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Strengthening the role of health authority members

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CHAPTER 1

This project paper is based on a programme of action research carried out between 1981 and 1985. The research had two aims. First, an attempt was made to analyse how the role of district health authority (DHA) members developed in the period around and after the 1982 reorganisation of the NHS. Second, the information and understanding gained in the research was used to help DHAs to clarify and develop the contribution of members. The full results of the research are reported elsewhere (Ham, 1986). This paper concentrates on the implications of the research for DHAs. Specifically, the paper seeks to identify how the role of members can be strengthened within the existing framework of the NHS.

The research was conceived in 1981 at a time when published work on the role of health authority members was limited to a handful of articles and a number of general studies of the NHS which commented on members in passing but which did not take members as their central focus. The evidence available on the experience of area health authorities (AHAs) indicated that members were typically in the position of approving and monitoring the performance of their officers and only occasionally did they themselves initiate action and play a major part in decision making (see, for example, Kogan et al, 1978). The project reported here sought to establish whether the same would apply to DHAs or whether the more local orientation of DHAs would enable members to make an effective contribution to the running of the NHS.

The main programme of work was conducted in the Bath and Croydon health authorities between October 1981 and July 1985. These authorities were selected because of their willingness to participate and to act as guinea pigs in the attempt to develop the role of members. In parallel, assistance was provided to thirteen other health authorities on a consultancy basis, and contact with these authorities was invaluable in offering a wider base from which to analyse and test out the ideas developed in the main study.[1] No claim is made that the authorities involved were in any sense typical of DHAs generally, although they included authorities in urban and rural areas, those with teaching responsibilities and those without, and RAWP-gainers and RAWP-losers. Rather, the research sought to establish how the members' role could be developed in authorities who

identified a need to draw on outside assistance to help them clarify their working practices.

The Role of Members: Theory

DHSS circular HC(81)6 sets out the official position on the composition of health authorities and on the role of members. The circular states that members will be appointed mainly by RHAs and in part by local authorities. In addition to the Chairman, who is appointed by the Secretary of State, each DHA should include:

"(a) members appointed by the RHA (after appropriate consultation):

(i) one hospital consultant
(ii) one general medical practitioner
(iii) one nurse, midwife or health visitor
(iv) a nominee of the appropriate university with a medical school in the region
(v) other members (known as 'generalists') in such numbers as to bring the total membership (excluding the Chairman), including the members referred to at (b) below, to the numbers specified in the constitution order(s) (normally 16)

(b) four members appointed by local authorities, except where a higher number is specified by the constitution order(s)."

Health authorities with substantial medical teaching responsibilities have additional university members.

The criteria for appointment set out in the circular are:

> "Ordinarily, members should reside or work in the district of their Authority but those with an interest in the health services of or who have other associations with the district are not precluded. Appointing authorities should ensure that members will be able to devote sufficient time to the DHA's business - participating in regular meetings, committee work and the other duties which are involved. As a general guide, members should be able and prepared to devote some 2-4 days a month, during and outside normal working hours, to the work of the Authority.
>
> There is a special need for younger men and women to serve on Authorities, to provide for continuity of experience for the future. It is important also to make appointments only where it is likely that prospective members will have the health and vigour to make an effective contribution throughout their term of office. Appointment or re-appointment over the age of 65 should be regarded as exceptional and should only be offered if equally suitable younger candidates are not available.

> As well as providing for a suitable geographical balance among the membership, RHAs should bear in mind a reasonable balance of age and sex, together with such factors as experience of management and administration in business or the public service, experience in the mental health and handicap fields, and in appropriate cases, suitable representation of ethnic minorities."

Despite the fact that a number of places on each DHA are set aside for members drawn from specific interests, HC(81)6 states that members are not appointed to represent a personal or sectional interest (although the circular does refer to "university representatives" on health authorities). In the view of the DHSS, members should:

> "contribute in a constructive as well as questioning way to the whole work of an Authority, avoiding the temptation to concentrate on matters of particular personal interest."

HC(81)6 adds that the specialised knowledge and expertise of members will be valuable, but health authority decisions are corporate and collective and members carry joint responsibility for decisions once taken.

The major function of members, as set out in the circular, is "to determine policies and priorities for their District". Taking account of national and regional guidelines and priorities:

> "it is the members' task, on the advice of their officers, to devise a sensible formulation and application of policy to local conditions."

