KINGS FUND
COLLEGE

THE MANAGEMENT DEVELOPMENT NEEDS OF THE NHS IN SCOTLAND

FINAL REPORT OF THE WORK CARRIED OUT BY THE KING'S FUND COLLEGE

A Report to the Manpower Directorate of the
Management Executive of the NHS in Scotland

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A NOTE ON THE FINDINGS OF THIS STUDY

Many readers, and particularly, many of those working in the NHS in Scotland, may regard the tone and substance of this report as overly critical and negative. To an extent, this is inevitable: the King's Fund team were asked to look at the need for management development in the Scottish NHS. Our approach to the work therefore was to seek out examples of needs and inadequacies and weaknesses that might be remedied through management development activity. This means that most of our findings reflect our perceptions of these needs, inadequacies and weaknesses.

Although our brief did not call for a commentary on the strengths of the NHS in Scotland, we did encounter a number of examples of what we would regard as good management, and good management development, practice. These do not however figure prominently in this report because a) we were not asked to focus on these; and b) they were outweighed by what we regarded as weaknesses and examples of poor practice. The Scottish NHS does have a number of strengths which we regard as particularly significant, and which may hold the key to acting successfully upon the findings and recommendations in this report. Primary amongst these are the very large number of individuals working in the NHS in Scotland who are fiercely committed both to the NHS and to public services in Scotland more generally. Moreover, many of these same people would appear to have an open mind about how best to approach the major programme of change facing the NHS in Scotland over the next few years. This combination of a strong, tightly knit public service culture, together with an openness of attitude in relation to change, represent a major strength which we believe augurs well for the future of the service.

OVERVIEW AND EXECUTIVE SUMMARY

This report describes the outcome of a six month study of the management development requirements of the NHS in Scotland, undertaken by the King's Fund College. The report which follows describes: (i) the scope and content of the original brief for the work; (ii) the methodology adopted by the King's Fund team; and (iii) the principal findings and recommendations arising from the study. Separate appendices describe aspects of the methodology and the findings of the study in further detail as well as the outcome of a postal and telephone survey of organisations which provide management development services to the NHS in Scotland (SNHS).

The NHS in Scotland faces a number of major managerial challenges in 1993. The nature and magnitude of these challenges is a product of the very substantial programme of change presently facing the service. The key elements in this programme are:

- the continued introduction and management of the NHS reforms;
- the continued introduction and management of the reforms which follow from the Community Care act;
- the pressing need to rationalise and reduce the quantum of acute services in most urban connurbations; and
- the equally pressing need to strengthen primary and community care by shifting resources from the acute sector into these services.

It is also important to note that these changes will need to be delivered against a background of little or no increase the overall level of resources - an unprecedented situation for most managers in the Scottish NHS.

This programme of change can be disaggregated into a number of more specific change management challenges: these are set out along the vertical axis of Figure 1. They are:

- developing effective purchasers
- developing effective providers
- developing an effective Centre
- developing effective Community Care.

One important finding of our field work is that one key -possibly the key - to addressing these successfully, lies in the concomitant need to address seven major management development challenges. These are set out across the horizontal axis of Figure 1. Our principal findings in relation to these are:

	KEY MANAGEMENT DEVELOPMENT CHALLENGES						
	SHIFTING THE CULTURE	CREATING NEW VERTICAL RELATIONSHIPS	DEVELOPING EFFECTIVE ORG'L LEADERSHIP	MANAGING HORIZONTALLY	BRINGING HEALTH PROFESSIONALS INTO MGMT.	ACQUIRING RELEVANT SKILLS	IMPROVING THE QUALITY & RELEVANCE OF INFORMATION
KEY CHANGE MANAGEMENT CHALLENGES FACING THE SCOTTISH NHS IN 1993							
1.0 DEVELOPING EFFECTIVE PURCHASERS							
1.1 Developing Boards							
1.2 Developing GP Fundholders							
2.0 DEVELOPING EFFECTIVE PROVIDERS							
2.1 Developing General Practice							
2.2 Developing Community Units							
2.3 Developing Acute Providers							
2.4 Reducing the Quantum of and Restructuring Acute Services							
3.0 DEVELOPING AN EFFECTIVE CENTRE (i.e. SNHS ME)							
4.0 DEVELOPING EFFECTIVE COMMUNITY CARE							
4.1 Phasing out Institutional Care							
4.2 Creating effective mechanisms for action							
4.3 Managing intersectoral initiatives							

FIGURE 1: KEY CHANGE MANAGEMENT AND MANAGEMENT DEVELOPMENT CHALLENGES FACING THE SNHS

* **Shifting the management culture:**

The attitudes and outlook of most of those with managerial responsibilities in the SNHS, reflect a culture that is not conducive to delivering on the above change agenda. For a start, there is considerable evidence to suggest that this agenda has not penetrated down into the very organisations that are supposed to deliver on it. There is also a lack of vision: no one seems to be clear about where all of this change is leading and why. In addition, many managers and others are skeptical: a number seem to believe that many of these changes will never happen (for example, Boards seem reluctant to let go of their previous responsibilities and assume the identity of purchasers). Partly as a result of this, many of those with managerial responsibility are adopting a 'wait and see' posture, waiting to be 'told' by the next level up in the hierarchy what changes are required next. The prevailing view of management (and management development) in the SNHS is that it consists of a series of 'tasks' which need to tackled within a 'project management' like framework: there is little evidence that notions of institutional 'governance' or 'stewardship' inform the thinking of senior managers. Finally, management and organisational development are seen largely as questions of training and skills acquisition: there is little evidence of a developmental focus in the organisations we visited. In short, **the prevailing culture in the SNHS is an administrative one whereas the radical change agenda facing the service, requires a managerial approach to change.** (For further detail on the observations in this executive summary, see sections 3.1. and 3.2 below.)

* **Creating new vertical relationships:**

As already noted, a number of senior managers and others seem to be adopting a 'wait to be told' posture in relation to change. A part of the reason for this is the lack of clarity as to the role of the SNHS Management Executive. There is evidence that Boards, Trusts and other providers are all receiving 'mixed messages' from the ME. Two such messages were mentioned repeatedly:

* the first is that while the ME talks decentralisation, in practice, individual members of the ME try to retain a high degree of central control;

* the second is that the ME does not speak with a single voice and is therefore unable to provide managerial leadership - "instead, it just meddles".

There is also evidence that the old, pre-reforms, managerial hierarchy is still in place with the ME

dealing mainly with Boards who, in turn, still see themselves as the 'overseers' of Trusts and DMUs. **It is clear that the change agenda set out above can only be addressed successfully if the Boards, Trusts and other units of SNHS management rapidly develop as self-sustaining, self- directed entities with a considerable degree of responsibility for their own destinies. This cannot happen until the vertical relationships which define how the different tiers of SNHS management interact, are fundamentally reformed.**

- **Developing effective organisational leadership:**

  The existence of a strong administrative culture in the SNHS, means that most managers are only just beginning to appreciate how important leadership is to effective institutional management. If the SNHS is to move away from an administrative to a managerial culture, a key building block is the development of strong organisational leadership: indeed, the shift in culture will only occur if the 'Chief Executives' throughout the service play a leadership role in bringing it about. A change agenda as radical as that facing the SNHS will inevitably create high levels of uncertainty and therefore, anxiety and apprehension, in many working within the service. In these circumstances, strong leadership is essential: in times of rapid change it falls to leaders to articulate the change agenda and the vision of the future that provides the rationale and context for that agenda; leaders must also foster ownership for change by finding ways of motivating people in the face of uncertainty and anxiety; and strong leaders represent and personify continuity in the throes of change.

  If this describes strong organisational leadership, there is evidence to suggest that the SNHS has far too few strong organisational leaders. As already noted, the old, pre-reforms hierarchy is in many respects still in place: this means that while the SNHS has no shortage of people 'in charge', these same individuals may well be responsible for the absence of strong leadership at lower tiers in the old hierarchy. These observations apply to all levels of the service - from the SNHS ME right through to semi-autonomous, operational sub-divisions at the point of service delivery. **Without developing strong organisational leadership, the SNHS has little chance of delivering smoothly and successfully the current change agenda.**

- **Managing horizontally:**

  Traditionally, senior institutional managers in the NHS have managed 'inward and downward' with their major external concern having been the interface with the next level up in the management hierarchy. The introduction of the NHS reforms and the Community Care Act change this fundamentally. The environment external to NHS units of management must now be more actively and

proactively, managed. 'Up and down' management is no longer good enough: senior and middle managers and, in many cases, health care professionals, must quickly develop the aptitudes and acquire the skills, to manage horizontally.

Although there is some appreciation of the need to manage horizontally within the SNHS, most relevant managers and professionals still seem to regard it as a 'second order' activity. For example, although Health Board managers are on the whole aware of the importance of developing tools to influence and motivate other agencies (such as GP fundholders and Local Government social services) in order to make joint commissioning a reality, there is little evidence to suggest that this is a high organisational priority; equally, although acute providers are aware of the importance of forging meaningful, cooperative links with their purchasers (including GP fundholders), existing initiatives - where they exist at all - seem to be based more on short term considerations of securing income for the 1993/94 financial year. In short, **although the change agenda facing the SNHS requires an emphasis on, and considerable sophistication in the practices of horizontal management, there is little evidence that this message has been translated into practice.**

- **Bringing health professionals into management:**

The majority of health care professionals in the SNHS, like many of their managerial colleagues, have yet to engage with the change agenda facing the service. Instead, most seem to be in a 'pre- reforms' mind set, in which their principal contributions to management are seen either as (i) 'experts' who provide professional advice to managers; or (ii) 'representatives' who articulate the views of their professional peers to management. Few seem to appreciate that the present changes require that practicing professionals become involved in the corporate management of their organisations. The clearest example of this is in the acute sector. In most of the larger acute hospitals there is an awareness that doctors need to become more involved in management, and many hospitals have introduced structural changes (e.g. the introduction of clinical directorates) in an attempt to encourage this. There is evidence however that this has yet to have an impact on the 'hearts and minds' of the great majority of doctors who still see their 'managerial' roles solely in advisory or representational terms. Indeed, it is not clear that even hospital management yet appreciate the importance of involving doctors and other professionals in corporate management.

It would be possible to put forward analogous arguments for most of the other principal professional groups in the SNHS. In particular, similar observations would apply to the great majority of nurses and PAMs (in both acute and community units); most doctors in community

units; most public health professionals working within purchasing; and the great majority of GPs working in practices large and complex enough to require an element of corporate management. This cannot continue: **evidence from all over the world (including other parts of the U.K.) makes it crystal clear that changes such as those facing the SNHS, can only be introduced successfully if professionals working in the service become more involved in both corporate and operational management.**

- **Acquiring relevant skills:**

  Major organisational change always requires those working within the organisation to acquire certain new skills and abilities. These are necessary both to manage the introduction of the change (e.g. project management skills) and to manage the organisations once the changes have been introduced (e.g. contracting skills). The SNHS is no exception. The changes to the service will require staff to acquire a variety of new skills. Some of these have already been mentioned and include such skills as: negotiating, writing and monitoring contracts; developing approaches to multidisciplinary and interorganisational audit; introducing clinical budgeting and resource management; creating and monitoring business plans; developing approaches to environmental management and 'markets'; developing approaches to joint commissioning; and so on.

  For the reasons set out below, this study (and this report) does not deal in any depth with the question of skills acquisition. (See section 2.1.3 below.) This is not because the acquisition of appropriate skills is unimportant: it is clearly very important. Rather, it is because a) skills acquisition is the most tangible and well-understood of the management development challenges facing the SNHS; and b) if the less tangible and more elusive challenges such as those of shifting the management culture and developing strong leadership, are not tackled at the same time and with equal vigour, much of the effort and resources invested in skills development is likely to have little lasting impact.

- **Improving the quality and relevance of information:**

  Like the rest of the NHS, the SNHS does not generate enough high quality and relevant information to allow the above changes to be smoothly introduced, and successfully managed and monitored. Equally, it does not possess a systems 'infrastructure' which would allow such informations to be utilised, were it to be available. For the reasons just summarised, however, this report does not deal with these issues in any depth. Although crucially important, the question of improving the quality of available information and information systems, is relatively tangible and well-understood. As such, it is likely to attract

> considerable attention and investment which again, could well be wasted if the less tangible issues are not tackled with equal vigour.

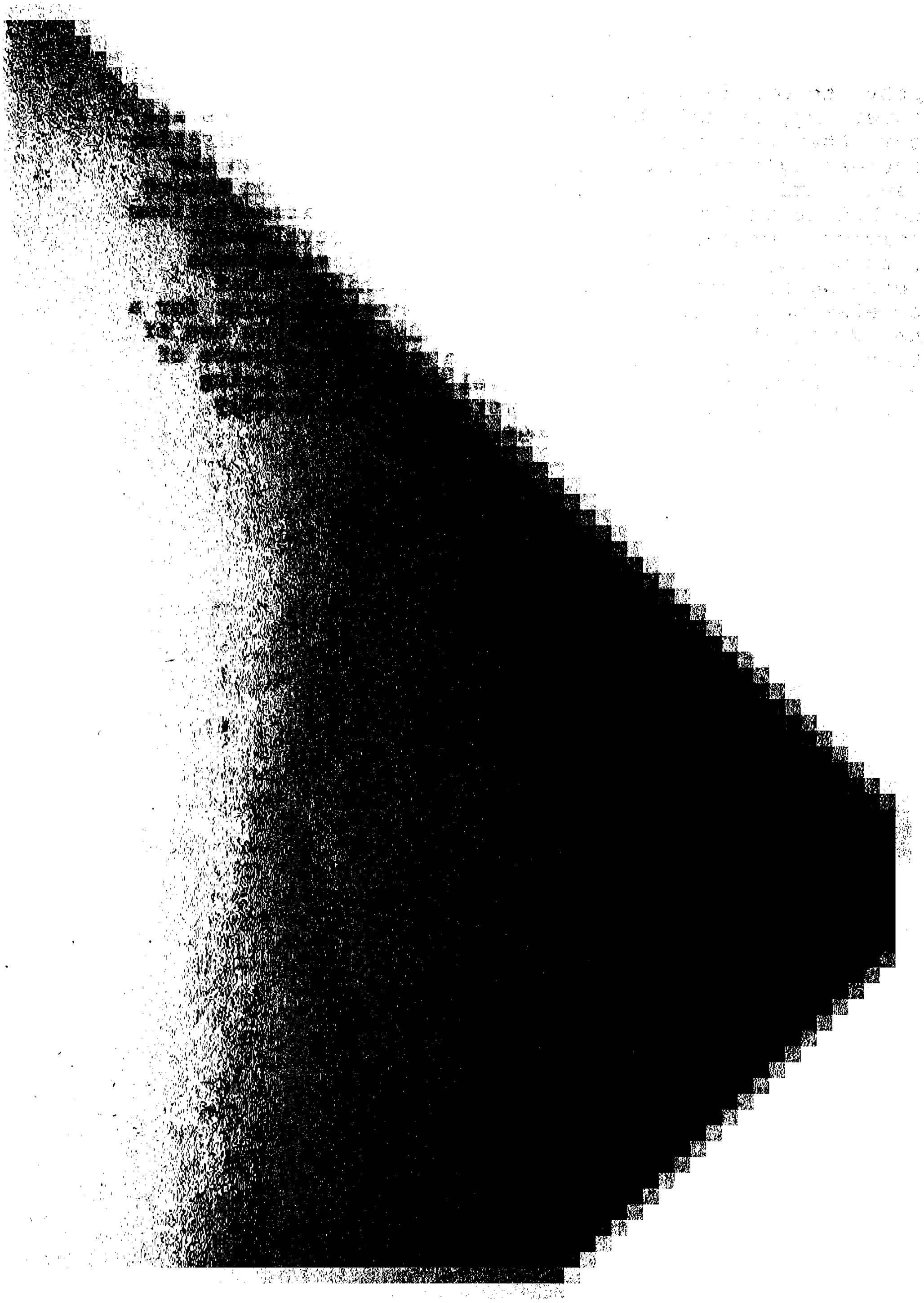
These findings make it clear that the management development (MD) requirements of the NHS in Scotland are both diverse and enormous. Devising a coherent national strategy for tackling them will therefore be extraordinarily difficult. The key to developing such a strategy lies in the recognition that in the last analysis, MD is simply a <u>means</u> for helping organisations to achieve their strategic ends. Effective MD therefore is that which supports the achievement of strategic organisational change. MD interventions undertaken outside such a strategic context are simply 'good things' which rarely have a lasting effect. **One starting point for a national MD strategy must therefore be the clarification and promulgation of the SNHS ME's strategic change agenda.** It is this which will provide the strategic ends to which a national MD strategy can be addressed.

