effective unit management

Edited by IDEN WICKINGS Contributors GORDON BEST
MAUREEN DIXON TOM EVANS JUNE HUNTINGTON
MAX RENDALL CATHERINE SHAW

KING EDWARD'S HOSPITAL FUND FOR LONDON

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From its inception in 1897, the King's Fund has been concerned, as the Act of Incorporation later expressed it, with 'the support, benefit or extension of the hospitals of London'. Today the Fund's interests also extend into community care, research, the promotion of good practices, and NHS managerial development.

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CONTRIBUTORS
Gordon Best
Maureen Dixon
Tom Evans
June Huntington
Max Rendall
Catherine Shaw

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CHAPTER ONE

About this book

IDEN WICKINGS

The Griffiths Inquiry team's report became available when this book was within days of publication. Many of the Inquiry's recommendations are similar to the views in this book. In a few cases there are differences. The contrasts and similarities are briefly discussed in the Postscript on pages 150–151. However, when considering the unit management teams that we describe readers may wish to keep in mind the possibility that one of the team may in future be designated as the unit's general manager.

The patients and staff of the NHS, and their relatives and friends, have paid a high price for the 1982 reorganisation. It has proved even harder to meet the cost this time than in 1974 because fewer resources remained in terms of goodwill, and of people with the necessary experience for the new or revamped jobs. Not least has this been true in the units of management with which this book is principally concerned and where disruption is still being suffered. The first advertisements for the reorganised posts, those at district management team level, were circulated in October 1981. In mid-summer 1983, the journals were still filled with advertisements for jobs in units, and the appointment of district functional managers is only beginning in some regions.

So, it must be asked: 'Has it all been worthwhile?'. The reply throughout this book is: 'Not yet, but it *could* be if . . .' Each chapter tries to show in a simple way how the practical application of some theoretical approaches might release the potential which lies within unit managers. But this opportunity will be missed by many health authorities, we judge, unless they act decisively. It is fair to emphasise that this judgment has not been reached in an ivory tower. The authors have been engaged, at the King's Fund and elsewhere, in the managerial development of many unit managers over the last twelve months. They have also worked in other capacities (as management consultants, undertaking research, serving on health authorities, and so on) in most of the NHS regions and numerous districts and units. This book deals with academic viewpoints that have developed during this practical experience.

The cost of the 1982 reorganisation in human and financial terms should not be allowed to obscure the fact that it is a source of potential benefits. The first is an end to 'NHS reorganisation' as a

managerial tool to be wielded every few years. This is not a plea for stagnation, but rather for different, less brutal methods of change. If the new health authorities and their district and unit management teams could be seen to be reasonably effective, then time could be given to the more important task of producing a healthier society whose members would receive better personal health care when they needed it. Health education and preventive measures are important, but the greatest need for improvement lies in the care given to the elderly, the mentally ill and handicapped, to children and to all those dependent on the NHS while living at home. These services comprise the bulk of NHS care. Standards of acute care must be protected at the same time, otherwise we shall lose our international standing in medicine and nursing. For a time, NHS managers must concentrate on the improvement and consolidation of existing systems and politicians and their advisers be diverted from the fascinating by-ways leading to yet more national reorganisations. The cost to the patients of further restructuring would be far too great.

The second potential benefit could be the destruction of the myth that the NHS is being submerged under the weight of its administrative bureaucracy. Such allegations are of course encouraged by evidence of ineffective or laborious management, just as they disappear when managers use their substantial powers dynamically. It is by no means certain that the NHS has suffered from too many administrators as several studies have shown, including Levitt (1977), NHS Consultants' Association (1980), Maxwell (1981), Culyer (1981) and Dixon (1983). But the Service's senior managers have been coping with needless organisational complexities while struggling with industrial action (usually a result of national policies on pay scales or resourcing levels), efficiency cuts, enquiries, new management advisory services, performance indicators, regional reviews, two new national planning systems and so forth. These or similar problems will also have to be faced over the next few years, because they are an inevitable part of the increasingly 'political' NHS. They could be coped with better through the simplified managerial arrangements we now have, provided the appointed managers are given clear briefs. If this happens, 'administrator-bashing' may become a less wide-spread sport.

However, these would be benefits for the entire NHS, whereas this book is mainly concerned with improving unit management. To this end we have concentrated on the new unit management teams (UMTs). We have used this term, despite some possibility of confusion with units of medical time – also known as UMTs – for the reasons advanced in Chapter 6. We believe that, given the right context, both individual unit managers and the UMT, could

become powerful agents of change, able to improve the effectiveness of unit staff. This in turn would improve the health service offered to the British public. Therefore a number of chapters attempt to show quite specifically how the creation of an appropriate context could perhaps release the potential that lies within unit managers; but understanding the effects of given contexts is seldom simple and deserves careful consideration.

At this point it is timely to declare one of our beliefs: that it is liberating and not restrictive for managers to have their territories and personal powers made explicit. Without such clarity, any manager will be forced either to act tentatively or to resort to pressure plays. The latter will often succeed at first, meeting and overcoming the initial apathy and timidity inherent in organisations that try to operate in such a manner. But the potential for high quality performance in a complex, multi-professional and often stressful social institution like the NHS will only be realised when managers in all disciplines can act confidently. It is in the establishment of well designed contexts for unit managers that health authorities and their DMTs can contribute best. This book makes a number of practical proposals for their consideration and action.