In fulfulling this task, members:

> "will need to take into account the views of the public in their District, as expressed formally by CHCs, local authority or other interests and through members' own knowledge and judgement of local aspirations and needs."

In order to concentrate on policy making and priority setting, members are "not....to intervene in day-to-day operational management". Rather, it is their role "to stand back in order to take policy and strategic decisions".

This guidance indicates that the main role of members is in the field of policy making and strategic management. In performing this role members are expected to be broadly representative of the public's interest in the NHS. This does not

mean that authorities are set up to represent local public opinion, nor that individual members are appointed to speak for the organisations from which they are chosen. Rather, it implies that authorities are bodies which help to introduce a measure of public involvement into the running of the NHS and contain members chosen in order to achieve a balance between different social characteristics. This derives from the underlying justification for health authorities which is that decisions on the allocation of resources cannot be resolved on managerial or professional grounds alone. Responsibility for these decisions in a democratic society must lie with a public body, and in this sense authorities are the local arm of the NHS, acting as trustees on behalf of the community as well as ministers.

The Role of Members: Practice

In summary form, the research found that:

- the influence of members over policy making was limited;
- the influence of members over policy making varied between health authorities;
- the influence of members over policy making tended to increase with the passage of time (Ham, 1986).

These findings are consistent with those of other researchers, most notably Stuart Haywood (Haywood, 1983; Haywood and Ranade, 1985). Evidence gathered also indicated that in a number of authorities it proved difficult to develop a corporate identity. In these authorities members differed in their views on priorities and on the proper role of a health authority, and this led to strained relationships. These were usually authorities where some members disagreed strongly with the policies pursued by DHSS ministers.

The research identified five main reasons why members found it difficult to determine policies and priorities as envisaged by the DHSS. These were:

(i) <u>the individual attributes of members</u>

although members had extensive experience of public service and were drawn overwhelmingly from professional and managerial backgrounds, they did not always have the time or the skills required to convert their talents into influence.

(ii) preparation and training

a considerable investment in member training and development has taken place since 1981 but training remains uneven in both coverage and content.

(iii) the organisational structure of DHAs

the way in which authorities organise their work, including the limited use of members' groups and sub-committees and the late involvement of members in policy making tended to constrain member influence.

(iv) the organisational culture of DHAs

the limited expectations which chairmen and chief officers have of members reinforced the lack of impact of members.

(v) the power structure in the NHS and the economic framework in which the NHS operates

the entrenched power of the medical profession, the interventionist stance adopted by DHSS ministers since 1981, the strengthening of management through Griffiths, and the limited resources available to health authorities, combined to restrict the freedom of manoeuvre of members and to reduce the policy space which members occupy.

In the light of this analysis, the research concluded that there were inherent limits to the contribution which a group of 16-19 appointed people drawn mainly from lay backgrounds could make to the running of the NHS. Indeed, caught between the organisational and planning skills of the officers responsible for running the service on a day-to-day basis, and the professional expertise of the doctors and nurses who actually deliver the service, it might be expected that members would struggle to identify the nature of their distinctive contribution. According to this line of argument, part-time appointed members are almost bound to be rubber stamps, endorsing and approving the recommendations of their officers, and performing a largely symbolic role, a token gesture to the need for some kind of public involvement in the NHS.

Against this, evidence from the research pointed to ways in which authorities could be helped to clarify and develop their working practices in order to strengthen the members' role. It was clear, for example, that some authorities

were more successful than others at involving members in policy making and giving members a useful job to do. The style of the chairman, the support provided by officers, the use made of members' groups and panels, and the opportunity for members to become involved in policy making on an early and informal basis were some of the factors which were important in shaping member influence. Furthermore, the contribution and influence of members tended to increase as members gained experience and as the working practices of authorities were refined. Analysing these developments, it became possible to identify steps which could be taken by DHAs and by other agencies to strengthen the members' role. The rest of this paper draws together the lessons of the research, building on earlier analyses reported elsewhere.[2]

CHAPTER 2

Although the Griffiths Report is bringing about fundamental changes to the management of the NHS, the argument of this Paper is that it will not radically alter the role of health authorities and their members. As Norman Fowler told the House of Commons Social Services Select Committee in 1984:

> "I do not think the role of the member of the Authority changes at all under what we are proposing." (Social Services Committee, 1984, p164)

The same point was made by Roy Griffiths who argued:

> "The authority is essentially going to be concerned with policy decisions at district level, for example, setting priorities in a major way and looking to the chairman and general manager to ensure that those things are implemented." (ibid p143)

Indeed, Griffiths went further to note that:

> "the general management function can give purpose to the Authority. It does not detract from their responsibility. It simply sharpens them up so they are getting a much better service, that the particular points which ought to be considered and put on the table are in fact there, well prepared, well documented and brought together ready for decision by the Authority, as distinct from what looks like, from the agendas of some of the authorities, a continual part serial which is published every month." (ibid p149)

More recently, Minister of State for Health, Kenneth Clarke, told the 1985 annual general meeting of the National Association of Health Authorities (NAHA):

> "To my mind the introduction of general management in the NHS does not spell the demise of the DHA member as some of you may fear. It will certainly mean a change in the members' traditional role but I think there is scope for developing a far more challenging and positive job for members to do."

What might this mean in practice? A variety of ideas and proposals are put forward in this chapter, grouped into four areas:

Getting Started: selecting and recruiting members, induction and training, providing support and attendance allowances, and drawing up an inventory of members' skills;

Becoming Involved: early involvement and seminars, members' groups and panels, agenda setting, the business agenda, papers and reports, and planning;

Reviewing Performance: visiting, accountability reviews, performance indicators, complaints, finance and appraising the general manager;

Relating to Others: the inter-corporate dimension, clinicians, chairmen, officers and the DHSS.

Fundamental to these proposals is the view that authorities need to pay particular attention to developing their corporate role. Put another way, the Paper is based on the premise that strengthening the role of members requires action both to develop the contribution of individual members and to clarify the work of authorities as corporate bodies. As already indicated, establishing a corporate identity has proved difficult to achieve in a number of authorities, yet progress in this area is vital if the full potential of members is to be realised. This will entail action on a number of fronts including induction, training and development, developing a shared view of the business the authority is in, and an investment of time by chairmen and general managers to ensure that individual members are encouraged to contribute to the collective tasks that have to be performed. These initiatives will typically require intensive effort over a period of time, and the proposals contained in this paper are offered as a framework for a programme of work likely to extend over a number of years.

GETTING STARTED

(a) Selection and Recruitment

A number of improvements should be made to selection and recruitment procedures.[3] To begin with, it is important to ensure that highly motivated people with time to give are appointed. At present, RHAs often choose members on the basis of written applications and informal soundings. The result is that members when appointed are sometimes surprised at the commitment they have taken on. Interviews with shortlisted applicants, as carried out in some regions,

would help avoid this. Second, a connected point is that more information should be made available to potential members before nomination forms are submitted. This should include written material, such as a popular leaflet explaining the members' role, and the use of video materials along the lines of those prepared by the NHS Training Authority. These materials should present a realistic view of the members' responsibilities and should emphasise the importance of members being able to contribute effectively to policy making.

Third, RHAs need to be seen to be acting fairly by making explicit the selection criteria used, and by opening up the selection process wherever possible. Public meetings at which shortlisted applicants give a speech about why they want the job could be part of this process. This would invest confidence in the appointments system and would help to counter charges of bias. Fourth, the selection net should be cast as widely as possible. This means giving extensive publicity to the appointments procedure and advertising vacancies when they occur. At present, members are overwhelmingly middle aged and middle class, and a wider pool of applicants would enable health authorities to be constituted on the broader base envisaged in HC(81)6.

(b) Induction, Training and Development

A considerable investment in member training and development has taken place since 1981, comprising:

induction seminars for new members supplemented by a Handbook for Members, produced with the assistance of funds from the DHSS, and the NHS Handbook published by NAHA;[4]

briefing seminars on key issues such as finance, planning, and committee skills;

refresher seminars for members, chairmen and officers drawn from different authorities, both to discuss specific topics, such as the Griffiths Report, and to exchange experiences on different methods of working;

in-house reviews for individual authorities examining the working practices of the authorities and the respective role of members, chairmen and officers;

action research and organisational development over a number of years in individual authorities.

Valuable as this training has been, it meets only part of the need. To begin with, training for members is voluntary and by no means all members take up training opportunities. Furthermore, many of the members who do undergo training attend only a one-day induction seminar early in their membership.