An MD strategy designed for this purpose must, at a minimum, address the seven challenges summarised above. To achieve this however, such a strategy will have to recognize that management development embraces a wide range of activities ranging from sustained organisational development interventions focussed on such issues as shifting a whole organisation's culture, to highly specific, didactic training interventions focussed on helping an individual or a group to acquire new skills. (See section 2.1 below.) This recognition has two important implications for developing a national MD strategy. The first is that there is a pervasive tendency within the service to see MD as training or, at best, a series of semi-autonomous, 'second order' activities such as 'team building' or 'resource management'. This tends to reduce MD to the status of a 'good thing', rather than a mainstream activity aimed at achieving the organisation's strategic ends. The second implication is that the design and implementation of an effective MD strategy is a complex and time consuming business which needs the constant attention of senior management. **A second starting point for a national MD strategy must therefore be raising awareness within the service - and particularly amongst senior management - of the strategic and often complex nature of MD activity.**

> (Indeed, as a first step in this process, it would be a good idea for all those reading this report to ensure that they have read Section 2.1 in detail before turning to the specific recommendations contained in Section 3.0.)

Finally, it should be clear from the foregoing that a while a national MD strategy can be <u>led</u> nationally (ie. by the SNHS ME) it can only be made to happen locally. Clearly, a large part of the change agenda set out earlier is aimed at fundamentally altering the broad structure of the SNHS from one in which most local organisations (e.g. Health Boards; hospitals) are 'cogs' within a regionally structured

hierarchy, to one in which they are more autonomous, self-governing, sustainable entities. If these changes are to occur, then the future success of each local organisation must increasingly depend on the endeavours of its own the staff and Board. In these circumstances it would be absurd for the NHS ME to try to define appropriate MD interventions for individual organisations. In management development terms, to do so, would be to disempower local management while once again portraying MD as a 'good thing' (that someone else wants you to do). **A third starting point for a national MD strategy must therefore be the judicious use of incentives to stimulate the initiation and maintainence of coherent MD strategies at local level which while being unique to each set of local circumstances, are broadly congruent with the national change agenda.**



1.0 THE BRIEF AND SCOPE OF THE STUDY

1.1 The brief:

In May of 1993, the King's Fund College was awarded a tender to undertake "A Needs Assessment and Market Analysis of the Management Development Requirements of the NHS in Scotland". The invitation to tender for this work described the rationale for the study as:

> "The NHS in Scotland's Management Executive (ME) has placed the management education and training of its managers, clinicians and other professional practitioners high on its list of priorities.
>
> These priorities have included:
>
> i) The development of local management development capability. Much of the work of the NHS in Scotland's Management Development Group is now devoted to helping provider Units develop their own expertise in this area.
>
> ii) The establishment of Health Service Management Centre, which will provide a rich source of expertise in management education and training, policy analysis research and consultancy. The contract (for this Centre) has been awarded to the University of Strathclyde and the University of Aberdeen and should become operational in 1993.
>
> iii) The introduction of effective manpower planning, career and succession planning in order to identify and develop managerial talent.

The considerable investment in management development over recent years has resulted in some excellent high quality programmes at both national and local level. There still remains some considerable challenges in achieving a better fit between the organisation and provision of management development and the current and emerging needs of Health Service Managers.

The terms of reference for the work stated that the study should address the following issues:

> i) "The implications of recent NHS policy in Scotland and its potential impact on management practice in both purchaser and provider organisations.
>
> ii) An analysis of the current and future management education and training implications of recent NHS policy.
>
> iii) An analysis of current trends and best practice in management education, training and development in health care systems in the U.K. and overseas.

iv) The identification of the current and future priorities in management education, training and development that need to be addressed if Health Care in Scotland is to be improved.

v) An analysis of the major development issues in Health and Health Care that are anticipated over the next 2-3 years and the effects they are likely to have on individual management roles, activities and expectations."

1.2 The scope of the study:

The King's Fund College's proposal to carry out the work set out our understanding of these terms of reference and of the scope of the work to be undertaken:

> "The Scottish Office publication, '**Framework for Action**' (FFA) sets out clearly the purpose, values and goals of the NHS in Scotland in the 1990s. By setting these out explicitly and by adopting explicit performance targets, '**Framework for Action**' provides a clear strategic direction for the NHS in Scotland. This is extremely important as a context for undertaking management training and development. The policy and managerial environments of the NHS are increasingly turbulent and fast changing: in the absence of an overall strategic direction, much training and development (e.g. career planning) can seem 'rarefied' and pointless.

We also regard "**Framework for Action**" as important to this study for two further reasons:

* The full-scale introduction of the NHS reforms including implementation of the Patient's Charter, will require a number of changes in management practice within the Scottish NHS. FFA sets out an action plan for introducing many of these changes. We believe that this action plan must be at the heart of any proposed management development strategy for the NHS in Scotland. The design of such a strategy in turn, must be seen as the principal rationale for undertaking the needs assessment and market analysis called for in the tender.

* FFA also emphasises the importance of learning from good practice, of personal recognition and feedback, and in general, the empowerment of staff. As such, the document makes it clear that management training and development can be a powerful tool in shifting the management culture of the NHS.

In addition, it is already becoming clear from experience in England, that the successful introduction of the NHS reforms requires just such a shift in culture. A successful management development strategy must therefore be seen as an

important means for bringing about a cultural change which empowers staff.

The tender terms of reference imply that our work must meet the needs of a number of different 'clients'. The first we take to be the whole of the NHS in Scotland. In this sense we regard this work as an important input to the creation of a management development strategy for the service. We see the objectives of this strategy as a) facilitating the introduction of the reforms, the Patient's Charter and FFA; and b) assisting the NHS in Scotland to build up its capacity to deliver appropriate change through the empowerment of staff. We take as our second 'client' the NHSME in Scotland and the Management Development Group. In this sense, we see our task as working with and through these bodies to help to ensure that the needs assessment and market analysis are translated into a management development strategy which is 'owned' by those who will be expected to spearhead its implementation. Thirdly, there is also a sense in which the new Health Service Management Centre at the Universities of Strathclyde and Aberdeen, is a 'client'. Indeed, in many respects it would be appropriate to regard the Centre as a 'partner' in the work. Any needs assessment and market analysis which does not result in a strategic direction and clear priorities for the activities of this Centre will, in important respects, be inadequate.

In summary, we see the needs assessment and market analysis called for in the tender, as key elements in the design of a management development strategy for the NHS in Scotland. We see this strategy in turn, as primarily a means to fostering the changes in organisational culture and management practice necessitated by the introduction of the NHS reforms, the Patient's Charter and **'Framework for Action'**. We do not however see it as our job to devise a management development strategy: our work can contribute to this but such a strategy must be designed and 'owned' by the parties noted above."

The remainder of this report describes the King's Fund team's approach to the work and sets out the findings and recommendations arising from it.

2.0 THE STUDY METHODOLOGY

This section of the report describes the methodology developed to undertake the study. The phrase 'management development requirements' incorporated in the brief from the SNHS Management Executive, encompasses a wide range of needs, inadequacies and felt demands that, in an organisation the size of the SNHS, are as varied as they are numerous. The first step in developing a practical methodology therefore, was to devise a reasonably straightforward way of describing and understanding this complexity. Section 2.1 below describes a simple conceptual model developed for this purpose. This model provided the theoretical framework for the study. Section 2.2 then describes the different phases of fieldwork undertaken in the SNHS. The fieldwork provided an opportunity to 'sample' the management development requirements of the SNHS and to measure these against the model. This resulted in the taxonomy already described and set out in figure 1 above. Together, these provide a framework for understanding and acting upon the study findings and recommendations included in section 3.0 and appendix 2.

2.1 Management development as a means to achieving strategic ends: the management development "matrix"

Management development activities - or interventions - range over a broad spectrum from those which are focussed on the development of a single individual, to those intended to have an impact on a whole organisation. Despite this broad range, an effective and appropriate MD intervention will always take account of three critical factors:

2.1.1 **The purpose or object of the intervention:** The purposes to which a management development intervention might be directed can range from the relatively straightforward -such as wanting to help a number of individuals to acquire certain specific skills - to the quite complicated - such as wanting to shift the culture of an entire organisation. In between these two extremes, lie a variety of other possibilities -such as wanting to help practising professionals to develop their managerial expertise, or trying to help experienced managers to reflect on their experience in order to gain insights relevant to improving their future performance. Management development is not a single, homogeneous activity aimed at a specific objective: it is, rather, a whole range of activities which can be directed towards a whole range of different objectives.

2.1.2 **The experience and expectations of those who are the subject of the intervention:** The experience, expectations and 'organisational location' of those who are the subject of the intervention can act as a strong mediating influence which can easily determine whether a management development intervention has the desired

effect. Some situations are relatively straightforward: for example, a management trainee new to both their job and the organisation they are working in, will typically need to learn at least a few basic facts about how the organisation works and how the job is done. In this case, the trainee is unlikely to have much previous experience and few expectations directly relevant to the intervention. By contrast, an intervention intended to help senior, experienced managers to develop as leaders, can easily be undermined unless it is recognised that these managers will almost certainly have experience and expectations relevant to the object of the intervention. Management development interventions therefore need to be designed so as to take account of backgrounds, organisational context and expectations of those that are the subject of the intervention.

2.1.3 **The means used to make the intervention:** Management development is not the same as training. Training can sometimes be an appropriate means for making a management development intervention but often, it is not. For example, if a group of junior managers need to learn some basic accounting skills, they can be 'trained' in these skills. In this case, an appropriate means for making the intervention could be straightforward didactic, classroom-based instruction. By contrast, an intervention intended to help experienced senior managers to reflect on their experience productively, will necessitate more complex and subtle means: for example, action- learning in a workplace setting or in a 'learning set' with managers doing similar jobs in different organisations. Such complex means are often necessary because management development is rarely about teaching: it is almost always about learning, reflection and change.

Figure 2 integrates these three components of MD by providing a number of illustrations of how different types of management development interventions might typically be used to meet the needs of different categories of staff in the SNHS. The five examples of MD interventions shown in figure 2 are not meant to be exhaustive: they are merely intended as illustrations of interventions that are directed toward different purposes (horizontal axis), and tailored to the needs, experience and expectations of different groups (vertical axis). The five are:

2.1.4 **Management education and training (ME&TR):** The example highlighted in figure 2 might be that of training GP practice managers in the techniques of business planning and accounting. This is a straightforward training need and the appropriate **means** might be a **classroom-based course or distance learning package, developed for that purpose.**

SUBJECT(S) OF THE INTERVENTION	PURPOSE OR OBJECT OF THE INTERVENTION				
	MANAGEMENT EDUCATION AND TRAINING	PERSONAL DEVELOPMENT	PROFESSIONAL DEVELOPMENT	MANAGEMENT DEVELOPMENT	ORGANISATIONAL & INTER-ORG'L DEVELOPMENT
Junior to middle managers (e.g. GP practice managers)	ME &TR				
Middle grade nurses (e.g.ward sisters; community specialist nurses)		P Dev.			
Senior professionals (e.g. Heads of PAM departments)			Pr Dev.		
Senior Institutional managers (e.g. Chief Executives)				Mgt Dev.	
Institutional 'critical mass' (e.g. senior managers and senior clinicians)					Org Dev.

FIGURE 2: A SPECTRUM OF MANAGEMENT DEVELOPMENT INTERVENTIONS: THE MANAGEMENT DEVELOPMENT MATRIX

2.1.5 **Personal development (PDev):** The example here might be that of assisting a number of middle grade nurses to develop the self confidence to take on more extensive general management responsibilities. This kind of personal development - which is often the key to realising the managerial potential of many professionals - clearly differs from ME&TR: you cannot teach or train people to have greater self-confidence. In this case the appropriate **means** for making the intervention might be for **a nurse who has already made this transition to work with an experienced facilitator over a sustained period,** in helping small groups of nurses to work through how they can best take on, and handle their new responsibilities.

2.1.6 **Professional development (PrDev):** The illustration here could be developing the heads of a number of 'para medical' directorates, so that they are able to assume responsibility for the management and future development of their speciality. In this case, the objective is to develop these individuals as professionals, given that their professional responsibilities have been broadened to include overseeing and developing their speciality. In these circumstances, an appropriate **means** for making the intervention might be to **provide an opportunity for these heads to work alongside 'role models' with analogous responsibilities elsewhere** (e.g. heads of professional arms of private sector organisations), and then to meet with one another regularly to a) think through how this experience can be applied to their circumstances; and b) compare their individual experiences in trying to do so.

2.1.7 **Management development (MgtDev):** The example highlighted here might be that of wanting to help a number of Chief Executives (CEOs) to develop greater leadership awareness and to become more effective as leaders of their organisations. Here an effective **means** for making an MD untervention might be to **subdivide the CEOs into groups of five or six to form 'learning sets'.** Members of each set might then invite recognised leaders -either from the NHS or elsewhere - to talk through what they see as effective leadership and how they try to put that into practice. Then, working with an experienced facilitator, each set might try to work through how these ideas could be put into practice in their own organisations. Thereafter, the set might continue to meet so that the CEOs could continue to compare experience and learn from one another.

2.1.8 **Organisational (or Inter-organisational) development (OrgDev):** The example here might be that of trying to shift the culture of (say) a large acute hospital so that a) senior management moves from an administrative to a managerial view of its responsibilities in relation to future change; and b) senior management and senior clinicians move from a 'them and us' view of

their respective roles, to a 'partnership' view of how best to negotiate future change. In these circumstances, an appropriate **means** for intervening would almost certainly involve a sustained programme of a) working with a critical mass of senior managers and senior clinicians together; b) combining 'on site' interventions aimed at creating partnerships in bringing about tangible change; c) conducting 'off site' reflective workshops aimed at creating a dialogue and then providing opportunities to 'take stock'; and d) working regularly with more junior managerial and professional staff to 'cascade' the change in culture and to create 'bottom up' expectations designed to sustain the shift in attitudes amongst senior managers and clinicians.

As noted earlier, these illustrations are not intended to encompass the entire spectrum of MD activity. For example, almost all effective interventions involve elements of two or more of the above. These illustrations should however make three things clear:

- **first, if the organisational ends to which an MD intervention is the means, are not clear, there is little point in investing in management development - it will simply not be effective;**
- **second, because MD is a means to achieving organisational ends, it must be seen as an on-going activity constantly being adapted to the strategic ends the organisation is pursuing; and**
- **third, because of this, serious MD cannot be 'farmed out' or 'delegated' - it must be at the very centre of top management's agenda**

The above illustrations should also make it clear that the design of effective MD interventions is a very complex business which may be able to be orchestrated, but cannot be made to happen, from 'head office': developing an effective MD strategy for the SNHS will not therefore be easy.

2.2 Using the framework in Scotland: fieldwork in the SNHS

The fieldwork undertaken in the SNHS was designed to seek answers to three questions which follow from the above framework. These were:

2.2.1 To what extent are the strategic objectives to which a national MD strategy might be directed, understood within the SNHS?

2.2.2 Given this, to what extent are the MD needs of the SNHS understood? and,

2.2.3 To what extent are these needs being addressed?

The fieldwork consisted of three different activities.

During the early stages of the study, members of the King's Fund team interviewed 28 'key stakeholders' working within, or closely with, the SNHS. These individuals were identified by members of the NHS in Scotland's Management Development Group, and were intended to represent a cross section of those with an interest in, or some responsibility for, MD in the SNHS. The names of those interviewed are listed at appendix A.1. These interviews provided the King's Fund Team with a preliminary view of the likely answers to the questions set out in 2.2.1 to 2.2.3 above.