A book of this type brings together authors with contrasting perspectives and I hardly need to emphasise that there is no 'party line' and no 'College view'. Indeed, on some issues there are clear differences between the approaches advocated: Tom Evans emphasises the need to improve the managerial process itself, whereas Maureen Dixon and Iden Wickings stress the importance of a well designed organisational structure; June Huntington has a major interest in the psychosocial factors which influence patients, doctors and nurses while quite different paradigms underpin the chapters by Gordon Best and Max Rendall. Despite these different viewpoints, which we hope readers will find stimulating rather than confusing, much more unites than divides us. In particular, we all share the view that the UMT's role is of crucial importance since it is the link between the operational staff and those working in the higher management posts charged with formulating strategy and implementing national policies. Effective unit management is a necessary condition if an effective service is to be delivered to the patient. For this reason, each chapter offers suggestions which we believe could contribute to this achievement.

In Chapter 2, Maureen Dixon sets out some of the criteria for forming units of management identified before the latest reorganisation. She describes the many different bases which have been adopted for units, ranging from the geographical, through client groupings, to particular clinical categories, such as obstetric care. UMTs, and indeed their individual members, have been set up to

work at very disparate levels and an understanding of the consequences is important for all managers. Where working levels across a health authority, or inside individual UMTs, are not congruent, then the contexts within which individual managers are expected to work are deficient. The likely result will be poor performances for which individuals will be blamed although it is their badly designed roles which are at fault. There is evidence in Appendix II by Catherine Shaw that the service has recently recreated some of the problems which Maureen Dixon's recommendations could help overcome.

In the third chapter, Tom Evans turns to the practice of effective management itself. If the context is right, what can be done to achieve high performance? He identifies the need for a situational diagnosis to be undertaken by each manager and emphasises that no general prescriptive theory will fit the wide variety of units that exists. To demonstrate his points, he covers four specific aspects of the unit managers' responsibilities: the implementation of policy, involvement in the planning system, being a top manager in the unit and being a part of the senior management cadre of the whole district. A number of practical examples are included in this chapter, which will help senior officers understand how to undertake their own situational diagnosis.

The three following chapters deal with a number of specific aspects of unit management that have only recently emerged as national issues in the Service, including performance indicators, the meaning of 'community', the psychosocial needs of patients and the behavioural aspects of financial management. In the first, Gordon Best analyses the theoretical background to the rapid growth of performance indicators in the NHS and is critical of much of the early work. He argues that a view of performance has been taken that is too narrow and has strengthened managerial accountability between statutory authorities rather than improved performance. He gives examples of both good and bad indicators, proposing that measures of final output need to be incorporated in any reputable appraisal system. The significance for unit managers is clearly argued, both as to the context in which they may find themselves being judged and how care should be taken in the design of indicators for use within the units.

The focus changes sharply in Chapter 5, where June Huntington discusses the meaning of 'community', to which so much lip-service is paid in the NHS; is it a term governments use to escape their responsibilities?, she asks. She also considers the importance – particularly from the patient's point of view – of the mix of technical and psychosocial stresses that professional staff impose on their clients. June Huntington mainly uses examples from the

obstetric services, but there are some from the care of the young and elderly as well. Her analysis is highly relevant to unit managers and to those directly responsible for patient care.

Chapter 6 draws on some of the lessons learned about the financial management of units during a series of workshops for members of UMTs held both at the College and elsewhere. Financial control mechanisms are easiest to construct when DMTs wish to keep a rein on their units, yet these mechanisms can help or hinder the emergence of powerful roles on UMTs. In this chapter, the real or imaginary significance of the distinction between UMTs and Unit Management Groups (UMGs) is drawn and practical steps are described to encourage delegation.

Since Chapter 7 deals with the axis of health care management – it is called 'Medical care and units' – it may seem perverse not to have placed it earlier. But whereas most of the earlier chapters have focused on matters of importance to the professional manager, relatively few doctors choose to fill such a role and Max Rendall explores some of the consequences. These include the emergence of more complex relationships – advisory committees, representative roles and others which he describes. The implications of clinical autonomy and what is sometimes called the 'primacy' of the clinician are also considered.

In Chapter 8 a number of the issues that have emerged in earlier chapters are gathered together. The question of whether units of management are truly new is discussed, as are the current interests in 'general management' and the possible role for a 'unit chief executive'. The chapter then describes how members of health authorities and DMTs, and unit managers themselves, could each help to achieve more effective NHS units. It concludes with an account of the plans of the King's Fund College for future work in this field. We are aware that many questions are raised in this book for which we do not have answers at present. Yet it seems to us that strengthening unit management is a genuinely important objective for the NHS, because patient care would be improved as a result. Furthermore, such improvements would not depend upon the availability of additional resources, and that is a significant consideration today.

Some mention should be made of the two appendices. Appendix I, by Gordon Best and Tom Evans, discusses planning as an idea. At the College we have found that people use the term to encompass widely different notions. Inevitably, confusion results. Best and Evans produce a modest taxonomy, go on to offer a critique of current NHS practice and end with some suggestions on the management of planning.

Appendix II is an analysis by Catherine Shaw of what has

actually been set up to form the new 'units of management'. She provides answers to such questions as: 'are the gradings of posts reflecting the national priorities?'; and 'do nurses and administrators get similar grades for their roles in identical units?'. Her appendix, however, also provides evidence to justify some of the concerns expressed by Maureen Dixon in Chapter 2 and Iden Wickings in Chapter 6 about the problems that face authorities with units of widely varying sizes and types.

That, in outline, is what this book covers, but we hope that the overall message will not be forgotten – that the benefits of this latest exercise in NHS reorganisation will only be realised if unit management achieves its full potential. This is largely the responsibility of the health authorities themselves and their DMTs, who must frame a constructive context for their UMTs to work in. If these issues are fudged, the patients and the staff will suffer. If the issues are well managed, all the costs of the 1982 reorganisation will have been worthwhile.