In general, much more should be done to prepare and brief new members and to provide experienced members with opportunities for specialist training. One model worth examining is the training provided for magistrates.[5] This is compulsory and before appointment magistrates are asked to indicate their willingness to participate in training. The first stage of basic training is organised before magistrates begin carrying out their responsibilities and this is supplemented by a second stage undertaken in the second six months of the magistrate's appointment. As well as basic training, magistrates are required to attend a minimum of twelve hours refresher training every three years. Specialist training is also provided for magistrates appointed to domestic and juvenile courts. One of the features of this model is that training activities involve a mixture of formal instruction, learning by observation and visiting, and learning from experience.

If the full potential of DHAs and their members is to be realised, then an equally rigorous training programme should be developed in the NHS. While the details remain to be worked out, the elements might include making training mandatory, ensuring that members are well briefed before they attend their first meeting, and developing specialist training in fields such as finance, visiting, Mental Health Act duties and personnel matters.[6] There is also a need to provide opportunities for members to meet with colleagues from other authorities to exchange experience, and to encourage individual authorities to regularly review their working practices. Longer term action research and organisation development involving outside facilitators has demonstrated its value (Ham, 1986) and needs to be made more widely available. This kind of training and development is particularly important in developing the corporate role of authorities.

In addition, individual authorities should pay more attention to member induction and development. This should include preparing a handbook for members (already done by 26% of DHAs (Ham and Haywood, 1985)) and arranging for new members

to be fully briefed on appointment by the Chairman and District General Manager. There is also merit in attaching each new member to an experienced member in the first six months of appointment as a way of helping new members to learn the ropes.

(c) Support Services

A national survey of health authorities, commissioned by NAHA, was conducted in 1985, and provided a comprehensive picture of the support available to members in areas such as information services, secretarial and general administrative services and officer support (Ham and Haywood, 1985). On the basis of the survey a number of recommendations were made, including:

- DHAs should consider appointing a members' support or liaison officer;
- information for members should be improved through (a) members and officers considering what information about the performance of services should be presented to the authority on a regular basis, and (b) each authority reviewing what information it requires about the quality of services as seen by patients and the public; and
- authorities should ensure that members are fully informed about the availability of official expenses and should review whether other expenses should be paid (eg for babysitting and telephones).

Implementation of these recommendations should help to ensure that members have the necessary support to perform their role. In addition, it is important that existing forms of support such as members' meeting rooms, library services, typing and photocopying are maintained.

(d) Attendance Allowances and Remuneration

Members are eligible to claim allowances in respect of travelling expenses, financial loss incurred in performing a member's duties, and subsistence expenses. Members do not receive an attendance allowance, nor are they paid, although chairmen do receive an honorarium of £9,600 a year (1985 prices). The vast majority of existing members are drawn from professional and managerial occupations and it is unlikely that attendance allowances or remuneration would change their willingness to participate in the work of the health authority.[7]

However, if there is a wish to attract as members people drawn from manual occupations then some kind of financial reimbursement may be necessary. The DHSS should examine this issue in more detail, both to establish the costs of introducing attendance allowances and remuneration and to assess their likely impact on the kinds of people coming forward for membership.[8]

(e) An Inventory of Members' Skills

Members bring to their authorities a wealth of experience of public life and a wide range of skills and knowledge. Yet often, this experience remains untapped, both because officers and chairmen are not aware of what members have to offer, and because members are sometimes reluctant to assert themselves. One way round this is for each authority to compile an inventory of members' skills which would be updated at each change of membership. The inventory would identify the areas of expertise members were prepared to make available and this could be drawn on by officers and chairmen when particular tasks had to be performed. The skills could encompass specialist knowledge of financial and legal matters, knowledge of local communities and their needs, and understanding of other agencies such as local authorities and voluntary organisations.[9] This will enable the expertise of individual members to be drawn on at the same time as attention is given to developing the corporate identity of the Authority.

BECOMING INVOLVED

(a) Early Involvement and Seminars

A common complaint of members is that too often they are involved towards the end of the policy making process at a stage when their views are unlikely to influence what is decided. Indeed, officers often do not take an issue to the authority until all the uncertainties have been resolved. More should be done to involve members early and informally when key issues are emerging for consideration. This is particularly important in relation to planning where decisions on priorities and new developments cast a long shadow forward. In this context, a number of DHAs have found it valuable to make use of discussion evenings, briefing meetings, supper clubs and seminars, both to explore issues early and to do so informally.