The second component of the fieldwork was designed to test these first impressions against the experience of those working at institutional level in the SNHS. For this purpose, members of the King's Fund team made one and two day visits to, and conducted a number of workshops in, 12 SNHS organisations. These were selected to provide a cross section of SNHS staff opinion. The organisations were:

- 2 Large acute providers
- 2 Medium/small acute providers
- 2 Community service providers
- 3 Health Boards/purchasers
- 3 GP Group practices.

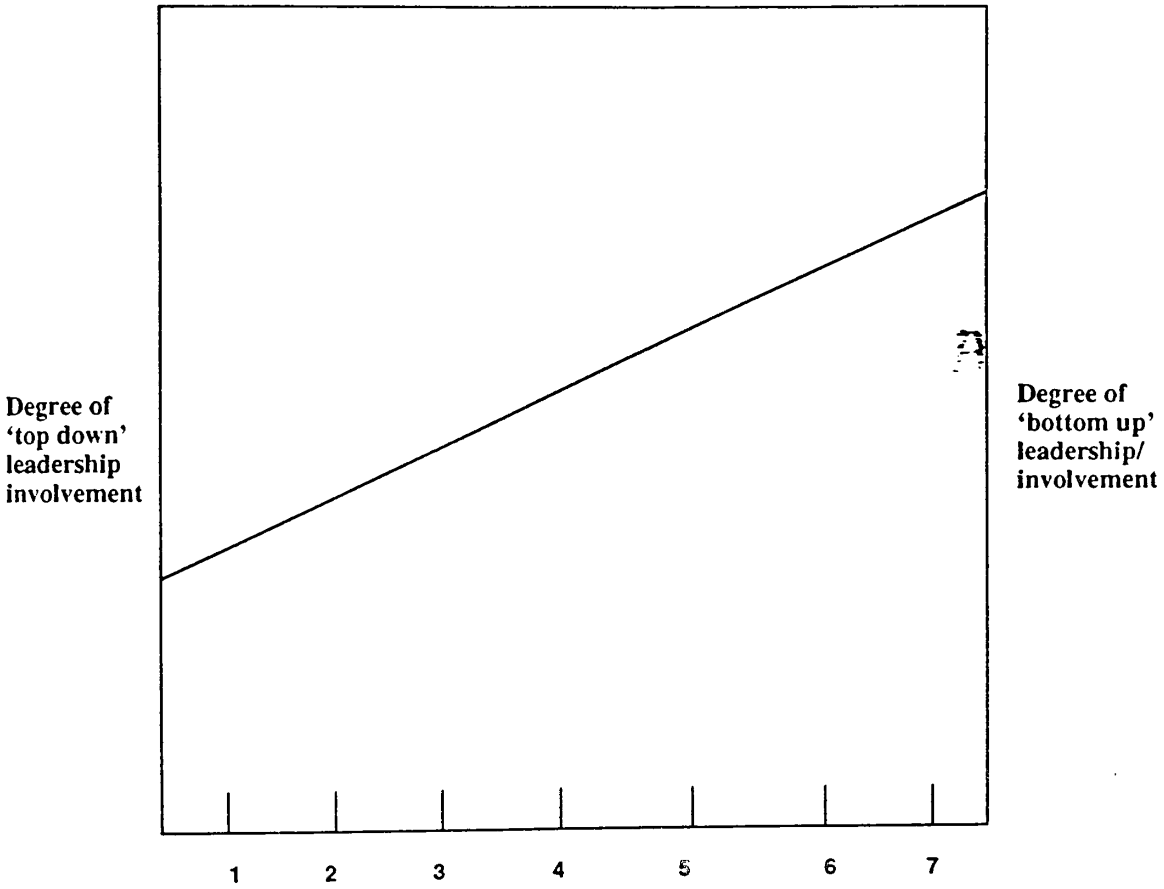
During these visits, members of the team interviewed a representative group of Board members and staff in each institution. These included Chairmen and Non-executive Directors; Chief Executives and General Managers; Executive Directors; middle and junior managers including clinical directors, business managers, nurse managers, PAM managers and GP practice managers; hospital doctors, General Practitioners and Public Health doctors; hospital and community nursing staff; health visitors, therapy helpers and nursing assistants; and a variety of junior administrative staff. The smallest number of staff interviewed in any institution was 7, the largest number 25, and the average 17.

In all, the King's Fund team interviewed, and undertook a number of 'feedback' workshops with, 205 Board members and staff. A list of the institutions visited and the interviews undertaken at each, can be found at /IN appendix A.1.

The third component of the fieldwork consisted of making use of a 'sounding board' group made up of approximately 24 SNHS staff. The members of the sounding board were again selected to represent a cross section of SNHS opinion. Meetings of the sounding board were used to report on the progress and emerging conclusions of the study, to obtain informed feedback, and to develop ideas for taking the work forward. The sounding board met with the King's Fund team and members of the Management Development Group on three occasions: shortly after the inception of the study; approximately midway through the study; and to receive and comment on a draft of this report at the conclusion of the study. The ~~names of the~~ members of the sounding board can be found ~~at~~ /IN Appendix A.1.

missing

All together, the King's Fund team interviewed and/or worked with between 250 and 300 individuals working within, or closely with, the SNHS. The findings and recommendations which follow are based in large part on the results of this fieldwork.



1. SHIFTING THE CULTURE
2. NEW VERTICAL RELATIONSHIPS
3. ORGANISATIONAL LEADERSHIP
4. MANAGING HORIZONTALLY
5. PROFESSIONALS IN MANAGEMENT
6. ACQUIRING RELEVANT SKILLS
7. IMPROVING INFORMATION

FIGURE 3: TOP DOWN AND BOTTOM UP INVOLVEMENT IN CREATING A NATIONAL MANAGEMENT DEVELOPMENT STRATEGY

3.0 PRINCIPAL FINDINGS AND RECOMMENDATIONS

The outcomes of a study as diverse and wide-ranging as this one, cannot be neatly summed up in the form of a number of discrete, definitive recommendations. Instead, in this section of the report, we try to put the findings of the study in perspective and make a number of recommendations that are intended to provide a clear direction for future action.

Earlier in this report we pointed out that one of the major challenges facing the SNHS is that of bringing about a shift in the managerial culture. At present, much of the SNHS seems trapped in a managerial culture that is characterised by a 'command and control' hierarchy; top-down line management; and a mechanistic commitment to addressing well-defined 'tasks', usually handed down from above. Management in the public sector will of course, always incorporate an element of each of these features. The programme of change facing the SNHS however demands a much broader view of what management is about. This new view must incorporate such features as: an emphasis on 'bottom up' initiatives within a broad but clear framework of national priorities; negotiation across organisational boundaries, rather than the crude use of top-down power; and, a more sensible balance between the longer term, developmental needs of the people and organisations that make up the SNHS, and the need to produce short term 'results' quickly. As noted earlier, it will not be easy to bring about this kind of transition in an organisation as large as the SNHS: a clear national strategy for management development can however provide a powerful starting point.

3.1 A national management development strategy:

A national management development strategy for the SNHS must address the seven key management development challenges summarised in figure 1 above. Although this will require commitment and action at all levels of the service, the SNHS Management Executive has an important leading role to play. Three key responsibilities are central to this role. These were summarised in the Executive Summary above and include the need to:

3.1.1 **Clarify, promulgate and share actively the national change agenda.** It is critically important that this is not interpreted as a call for a 'strategic plan' for the future of the SNHS. Rather, a national change agenda consists of a clear statement of the key managerial challenges facing the service (e.g. the introduction and management of the NHS reforms, the Community Care Act, etc.) together with a clear understanding that all parts of the service are accountable for delivering on this agenda. Without such a clear statement of intent and clarity in relation to accountability, there will be no strategic ends, to which a national MD strategy can be addressed.

3.1.2 **Clarify the nature and utility of management development as a means to achieving strategic ends** consistent with the national change agenda. It is critical that management and organisational development (OD) are not seen as 'semi autonomous', somewhat 'rarefied' activities which, while intrinsically desirable, are not central to senior management's agenda. With rare exceptions, this is how MD and OD are presently perceived within the SNHS: the Management Executive has a lead role to play in dispelling this myth and sharing actively a more realistic and strategic conception of MD and OD.

3.1.3 **Introduce and share actively responsibility for incentives** designed to stimulate and maintain coherent 'local' MD and OD strategies at all levels of the service. The SNHS Management Executive cannot devise a national MD strategy which is then 'handed down' for lower tiers to implement. That would be consistent with the prevailing culture of the service. The philosophy underlying the new change agenda however emphasises greater local autonomy with self-governing units of management taking greater responsibility for their own destinies. In these circumstances, a national MD strategy must consist of numerous local strategies tailored to local circumstances but designed to deliver changes consistent with the national change agenda. The SNHS ME has an important role to play in stimulating an interest in and commitment to serious MD and OD activity: but **a national MD strategy must, in important part, be constructed and initiated from the bottom up.**

It should be clear from the foregoing that a national MD strategy can only succeed in strengthening the SNHS if it is 'owned by' and attracts the commitment of, all parts of the service. This means that all levels of the service have a role to play in addressing the seven management development challenges set out above. Some initiatives may benefit from a 'top down' lead, while others will almost certainly fail unless they take the form of genuinely local initiatives. Figure 3 attempts to express this point graphically by indicating that while all seven MD initiatives may benefit from explicit ME and/or local leadership, it is also the case that none of the seven can be addressed successfully without the involvement of all parts of the service.

The role of the ME in initiating and sustaining this process is however critical, and must be handled very carefully. On the one hand, **if too great an emphasis is placed on the initiating/leadership role of the ME, this will invite others parts of the service to 'sit back and wait' to see what happens next. On the other hand, if the ME doesn't take decisive action at an early date, the management culture of the SNHS is unlikely to shift because changes in the ME itself, are so central to this shift.** The recommendations which follow therefore begin with those relating to the role of the Management Executive.

3.2 Recommendations:

This part of the report summarises the recommendations arising from the study in relation to The SNHS Management Executive; Health boards; acute hospitals and Primary Care Providers (community units and general practice) Appendices A2.1 through A2.3 provide further detail on our findings in relation to the latter three of these.

3.2.1 The Management Executive

As just noted, the ME has a critical role to play in initiating the changes which will be necessary to trigger a change in the management culture of the SNHS. To set this process in motion, the ME should take the following actions at an early date.

- **The ME should clarify and make explicit its intended approach to managing the SNHS.** At a minimum, this should move beyond the crude idea of line management, to one which emphasises influence and control through 'contracts' in the broadest sense of that term. A good model which could be adapted for this purpose is propounded in the 'Next Steps' report [1] on the management of central government agencies.

- **In clarifying its approach to management, the ME should draw a sharp distinction between those arrangements which apply to the management of short term 'incidents', and those which apply to managing the service on a sustained, long term basis.** A degree of direct line management will always be required in any public organisation accountable to the electorate through elected politicians. Provided these line arrangements are in place and can be activated at short notice, they can be used to manage pressing, short-term events. Such arrangements are however rarely appropriate to managing large and complex organisations over a sustained period. Certainly they would not be appropriate to managing the 'new' SNHS where the emphasis will be on greater autonomy, responsibility and diversity. A more developmental approach such as that advocated in the 'Next Steps' report would be a more appropriate model for this latter purpose.

[1] Improved Management in Government: The Next Steps. Report to the Prime Minister, Efficiency Unit (Kate Jenkins, Karen Caines, Andrew Jackson) IBBS, London HMSO, 1988

- **The ME should also spell out what it regards as the characteristics of a successful NHS in Scotland.** These characteristics should be of at least three kinds. First, those which describe what the broad shape of the service should be in the future (this should follow from and be consistent with, the change agenda described in 3.1.1 above). Second, those which describe how the service will be 'governed' (for example, more autonomy, more responsibility, more accountability and more diversity). And third, those which describe what will be 'Scottish' about the service (for example, a different but equally cohesive and committed managerial culture).

Once the ME has made clear its intended 'modus operandi' for managing the SNHS, and spelled out what it sees as a desirable future shape for the service, it must begin to behave in a way that is consistent with these statements of intent and gives them a reality in the eyes of those working in the service. This, in turn, will require a large number of concomitant actions and changes many of which, fall outside the scope of this study. Some of the more obvious of these are:

- **The ME should promote, share and 'sell' the above message actively.** Those working in the SNHS - and senior managers in particular - will need to be persuaded that the new agenda and new 'rules of the game' are real.

- **The ME will need to develop new and more effective relationships with Boards and health care providers** to ensure that it remains aware of issues in the field and continues to support Boards and providers to develop within the overall national strategy.

- **To achieve improved relationships with the field, the ME should review its current structure** which appears to be functional~~ly~~ resulting in overlapping and conflicting relationships with Boards and providers.

- **The ME should examine the current pattern of incentives and rewards (both financial and otherwise) in the NHS in Scotland** to ensure that they are aligned with and support the new approach to management.

- **The ME should develop strategies to support staff during the significant change programme they are experiencing.** The ME needs to encourage risk taking by agencies seeking to implement change, and manage the associated fear staff feel for their future.

- **The ME should review ways in which it can promote learning from successful initiatives within the SNHS.**

- **The ME must ensure that it behaves in a manner consistent with the changes it wishes to promote elsewhere in the service.** For this purpose, it must ensure that in its relationships with Boards and providers it maintains a

consistent approach to the changes it seeks.

3.2.2 Health boards:

Health Boards are undergoing more profound changes t other organisational unit within the SNHS. They are devolving functions to trusts and are taking on new commissioning responsibilities. They are changing their relationship with providers from one based on hierarchical directive to one negotiated and embodied in contracts.

These changes present a considerable challenge to Health Boards. Meeting this challenge effectively is essential not only for the benefit of the Boards, but for the welfare of the whole SNHS in relation to which they hold a pivotal position.

Set out below are recommendations in relation to Health Boards abstracted from Appendix A 2.1. Further background and rationale for these recommendations can be found in this appendix.

Shifting the Culture

Capitalize

To achieve the necessary shift in culture, the following OD/MD needs have been identified:

1. Both Health Boards and Trusts need to develop an understanding that their relationship in the domain of purchased health care is governed by negotiated contracts. Outside the contract Trusts do not need to ask for permission and Boards cannot direct.

2. Boards need to actively explore options for health care provision and to stop viewing providers with whom they have never had a direct management relationship as competitors of "their" system.

3. Boards need to engage with their providers to foster relationships in which the need for Boards to understand the processes and cost base of providers is recognised.

4. The development of strategic thinking by all involved in the commissioning process, especially the executive and non executive board members and Public Health doctors. In particular, Boards need to develop their capacity for Primary Care strategy (see below). ?

5. To understand the concepts of learning organisations and networks and to promulgate these throughout the system.

? stick to Public Health doctors

Creating new vertical relationships

New vertical relationships need to be established wi
ME, Providers and the community for which the Health
have responsibility. The following OD/MD needs have
identified.

1. Boards need to define a policy for assessing and responding to ME directives and a reasoned and consistent approach to exploring the legitimacy of directives which place demands on Trusts.
2. Boards should communicate clearly to Trusts the two kinds of relationship in which they will be engaged. The short term, emergency related interventionist approach and the long term operational and strategic norm.
3. The new role of Boards needs to be conveyed to the public and mechanisms developed for effective two way communication with them.
4. Boards needs to develop skills in representing themselves in a variety of public fora and with the media. To understand opportunities and mechanisms for engaging with the community and users on issues of service configuration and quality.

Developing effective organisational leadership

Health Boards will be small organisations in which leadership will be required from all levels of the organisation. At the top there is a particular need for a coherent strategic stance to be taken by executive and non executive directors acting together.

The following OD/MD needs have been identified.

1. Executive and non executive directors should develop a common strategic agenda and operational guide-lines which govern their communication with providers and the public.
2. Health Board senior executives should critically review their leadership style and endeavour to develop leadership capabilities in their staff.

Managing horizontally

Health Boards have taken on a whole range of new horizontal relationships may of which replace traditional vertical ones.

