in which purchaser and provider functions are separated?

Does this structure enable the DHA and its top managers to monitor the performance of units and to carry out the purchasing role?

Has a core group of staff with relevant skills been identified to take responsibility for the purchaser function?

Has the district considered entering into partnership or consortium arrangements with other DHAs for purchasing purposes?

Has the district started devolving management responsibilities to units?

Do units have the capacity they need in functions such as finance, personnel and estates to run their services independently?

Are the staff who remain at district headquarters only those who are essential to the purchasing role and the role of the authority in managing provider units?

Has the authority reviewed the configuration of units with the aim of creating units able to run their own affairs?

Is there a management culture in which there is a loose-tight relationship between district and units?

Has the role of the DGM been clearly established both in relation to the purchaser and provider functions, and in managing the transition?

Has the DGM agreed with UGMs explicit intervention rules for the involvement of the DGM in unit affairs?

Are there agreed procedures for UGMs to negotiate contracts with purchasers other than the DHA?

Has the role of the director of finance been clearly established in relation to the purchaser and provider functions?

Is the director of finance able to control purchasing expenditure and ensure that units break even?

Has the authority considered the role of non-executive directors in relation to DMUs?

Is there a role for a DMU board of the kind under development in Riverside and Frenchay?

Are the managers who will lead the purchaser and provider functions at the same management level within the district?

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