(b) Members' Groups and Panels

There are considerable variations between DHAs in their use of members' groups and panels. Some authorities in effect use no groups and do all of their business as a full authority. Others operate through formal standing committees. Yet others make use of ad hoc issue groups and special interest groups, appointed to investigate specific topics within a set period of time. Some authorities make use of a combination of standing committees and ad hoc groups.

While there is not enough evidence to indicate which of these methods of working is most effective, there is a growing body of work which suggests that some form of group system is valuable in enabling members to become more closely involved in the work of DHAs and in helping members to specialise in areas of particular interest. Given the limited amount of time most members are able to devote to health authority work, it is unlikely that many authorities would be able to sustain a standing committee system. Accordingly, it is recommended that DHAs should review their working practices to examine the use made of members' groups with a specific task and a finite life.

(c) Agenda Setting[10]

The variation in the length of monthly agendas in different DHAs is quite striking: some authorities limit the agenda to ten items or less, others attempt to consider 40 items or more. In general, authorities suffer from overcrowded agendas with the result that some issues receive inadequate discussion. Part of the reason for this is that authorities have not discussed explicitly what decisions they should take and what decisions should be delegated to officers, as recommended in the Griffiths Report.

A business agenda (see below) is a useful way of identifying key issues for an authority to concentrate on, and in addition there is a need to limit the number of issues appearing on the monthly agenda. In the course of a normal meeting it is possible to do justice to only two or three major items in most authorities. Linked to this, there is merit in dividing the agenda into items for discussion and decision, items for discussion only, and items for information. If items for decision are placed at the beginning of the agenda, then members will be in a better position to subject these items to detailed and informed debate.

(d) Business Agenda

The idea of a business agenda is to identify key issues which the Authority should debate: it provides a framework within which the Authority works. The business agenda is jointly agreed by officers, members and the chairman and it includes issues of national, regional and local importance. The agenda constitutes a realistic work programme for a twelve month period and is rolled forward annually. Issues are drawn from the accountability review with the RHA, strategic and operational plans, and from members' own interests. By implication, issues not included in the business agenda would not receive priority attention. Some issues on the agenda are delegated to officers to work on and bring back to the Authority, others are identified as issues with which members themselves wish to be closely involved. The advantage of a business agenda is that it gives coherence to the Authority's work and enables members to shape the kinds of issues receiving attention. From an officer's point of view a business agenda enables managers to secure the Authority's agreement that not everything can be done and that certain issues should be given priority. Devising a business agenda is one mechanism through which the corporate role of the Authority can be clarified and developed. Not least, the agenda provides an explicit statement of the issues the Authority considers to be important and on which officers, members and the chairman wish to focus their efforts.

(e) Papers and Reports

The quality of the written reports prepared for members is extremely variable. In general, much more attention should be given to this issue so that reports are written and presented with members in mind. Reports should always contain a statement of purpose, a summary (at the beginning), and they should identify clearly the issues members are being asked to decide. These requirements may seem obvious but in many authorities they are not met. Particular attention needs to be given to the presentation of financial and statistical information, including performance indicators. Devices such as graphs, histograms and pie charts are invaluable in helping members to make sense of quantitative data and could be used much more extensively. The greater use of exception reporting, in which members receive reports only if the performance of services falls below an agreed level, would also assist members to concentrate their limited time on key issues.

(f) Planning

Members should be involved in planning in two levels. First, in developing plans for specific services; and second, in deciding the overall plan and strategy for the district. The latter is the responsibility of the authority as a whole but in a number of districts members' planning groups and seminars have demonstrated their value as mechanisms for discussing the development of plans and strategies. Not least, these mechanisms enable members to become involved in the planning process at an early stage. In terms of planning for specific services, there are various possible channels of member involvement, including participation in planning teams and the establishment of members' groups to take responsibility for the preparation of plans in association with relevant officers and professional staff.