The unique perspective of the Health Boards is provided by their view of the overall health care system within their area. They have, and can exploit, insights no only in relation to individual providers but to the interface between those providers.

To support the range of horizontal management issues, the following OD/MD needs have been identified:.

INSERT No 1 FROM APPDX

1. Boards should adopt a system wide view of health care in their area and explore options for commissioning care across provider boundaries.

2. Boards should explore opportunities for the development of primary care networks to promote learning between organisations and enhance their capacity.

3. Boards should develop a strategy at all levels of their organisation for effective collaboration and contracting with social services.

4. Develop coaching and facilitation skills to tap the creative potential of provider units and to enable them to gain a system wide view of health care.

5. Need to recognise the potential for MD/OD interventions in their own and in provider organisations. Perhaps more importantly to focus these interventions on inter-organisational issues.

6. Need to have insight into the resource utilisation and the primary processes of provider units so that the impact of purchasing decisions is predictable. To ask the right questions in the right way and to understand the responses.

Bringing health professionals into management

Public Health Doctors in Health Boards have changed their role and their relationships with professional colleagues in provider units. To sustain these changes the following OD/MD needs have been identified:

1. Public Health doctors should be engaged in commissioning strategy at the highest level and should undertake their professional research guided by this strategy.

2. The relationship between Health Promotion, service development and the public profile of Health Boards should be recognised and exploited.

Acquiring relevant skills

The changing roles of Health Boards demand that their personnel possess a number of new or enhanced skills in addition to those which have been referred to elsewhere. These include:

1. purchasing and contracting skills and an understanding of the health gain opportunities which create objectives for these activities.

2. to develop an understanding of the importance and methodology of Information Strategy formulation.

3. to develop a sophisticated but communicable understanding of quality which is shared with and endorsed by providers.

4. to understand national strategy issues (e.g. trauma centres and centres of excellence) and their relation to local strategy.

Improving the validity and relevance of information

1. Health Boards need to develop an information strategy which enables them to create rich pictures of the community for which they are responsible by integrating hard and soft data from a variety of sources.

2. Health Boards need to investigate the possibilities of joint information strategy development with providers.

3.2.3. Acute Units

Introduction

Acute units are very complex organisations. This is contributed to by their size and the complicated nature of the work they do. Their management and organisation development requirements are, therefore, significant and in themselves complex. To achieve the strategic agenda for the NHS in Scotland, it is critical that these **units develop themselves** successfully. Further details of the recommendations listed below are provided in Appendix A.2.2.

Shifting the culture

To achieve the shift in culture from administration to management, the acute units need to:

1. develop a corporate identity (In which staff feel they belong to the organisation rather than to their profession, department, or the NHS in general).

2. develop a market sense. (The hospital's income will depend on delivering services at the price, quality, relevance, and style that purchasers will buy).

3. develop a "contract culture". Relationships between organisation and rest of NHS (the ME, purchasers, other providers) and between components of the organisation (e.g. between management and professionals) will progressively be based on "contracts" (i.e. explicit, and increasingly sophisticated, agreements on what each party to the "contract" will do for the other party(ies)).

Creating new vertical relationships

To develop as more autonomous, self-determining organisations acute units need to:

1. develop their Boards of Directors.

2. develop their Chief Executives.

3. "Get the consultants `on-board'" - to dev
consultants in leadership roles so that t
`on-board' the corporate well-being of the

4. develop a `contract culture' (see item 3 ab

5. develop the administrative infrastructure to support decentralised management.

Developing effective organisational leadership

Effective organisational leadership provides the starting point for the complex OD/MD initiatives suggested in this study.

The following OD/MD needs have been identified:

1. develop Chief Executives. Chief Executives of acute units will have to take the lead role in developing organisation wide change strategies. Relevant MD/OD strategies for a hospital support the strategic agenda of the hospital. This can only be achieved if the Chief Executives personally drive the MD/OD strategy.

2. develop medical leadership. Ideally medical staff leadership will be reflected in clinical director appointments. It may be necessary to develop supporting leadership from senior respected and influential clinicians if clinical director leadership is still emerging.

Managing horizontally

Acute units face greater pressure to manage horizontally.

They need to:

1. develop co-ordination of their horizontal relationships. Managing horizontally can be a problem for overall hospital control because it occurs at many points within the hospital. This is particularly so in clinical areas where all clinical directorates may need to manage horizontally with overlapping providers. This places pressures on careful contracting between directorates and management, and effective communication between directorates.

2. develop the appreciation for, and skills to manage relationships, outside one's own organisation.

Bringing health professionals into management

Central to improving the management of acute units in the NHS in Scotland is the involvement of health professionals in

management.

Acute units need to:

1. develop a context for involvement of health professionals in management.

2. re-consider the structure of clinical directorates in some hospitals.

3. develop the leadership and management skills of clinical directors and their corresponding nurse manager. There seems to be a temptation to turn clinical directors into administrators by over-focusing on developing their administrative skills. Clinical directors should be developed to use the hospital's administrative infra-structure and contribute themselves as leaders, rather than becoming partly trained administrators.

4. develop within directorates to help them determine roles and a sense of corporate identity and affiliation through membership of the directorate.

Acquiring relevant skills

The new structure of acute units requires a number of new skills to support the developments described above.

The following needs have been identified:

1. Skills to develop, negotiate, monitor and deliver contracts with purchasers.

2. Skills in administrative support departments to enable them to provide service to "production" departments (those delivering patient care). These include budget information, quality assurance information, planning, marketing, policy guidelines, and management development.

3. Management skills for professionals in management roles (see above).

Improving the validity and relevance of information

Effective contracting depends on the availability of appropriate information to support the level of sophistication of the contract.

The development of information systems should be the responsibility of acute units themselves if they are to accept responsibility for them and to ensure that they reflect the needs, priorities and level of sophistication of the organisation.

The following needs have been identified:

1. The ME needs to rethink its "Resource Management" methodology to ensure that it supports the overall

strategy of developing responsible components.

2. Acute units need to develop information system capacities that reflect their overall organisational development.

Acute Unit - Conclusions

A key strategy will be for the ME to ensure that the context within which these hospitals are to work is clear, consistent and coherent. Within that context, hospitals themselves need to develop their own MD/OD strategy to reflect their own needs and priorities. Hospital-wide MD/OD will be required in most cases. This will require an incremental approach and an acceptance that MD/OD is the responsibility of all managers, including the Chief Executive - not that of and MD/OD department or function within the hospital, nor that of external consultants.

This assessment leads to the priority areas for development being, in the first instance:

- The Board of Directors
- Chief Executive
- Clinical Directors
- Heads of administrative support departments.

3.2.4 Primary Care Providers

Primary Care is now front of stage on the NHS agenda. Whilst the expectations of primary care led systems are high, historically there has been a relative underdevelopment in the management and organisational infrastructure of primary care.

Despite the focus of this and the following section on Community Health Services and General Practices, we stress that the development of appropriate, local, Scottish models of primary care will involve working with all purchasers (Health and Local Authority) and all providers including acute, voluntary organisations, carers etc.

Further background and elaboration of these recommendations can be found in the Appendix 2.3.

3.2.4.1 Community Health Services

The role of Community Health Services (CHSs) has largely remained hidden in the changing SNHS. Yet these services play an essential part in the management of chronic ill health and disability. CHSS also provide distinctive elements of community based care which are necessary to meet the needs of diverse - and often disadvantaged populations, particularly within cities.

Whilst many of the development needs of Community/Priority units will be identical to that of acute units (eg developing a corporate identity, developing a market sense) it will not automatically follow that the process by which

they will be achieved, or the outcome (what a community unit with 'market sense' would look like) will be the same.

Shifting the culture

There is an urgent need to create new CHS organisations to help lead the future pattern of primary care as it moves from the margin to mainstream.

Key issues the CHSs need to address include:

1. clarifying the nature of the 'business' they are in and developing an appropriate identity and cohesion that builds models of authority, accountability and support which take into account the distributed nature of the work but are not based on professional identity. (?)

2. managing in a potentially competitive environment. CHSs face potential pressure from a number of directions: acute units are developing 'outreach'/community based programmes, GPFHs have the option of employing staff directly as well as the opportunity to provide direct services themselves. Social Service departments have the potential to increase control over a number of services traditionally provided by CHSs, and private and voluntary organisations are entering the market. CHSs need to understand their strengths and weaknesses and the unique contributions they can make to the system of health care as well as their cost base, quality of service and style of delivery if they are to generate contracts from purchasers.

3. managing the fear that is current in CHS organisations. This may be fear of being employed by a GPFH, of professional irrelevance (eg Health Visitors), of changing working practice, or redundancy.

New Vertical Relationships

To develop as more autonomous, self-directed, service shaping organsations, CHS organisations need to develop their vertical relationships with the M.E, their Health Board and within their own organisations.

Units need to:

1. develop their relationship with Health Boards so that they can contribute to the Boards' strategy for integrated commissioning of, and investment planning in, primary care.

2. develop their own Boards of Directors. Initial IN orientation and development of Directors ~~in of~~ their roles, their relationships and their modus operandi (including the role of the Chair and the CEO, establishing sub-committees); defining the 'governing' role and distinguishing it from the 'managing' role; developing reporting/listening systems - from the organisation to the Board and from the Board to the ME

and vice versa.

3. develop their Chief Executives. Given the network nature of CHSs, the CEOs will face particularly challenging times. They will need a rich understanding of the whole health system in order to represent their organisation successfully outside, as well as leading the "culture shift" within their organisations.

4. develop organisational forms and management styles to match the changing nature of their business of making connections between:

   General practice focus.......locality focus
   Providing personal care......population-based care
   Community-based specialist...generalist providers
   Community-based specialist...hospital-based specialist

   Strategies for building congruent management processes will need to be developed, bearing in mind that these often interpreted by relatively junior and geographically dispersed staff.

5. support innovations, encourage risk and not collude with maintining the status quo because "its always been done this way".

6. develop appropriate forms of managerial accountability as well as professional accountability. Since CHSs centre on people and relationships rather than bricks and mortar, they can be flexible and respond to changing patterns of needs. Too often this potential flexibility has been undermined by the tribalism common in professionally dominated organisations.

7. develop a more sophisticated understanding of the use of contracts as a tool in managing vertical relationships in which the parties share power and a greater responsibility for corporate outcome. The "top" of the organisation has to find ways of staying connected to what actually goes on further down.

8. building a model of management that is enabling and not simply a controlling activity that occurs "behind locked doors". Most employees have only experienced professional models of accountability and decision making and need to be 'sold' the virtues of a managerial model.

Organisational leadership

Given the network nature of CHSs and its critical role in reshaping the provision of primary care, we can expect to see many leaders in CHS organisation whose key feature is their capacity to enable.

The following OD/MD/PD needs have been identified:

1. develop Chief Executives. The CEO has to take the lead role in developing their organisations. Given the inherent loneliness of the position, there is significant benefit in providing opportunities for personal support and development.

2. develop the professional leadership. Practitioners have, by and large, been led by a person acting as Head Professional. They will need support in developing a managerial dimension to their leadership.

3. develop Nurses. The majority of professionals in CHSs have a nursing background.

Managing Horizontally

The provision of primary care is likely to remain a complex network of agencies/service if it is to retain the flexibility needed to meet the diversity of people's needs. This legitimate diversity could be damaged if simplistic notions are employed to reduce boundaries by tidying up providers (usually into general practice or into hospitals). The task in primary care is to manage the inevitable boundaries between providers rather than to seek to abolish them.

CHSs should:

1. offer "connectedness" or service integration through contracting, subcontracting and service agreements. These more concrete forms of accountability would replace traditional exhortations to professionalism and collaborations.

2. be able to contain/maintain a creative tension in which there is both a practice and a locality focus. Developing a locality focus will be crucial for the successful implementation of community care and CHSs could play a central role in facilitating relationships between Social Services departments and General Practices.

3. develop mechanisms for sharing/learning from experiences, innovations and good practice both within its own organisation as well as between different CHS.

4. develop tools for influencing other agencies and finding ways to motivate and manage beyond the boundary of its own organisation.

Bringing Health Professionals into management

To a large extent the management of CHS organisations understand the nature of the business they are in very well as many of the managers have come up through the professional route. The consequences have often been that:

1. the organisation is structured along professional lines and

2. accountability and relationships have been professional and not managerial.

To enhance the development of health professionals in their management, CHSs will need to:

1. develop the context for involvement of health professionals in management. This context derives from appreciating the above challenges - staffing the culture, new vertical relationships, leadership and new horizontal relationships.
2. reconsider, in those places where it has not already been done, the way professional groupings are currently structured and managed.
3. develop leadership and management skills of those professionals who are managers (of professional groupings or localities). Most have no formal management development. It may be necessary to run tailored programmes for those who have a nursing background.

Acquiring relevant skills

CHSs will not succeed unless they equip their staff with the knowledge and skills required to manage in the new environment. The skills gap is most noticeable in regard to middle managers who have to translate the new contractual framework into appropriate action.

The following have been identified.

1. Skills to develop, negotiate, monitor and deliver contracts with purchasers.
2. Skills in administrative departments to enable them to provide support to those delivery services. These include budget information, quality assurance, business planning, marketing, etc.
3. Building relationships and negotiating service agreements with general practices.
4. Performance monitoring techniques.
5. Developing a management style that will enable them to manage in an appropriate tight (command and control) loose (influence and persuasion) mix.
6. Internal change agency skills.
7. Information management.
8. Use of information technology.

Improving the validity & relevance of information

There was little evidence to suggest that informatic strategies were contributing in a systematic and comprehensive way to organisational objectives.

CHSs need information primarily for three purposes:

1. to feed into the needs assessment process and influence the shape of health service commissioners' strategies and contracts.

2. to support the delivery of their contracts.

3. for managerial purposes.

CHSs Conclusions

The Scottish NHS will need to grow strong and flexible Community Health Services if it is to deliver on the primary care agenda. CHSs face a particular challenge in inventing new forms of organisational structure and management that allow them to deliver their key role of "connectedness".

This suggests that priority development areas are:

The Board of Directors ~~(exec and non-execs)~~
Chief Executives
Middle Managers

The focus of this development should be shifting the culture and developing a managerial style that frees up the organisation and allows multiple leadership to deliver on the strategic agenda.

3.2.4.2 General Practice

Primary health care services deal with 90% of the population's contacts with the NHS. These services are a network of small organisations and individual practitioners. They are central to the effective care of an aging population and in the management of chronic disease, and will therefore have an even greater role in health service systems in the next century.

While there will be increased diversity in both the career of a general practitioner and the organisation of general practice, it is important that this diversity is legitimatized and valued and does not fragment the profession.

Shifting the Culture

Many of the cultural challenges facing General Practice are of a fundamentally different nature than those facing the rest of the SNHS. The independent contractor status means that 'contracts' are not new. General Practitioners (GPs) have always been regarded as quintessential small

businessmen and GPs have long regarded neighbouring practices as competitors.

One impact of the changes is that it is forcing GPs to separate the profession from the organisation. General Practice used to be synonymous with both. Now they need to explore more fully the difference between the general practitioner (the profession) and the general practice (the organisation). A consequence is the recognition that (i) all the demands being placed on the organisation don't have to be met by the general practitioner (ii) they need to think what sort of organisation is general practice and what does it need to do to survive and thrive in the changing environment.

The second transition that is demanded from general practice is that it shifts its focus from the individual to the list. Whilst the GP can focus on the needs of an individual patient, the practice needs to understand the needs of the list.

The third transition is the shift from illness to health.

The final major change is from individual practitioner focus to a primary care team approach. Practice - based primary care is interpersonal, interprofessional and interorganisational and requires a shift in culture from the traditional model of general practice.

To achieve this culture change:

1. GPs should explore different visions/models of what it might be to have a career as a general practitioner in the future. Many (often women) do not wish to follow the 'heroic, all hours' model, others want part-time jobs, some wish to be salaried, some wish to manage as well as practice etc.

2. GPs should rethink what sort of organisation they wish their practice to be and what capacities the organisation needs to meet the demands being placed upon it.

3. General practice needs to shift its focus from 'doctor, his patient, and the illness' to 'the practice, its population, and their health' and the practice relationships to the Health Board and its Contract.