Maureen Dixon BA MPhil PhD
King's Fund Fellow in Organisational Studies

In addition to her general role as a Fellow of the College, Dr Maureen Dixon is responsible for the direction of the Corporate Management Programme. Her first degree is in social administration from the University of Nottingham and she holds an MPhil and PhD in sociology from Brunel University. After three years with Shell International she joined the NHS in 1966 as Assistant Regional Staff Officer in the Oxford Region. From 1967 to 1976 she worked jointly in the Health Services Organisation Research Unit, Brunel University and at the King's Fund College. From 1974 to 1976 she was vice-chairman of an area health authority. In 1976 she joined the Department of Health Administration, University of Toronto, where, as Associate Professor, she taught and carried out research in the organisation and management of health services. She took up her present post in October 1980.

CHAPTER TWO

The organisation and structure of units

MAUREEN DIXON

Some emerging problems

In a King's Fund Project Paper published just before reorganisation in 1982, (King Edward's Hospital Fund for London 1982) the following criteria were identified for assessing unit structures:

> Do the proposals preserve as much flexibility as possible to adjust structures in light of future learning?
> Do they fit in with the DHA's strategy, in the sense of facilitating and not obstructing general lines of intended development?
> Do they seem workable for all the main professions and for all four of the organisational facets mentioned above (institutional, geographic, client group, functional specialisation)?
> Do they make sense in the local context (ie do they pass the test of common sense and of minimum unnecessary disruption)?
> Do they represent value for money compared with other possible solutions?

These criteria seem as good a place to start as any in assessing the actual experience of unit organisation a year or so later. Of course, a year is a short span in the life of an organisation and some districts are still in the process of making appointments to their unit management posts. But few would argue that the criterion of minimum disruption has been met and experience of the new units over the last year or so suggests that the other aims may be equally elusive.

Decentralisation

Maximum delegation to units was the central theme of the 1982 reorganisation. Yet there are already indications that greater centralisation of decision-making may be the outcome. This trend cannot be related totally to reorganisation. The contemporaneous development of performance review mechanisms between DHSS and regions and districts has also been a centralising influence, paradoxically creating more rather than less intervention by the 'centre'. At district level, there seems to have been varied success in honouring the principle of maximum delegation. For example, some districts have few district level posts in support functions and paramedical services, but these districts seem to be the exception

rather than the rule. In general, the various occupational groups have been able to safeguard the senior posts at the top of their management structures and thus establish district-managed services.

Another pressure for centralisation in some districts is the great inequality in the size of the units. (Evidence of this and of other inequalities among units is set out in Appendix II). Recognising that post gradings are at best a proxy for size or level of responsibility, it is quite striking how widely separated these are in some districts. There seem to be two dangers in such inequality among units. First, the units that are in this sense very large do appear to involve decisions that, in terms of their consequences for the district as a whole, are barely distinguishable from decisions taken by the DMT. The very small units on the other hand appear to have difficulty getting items on the district agenda. In either case, it would not be unreasonable for district managers to delegate less to their unit subordinates in an attempt to ensure that the weaker units are not swamped by the stronger.

Reflecting DHA priorities

It is hard to find a district that does not have the development of services for the elderly, the mentally ill and the mentally handicapped as a high priority. Similarly, there are few districts where the strategy is not to broaden the base of services in the community and rationalise or reduce hospital services. Yet few districts have a unit structure that reflects these priorities. Again, using post gradings as an indicator of relative strength of units, the stronger units are almost invariably the 'acute' hospital units whereas the unit posts with responsibility for mental illness, mental handicap and services for the elderly usually carry much more junior gradings.

Some districts have tried to overcome this asymmetry by grouping two or three of the 'care group' units under a single administrative role, thus justifying a higher grading for the post. But this device does not, of course, achieve the same effect as having a full-time unit administrator concerned with a single unit.

It may be argued that size, as measured by any of the traditional proxies (population served, number of beds, geographical area, size of budget) is not the point. Rather we should be concerned with the intrinsic complexity of the work in the unit. The higher gradings generally given to the acute unit posts suggest that the work is seen to be more complex and challenging than the work in, say, the community unit. But how justified is this assumption? In the absence of clear managerial relationships and understood linkages to medical and other staff, the unit manager's task in a

community or client care group unit can be both more uncertain and demanding of individual initiative and creativity. Linkages have to be established with local authorities and agencies in the community; innovative patterns of service have to be created; funding is both lower and less predictable than in the hospital setting. So should not the unit managers be of comparable seniority and experience?

This lower grading of non-acute care in health services did not, needless to say, arrive with the 1982 reorganisation. Even within the pre-1974 hospital service, the psychiatric sector was often regarded as something of a backwater for the aspiring administrator and the old public health service image still affects our view of community services. But it does seem that the latest reorganisation has done little to redress the balance. Some determined districts did fight the grading battle to bring their priority units up to competitive levels but in general the application of the grading rules has resulted in a reinforcement of the status quo.

Defining units

The analysis so far has revealed one of the difficulties in talking about units – the lack of commonly understood definitions. So one so-called acute unit can include a DGH less psychiatry and obstetrics, whereas another can cover six small hospitals and all associated services in the community. Or one mental illness unit can be concerned with all mental illness services across the district, wherever they occur, whereas another includes only the hospital-based psychiatric services.

Another sense in which the term unit has already become relatively meaningless is as it is applied in nursing and administration. The normal situation is a one-to-one match of unit nursing and administrative roles. But it is by no means rare for there to be more nursing than administrative units. This is usually the result either of a single administrator holding two or three unit roles or of there being a unit for nursing purposes with no reflection in the administrative structure, for example, midwifery or health visiting.

This emerging pattern challenges the integrity of the unit management team concept as originally espoused. The notion of an administrator, nurse and representative of the medical staff working closely together does seem to be sustainable in the management of large hospital units. But elsewhere the unit management triumvirate may not be the natural organisational model. In some situations it has clearly been felt artificial to set up matching nursing and administrative roles and in many non-hospital units the single medical representative is turning out to be either un-

acceptable (to clinical colleagues) or difficult to find. Some community units report difficulty in identifying a single representative of general practice for example and in some mental illness or mental handicap units the total electorate of clinicians is so small as to render the representation principle meaningless. Furthermore, some of the paramedical professions are arguing that their input at unit level is vital in the priority care areas and so it is not uncommon to find a unit management team encompassing seven or eight roles. So the wide variation in organisation that has already developed really does bring into question the idea of a uniform model for unit management.