REVIEWING PERFORMANCE

(a) Visiting

The importance of effective member visiting has been emphasised in official guidance and in documents like the report of the committee of enquiry into Normansfield Hospital. Arrangements for visiting vary between DHAs, but a method used in a number of districts is for members to be divided into visiting groups based on units of management. Despite this, it has been argued that visiting mechanisms and monitoring systems are not good enough and that far too often visitors are naive, ignorant or simply compliant to a system which offers little chance of change.[11] Certainly, there is sometimes a lack of clarity regarding the purpose of visits (familiarisation? flying the flag? monitoring the quality of care?) and a lack of commitment by members to visiting. Each authority should assess whether the time that goes into visits is well spent, and whether more can be done to support members in this role.[12]

(b) Accountability Reviews

Since its establishment in 1982, the annual accountability review process has emerged as a significant mechanism for monitoring performance. To date, members have been marginal participants in the review process, and in future more should be done to secure appropriate member involvement. This should involve members discussing the agendas and papers for district and unit reviews in advance of the review meetings; members having a say in the choice of agenda

items; arranging for some members to participate in district reviews and to attend unit reviews as observers; submitting the draft district action plan to the authority before it is agreed as the basis for action by the district; and providing the authority with progress reports on the implementation of action plans.

(c) Performance Indicators

Performance indicators are a useful tool for members, particularly in enabling comparisons to be made with other authorities. Member involvement in analysing performance indicators varies between authorities, in some cases taking the form of a regular report to the authority, in others being delegated to a members' group. The accountability review process offers a formal mechanism for routinely assessing performance indicators and should be used for this purpose.

(d) Complaints

Members have a particular responsibility to assure that complaints by patients and their relatives are dealt with expeditiously and effectively. This should involve one or more members regularly reviewing the handling of each complaint and reporting to the authority on any problems which arise. More generally, the authority as a whole should review the number and type of complaints received over, say, a twelve month period, comparing the volume of complaints with previous years, identifying areas of service provision which attract a significant number of complaints, and initiating appropriate action.

(e) Finance

One of the most fundamental tasks of members is to review the pattern of expenditure in the authority and to ensure that spending does not exceed the money available. Regular financial reports, usually provided monthly, enable performance in this area to be assessed. Over and above this, members should insist that expenditure programmes are kept under review and that every effort is made to achieve value for money in the provision of services.

(f) Appraising the District General Manager

Appraising the performance of the district general manager is a process in which members must be involved. To some extent, appraisal goes on all the time with

members continually making judgements about the effectiveness of the general manager, but appraisal should also involve periodic formal assessments. The chairman has a special responsibility in carrying out these assessments but members should also play a part both in helping the chairman to form a judgement about the general manager's performance and, in the case of one or two members, in the formal assessment itself.

RELATING TO OTHERS

(a) The Inter-Corporate Dimension

DHAs have to relate to a range of other bodies both within the NHS and outside. These include FPCs, local authorities, CHCs, voluntary organisations, and the RHA. Examination of the agendas of DHAs indicates striking variations in the extent to which members are kept informed of developments involving these other agencies. As part of the review of agendas and procedures proposed in HC(84)13, DHAs should agree what regular reports they require in this area.

(b) Clinicians

The Griffiths Report drew attention to the influence exercised by clinicians over resource allocation and policy making. If health authorities and their members are to strengthen their role, and if, as Griffiths argued, doctors are to be involved more effectively in management, then this must involve members opening up a dialogue with clinicians. The basis for such a dialogue already exists in the shape of consultant members of health authorities and district management groups, and this should be extended further both through the encouragement of informal contacts and through occasional formal meetings at which members and clinicians are able to discuss the development of plans and strategies in the district. The establishment of a joint consultative forum might help to give these contacts a sharper focus.

(c) Chairmen

Ideally, chairmen should provide a link between members and officers, ensuring that an effective partnership develops. In practice, many chairmen are drawn towards their officers, in some cases being seen by members as an additional member of the District Management Group. Those authorities where members are encouraged to question and probe their officers and play a full part in policy

making tend to be authorities where the Chairman has been careful to maintain his or her independence. It will require strong leadership by chairmen in future to maintain this position and to ensure that members have a useful job to do. In this context, one of the key responsibilities of chairmen is to establish a corporate identity in the authority and to ensure that individual members are encouraged to contribute to the collective tasks that have to be performed. This can be achieved in various ways including briefing new members on appointment, developing a business agenda, and ensuring that there are opportunities for the authority to review its role and determine its priorities. These are sensitive tasks which call for considerable tact and skill. It follows that rigorous selection of chairmen is needed to ensure that the individuals appointed have the qualities needed to do the job.