4. Practices need to understand the nature of the primary care business they are in and the nature of the team or network that is needed to deliver it and then design working methods to implement it.

Vertical relationships

General practices need to be develop their vertical relationships with

1. the ME

2. their Boards

3. within the practice

General Practices need to:-

1. develop a way of collectively influencing the strategic direction of the SNHS from their organisational (not professional) perspective.

2. influence the strategic direction of their Boards. One way is to be proactive in feeding their rich practice based information data into the health needs assessment process to influence the purchasing strategy. They also have a capacity for spreading innovation and development of new forms of provision, particularly in partnership with CHSs and other providers.

3. need to develop a non-hierarchal, non-professional model of managing within a practice. Currently the predominant model is a model of professional expectations, leaving each staff grouping (admin, receptionists, nurses.....) to work independently. There is no 'connectedness' in the managerial sense. The communications, when it exists is almost exclusively about patient issues, and rarely about the practice as an organisation.

4. develop a strategic decision making group responsible for the practice as an organisation.

5. rethink and redevelop the role of the practice manager (often seen as the only manager in the organisation). This is a critical role and often used as the layer in the organisation between the GPs and the rest of the practice staff. The tendency to separate entirely professional and managerial spheres of influence should be rethought and other professionals (eg Practice Nurses, Community Nurses) should engage in operational management as part of their role. Equally, the practice manager should make a major contribution to the strategic direction of the practice.

Bringing health professionals into management

Given the partnership (or sole practitioner) model of general practice, the issues for GPs is more one of bringing management into professionals. This is at the strategic/corporate level of the organisation. At the operational level, there are clear advantages in getting other professional staff involved in a managerial capacity.

To enhance the effective running of general practices, they should.

1. develop the strategic role of the general practitioners (see section on leadership)

2. explore methods of involving practice nurses and

attached community nurses in the operational management of the practice.

3. develop an understanding of and mechanisms for accountability.

Developing effective organisational leadership

The organisational leadership in General Practice comes from the General Practitioners. Currently, most partnerships operate on a professional model of consensus (with a senior partner) and have a very hierarchical relationship with the rest of the organisation. This is not seen as helpful in enabling the delivery of care by the rest of the team.

1. Partnerships need to develop a strategic agenda for the practice as a whole.

2. Partnerships should explore other models of reaching and implementing decisions. (eg. consent rather than consensus).

3. GPs should develop models of leadership and engagement that do not depend solely on their role.

4. Leadership should be developed in the practice manager and other members of the primary health care team.

Managing Horizontally

General Practice is seen as the major entry point into all NHS services both primary and secondary. This places a premium on General practice's ability to network across the system. The increased focus on health needs assessment has also raised the profile of general practice in the eyes of the Boards. Boards (and patients) are placing increasing demands on practices to deliver a variety of services, all of which may not be delivered from a single practices premises. The raised profile of primary care places a premium on general practices ability to coordinate a wide range of services. The pressures acute hospitals are facing are encouraging them to rethink care protocols with general practice. The implementation of Care in the Community has placed greater demands on general practice's links with Social Services. All these greatly increase the need for general practice to manage horizontally.

General practices will need to:

1. develop co-ordination of their horizontal relationships.

2. develop their relations with community units. This includes joint health needs assessment, development of new service and discussions regarding the role of attached staff.

3. develop connections, cohesion and common culture between practice's (whether fundholding or non-fundholding,

large partnerships or single-handed practices) over a range of strategic operational issues.

4. develop mechanisms for relating to Social Service Departments.

5. engage with local trusts over a range of issues ranging from referral protocols and discharge letters to reshaping the provisions of service.

Many of the above arrangements will need to be done by representative groups on behalf of a number of practices. These arrangements themselves will require some OD/MD development.

Acquiring relevant skills

In the main, general practices do not have a good track record in developing skills aquisitions within the practice. Health professionals are meant to have somehow acquired them as part of their professional training and administrative staff pick them up on the job. This is no longer a viable model.

The following needs have been identified.

1. Skills to influence both Boards and other providers.

2. Skills to monitor and evaluate the services they provide.

3. Skills to do small scale epidermilogical assessment of their list.

4. Use of information technology.

5. Management skills and development for professionals (including time management and stress management).

6. Management skills and development for the Practice Manager.

Improving the validity and relevance of information

General practices are sitting on a particularly rich set of data. Unfortunately most practices do not get the full value of the information available, or use what is available to influence their decisions.

Particular development needs are to:

1. develop their capacity to take a list perspective of any issue under consideration.

2. develop and link their information systems in such a way that they can contribute to the Boards Health needs assessment.

3. find ways of ensuring greater transparency/acc
information across the primary care team.

4. general systems to support the organisations st
direction.

Conclusion for General Practice

General Practice will need to make a significant transition if it is to deliver on the SNHS strategic agenda. The key enabler to its ability to meet the demands placed on it will be the recognition and development of the practice (as an organisational form) as the key player.

Thus the priority is to develop:-

1. the general practitioners who should be encouraged to involve other member of the primary care team.

2. the Practice Manager.

APPENDIX

APPENDIX A.1

Management Development Needs Analysis

Key Stakeholders interviewed during Stage 1 of project

1 Brian Broomfield
Trust Chairman
Aberdeen Royal Hospitals NHS Trust

2 Tim Brett
Chief Executive
Dundee Teaching Hospitals NHS Trust

3 John Connaghan
Chief Executive
The Victoria Infirmary NHS Trust

4 David Piggot
Unit General Manager
Edinburgh Priority Services Unit

5 Derek Sinclair
Medical Director
RSNH and Community NHS Trust

6 Libby Campbell
Director of Nursing and Quality
West Lothian NHS Trust

7 Sheena Parker
Management Education for Clinicians

8 Gary McFarlane
GP Fundholder
Kirkintilloch

9 Professor Chris Greenstead
Strathclyde Business School

10 Professor Elizabeth Russell
Aberdeen Health Research Unit

11 Bill Moyes
Director
Management Executive

12 Mike Collier
Director
Management Executive

13 Isobel Low
Director
Management Executive

14 Andrew Matheson
Director
Management Executive

15 Stanley Bonthron
Community Development Unit
Management Executive

16 Angus Skinner
Chief Inspector of Social Work Services
Social Work Inspectorate

17 Jim Connechan
Deputy Director
Management Development Group

18 John Howie
Professor of General Practice
University of Edinburgh

19 Jane Hopton
Research Assistant
University of Edinburgh

20 Nigel Clifford
Unit General Manager
Glasgow Royal Infirmary

21 Hugh Sutherland
Chief Executive
Ayrshire and Arran Community Health Care NHS Trust

22 Agnes Robson
Director
Management Executive

23 W A Anderson
Unit General Manager
General Services Unit
Borders General Hospital

24 Harry Burns
Acting Director
Greater Glasgow Public Health Board

25 James Barbour
Chief Executive
Aberdeen Royal Hospitals NHS Trust

26 Ian Bouchier
Chief Scientist
Scottish Office

27 Don Cruikshank
Chief Executive
SNHS Management Executive

Project Interviews Completed 3 September 1993

Large Acute Hospitals

1 **Dundee Teaching Hospitals NHS Trust**

CEO & 5 Executive Directors
5 Clinical Directors
14 Middle Managers supporting Clinical Directorates

2 **Glasgow Royal Infirmary Unit**

UGM & 3 Senior Managers
6 Clinical Directors
6 Business Managers
2 Nurse Managers

Medium/Small Acute Hospitals

3 **Borders General Hospital**

UGM & 2 Directors
5 Middle Managers
8 PAM Managers
5 Nurse Managers
4 Senior Doctors

4 **Law Hospital**

UGM & 4 Senior Managers
2 Clinical Directors
3 Middle Managers
5 PAM/Nurses

Community/Priority Services Unit

5 **Edinburgh Priority Services Unit**

UGM & 2 Directors
7 Middle Managers
3 Clinical Directors
2 PAM Managers
3 Nurse Managers

6 **Ayrshire and Arran Community Health Care NHS Trust**

CEO & 3 Executive Directors
Chairmen & 3 Non-Executive Directors
6 Middle Managers
7 Nurse/Health Visitors
3 Therapy Helpers/Nursing Assistants

Boards/Purchsers

7 **Dumfries & Galloway Health Board**

General Manager & 4 Executive Directors (including Public Health)
Chairman & 1 Non-Executive Director
4 Middle Managers

8 **Lanarkshire Health Board**

General Manager & 3 Executive Directors (including Public Health)
1 Middle Manager
1 CANO

9 **Tayside Health Board**

Chairman
General Manager
CANO
CAMO
2 Executive Directors
1 Middle Manager

GP Practices

10 **Thompson & Partners, Kirkintilloch**

5 GPs, 5 Managers
7 Nurses/Health Visitors
6 ADMIN

11 **Stonehaven Medical Group**

5 GPs, 3 Managers
2 Nurses
5 ADMIN

12 **Dr Graham Buckley's practice, Livingston**

APPENDIX A2

Appendix 2.1

Management and Organisation Development Needs Assessment of Health Boards

Introduction

The impact of the reforms on Health Boards has probably been greater than on any other organisational unit within the NHS. At the time of this study, they are in the process of changing their roles and external relations with the rest of the system. This transitional state is characterised by a confusing mix of organisational behaviour, style and attitude. Some of this mix is appropriate to their traditional role as a management tier within the hierarchy and some as commissioning authorities whose relationships with provider trusts are negotiated and embodied in contracts. This combination of approaches is more legitimate when it matches and actual combination of Trusts and DMUs within the Health Board's domain. This is not always the case.

In this report we have discussed the underlying principles which should govern the relationship of the ME to the rest of the system. A Health Board operating in an area in which all its providers are Trusts is subject to a very similar set of principles. This in turn will lead to recommendations for Health Boards which are closely related to many of those made for the ME itself. This is an important example of the need for consistency of behaviour throughout the NHS when administrative tiers are attempting to re-define their own role and their relationship with organisations which were previously line-managed by them.

Mixed messages can originate from many sources. Both the ME and Health Boards are trying to change their relationships with the providers. If the providers are to respond appropriately, it is essential that Health Boards mirror the approach which this report advocates for the ME.

Health Boards have responsibilities in relation to the provision of primary care for the areas they serve. Organisational barriers to the effective integration of primary, community and secondary care at the commissioning level are, therefore, theoretically minimised. Unfortunately, in practice, this opportunity has not been exploited and primary care remains the poor relation of the commissioning system. We will return to this point later.

Shifting the Culture

Much of the recent agenda of Health Boards has been dominated by the need for them to rapidly and radically restructure and reduce the size their operation. This has included the devolution of many functional responsibilities to Trusts and those DMUs moving to Trust status and the transfer of Health Board staff to other organisations. For many employees of Health Boards, this has been a period of profound uncertainty and personal insecurity. This has inevitably led to a process likened by

one Sounding Board member to bereavement.

In one model of bereavement, the first three stages are described as denial, anger and depression. These are not states conducive to either the recognition of new opportunities and powers or the willing sacrifice of traditional authority rooted in hierarchy. This process ma~~n~~y, in part, explain the common complaint that Health Boards have been unwilling to let go their historical line management approach and have continued to attempt to direct the autonomous entities of Trusts and GP Fundholders.

Additional explanations of this phenomenon are provided by:

- the transitional state of many boards where they continue to have responsbilitiy for DMUs.

- the failure of Trusts to accept their new independence and their continued deference to Health Boards. Health Boards and Trusts thus collude in the continued command and control approach of Boards.

In order to achieve the potential benefits of the reforms, Health Boards need to recognise the opportunities created by the change in their relationship with providers. They no longer operate within a sealed system defined by its geographical boundary and with line responsbility for the providers within it. Opportunities exist to contract with providers outside their boundaries and with the private and voluntary sectors. Such opportunities are often ignored by Health Boards which view changes in the traditional flow of money as "hemorrhages" from "their" system.

Health Boards are not responsible for the welfare of trust providers, but neither should they be indifferent towards them. This is particularly true in much of Scotland where geographical isolation sevrely limits the range of providers available. They thus walk a narrow path between the dual commissioning "sins" of cosiness and machismo. The minimum responsibility which they have for providers is driven by enlightened self-interest. In their purchasing decisions, they should not damage the ability of providers to continue to provide (to the required quality) those services for which they are still contracted. It is thus not appropriate for Boards to treat providers as black boxes into which they pour resources and from which cared for patients emerge. They need to understand the cost base and process contingencies of the provider units in order to determine the impact of their purchasing decision, but not to meddle in the management of those organisations.

Some Health Boards have developed sophisticated strategies for the commissioning of secondary health care. They still, however, tend to view their principal role in relation to primary care as the "pay and rations" of GP practices. Strategic thinking in primary care and community health services is undeveloped and potential levers of influence unrecognised (see Managing Horizontally below).

From the above, the following OD/MD needs have been identified:

1. Both Health Boards and Trusts need to develop understanding that their relationship in the purchased health care is governed by negotiat contracts. Outside the contract, trusts do no ask for permission and Boards cannot direct.

2. Boards need to recognize the legitimacy and benefits of diversity within their provider units. In their pursuit of quality they should not attempt to impose organisational uniformity.

3. Boards need to actively explore options for health care provision and to stop viewing providers with whom they have never had a direct management relationship as competitors of "their" system. They need to focus primarily on health gain rather than provider organisations.

4. Boards and their providers need to foster a trusting relationship in which the legitimate need for Boards to understand the processes and cost base of providers is recognised by those providers.

5. The development of strategic thinking by all involved in the commissioning process, especially the executive and non-executive board members and Public Health doctors. In particular, Boards need to develop their capacity for Primary and Community Care strategy (see below).

6. To understand the concepts of learning organisations and networks and to promulgate these throughout the system.

Creating new vertical relationships

ME

If the ME begins to address its role in the way advocated in this report then the pressure of uncoordinated, task-oriented directives to Health Boards will be reduced. This will not only reduce the direct interference with their activities, but will reduce their requirement to pass on directives to provider units, thereby compounding the "mixed messages" from the hierarchy.

This change in ME posture will not happen overnight. In the meantime, it is hoped that this report will legitimise feedback from Health Boards to the ME, drawing attention to inappropriate directives, particularly when the Boards are required to act as conduits, passing these on to more autonomous provider units.

Providers

Long terms relationships between the Health Boards and the rest of the system should not be characterised by an administrative interventionist approach. However, Health Boards will continue to retain functions which require occasional short term, emergency interventions. As with the ME (Section 3.2.1 in the body of the report) this twin role and its implications needs to be explained to providers. If

this does not happen effectively, then every direc
legitimate intervention demanded by emergencies w
as backsliding to outdated modes of operation.
disempower providers and undermine their perceptio
independence and responsibility.

Public

When Health Boards had direct line management responsibility for provider units, it was acceptable that they remained largely unrecognised by the community they served. Hospital, community units and health centres, etc, are the traditional face of health care. The hospital, in particular, is of immense historic and symbolic significance to its local population.

With the purchaser/provider split, health care institution are no longer responsible for the care of their host community. They are responsible for fulfilling their contracts. The organisation with responsibility for arranging the provision of health care for the community is the commissioning arm of the Health Board.

The availability of care, care priorities and the quality of care are all the ultimate responsibility of the Health Board. Prior to the reforms, a dialogue with provider units on these issues was also a dialogue with the Health Board. This is not longer true. It is thus essential that the public are aware of the Health Boards' responsibilities and accountability and that mechanisms are in place for direct communication between system users and the Boards. Until the reforms, Health Board HQ staff were relatively protected from the impact of their prioritisation and rationing decisions. They are now at the ethical sharp end and must be prepared to directly address their new and often uncomfortable role.

The following OD/MD needs have been identified:

1. Boards need to define a policy for assessing and responding to ME directives and a reasoned and consistent approach to exploring the legitimacy of directives which place demands on trusts.

2. Boards should communicate clearly to Trusts the two kinds of relationship in which they will be engaged: the short-term, emergency related interventionist approach and the long-term operational and strategic norm.

3. The new role of Boards needs to be conveyed to the public and mechanisms developed for effective two-way communication with them.