Bases for units

The limited experience of unit management so far suggests that it has rarely been possible to define units on bases which are both distinct and complementary. The predisposing effect of the previous structures no doubt has something to do with this as does the perceived need to strengthen hospital management.

We have conventionally thought of the alternative bases for units as reflecting four facets of health services organisation: institutional, geographic, client group and functional/specialist. But it is becoming clear that these four classifications are inadequate if we are to understand how units are structured at present and how they might be changed in the future. Hidden within those four broad categories lie a number of significantly different ways of thinking about, and providing, health services.

Primary dimensions often used in classifications of health systems* include:

medical/nursing specialties (maternity, obstetrics and paediatrics, psychiatry, orthopaedics)
settings (hospital, nursing homes, health centres, community)
resources (hospital beds, equipment, nurses, doctors)
intervention modes (prevention, diagnosis, treatment, rehabilitation)
disease categories (cancer, heart disease, mental illness)
level of specialisation of care (primary, secondary, tertiary)
geography (all those services being provided and/or all those receiving or requiring services within a particular geographical area)
care group by age (the elderly, children)
client care group (the mentally ill, the mentally handicapped, the terminally ill).

* See for example, US Department of Health, Education and Welfare 1977.

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Each of these dimensions is discrete; that is, if two or more dimensions are used as the basis for defining areas of responsibility at the same level within the same organisation, there are bound to be areas of 'overlap' which could logically fit within one area or another. A familiar example is the juxtaposition of a unit of management for a DGH alongside a unit of management for mental illness services. Which managers are then to be responsible for the acute psychiatric services within the DGH?

In practice, these grey areas of accountability are often easily identified and managerial accountability specified one way or the other. But the larger the number of dimensions used for defining managerial roles at the same level, the greater the potential for overlap and confusion of accountability.

No district had the luxury of designing its new organisation from scratch and the legacy of the pre-1982 organisations inevitably had an important influence on the shape of the unit arrangements. Nonetheless, some districts have been able to go further than others, in simplifying inter-unit relationships by keeping their respective areas of responsibility as mutually exclusive as possible.

There is a second sense in which the choice of bases for units is not a neutral one. Although we do not yet have much experience of the new units, there is evidence from elsewhere about the consequences of choosing one type of basis rather than another. For example some work of mine with health planning organisations in Canada produced the following analysis:

> To the extent that the structure is based on dimensions that are basically institutional or professional in character, so there is the tendency to reinforce the existing patterns of service and to prevent developments which challenge institutional and professional boundaries. To the extent that the structure is based on dimensions such as areas of health care, health care groups or programmes, so there is an increased likelihood of identifying needs that are not being met, of producing innovative solutions and of providing services that cut across jurisdictional boundaries. (Dixon 1981)

In a number of health care systems, there does seem to be a move away from the institutional/professional model because it tends to reinforce the status quo and limit the possibilities of innovation. Models based on care groups have the intrinsic advantage of directing attention to the consumers or potential consumers and also tend to be more consonant with the organisations' priorities. So, for example, if accountability for all mental health services is within one unit concerned with the full range of services in

hospitals, in the community and in the home, coordinated planning and development of services are facilitated rather than impeded by the organisational arrangements.

In a confidential report prepared for one health district in England, the problem was described as follows:

> The 'overlap' consequences of using different bases for defining the Units were identified. For example, geriatric services appear in at least four of the Units, mental illness services in at least five Units and services for mothers and children in at least three Units. The Mental Handicap Unit is apparently the only one which comprehends accountability for a discrete area of service for care groups.
> Some difficulties are likely to be created by this situation including:
> continuation of the relative dominance of the hospital sector, five of the Units being hospital based;
> no organisational arrangements at Unit level to manage or plan some services on a comprehensive, District-wide basis;
> the complex financial arrangements required if budgets and allocations are to be made to areas of service rather than through the traditional functional hierarchies.

There has been some debate about the pros and cons of a totally geographical model for units – simply dividing the district into discrete geographical zones with each unit management group accountable for the services that happen to be provided (or needed) within its zone. Indeed, this is the situation in the Northern Ireland health and social services system. Simple and clear as this geographical model is, it has not proved either possible or popular in the English context. Few units, particularly those in urban settings, could claim to encompass anything close to a comprehensive range of services. So in practice, each unit has to provide a more or less specialised range of service and draw its clients from across the district.

Levels of work

We have already noted that in some of the new districts the units are seen to be operating at significantly different levels of work, reflected in the widely differing grades given to unit management posts. It is also generally recognised that districts themselves differ in the range and complexity of services for which they are accountable and in population served. Do either of these phenomena matter? Does it matter that a DHA/DMT will receive a different

kind of response from its constituent units and a region from its districts?

Research and development work with districts over the last year or so suggests that these organisational inequalities do matter and do limit the effectiveness of the organisation as a whole. In particular, problems arise in:

- distinguishing the roles of the HA and the DMT
- clarifying the relationship between district and unit officers in the same discipline
- establishing structures within units.