(d) Officers

Officers' attitudes towards members vary but a commonly recurring theme in these attitudes is that members are relatively unimportant actors in the health service arena. While this judgement reflects fairly the actual influence of members in most authorities, it tends to result in a self-fulfilling prophecy: that is, members exercise limited influence because officers believe that members are unimportant. In contrast, officers are influential actors both in their own judgement and that of members. The implementation of the Griffiths Report is likely to enhance the power of those officers appointed as general managers and this has led some members to fear that their own role will be diminished by Griffiths. In practice, general managers on short-term contracts may be more disposed to seek the support and respect of their authorities than the old-style district management team. Furthermore, the replacement of consensus management by general management is likely to mean that on some issues authorities will be faced not with a single proposal for action but with one recommendation from the general manager and an alternative recommendation from professional advisers. Authorities will then have to choose which course of action to pursue, a situation which has occurred relatively rarely in the experience of most DHAs. For these reasons, it can be argued that Griffiths offers an opportunity for authorities to strengthen their role. One of the tests of the new breed of general managers will be how effective they are at sharpening up the work of their authorities and assisting members to make an effective contribution to policy making. An important aspect of this is working

with the Chairman to develop a common understanding of the role of the Authority and to promote the development of a corporate identity.

(e) The Role of the DHSS

Since 1981 DHSS ministers have intervened increasingly in the work of health authorities. This is despite the declaration in Patients First that:

> "We are determined to see that as many decisions as possible are taken at the local level....We are determined to have more local health authorities, whose members will be encouraged to manage the Service with the minimum of interference by any central authority, whether at region or in central government departments. We ask that our proposals should be judged by whether they achieve these aims." (DHSS, 1979, p2)

The result of increasing centralisation - as manifested in the imposition of manpower targets, the manner in which Griffiths has been implemented, and the policy on competitive tendering - is that the freedom of manoeuvre of health authorities has been significantly restricted. If able people are to be attracted to serve as chairmen and members, this trend must be reversed. DHSS ministers and the Management Board should take seriously the view expressed in the Griffiths Report that:

> "the centre is still too much involved in too many of the wrong things and too little involved in some that really matter....local management must be allowed to determine its own needs for information, with higher management drawing on that information for its own purposes. The Units and the Authorities are being swamped with directives without being given direction." (Griffiths, 1983, p12)

Of course, the DHSS must set broad policy directions for the NHS, allocate resources to regions and monitor performance through the review process. In turn, regions must establish strategic guidelines for DHAs, allocate resources within the region, and monitor performance through the review process. Over and above these functions, there is no case for central or regional involvement in the activities of DHAs, provided that districts keep within their cash limits. The right of DHAs to interpret national and regional policies in a way which is appropriate to local circumstances should be guaranteed by ministers.

CHAPTER 3

The proposals contained in this paper are in essence a distillation of good practices and a reflection on bad practices in the health authorities in which research was undertaken. In carrying out the research, what was striking was the variation that existed in the working practices of DHAs and the uneven development of good ideas. Of course, it is entirely appropriate for each DHA to decide on its own method of working, and the purpose of this paper is not to advocate a blueprint which should be followed slavishly in every district. Rather, it is to offer some ideas and principles which it is hoped are of relevance to DHAs, and in this sense the proposals contained in the paper provide a checklist for use by authorities. Those DHAs already actively working on the proposals can be satisfied that they are ahead of the field; those who were slower off the mark can use the checklist to audit their working practices.

To facilitate this process, the rest of this Paper presents the proposals in the form of a series of questions for DHAs and others. In interpreting the questions, two points should be borne in mind. First, the time of members and officers is limited. If this time is to be used most effectively, it may not be possible to take action on all the proposals at once. Rather, strengthening the members' role will probably involve a programme of work undertaken over 2-3 years.

Second, the proposals have been designed to improve the process of policy making and should be judged with this in mind. The assumption is that an authority which has acted on the ideas set out in the paper is more likely to take decisions after full and rigorous questioning and testing than an authority which has not. Given our present state of knowledge, it is not possible to assess whether the result is 'better' decisions.

Checklists

DHSS

1. Should training for members be comprehensive and mandatory?
2. Should the case for attendance allowances and remuneration for members be reviewed?

3. Should DHAs be allowed more freedom of action to interpret central and regional policies, provided that they keep within their cash limits?