4. Boards need to develop skills in representing themselves in a variety of public fora and with the media. To understand opportunities and mechanisms for engaging with the community and users on issues of service configuration and quality.

Developing effective organisational leadership

Heading to next page

We discussed above the importance of a public understanding of the responsibility of Health Boards in relation to the community and the necessity of a clear and accessible public face. This is a critical leadership role and one in which the non executive directors of Health Boards can play an essential part. Probably more than in any other health organisation it is important that the non executive directors share a common agenda with the organisations executive leadership and contribute fully towards an agreed strategy.

During the recent major transitions undergone by Health Boards it has often been necessary for the executive leadership to adopt a very directive, project management oriented, approach to effecting change. However, as discussed below, (Managing horizontally) on-going relations with providers will be characterised by subtle and continuous dialogues which cannot be conducted by executive management alone.

Health Boards will be small organisations in which the majority of commissioning related personnel will be called upon to represent the organisation in high level discussion and negotiation. They must themselves posses leadership characteristics. They will need to operate in a strategic framework which they understand intimately and for which they feel ownership.

It is essential that Health Boards do not continue to be dominated by a leadership style which may have been appropriate for short term dramatic transition or for the management of large bureaucracies. Such an approach will not sustain creative, energetic and enthusiastic enterprises which are sensitive to their political, community and professional environments.

The following OD/MD needs have been identified

1 Executive and non executive directors should develop a common strategic agenda and operational guide-lines which govern their communication with providers and the public.

2 Health Board senior executives should critically review their models and style of leadership and endeavour to develop leadership capabilities in their staff.

Managing horizontally

The unique perspective of the Health Boards is provided by their view of the overall health care system within their area. They can have, and can exploit, insights not only in relation to individual providers but to the interface between those providers. Boards are not responsible only for purchasing services from provider but for purchasing the inter relationship between providers which leads to an integrated system. The Boards approach to service specification has to recognise the difficulty of purchasing care which spans provider organisation boundaries.

If the commissioning strategies of Health Boards are to be

effective it is important that they are congruent approach taken by GP Fund Holders in their area. clearly essential where there is a significant pe Fund Holders. Where there is good communication b fundholders and broad agreement on their commissio Strategy Boards need to establish mechanisms for sh commissioning priorities and the alignment of strat Where Fund Holders do not speak with a coherent voic oards need to facilitate communication between Fund Holders as well as between them and the Board.

In many areas a number of Boards purchase from a single health care organisation. Where this is the case it is necessary for these boards to co-ordinate their commissioning and quality initiatives if they wish to be assured that they understand the impact of their decisions on the provider organisations.

Boards do not appear to have the capacity for integrated purchasing of, and investment planning in, primary care. In particular they do not understand and manage the differences in the two major strands of primary care provision (GP practices and Community Health Services) and their relationship to secondary care. Successful commissioners would need to produce service specifications which reflect the legitimate differences in philosophy, operating principles, finance, mechanisms for performance monitoring, populations served, range and level of expenditure.

The implementation of community care represents a major challenge for Health Boards. Significant stylistic, managerial and ideological differences exist between many Boards and their colleagues in Social Services. The tight integration of health and social services which is necessitated by the Act can be jeopardised by poor working relations between all levels of the Board and the Local Authority.

The following OD/MD needs have been identified

1 Boards should adopt a system wide view of health care in their area and explore options for commissioning care across provider boundaries

2 Boards should actively facilitate joint commissioning strategy development between themselves and GP Fund Holders in their area.

3 Boards should explore opportunities for the development of primary care networks to promote learning between organisations and enhance their capacity

4 Boards should develop a strategy at all levels of their organisation for effective collaboration and contracting with social services

5 Develop coaching and facilitation skills to tap the creative potential of provider units and to enable them to gain a system wide view of health care

6 Need to recognise the potential for MD/OD interventions

Public Health doctors

stick to &

in their own and in provider organisations. Per
more importantly to focus these interventions on
organisational issues

7 Need to have insight into the resource utilisatio primary processes of provider units so that the impact of purchasing decisions is predictable. To ask the right questions in the right way and to understand the responses.

Bringing health professionals into management

Public Health Doctors in Health Boards have undergone a significant change of role as a result of the reforms. They have new responsibilities in relation to the commissioning process which focus particularly on health needs assessment and clinical quality. At the same time they retain a a variety of statutory Public Health responsibilities as well as a Health Promotion role which can itself impact on service development in health care.

Health needs assessment relates in part to epidemiological community profiles but also to the possible responses to these patterns of disease. Provider units (in particular GPs and (Community Units) are a contributor to epidemiological insights (see "Improving the validity and relevance of information" below). They are also an essential source of technical expertise and creativity in formulating appropriate responses to disease patterns. Dialogue between Public Health doctors and providers, combined with research initiated by Health Boards or in the public domain, enables Public Health to formulate a rich but fuzzy picture of need. This is integral to the commissioning strategy. It is essential therefore that Public Health Doctors are closely engaged in strategy formulation and are not just an expert resource called upon for the clarification of technical issues. They should inform the strategy and the strategy should inform the focus of their professional work.

Public Health doctors have seen a major shift in the nature of their relationships with senior clinicians in provider units. In their discussion on service development and quality issues they have moved from being a colleague to having both a development and policing role. Through good personal relations, mutual respect and a history of effective collaboration some Public Health doctors have adapted to this twin role with relative ease. Others have not.

The following OD/MD needs have been identified

1 Public Health doctors should be engaged in commissioning strategy at the highest level and should undertake their professional research guided by this strategy

2 The relationship between Health Promotion, service development and the public profile of Health Boards should be recognised and exploited.

Acquiring relevant skills

The changing roles of Health Boards demand that ~~there~~ their

personnel possess a number of new or enhanced skill
addition to those which have been referred to elsewl
These include:

1 Purchasing and Contracting skills and an underst of the health gain opportunities which create obj for these activities

2 To develop an understanding of the importance and methodology of Information Strategy formulation

3 To develop a sophisticated but communicable understanding of quality which is shared with, and endorsed by, providers

4 To understand national strategy issues (e.g. trauma centres and centres of excellence) and their relation to local strategy

Improving the validity and relevance of information

When Health Boards request information from their providers they should be sure that the information is relevant and necessary to their commissioning strategy and/or contracting process. They need to develop an Information Strategy and this needs to be aligned with their broader corporate strategy. This means that it should be developed with provider agency collaboration. There are two main areas in which possibilities for useful collaboration exist.

Needs Assessment

As discussed above it is necessary for Health Boards to conduct a community focused health needs assessment as a contributor to the development of their purchasing priorities. This epidemiological data combined with the providers diagnostic care activity and outcomes data ~~constitutes~~ essential core information for purchasers. The benefits of a purchaser/provider shared approach to information systems specification and development include an enhancement in:

- the value of providers data
- the ease of synthesis of provider data
- ease of comparison between providers
- greater clarity of outcome and health gain measures
- direct access by providers to local public health data which will inform their service development priorities
- early sharing of provider development concepts with purchasers

In this two way flow of need data and service delivery ideas the purchaser remains responsible but the richness of thinking and value of ideas from providers is greatly enhanced.

Contract Monitoring

It is necessary to invest in Information Systems for contract monitoring. This has tended to be done in one of three ways.

1 Boards demand information of their providers with no concern for the practicality or impact of their demands

2 Boards contribute to the Information Systems development costs of their providers because they have imposed contracts which can only be monitored by data from new provider systems

3 They develop their own information systems which duplicate but improve upon those of their providers.

These approaches are either inappropriate or inefficient. 2 tends to be post hoc, with little control and involvement of Boards. They may find themselves paying for systems functionality which provides no health gain benefits for the community. 3 is straight systems duplication which is not only wasteful but a rich ground for endless disputes on the relative validity of purchaser or provider data.

Every contract contains its own information systems requirements. These should be jointly identified during negotiation and plans to improve the specificity and refinement of contracts should be jointly explored for the most efficient and robust information system solution.

The following OD/MD needs have been identified

1 Health Boards need to develop an information strategy which enables them to create rich pictures of the community for which they are responsible by integrating hard and soft data from a variety of sources.

2 Health Boards need to investigate the possibilities of joint information strategy development with providers.

Conclusions

It is clear that Health Boards have a significant MD/OD agenda. However as their provider units complete the move to trust status and the numbers of direct Health Board employees decreases this makes the agenda more manageable.

The two major areas of focus are:

- the need to address their relationships with provider units. In particular to establish commissioning and not line management as the basis of their relationships.
- the development and integration of a primary health care strategy with the rest of the commissioning agenda.

Priority development is with the chief executive and the executive and non executive board members, followed by the Public Health Doctors ~~by~~ and the strategic development of the Public Health function.

Appendix 2.2

Management and Organisation Development Needs Assessment of Acute Units

Introduction

Acute units are very complex organisations. This is contributed to by their size and the complicated nature of the work they do. Their management and organisation development requirements are, therefore, significant and in themselves complex. To achieve the strategic agenda for the NHS in Scotland it is critical that these units achieve the strategic agenda for the NHS in Scotland it is critical that these units develop themselves successfully.

Acute units consume a large proportion of the resources of the NHS in Scotland. They face significant demand and supply pressures with the ageing of the population and the inexorable growth in medical therapeutic wherewithal. Their efficiency is critical to the overall efficiency of the NHS. Their support is necessary if new modes of organising therapy, such as day and short stay surgery, are to spread; if medical and other health professional education and medical research are to adapt to the evolving structure of the NHS; if the significant reduction in acute bed numbers is to be achieved rationally; and, if the political framework supporting the strategic changes is to be maintained.

The findings from the acute units are summarized below within the framework of our model. The MD/OD implications are then considered.

Shifting the culture administration to management

The strategic agenda as outlined in the body of the Report requires a shift in culture in acute units from one in which they were a 'cog' within a large regionally structured hierarchy of the NHS in Scotland, to one in which they are more autonomous, self-determining, responsible entities. One in which the future success of the organisation depends totally on the staff and Board of the organisations.

To achieve this shift in culture acute units need to:

1. Develop a corporate identity (in which staff feel they belong to the organisation rather than to their profession, department, or the NHS in general.)

2. Develop a market sense. (The hospital's income will depend on delivering services at the price, quality, relevance, and style that purchasers will buy).

3. Develop a 'contract culture'. Relationships between organisation and rest of NHS (the ME, purchasers, other providers) and between components of the organisation (e.g., between management and professionals) will progressively be based on 'contracts' (i.e., explicit, and increasingly sophisticated, agreements on what each

party to the 'contract will do for the other party(ies)).

Creating new vertical relationships

To develop as more autonomous, self-determining organisations acute units require new vertical relationships to ensure that the mandate of the NHS is achieved and that relationships within units are effective.

These new vertical relationships operate at two levels:

1. Between the organisation and its 'mandator' (the NHS in Scotland.

2. Within the organisations (between the Board and management, between different levels of management, between managers and professionals and between managers and other staff).

Units need to:

1. Develop their Boards of Directors. Initial orientation and development of Directors in terms of their roles, their relationships and their modus operandi (including the role of the Chairman and the CEO, establishing sub-committees); defining the 'governing' role and distinguishing it from the 'managing' role; developing reporting systems -- from the organisation to the Board and from the Board to the ME. Effective Boards are key to achieving new effective vertical relationships.

2. Develop their Chief Executives. A Chief Executive recruited from outside the NHS may have a background in corporate management and governance, but will need development regarding the nature of the business of the acute hospital and the particular power structure of health professionals and affiliated universities. Chief Executives recruited from the NHS will need development of their new corporate management and governance roles. All Chief Executives will need to play a key leadership role in "shifting the culture" and in establishing and implementing a development agenda for their organisations.

3. "Get the consultants 'on-board" - the development of consultants in leadership roles so that they take 'on-board' the corporate well-being of the hospital. This involves developing a new, mutually constructive, vertical relationship between the Chief Executive and the medical staff leadership (including, but not limited to, clinical directors).

4. Develop a 'contract culture' (see above) as an important adjunct to developing a new vertical relationship. 'Contracts', as defined above, are an effective basis of managing a vertical relationship in which the parties share power and a greater responsibility for corporate outcome. In acute units doctors and other health professionals control the patient care process and

managers control the inputs into this process. Under the strategic agenda for the NHS in Scotland, units have to be able to develop, negotiate, and deliver contracts that link inputs, patient care process and outcomes as defined in purchaser contracts. To do this they must be able to span the domains of doctors and other health professionals and that of managers. Supervision, the traditional organisational control mechanism, is usually not effective in spanning these domains in acute hospitals. Doctors and many other health professionals will not be supervised by lay managers. 'Contracts' form an effective basis for spanning these domains within the hospital and achieving overall corporate control.

5. Develop their administrative infrastructure to support decentralised management. When hospitals were small 'cogs' in vertically integrated regions of the NHS in Scotland, administrative support departments (e.g., Finance, Personnel, Planning, etc) were centralised and focused on 'administering' central bureaucratic control systems. As a stereotype, clinical departments existed to provide central controllers with information they needed to control. With the implementation of the strategic agenda and the development of decentralised management within units, these administrative departments take on a reversed and more difficult role. Not only must they collect information for the purpose of corporate control, they must also provide an information service to 'production' departments to enable them to manage and deliver on their 'contract'. This new role was not yet developed in the study sites and is responsible for many of the mixed messages managers receive about decentralised responsibility and central control behaviour.

   Similar confusion exists in some nursing/quality departments that traditionally had line responsibility for nursing, but now find themselves in a staff relationship with nurses in clinical directorates and in an ambiguous relationship with clinical directors in regard to responsibility for delivering quality.

Developing effective organisational leadership

Effective organisational leadership provides the starting point for the complex OD/MD initiatives suggested in this study. Leaders need to be able to articulate the new management culture, interpret challenges to their constituents and provide motivation and guidance to address these challenges. This leadership will not just reflect hierarchical positions within the structure of acute units, but will also be needed from medical staff and other staff group representatives.

The following OD/MD needs have been identified:

1. Develop Chief Executives. Chief Executives of acute units will have to take the lead role in developing organisation wide change strategies. Relevant MD/OD strategies for a hospital support the strategic agenda

of the hospital. This can only be achieved if the Chief Executives personally drive the MD/OD strategies.

2. Develop medical leadership. Ideally medical staff leadership will be reflected in clinical director appointments. It may be necessary to develop supporting leadership from senior respected and influential clinicians if clinical director leadership is still emerging. Needs for clinical director MD/OD are elaborated below.

Managing horizontally

Acute units face greater pressure to manage horizontally than before. A number of factors are responsible. These include:

* A consequence of increasing day or short term care is that linkage with community based providers becomes necessary to co-ordinate overall care.

* Efficiency pressures on acute units will force them to improve discharge planning which can only be achieved in relationship with other providers.

* GP Fundholding will lead to pressures to link care with GPs.

* Specific legislative targets such as Care in the Community.

Acute units will need to:

1. Develop co-ordination of their horizontal relationships. Managing horizontally can be a problem for overall hospital control because it occurs at many points within the hospital. All clinical directorates may need to manage horizontally with overlapping providers. This places pressures on careful contracting between directorates and management and effective communication between directorates.

2. Develop the appreciation for, and skills to manage, relationships outside one's own organisation.

Bringing health professional into management

Central to improving the management of acute units in the NHS in Scotland is the increased involvement of health professionals in their management. This arises because improved contracts will require hospitals to manage production (patient care) rather than simply to administer the unit (control inputs, report to the centre).

Most hospitals have implemented a clinical directorate structure - in some cases only because this has been mandated in trust application procedures. There are, of course, other structures that could be used.

To enhance the involvement if health professionals in their

management acute units will need to:

1. Develop the context for involvement of health professionals in management. This context derives from appreciating the above challenges - shifting the culture, new vertical relationships, skills acquisition and better information. Just implementing clinical directors, as some hospitals appear to be doing, without careful attention to developing the correct context is unlikely to be successful and may indeed be counter-productive by creating false expectations among medical staff.