Distinctions between these levels in terms of 'planning' versus 'operation', or 'policy-making' versus 'implementation', do not capture what the people in the posts experience as the differences. The HA, district managers and unit managers must all generate policy and plan. The DNO is no less concerned with the operation of nursing services than the ward sister. So the perceived differences lie not in the type of activity being carried out but in the degree of complexity and the breadth of perspective applied to the activity. (Kinston 1982a)

During consultancy work with one district, I described the problem in the following way:

> A further concern . . . had been to produce units of similar size, measured in terms of numbers of beds or developmental needs or catchment area. Since there could be no intermediate level of management between district and unit, this equivalence of units is necessary if they are to carry comparable decision-making authority and thus compete equally for their share of district resources. Another way of describing this equivalence of level among the units is that they should be delegated the same amount of decision-making authority or discretion by the DMT. If any one unit is, in this sense, too close or too far away from the DMT, it is unlikely that the unit could develop as the authoritative level of management it is intended to be.

These issues have been explored with a number of districts by applying a model of work stratification. The model is fully described and developed elsewhere (Jaques 1976) but the essence of the theory is that work in organisations falls naturally into different levels (or strata) with distinct characteristics. If work in units and whole districts is organised with these strata in mind, then many benefits follow. The theory can be described in more detail as follows:

> The work to be done in organisations falls into a hierarchy of discrete strata in which the range of the ends or the objectives to be achieved and the range of environmental circumstances to be taken into account both broaden and change in quality at successive steps;
> the work at successively higher strata is judged to be more responsible but significant differences of responsibility are also felt to arise *within* strata, ie these qualitative strata form stages within a continuous scale of increasing levels of work or responsibility;
> at least five such possible strata can be precisely identified in qualitative terms;
> these strata form a natural chain for delegating work and hence provide the basis for constructing an effective chain of successive managerial levels within the organisation;
> the understanding of these strata can also provide a practical guide to designing new organisations (or part-organisations) according to the kind and level of organisational response required in relation to the social and physical environment in which the organisation is to operate. (Rowbottom and Billis 1978)

(The main features of these strata or levels of work are summarised in Table 1).

District-level work

It has been argued that the DHSS expectation of the 1982 reorganisation was that it would produce stratum 5 districts, capable of developing and implementing 5 to 10 year strategic plans. (Kinston 1982a) In the larger and more complex districts this expectation is clearly being realised. But there are, no doubt, other districts in which work at level 5 will not naturally be thrown up.

Kinston has discussed the significance for RHAs of having districts operating in different modes:

> This raises the question of whether such a mix of Districts at different levels should be a transitional phase to be overcome by fusing Districts or injecting more resources and up-grading smaller Districts; or whether the mixture is to be accepted as a permanent state of affairs. The existence of Districts doing different levels of work has implications for the functioning of District Health Authorities and for the relationship between Region and the Districts. A major concern for Region must be neither to expect too much from level 4 Districts nor to duplicate the strategic work of level 5 Districts. (Kinston 1982a)

Table 1 Summary of work strata

Stratum and time span of responsibility	Description of work	Upper boundary
5 (10 years)	*Comprehensive field coverage* making comprehensive provision of services within some general field of need throughout some given territorial or organisational society	Not expected to make any decisions on the reallocation of resources to provide services outside the given field of need
4 (5 years)	*Comprehensive service provision* making comprehensive provision of services of some given kinds according to the total and continuing needs for them throughout some given territorial or organisational society	Not expected to make any decisions on the reallocation of resources to meet needs for services of different or new kinds
3 (2 years)	*Systematic service provision* making systematic provision of services of some given kinds shaped to the needs of a continuous sequence of concrete situations which present themselves	Not expected to make any decisions on the reallocation of resources to meet as yet unmanifested needs (for the given kinds of services) within some given territorial or organisational society
2 (1 year)	*Situational response* carrying out work where the precise objectives to be pursued have to be judged according to the needs of each specific concrete situation which presents itself	Not expected to make any decisions, ie commitments, on how future possible situations are to be dealt with
1 (3 months)	*Prescribed output* working towards objectives which can be completely specified (as far as is significant) beforehand, according to defined circumstances which may present themselves	Not expected to make significant judgments on what output to aim for or under what circumstances to aim for it

Adapted from *Health Services* ed. E Jaques. Heinemann, 1978, p. 119.

The DHA itself is similarly crucial in determining the level of work to be carried out within its districts. If the authority sees its role as essentially strategic, it will increase the likelihood of level 5 work at district and, by extension, level 4 work in units. If, on the other hand, the authority seeks responses from its senior officers in level 3 and level 4 terms, the whole organisation will have difficulty in breaking out of the constraints of its existing situation and systems into more significant and higher levels of decision-making. (King Edward's Hospital Fund for London 1981)

Unit-level work

The level of work in units will be similarly constrained by the actual level of work in the DMT. Ideally, the unit managers in nursing and administration will be at one level of work removed from their respective managers. So, in a level 5 district, the unit managers would be delegated the discretion to undertake level 4 work:

developing comprehensive and costed plans up to a 5-year time scale,
deciding priorities for the unit, and
relating to the clinicians who affect such decisions.

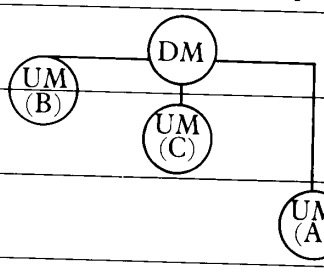
Although level 4 unit managers are accountable for the operational management of services in their units they characteristically stand back from the day-to-day operation and tackle the longer-term issues involved in development and reallocation of services and resources.

If, in practice, units are working at different levels, it is possible that there will be a blurring of these district-unit managerial relationships in two ways. The managers of some of the smaller units may in fact be at two work levels removed from their district counterparts, creating a managerial 'vacuum' in the intermediate level into which there is a tendency for other roles (for example, the deputy district administrator or the district planning officer) to be drawn. In Table 2, this is shown as situation A.

Perhaps a less common situation is the unit managers in very large units being too close to the district in level of work terms (situation B), resulting in a blurring of decision-making and authority. The unit managers will want to take on issues which affect the district as a whole and will probably be seeking frequent direct contact with the DHA. The district managers will be conscious of this organisational crowding and may respond by attempting to control the unit too tightly.