4. Is the process of selecting chairmen as rigorous as it should be?

RHAs

1. Are DHA members interviewed before appointment?

2. Are members given adequate information about the members' role before nomination forms are submitted?

3. Are the selection criteria used in making appointments made explicit?

4. Is the selection process as open as it can be?

5. Are vacancies for members advertised and given wide publicity?

DHAs

Getting Started

1. Are members encouraged to undergo induction training, refresher training and specialist training?

2. Has the Authority set aside time to review its working practices?

3. Has the Authority considered making use of an outside facilitator to help in the development of the members' role?

4. Has the Authority prepared a Handbook for members?

5. Has the Authority considered attaching new members to experienced members in the first six months of appointment?

6. Is there a designated officer who provides support to members? If not, how is member support provided?

7. Have members and officers considered what information about the performance of services should be presented to the Authority on a regular basis?

8. Has the Authority reviewed what information it requires about the quality of services as seen by patients and the public?

9. Are members fully informed about the availability of official expenses and has the Authority reviewed whether other expenses should be paid?

10. Are existing forms of member support (eg library services, typing and photocopying) adequate?

11. Has the Authority considered compiling an inventory of members' skills?

Becoming Involved

1. Are members involved early in policy making on key issues?

2. Are there opportunities for members to be involved informally in the work of the Authority?

3. Has the Authority reviewed its use of members' groups and panels?

4. Has the Authority reviewed the length of the monthly agenda and the nature of the reports it requires?

5. Has the Authority considered preparing a business agenda?

6. Has the Authority reviewed the quality of the written reports it receives?

7. Are members effectively involved in the development of strategic plans and short-term programmes?

Reviewing Performance

1. Has the Authority reviewed its arrangements for visiting and assessed whether more can be done to support members in this role?

2. Do members discuss the agenda and papers for the accountability review meeting in advance of the meeting?

3. Are members able to influence the choice of agenda items for unit and district reviews?

4. Are members able to attend the district and unit reviews?

5. Is the draft district action plan submitted to the authority before it is agreed as the basis for action by the district?

6. Do members receive progress reports on the implementation of district and unit action plans?

7. Is the review process used to assess performance indicators for the district?

8. Do members take responsibility for reviewing the handling of individual complaints and assessing the number and type of complaints received?

9. Are members effectively involved in financial monitoring?

10. Have arrangements been made for members to be involved in the appraisal of the district general manager?

Relating to Others

1. Has the Authority determined what regular reports it wishes to receive on relationships with FPCs, local authorities, CHCs, and other agencies?

2. Has the Authority discussed ways in which a dialogue can be started with clinicians?

District Chairmen

1. Are you satisfied that everything reasonable has been done to develop an effective partnership between members and officers?

2. Do you personally brief all new members on appointment?

District General Managers

1. Have you encouraged and assisted the Authority to review its role after Griffiths and to clarify its relationship with you and the Chairman?

NOTES

1. Of these 13 authorities, three commissioned work which extended over six to nine months and involved interviews with members, chairmen and officers, observations at meetings and analysis of papers. In the remaining ten authorities, assistance took the form of a day or half-day seminar, usually preceded by discussion with the chairmen and chief officers and analysis of papers.

2. See Ham (1984a, 1984b, 1984c, 1984d, 1984e, 1985), Ham and Haywood (1985), and Ham and Haywood (1986).

3. These proposals are directed mainly at the appointment of generalist members by RHAs, but some, such as providing more information before appointment, are relevant to other types of member.

4. Ham and Haywood (1985a) and NAHA (1985).

5. Ham and Buchanan (1985).

6. NAHA has provided useful advice to members on some of these issues. See Harrison (1983) and Williamson (1985). Furthermore, NAHA's regional forum meetings enable members from different authorities to exchange experiences.

7. Although John Bettinson, a former chairman, has argued that remuneration for members would help to attract a high calibre of men and women. See Bettinson (1984).

8. The Secretary of State already has the power under the NHS Act 1977 to pay attendance allowances. See schedule 5 paragraph 9(4) of the Act.

The principle of paying members of public authorities is well established. For example, since 1983 the members of water authorities have been reimbursed according to their time commitment. A member who gives three days a month is paid £3,300 per annum. Chairmen are also reimbursed according to time commitment, the notional salary of chairmen of the largest authorities being £44,000 per annum. These figures are all based on 1985 pay rates.

9. I am grateful to Keith Barnard for suggesting this taxonomy.

10. See also Ham and Haywood (1986).

11. Yates (1985).

12. Mike Drummond is in the process of preparing guidance on member visiting for NAHA and this should be of considerable use.

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