2. The structure of clinical directorates needs to be re-considered in some hospitals. Grouping of clinical units into directorates does not always seem appropriate in terms of organisational interdependence or size. The administrative infra-structure of some directorates is insufficient or inappropriately organised. Greater administrative support should be developed from administrative departments rather than by building decentralised competencies within diverse directorates.

3. Develop leadership and management skills of clinical directors and their corresponding nurse manager(s). Most have no formal management training. In particular developing the skills to involve other professionals within their directorates and effective delegating so that the burden of production management does not fall only on the individuals in the directorship position.

   There seems to be a temptation to turn clinical directors into administrators by over focusing on developing their administrative skills. Clinical directors should be able to use hospital's administrative infra-structure for administrative tasks and contribute themselves as leaders, rather than becoming partly trained administrators.

4. Within directorate development is needed to help directorates determine roles within it and a sense of corporate identity and affiliation through membership of the directorate.

Acquiring relevant skills

The new structure of acute units requires a number of new skills to support the developments describe above.

The following OD/MD needs have been identified:

1. Skills to develop, negotiate, monitor and deliver contracts with purchasers. (These skills are sometimes referred to as 'marketing', however this term is not used in this context because it tends to focus only on getting contracts and not on monitoring and delivering them).

2. Skills in administrative support departments to enable them to provide service to 'production' departments

(those delivering patient care). These include budget information, quality assurance information, planning, marketing, policy guidelines, management development, etc.

3. Management skills for professionals in management roles (see above).

Improving the validity and relevance of information

The 'contract' culture depends on the availability of appropriate information to support the level of sophistication of the contract.

There is a dearth of evidence to link information strategy to overall strategic development of the sample units. "Resource Management" is being implemented because it has been the centre's agenda and because it is a way of financing computer hardware. The linkage between "Resource Management" and organisational development is understood in the context of past experience of demonstrating that the implementation of expensive computer hardware and software is just that, if it is not accompanied by associated organisation development. However, running both information systems implementation and attached organisation development from the centre runs counter to the principles of the new strategic agenda. It is now the tail wagging the dog. The development of information systems should be driven by the organisation themselves if they are to accept responsibility for them and to ensure that they reflect the needs, priorities and level of sophistication of the organisation.

The following OD/MD needs have been identified:

1. The centre needs to rethink its "Resource Management" methodology to ensure that it supports the overall strategy of developing responsible components.

2. Acute units need to develop information system capacities that reflect their overall organisational development.

Conclusion

The MD/OD agenda in acute units is very significant. Organisations with very large numbers of staff (often over 4,000), significant historic relationship (such as medical school affiliations), with influential staff groups (especially medical staff), that have operated for many years as 'cogs' within a larger regional component of the NHS are suddenly being asked to accept responsibility for their own governance, management and, in the end, well-being (or even in some cases, survival). This is a mammoth task that will require sophisticated strategies and realistic time-frames.

A key strategy will be for the centre to ensure that the context within which these hospitals are to work is clear, consistent and coherent. Within this context hospitals themselves need to develop their own MD/OD strategy to reflect their own needs and priorities. Hospital-wide MD/OD

will be required in most cases. This will require an incremental approach and an acceptance that MD/OD is the responsibility of all managers, not that of an MD/OD department or function within the hospital, nor that of external consultants (the cost would be prohibitive and the ownership of MD/OD would not be properly located)

This assessment leads to the priority development areas being, in the first instance:

The Board of Directors
Chief Executives
Clinical Directors
Heads of administrative support departments.

The focus of this development should be shifting the culture and developing new vertical relationship. As these emerge each hospital will identify priorities for skill acquisition, better information and managing horizontally.

Appendix 2.3

Management and Organisation Development Needs Assessment of Primary Care Providers

Introduction

Primary Care is now front of stage on the NHS agenda. Whilst the expectations of primary care led systems are high, historically there has been a relative underdevelopment in the management and organisational infrastructure of primary care.

Unfortunately, purchasing boards have not developed either the understanding of the vision or the available mechanisms in order to deliver on the primary care agenda - there is a high imbalance between the management capacity and the massive change agenda.

The provider needs in primary care differ from their acute equivalents. Community provider units operate within multiple client demand systems and have significantly greater managerial complexity of managing multi-location and outreach services.

Scotland will require rapid development in several areas:

- core general practice
- extended primary Health Care Teams providing appropriate mixes of generalist and specialist care in or near to people's home
- Community Health Services providers
- new service configurations which reshape the secondary/ primary care boundary

From this agenda arise a set of wider concerns relating to the organisational development needed to enable local organisations to:

- develop effective strategies for purchasing primary care
- develop locally appropriate and accountable primary care provider organisations
- legitimate diverse approaches (both structures and nature of provision)

Achieving these strategic goals will require change and development in the managerial and organisational capacities of Boards and Provider units. To meet the new strategic challenges, they require a systematic and sustained approach to OD to create appropriate management styles and organisational forms.

Despite the focus of this and the following section on Community Health Services and General Practices, we stress

that the development of appropriate, local, Scottish models of primary care will involve working with all purchasers (Health and Local Authority) and all provides including acute, voluntary organisations, carers etc).

Community Health Services

The role of Community Health Services (CHSs) has largely remained hidden in the changing SNHS. Yet these services play an essential part in the management of chronic ill health and disability. CHSS also provide distinctive elements of community based care which are necessary to meet the needs of diverse - and often disadvantaged populations, particularly within cities. These include standard community nursing and school health services as well as support for homeless people and families, and people with mental health problems or learning disabilities.

Whilst many of the development needs of Community/Priority units will be identical to that of acute units (eg developing a corporate identity, developing a market sense) it will not automatically follow that the process by which they will be achieved, or the outcome (what a community unit with 'market sense' would look like) will be the same.

Shifting the culture

As described in the body of the report, the strategic agenda of the SNHS will require Community Health Services to operate as more autonomous, self directed, service shaping organisations.

There is an urgent need to create new CHS organisations to help lead the future pattern of primary care as it moves from the margin to mainstream. This renewal will require the SNHS to support the development of organisations which can deliver on their potential for connections and flexibility geared to local needs. CHSs have the potential to develop a more appropriate balance between primary and secondary care by offering an expanded range of services to patients' own homes or from community-based centres or general practices.

Key issues the CHSs need to address include:

1. clarifying the nature of the 'business' they are in and developing an appropriate identity and cohesion that builds models of authority, accountability and support which take into account the distributed nature of the work but are not based on professional identity.

2. managing in a potentially competitive environment. CHSs face potential pressure from a number of directions: acute units are developing 'outreach'/community based programmes, GPFHs have the option of employing staff directly as well as the opportunity to provide direct services themselves. Social Service departments have the potential to increase control over a number of

services traditionally provided by CHSs, and private and voluntary organisations are entering the market. CHSs need to understand their strengths and weaknesses and the unique contributions they can make to the system of health care as well as their cost base, quality of service and style of delivery if they are to generate contracts from purchasers.

3. managing the fear that is current in CHS organisations. This may be fear of being employed by a GPFH, of professional irrelevance (eg Health Visitors), of changing working practice, or redundancy.

New Vertical Relationships

To develop as more autonomous, self-directed, service shaping organsations, CHS organisations need to develop their vertical relationships with the M.E, their Health Board and within their own organisations.

Units need to:

1. develop their relationship with Health Boards so that they can contribute to the Boards' strategy for integrated commissioning of, and investment planning in, primary care. CHS organisations have most of the systems experience of working across boundaries and some of the very few of the evaluated examples of service reconfigurations. This sharing of good practice to enhance purchasing intelligence should be facilitated across Scotland.

2. develop their own Boards of Directors. Initial orientation and development of Directors in their roles, their relationships and their modus operandi (including the role of the Chair and the CEO, establishing sub-committees); defining the 'governing' role and distinguishing it from the 'managing' role; developing reporting/listening systems - from the organisation to the Board and from the Board to the ME and vice versa. It is essential that Unit Boards lead the process that forges the organisation's strategic agenda. Effective Boards are key to achieving new effective vertical relationships.

3. develop their Chief Executives. Given the network nature of CHSs, the CEOs will face particularly challenging times. They will need a rich understanding of the whole health system in order to represent their organisation successfully outside, as well as leading the "culture shift" within their organisations.

4. develop organisational forms and management styles to match the changing nature of their business of making connections between:

    General practice focus.......locality focus
    Providing personal care......population-based care
    Community-based specialist...generalist providers

Community-based specialist...hospital-based
specialist

CHS organisations will need criteria for deciding both their unique contributions to the network of service to best suit local population needs (the task) and the style best suited to their configuration of businesses. Strategies for building congruent management processes will need to be developed, bearing in mind that these are often interpreted by relatively junior and geographically dispersed staff.

5. support innovations, encourage risk and not collude with maintaining the status quo because "its always been done this way". If CHS organisations are going to help lead the future pattern of primary care they will have to reward and support the development of new ways of providing services. This requires a different relationship between managers and service providers and a recognition that diverse solutions may operate within the same organisation.

6. develop appropriate forms of managerial accountability as well as professional accountability. Since CHSs centre on people and relationships rather than bricks and mortar, they can be flexible and respond to changing patterns of needs. Too often this potential flexibility has been undermined by the tribalism common in professionally dominated organisations.

7. develop a more sophisticated understanding of the use of contracts as a tool in managing vertical relationships in which the parties share power and a greater responsibility for corporate outcome. Those who have to deliver the organisations' contract need to be involved in negotiating it, and the output can be subcontracted internally as a means of spanning control in a distributed organisation. The "top" of the organisation has to find ways of staying connected to what actually goes on further down.

8. building a model of management that is enabling and not simply a controlling activity that occurs "behind locked doors". Most employees have only experienced professional models of accountability and decision making and need to be 'sold' the virtues of a managerial model.

Organisational leadership

Effective organisational leadership provides the starting point for the complex OD/MD initiatives suggested in this study. Leaders need to articulate the vision and culture and model it in their own behaviour. Given the network mature of CHSs and its critical role in reshaping the provision of primary care, we can expect to see many leaders in CHS organisations whose key feature is their capacity to enable.

The following OD/MD needs have been identified:

1. develop Chief Executives. The CEO has to take the lead role in developing their organisations. They will need to understand the potential and limitations of MD/OD strategies in contributing to the strategic agenda of their organisations. Given the inherent loneliness of the position, there is significant benefit in providing opportunities for personal support and development.

2. develop the professional leadership. Practitioners have, by and large, been led by a person acting as Head Professional. They will need support in developing a managerial dimension to their leadership.

3. develop Nurses. The majority of professionals in CHSs have a nursing background. There is a case for specially designed programmes to support their transition to leadership positions.

Managing Horizontally

The provision of primary care is likely to remain a complex network of agencies/service if it is to retain the flexibility needed to meet the diversity of people's needs. This legitimate diversity could be damaged if simplistic notions are employed to reduce boundaries by tidying up providers (usually into general practice or into hospitals). The task in primary care is to manage the inevitable boundaries between providers rather than to seek to abolish them.

CHSs should:

1. offer "connectedness" or service integration through contracting, subcontracting and service agreements. These more concrete forms of accountability would replace traditional exhortations to professionalism and collaborations.

2. be able to contain/maintain a creative tension in which there is both a practice and a locality focus. Developing a locality focus will be crucial for the successful implementation of community care and CHSs could play a central role in facilitating relationships between Social Services departments and General Practices.

3. develop mechanisms for sharing/learning from experiences, innovations and good practice both within its own organisation as well as between different CHS.

4. develop tools for influencing other agencies and finding ways to motivate and manage beyond the boundary of its own organisation.

Bringing Health Professionals into management

To a large extent the management of CHS organisations understand the nature of the business they are in very well

as many of the managers have come up through the professional route. The consequences have often been that:

1. the organisation is structured along professional lines and
2. accountability and relationships have been professional and not managerial.

To enhance the development of health professionals in their management, CHSs will need to:

1. develop the context for involvement of health professionals in management. This context derives from appreciating the above challenges - staffing the culture, new vertical relationships, leadership and new horizontal relationships.
2. reconsider, in those places where it has not already been done, the way professional groupings are currently structured and managed.
3. develop leadership and management skills of those professionals who are managers (of professional groupings or localities). Most have no formal management development. It may be necessary to run tailored programmes for those who have a nursing background.

Acquiring relevant skills

CHSs will not succeed unless they equip their staff with the knowledge and skills required to manage in the new environment. The skills gap is most noticeable in regard to middle managers who have to translate the new contractual framework into appropriate action.

The following have been identified.

1. Skills to develop, negotiate, monitor and deliver contracts with purchasers.
2. Skills in administrative departments to enable them to provide support to those delivery services. These include budget information, quality assurance, business planning, marketing, etc.
3. Building relationships and negotiating service agreements with general practices.
4. Performance monitoring techniques.
5. Developing a management style that will enable them to manage in an appropriate tight (command and control) loose (influence and persuasion) mix.
6. Internal change agency skills.
7. Information management.

8. Use of information technology.

Improving the validity & relevance of information

There was little evidence to suggest that information strategies were contributing in a systematic and comprehensive way to organisational objectives. Where information was being collected, it was mostly around professional activity levels and there was no obvious connection to any managerial decisions.

CHSs need information primarily for three purposes:

1. To feed into the needs assessment process and influence the shape of health service commissioners' strategies and contracts.

2. To support the delivery of their contracts.

3. For managerial purposes.

Conclusions

The Scottish NHS will need to grow strong and flexible Community Health Services if it is to deliver on the primary care agenda. CHSs face a particular challenge in inventing new forms of organisational structure and management that allow them to deliver their key role of "connectedness".

This suggests that priority development areas are:

The Board of Directors (exec and non-execs)
Chief Executives
Middle Managers

The focus of this development should be shifting the culture and developing a managerial style that frees up the organisation and allows multiple leadership to deliver on the strategic agenda.

General Practice

Primary health care services deal with 90% of the population's contacts with the NHS. These services are a network of small organisations and individual practitioners. They are central to the effective care of an aging population and in the management of chronic disease, and will therefore have an even greater role in health service systems in the next century. The actual and potential contribution of general practice is widely recognised. They have a capacity for innovation and service development (demonstrated through fundholding and in other ways) and are expanding the scope of general practice. However, the 'new' contract (1991) has resulted in many GPs feeling they have lost their power/ability to influence the system. In parallel they are struggling with the demands on the contract and other reforms are making for them to separate out their

professional identity (general practitioner) from their organisational status (general practice).

While there will be increased diversity in both the career of a general practitioner and the organisation of general practice, it is important that this diversity is legitimatized and valued and does not fragment the profession.

Shifting the Culture

Many of the cultural challenges facing General Practice are of a fundamentally different nature than those facing the rest of the SNHS. The independent contractor status means that 'contracts' are not new. General Practitioners (GPs) have always been regarded as 'quintessential small businessmen and GPs have long regarded neighbouring practices as competitors.

One impact of the changes is that it is forcing GPs to separate the profession from the organisation. General Practice used to be synonymous with both. Now they need to explore more fully the difference between the general practitioner (the profession) and the general practice (the organisation). A consequence is the recognition that (i) all the demands being placed on the organisation don't have to be met by the general practitioner (ii) they need to think what sort of organisation is general practice and what does it need to do to survive and thrive in the changing environment.

The second transition that is demanded from general practice is that it shifts its focus from the individual to the list. Whilst the GP can focus on the needs of an individual patient, the practice needs to understand the needs of the list.

The third transition is the shift from illness to health.

The final major change is from individual practitioner focus to a primary care team approach. Practice - based primary care is interpersonal, interprofessional and interorganisational and requires a shift in culture from the traditional model of general practice.

To achieve this culture change:

1. GPs should explore different visions/models of what it might be to have a career as a general practitioner in the future. Many (often women) do not wish to follow the 'heroic, all hours' model, others want part-time jobs, some wish to be salaried, some wish to manage as well as practice etc.

2. GPs should rethink what sort of organisation they wish their practice to be and what capacities the organisation needs to meet the demands being placed upon it.

3. General practice needs to shift its focus from 'doctor,

his patient, and the illness' to 'the practice, its population, and their health' and the practice relationships to the Health Board and its Contract.