To summarise, the most effective district-unit relationship,

Table 2 Different unit-district relationships

Work strata	*Managerial relationships*	*Description*
5		Comprehensive field coverage
4		Comprehensive service provision
3		Systematic service provision
2		Situational response
1		Prescribed output

Key: DM = district manager
UM = unit manager

towards which organisations might change over time, would have all the units in a district at the same level of work, one level removed from the DMT. This is shown as C in Table 2. The units can then compete on equal terms for their share of district resources and effective managerial relationships with maximum delegation can be established.

Levels of work within units

If we apply the same kind of analysis to work within units, it is again apparent how the actual level of district work will predict the number of managerial levels in the hierarchy. In a level 5 district with level 4 units, the nursing hierarchy within a unit, for example, could sustain two levels of management – senior nurse and ward sister are the usual role titles. If the director of nursing services in the unit is in practice working at level 3, there would appear to be only one level of nursing management required below the director of nursing services role. Indeed, if an attempt to operate with more managerial levels is made, the experience will be one of 'overcrowding' with insufficient authority being vested in the intermediate managers' roles.

Unit management teams

As mentioned earlier, the 'classic' unit management team, comprising nurse, administrator and a representative of the medical staff, is by no means the only model of unit management emerging. In some units there are two or more medical representatives; some

units share their administrator with other units; representatives of paramedical disciplines have been included in some, particularly long-stay unit management groups; two directors of nursing services are included in a number of cases and in yet another variant there is no elected medical representative but a specialist in community medicine instead.

This variety of unit management arrangements seems inevitable. Different types of service, the size and distribution of the medical staff, the geography of the district and the political forces at local level all combine to create different managerial needs. A unit comprising a large teaching hospital is likely to throw up quite different coordinative and planning tasks from a primary care or community unit.

Inevitably, units will develop their own systems and procedures for meeting, making decisions and communicating with the rest of the organisation. Most unit management groups seem to be developing a regular meeting schedule with associated agendas and minutes and where all the members of the group work in the same place these arrangements are usefully extended by more informal contacts.

Collective or individual accountability for units

As implementation of the new structure continues, and as the unit managers concentrate on cooperation and teamwork, some confusion has appeared about the nature of accountability at unit level. Many of the unit management job descriptions describe both individual and collective responsibilities. It has become common parlance to talk of the DMT delegating to the UMT or of the UMT being collectively responsible for the quality of services in its district. But how can this be so? The unit administrator and nurse are fully accountable to their respective managers at district level and the medical representatives are answerable to the doctors who elected them. In the final analysis, it is these individual accountabilities that will guide and affect the decision-making of members of UMTs. Similarly it is these individuals who will be called to account for their decisions to their managers or their constituents.

So as long as the fundamental working relationships of UMT members are either as part of a managerial hierarchy or as an elected representative, it is at least confusing to talk of collectively or corporately accountable teams. This point applies equally well, of course, to the DMT.

Team decision-making

This is not to down-play the importance of collective decision-making in unit management groups. Individual accountability could in no way be adequately fulfilled in isolation from other crucial colleagues. The major purpose of establishing cooperating groups at unit level is to ensure that individual decisions are informed by what is going on elsewhere in the organisation and by the views of colleagues, so that qualitatively the decisions are greater than the sum of the parts.

Prior to reorganisation, there was some suggestion that unit management teams might make decisions by majority vote. This was usually a response to an alleged slowness and levelling down of decisions when consensus was the aim. But if unit management teams are not collective or corporate bodies, it seems inescapable that their decisions are made by consensus. The unit nurse or administrator have somehow to reconcile the team's decisions with their own managerial responsibilities just as the medical representative has adequately to satisfy the wishes of the group of doctors being represented. It would therefore be just as inappropriate to have a vote as it would to have a chairman or coordinator making the decision when agreement cannot be reached. In either case, the outvoted or overruled member of the unit management group could not be expected to support, far less to implement, the decision. If agreement cannot be reached, the administrator and nurse must discuss the issue with their managers and the medical representative must check back with his or her colleagues.

Medical representation in units

Although many aspects of the role of doctors in unit management are discussed in Chapter 7, this analysis of unit organisation would be incomplete without some consideration of the medical representative's role.

The rationale for the involvement of elected representatives of consultant medical staff and general practitioners at unit level is essentially the same as that leading to their inclusion on DMTs since 1974. If services are to be managed effectively, planned creatively and controlled financially, it is essential that clinical medical staff contribute to the decision-making process. Since consultants and GPs are not hierarchically organised, this contribution has to be channelled through elected representatives of groups of medical staff. These representatives speak for the groups which elected them, are accountable to those groups and are sanctioned by them in carrying out their representative function. (Cang 1978)

So the medical representatives are constrained by expectations and relationships that are very different from those affecting the managers in the system. Effective medical representatives will have a sense of the views of their constituents and reflect these views even if they differ from their own. But they will also try to influence their constituents to reach a consensus which is acceptable to other medical and managerial colleagues. (Jaques 1976) The considerable skill required to mediate the potential power and conflict in such roles is emphasised in Chapter 7.

Even before reorganisation, it became clear that no single arrangement would provide appropriate medical representation in all units. (McQuillan 1981) It was envisaged that units comprising a single DGH might need only one representative of the consultants but other units, particularly community units, might well need more than one doctor to reflect the full range of clinical involvement. (DHSS 1981a) Furthermore, the different district medical advisory structures and their natural histories would indicate different kinds of linkages between units and the medical staff.

We do not yet have adequate data about the medical advisory arrangements across the country so it is not possible to be certain about the emerging patterns. But one can already see that some interesting variations on the basic theme are developing. The first of these arises in units where, for particular local reasons, there are two and sometimes more identified clinical representatives. In some instances this reflects the bringing together of two previously separated hospitals (and medical advisory structures) in one unit, both hospitals requiring medical representation on the unit management group. Another example is the inclusion of two or three GPs in a unit management team for community services. As argued below, this may be quite a natural response to the local political realities and in some of these cases it is the hope and intention that representation will eventually become more streamlined. But if this does not happen, a real concern would be that differences of view among the medical staff will be debated and worked through in the unit management team instead of in the appropriate forum of the medical committees. This could both slow down decision-making in the unit management team and reduce the medical representatives' credibility with their constituents since the view reached would properly be regarded as that of the team and not necessarily that of the collective medical group.

Another variation, encountered in a few districts in England so far, is the inclusion of a community physician as the sole doctor on a unit management team. The Welsh report on medical advisory arrangements suggested that a named community physician should

be involved with each unit management group. (Welsh Office 1981) There would often seem to be obvious benefits in having a community medicine input, particularly in community units. But the community physician cannot fill the representative role in the sense of being able to speak on behalf of the consultants or GPs because, ultimately, he or she is part of the executive system and so cannot be expected to take the place of the elected medical representative at unit level.

Team size and relationships

The phenomenon of rather large unit management teams or groups was noted earlier. This seems to occur particularly in the priority care group units where there is a need to involve a wider range of professions. (DHSS 1980a) Some unit teams are also including a senior member of the finance staff to assist in developing local budgets and financial control mechanisms. In some instances, the finance adviser is regarded as a full member of the unit management team, in others as a regular attender at the meetings.

This trend may be unexceptionable: those who need to work together at unit level should do so and not worry about whether they are members of the team or not. But there do seem to be two important aspects of large unit management teams that deserve attention:

- limiting the size of the team so that decision-making and accountability in the unit do not become amorphous;
- ensuring that the unit team comprises roles at the same or reasonably similar level(s) of work.

On the question of team size, some districts have found it useful to establish the idea of a 'core' unit management team, consisting of the three (or four) roles which are primarily involved in management and planning issues – resource allocation, setting priorities, developing policy consistent with district guidelines and setting and monitoring the standards of care being provided. Other crucial roles have then been identified (in finance, the paramedical professions and local authority social services for example) which will routinely be kept in touch with the core members' work. The team's agendas, minutes and papers will be shared with those working in these critical roles and their attendance at team meetings arranged as necessary. But the members of the core team will remain responsible for incorporating these external views in a coordinated and budgeted plan for the unit. It is hoped that such an arrangement will both reduce bureaucratic procedures to a minimum and locate accountability clearly in the structure.

It is inappropriate to regard local authority social services staff as members of the core team because, crucial as their input may be, the DHA cannot hold these persons accountable in any way. Their allegiance will be to their own employing organisation through their own managers.

The UMT-local authority relationship takes us back to the question of similarity of level. Pre-1982 experience with, for example, health care planning teams demonstrated the need for members of such groups to be at reasonably comparable levels in their respective organisations. Where there was a considerable inequality in the levels of work, a number of problems arose. Two examples can be quoted. Firstly, because people were working to different time scales, some complained about the trivial issues raised while others saw the whole exercise as irrelevant to their 'real problems'. Secondly, when more 'junior' people attended, they clearly felt unable to commit their organisations and therefore tended to bring their managers with them to meetings. So it does seem important that those concerned with unit/local authority issues, should operate with similar perspectives, power and time-scales. In other words, they should be working at or near the same level.

Functional and paramedical management

In reviewing the management arrangements being established for functional and paramedical services, two quite obvious trends appear which might give concern to unit managers. First, some districts have been unable to avoid continuing with large numbers of district level posts in these areas of work, in spite of official encouragement to the contrary (DHSS 1980b).

For some activities, it would clearly be wildly uneconomic to have each unit with its own department. Also it seems that some functions, such as personnel, need a district presence so that uniformity of policy and practice can be ensured. But many unit managers point out that promises of greater delegation will be frustrated if a whole range of the support and clinical services are managed by specialists outside the unit's control.

A second concern is the confusing way in which some of the functional roles have been described. In what is often an attempt to get round the fact that managers in a particular discipline do not accept the idea of control by another profession, a whole series of complicated and sometimes conflicting role relationships are defined. An actual example described the district head of a paramedical department as being (a) administratively accountable to the district administrator, (b) subject to the staff authority of the assistant district administrator on management matters, (c) coor-

dinated by the district medical officer on development and planning and (d) advised clinically by a named consultant. It is important to be clear why such arrangements should not be acceptable. Dual or multi-accountability places pressures on both the managers and the managed. Each of the several senior managers given some authority will be frustrated by being incapable of assessing the full range of demands the collectively managed person faces. But, of more importance ultimately, none of the senior managers involved can accept full responsibility for assessing the performance or arranging for professional training and development of the individual concerned.

Aberrant as this example may be, it is not hard to find similar organisational fantasies in the role specifications and job descriptions now extant. It does seem that these structures need to be analysed in rather basic terms if we are to avoid extraordinarily complicated and confusing patterns of work. Three simple questions will help here:

1 *Is the function 'manageable' at all?*
In some of the paramedical functions in particular, the heads of department have established a position of independent professional status. They have not been full managerial subordinates of any other role for some time. Where this is the actual and recognised situation (and not simply an obfuscation to avoid trouble), explicit monitoring and coordinating relationships will be both sufficient and necessary. (Brunel University 1977)

2 *To what level in the district does the function require professional management?*
There are some districts in which particular specialist functions have been developed to a high level of sophistication and where level 4 roles are sustainable. An example might be a large physiotherapy department with its own training school in a teaching district. But there are many functional or paramedical departments where the head is characteristically a level 3 role, directly managing the qualified, experienced staff and often retaining personally a 'clinical' or 'casework' element. It would be artificial, and felt to be so, if these roles were linked into the organisation at an inappropriate level.