4. Practices need to understand the nature of the primary care business they are in and the nature of the team or network that is needed to deliver it and then design working methods to implement it.

Vertical relationships

General practices need to be develop their vertical relationships with

1. The ME

2. Their Boards

3. Within the practice

General Practices need to:-

1. develop a way of collectively influencing the strategic direction of the SNHS from their organisational (not professional) perspective.

2. influence the strategic direction of their Boards. One way is to feed their rich practice based information data into the health needs assessment process to influence the purchasing strategy. They also have a capacity for spreading innovation and development of new forms of provision, particularly in partnership with CHSs and other providers.

3. need to develop a non-hierarchal, non-professional model of managing within a practice. Currently the predominant model is a model of professional expectations, leaving each staff grouping (admin, receptionists, nurses.....) to work independently. There is no 'connectedness' in the managerial sense. The communications, when it exists is almost exclusively about patient issues, and rarely about the practice as an organisation.

4. develop a strategic decision making group responsible for the practice as an organisation.

5. rethink and redevelop the role of the practice manager (often seen as the only manager in the organisation). This is a critical role and often used as the layer in the organisation between the GPs and the rest of the practice staff. The tendency to separate entirely professional and managerial spheres of influence should be rethought and other professionals (eg Practice Nurses, Community Nurses) should engage in operational management as part of their role. Equally, the practice manager should make a major contribution to the strategic direction of the practice.

Bringing health professionals into management

Given the partnership (or sole practitioner) model of general practice, the issues for GPs is more one of bringing management into professionals. This is at the strategic/corporate level of the organisation. At the operational level, there are clear advantages in getting other professional staff involved in a managerial capacity.

To enhance the effective running of general practices, they should.

1. Develop the strategic role of the general practitioners (see section on leadership)

2. Explore methods of involving practice nurses and attached community nurses in the operational management of the practice.

3. Develop an understanding of and mechanisms for accountability.

Developing effective organisational leadership

The organisational leadership in General Practice comes from the General Practitioners. Currently, most partnerships operate on a professional model of consensus (with a senior partner) and have a very hierarchical relationship with the rest of the organisation. This is not seen as helpful in enabling the delivery of care by the rest of the team.

1. Partnerships need to develop a strategic agenda for the practice as a whole.

2. Partnerships should explore other models of reaching and implementing decisions. (eg. consent rather than consensus).

3. GPs should develop models of leadership and engagement that do not depend solely on their role.

4. Leadership should be developed in the practice manager and other members of the primary health care team.

Managing Horizontally

General Practice is seen as the major entry point into all NHS services both primary and secondary. This places a premium on General practice's ability to network across the system. The increased focus on health needs assessment has also raised the profile of general practice in the eyes of the Boards. Boards (and patients) are placing increasing demands on practices to deliver a variety of services, all of which may not be delivered from a single practices premises. The raised profile of primary care places a premium on general practices ability to coordinate a wide range of services. The pressures acute hospitals are facing are encouraging them to rethink care protocols with general practice. The implementation of Care in the Community has

placed greater demands on general practice's links with Social Services. All these greatly increase the need for general practice to manage horizontally.

General practices will need to:

1. Develop co-ordination of their horizontal relationships.

2. Develop their relations with community units. This includes joint health needs assessment, development of new service and discussions regarding the role of attached staff.

3. Develop connections, cohesion and common culture between practice's (whether fundholding or non-fundholding, large partnerships or single-handed practices) over a range of strategic operational issues.

4. Develop mechanisms for relating to Social Service Departments.

5. Engage with local trusts over a range of issues ranging from referral protocols and discharge letters to reshaping the provisions of service.

   Many of the above arrangements will need to be done by representative groups on behalf of a number of practices. These arrangements themselves will require some OD/MD development.

Acquiring relevant skills

In the main, general practices do not have a good track record in developing skills aquisitions within the practice. Health professionals are meant to have somehow acquired them as part of their professional training and administrative staff pick them up on the job. This is no longer a viable model.

The following needs have been identified.

1. Skills to influence both Boards and other providers.

2. Skills to monitor and evaluate the services they provide.

3. Skills to do small scale epidermilogical assessment of their list.

4. Use of information technology.

5. Management skills and development for professionals (including time management and stress management).

6. Management skills and development for the Practice Manager.

Improving the validity and relevance of information

General practices are sitting on a particularly rich set of data. Unfortunately most practices do not get the full value of the information available, or use what is available to influence their decisions.

Particular development needs are to:

1. Develop their capacity to take a list perspective of any issue under consideration.
2. To develop and link their information systems in such a way that they can contribute to the Boards Health needs assessment.
3. Find ways of ensuring greater transparency/access to information across the primary care team.
4. General systems to support the organisations strategic direction.

Conclusion

General Practice will need to make a significant transition if it is to deliver on the SNHS strategic agenda. The key enabler to its ability to mee the demands placed on it will be the recognition and development of the practice (as an organisational form) as the key player.

Thus the priority is to develop:-

1. the general practitioners who should be encouraged to involve other member of the primary care team.
2. the Practice Manager.

APPENDIX A3

Management Development Providers Survey

In accordance with the terms of reference a survey of consultancy organisations with an SNSH track record of supporting Management and Organisational development initiatives was conducted.

Purpose of the Survey

The survey was intended to obtain a snapshot of the current availability of MD and OD consultancy and training to the SNHS. It was not expected that a qualitative analysis of providers would be possible. However the capacity of providers and their claimed areas of experience and expertise would be determined.

It is recommended that MDG use the data obtained in this survey to enhance their provider database. This should be maintained by feedback from SNHS users of these services.

Target of Survey

The survey was targeted at thirty organisations identified by the ME Management Development Group database of relevant service providers. They had all provided MD/OD services to SNHS within the last two years. Qualitative data is available from MDG on the track record of these providers within the SNHS but this was not used to select targets.

A full list of target organisations identifying those who responded is included below.

Process

The survey was initiated during the needs assessment work and was thus informed by work in progress during this phase. The attached letter was sent to all organisations and followed up twice by telephone reminders if responses were not received. A considerable number of telephone and face to face discussions were held in order to clarify information requirements.

The analytical matrix used in the survey letter was an earlier version of the one used in this report and excluded the key management development challenge of "developing effective organisational leadership" which had not been explicitly identified at the time of the survey.

The survey letter distinguished between, and gave examples of, five different types of intervention

- Personal Development
- Professional Development
- Management Development
- Organisational Development
- Interorganisational Development

Database

The survey invited respondents to make use of standard brochures and case studies of their work to elaborate their capabilities.

Their full responses together with telephone numbers and addresses can be obtained from MDG.

Categories of Response

18 organisations responded. These ranged from large consultancies covering the full range of intervention approaches to sole traders with a specific niche business. Below we have distinguished three dimensions of responding organisations.

Focus

Broad (across large areas of the matrix) or narrow.

Approach

Eclectic or specialised

Size

Significant number of permanent consultancy staff or sole traders with/out associates

1. Organisations with a broad focus and eclectic approach included:

1.1 Larger Organisations

The Centre for Consultancy
Darden Management Ltd.
Ernst & Young
Frontline
King's Fund College
KPMG Management Consultancy
Resource Management Services
Touche Ross
Young Samuel Chambers

1.2 Sole Trader - Associates

Nancy Foy
Havergal Associates
MTDS - John Edmonstone

2. Broad Focus & Specialist Approach

2.1 Larger Organisations

MSL (Occupational Psychology)
Hay (Human Resource Systems)

2.2 Sole Trader Associates

Howard Affiliates (Occupational Psychology)

Steve Engleman (includes Health Economics)

3. Narrow Focus

Jacqueline Atkinson - Stress & Time Management
Victoria Group - Quality Management Systems

KINGS FUND
COLLEGE

3 August 1993

Dear

Management Development Requirements for the NHS in Scotland

The King's Fund College is conducting a project to assess the management development needs of the NHS in Scotland. The client for this project is the Management Executive of the NHS in Scotland. Responsibility for the successful administration of the contract lies with the Management Development Group which is part of the Manpower Directorate of the Management Executive.

The terms of reference for the study can be briefly summarized as follows:

- the NHS in Scotland is in the early stages of implementing a number of new policies which will have a significant impact on how the service runs
- the introduction of these policies will present a number of new challenges to management and professional practice and will necessitate rethinking of current practice

The objective of this part of the study is to:

- identify those challenges which will require management development support to enable the changes to be introduced as smoothly and effectively as possible
- identify those management development organizations who will be able to provide elements of the NHS in Scotland with various aspects of this essential support.

King Edward's Hospital Fund for London
2 Palace Court, London W2 4HS
Telephone 071 727 0581 Facsimile 071 229 3273

The analysis phase of this project is still progressing. However, it is possible to begin to address the task of management development provider evaluation identified above. We would like to be able to map your service to the needs identified in our study.

To help you to respond to this request in a structure which will enable us to categorize and synthesize the responses, we have established a framework which is described below. We request your cooperation in using this framework in your response.

We have created a matrix (see attached) of structural elements in the NHS and change themes which are common across many of those elements. Thus, developing Health Boards (purchasers) will entail aspects of "Skills Acquisition" such as developing an understanding of quality and "Shifting the Culture" such as units giving a higher priority to developing community care strategy and letting go of a traditional hierarchical administrative role in relation to providers. Within each cell of this matrix a number of interventions are possible from formal structured training programmes to process consultancy. We have categorized these as follows:

1. Personal Development, eg Stress Management, Problem Resolution, Conflict Management

2. Professional Development, eg Clinical Audit, Management Accounting

3. Management Development, eg Leadership, Information Management and Decision-Making

4. Organization Development, eg Multi-Disciplinary Team Building, Learning Set Facilitation

5. Interorganizational Development, eg supporting the establishment of interorganizational collaboration in the delivery of care pacakages.

It would help us if you could use the matrix, together with the taxonomy of development interventions above, to indicate and describe the particular areas of experience of your organization. It would also help if you could provide some data on the overall size and shape of your organization. We would welcome your including and referring to any standard brochures, curriculum descriptions, etc., relating to your activity.

If you consider that the framework we are suggesting is overly constraining or does not enable you to adequately represent your organization, please explain why and represent your acitivity is some other way which will enable us to understand where you fit within the range of providers.

Would you please return your response to Nancy Moorcraft, King's Fund College, 2 Palace Court, London, W2 4HS, by 31 August 1993.

If you have any queries regarding any aspect of this work, please contact any member of the King's Fund College Faculty team: Gordon Best, Martin Fischer, John Harries and Just Stoelwinder or Nancy Moorcraft, the project administrator.

Yours sincerely

John Harries
Fellow

encl.

OD/MD PROVIDERS

Those who have responded as at 2 September 1993

Jacqueline Atkinson, University of Glasgow
Dearden Management Limited
Steve Engleman, Health Economics Consultant
Ernst & Young (Glasgow office)
Nancy Foy, Management Consultant
The Centre for Consultancy (Harrison Associates)
Havergal Associates
Hay Management Consultants
Howard Affiliates
KPMG (Glasgow office)
King's Fund College
(LCJ Associates - Glasgow. Enevelope returned marked "No longer at this address")
MSL Human Resource Consultant (London office)
MTDS - John Edmonstone
Resource Management Services
Touche Ross (Glasgow office)
The Victoria Group
Young, Samuel, Chambers (YSC)

To date there have been no substantive responses from:

Care Solutions Limited
Coopers & Lybrand Deloitte - London
CSL Group Limited
Mr Gordon Hall
Mr Derek McLeod
MDG
Pannell Kerr Forster (Edinburgh office)
Price Waterhouse (Edinburgh office)
Mr Bob Rankin, Napier University
Savage, Young & Associates
J & E Sedgewick Company Limited

Your Name ______________________________

Please fill in the matrix below
by 31 August and return to

Nancy Moorcraft
King's Fund College
2 Palace Court
London W2 4HS

	Shifting the culture	New vertical relationships	Managing horizontally	Skills acquisition	Better information	Developing Health Professionals in Manageme
DEVELOPING EFFECTIVE PURCHASERS						
Developing Boards						
Developing GP Fundholders						
DEVELOPING EFFECTIVE PROVIDERS						
General Practice						
Managing Primary Care						
Community Care Trusts						
Acute Providers						
Massive Reduction in and Restructuring of Acute Services						
Developing an Effective Centre						
DEVELOPING EFFECTIVE COMMUNITY CARE						
Creating Effective Mechanism for Action						
Phasing out Institutional Care						
Managing Intersectoral Initiative						

Please [illegible]
by 31 [illegible]

APPENDIX A4

The King's Fund Team

GORDON BEST

Gordon Best is a part-time Fellow in NHS Management at the King's Fund College. He also acts as an Organisational Development Consultant to a number of senior managers within the NHS, in local government and overseas. From 1985-1990 he was the Director of the King's Fund College. Previous to that he had been a member of the College Faculty. Previous to joining the College, Gordon held academic appointments at University College London, the University of Colorado Medical Centre and Guy's Hospital Medical School. Originally trained as an architect in the United States, he has also had extensive experience as a health planner and as a management consultant both within the U.K. and overseas. He holds degrees in Operations Research, in Architecture, and in Economics and has published widely in all three fields. For five years he was a member of an Inner London Health Authority and also serviced on the National Health Service Training Authority. He has a special interest in the challenges in managing effectively within the public sector, in the role of clinicians in management and in how senior managers develop organisational strategies.

MARTIN FISCHER

Martin Fischer is Fellow in Organisational Development. He joined the College in 1990. He has a BSc in Mathematics and an MSc in Economics. In his first job, he was responsible for designing and running a number of change projects around the world. These involved the introduction of technology and the development of managerial systems. He left World ORT Union in 1987 to go to the Open College where he became Commissioning Editor for management courses. Here he developed a range of practical, competence-based, open-learning materials and workshops in a variety of media. He also worked closely with a number of blue-chip commercial organisations who required individually designed solutions to their corporate performance objectives.

At the King's Fund, he works across a broad spectrum of management and organisational development issues. These include programmes for clinicians as well as managers, in both primary and acute care. Particular interests include the role of boards, strategy, purchasing and public choice and interface issues within and between organisations. He works with clients at unit, district and regional level as well as Social Services and the voluntary sector.

JOHN HARRIES

John Harries' management experience began in the shipping industry as a Sales and Marketing Manager for an international shipping agency. He became interested in the problems of Information System design and implementation, through supervising the installation of systems with his employer and client companies. He subsequently decided that Information Technology would ultimately provide a more challenging arena.

Since retraining in 1983/4, he has worked as a consultant in the Information Systems field. Before joining the King's Fund College he was a principal consultant with LBMS, a leading British Information Technology organisation. He has considerable experience in the management of significant projects in large, professional organisations and in the management of professional consultants. His special interest has been in the development of corporate information strategy and the relationship of technology to organisational change and development.

John has degrees in Psychology and Business Systems Analysis from London University and City University respectively and an MBA from the Open Business School.

JOHANNES (JUST) STOELWINDER

Professor Stoelwinder is a Visiting Fellow at the King's Fund College for 1993. He is Chief Executive Officer of the Monash Medical Centre (a large multi-campus teaching hospital) and Adjunct Professor in the Graduate School of Management, Monash University in Melbourne, Australia.

His administrative experience, apart from 10 years on-going operation of a large teaching hospital, includes the construction and commissioning of teaching hospitals, hospital mergers, relocation and significant strategic reorientation. He has, for over 20 years, been active in developing clinicians (including senior consultants, doctors in training, nurses and other health professionals) as managers and has been a pioneer in the design of clinical costing and clinical budgeting systems.

Prof. Stoelwinder has taught post graduate health administration students in Australia and the U.S.A. and has numerous publications in the international literature on hospital organisation control, change and structure, clinical budgeting, drug prescribing, managing health professionals and continuing education of clinician managers. He has consulted to a number of government studies on information technology, performance indicators, Diagnosis Related Groups and the strategic planning, and to hospitals in Australia and the U.S.A. on facility planning, operating efficiently, and clinical unit performance. He is Managing Director of Monash Healthcare Consulting and a Director of a private hospital in Australia.

Prof. Stoelwinder initially trained as a General Physician and also has specialist qualifications in public health and health care management.