3 *To whom should the head of department be accountable?*
In spite of the persuasiveness of so-called matrix management, the experience in the NHS does seem to argue against forms of dual accountability. The construct of 'professionally accountable to X and administratively to Y' just has not worked in practice. It seems pragmatically that where a full managerial relationship *is* appropriate, a single accountable manager should

be identified. This manager should, of course, have the capacity and knowledge to manage the head of department and should be at the next higher level of work.

These principles can be combined in a number of ways, each of which has predictable outcomes for unit management. These models are shown in Table 3.

A variant of the district/unit adviser models which is quite common involves one of the unit specialists moving between the unit and the district roles and being accountable to both the unit manager and a district manager respectively. This model depends on the assumption that an individual can move in and out of roles at two different levels of work and make decisions and work equally effectively at both levels.

This idea, which is incidentally the same idea as 'acting-up' or 'deputising' in a managerial hierarchy, has not been found successful in practice. If the individual is able to operate satisfactorily in, say, a level 4 district role, then he or she is probably under-utilised in the level 3 unit post. Conversely, if level 3 is for the time being the individual's natural level of work, he or she would not be able to adjust their perspectives on demand to meet the requirements of the level 4 post. Of course individuals do grow and mature over time into levels of work demanding greater capacity. But having developed in this way, they do not readily, or particularly effectively, do work at a level below their natural capacity. (Jaques 1976)

Applying the organisational principles

This chapter has explored various questions about unit organisation and put forward some principles against which to assess and develop particular structures.

1 The effect of a large number of district-level posts in paramedical and support functions and of considerable inequality of size (as indicated by gradings) among units, is likely to be greater centralisation of decision-making rather than greater delegation.
2 If the DHA's priorities are not reflected in unit organisation by priority care units having comparable power and status to acute units, it seems unlikely that the relative position of the priority care services will improve.
3 The particular basis for delineating the work of units within a district should, as far as possible, be of the same kind in order to minimise grey areas of accountability and authority.
4 Using institutions or professions as the basis for units seems

Table 3 Four models of functional or paramedical management

	Model	Relationship to unit	Characteristics
i	*Centralised* District head of specialist function accountable to district manager (or DHA) District head of specialist function manages specialist staff some of whom may be outposted to units	Service-giving and/or staff relationship	Potential economy of scale Uniformity of service across district Optimum use of scarce skill/resource Unit managers cannot control managerially or financially
ii	*Decentralised* No district head of specialist function Unit heads of specialist functions accountable to unit managers	Managerially accountable in units	Control at unit level Local variation Close links with operational managers Greater flexibility within units No uniformity across districts
iii	*Unit Adviser* No district head of specialist function One unit head of specialist function coordinates other unit heads of same function when required	Managerially accountable in units In coordinating role unit head of specialist function remains accountable to unit manager	Provides for inter-unit cooperation in specialist function Retains control at unit level
iv	*District Adviser* District head of specialist function accountable to district manager (or DHA) Unit heads of specialist function accountable to unit managers District head of specialist function monitors and coordinates unit heads of same function	Two levels of managerial accountability – district and unit	Creates senior role within specialist function High-level specialist advice to DMT and DHA Tends over time to create dual accountability for unit heads of specialist function

likely to reinforce existing patterns of service and resource allocation.

5 It is important that all units in a district embody the same level of work and that the DMT is working at the next higher level in terms of decision-making and time span.

6 The level of work in a unit predicts the number of subordinate levels available in the managerial hierarchies.

7 There is no single model of management which will meet the needs of all units. But it does seem important to limit the size of the 'core' UMT and to ensure that the unit managers are working at the same or reasonably similar levels.

8 UMTs cannot be held collectively accountable for work but they need to make collective decisions. If such decisions are to be acceptable and implementable, consensus is the appropriate method of decision-making.

9 Medical representation is a vital aspect of unit management. Wherever feasible, the views of the relevant medical staff should be represented in a single elected role to avoid differences of view among medical staff being debated in the UMT instead of in the medical committees. Community physicians can make a special contribution in some units but they cannot take on the role of medical representatives.

10 The heads of functional and paramedical departments should either be clearly accountable to a single manager at district or unit level or be recognised as independent, free-standing managers accountable to the DHA and monitored and coordinated by district-level staff.

Conclusion

This chapter has concentrated on the organisational questions surrounding unit work. This is in no way meant to imply that the skills, knowledge and capacity of the unit managers are not just as important as organisational characteristics. But we now have a good deal of evidence and experience about the conditions under which effective work can be carried out, in units or elsewhere. There has often been a tendency to blame individuals for poor personal performance when the real problem has been an unclearly or unrealistically defined role. Just as in any other part of the organisation, it is vital that the unit managers understand and see the sense in their roles and working relationships in order that their personal performance can be enhanced.

likely to reinforce existing patterns of [illegible]
allocation.

5 It is important that all staff in a [illegible]
of work and that the DMT [illegible]
to make decisions [illegible]

6 The level of work in a [illegible]
levels available at the [illegible]

7 There is an implicit model of [illegible]
needs at all times [illegible]
[illegible] (NRI) and [illegible]
[illegible]

Tom Evans MSc (Econ)
Director, King's Fund College

Tom Evans took the post of Director of The King's Fund College in August 1981. He graduated in statistics from the London School of Economics, where he also took his masters degree in economics. He was an Economic Adviser at the Department of Economic Affairs, before teaching at the London Business School, where he was the founding Director of the Institute of Public Sector Management. He has worked as a consultant for public and private organisations in the UK and the developing world and has authored books and articles on corporate social responsibility, corporate planning and public enterprise. He has been a member of ILEA and an area health authority and is currently a member of a district health authority.

CHAPTER THREE

The unit manager

TOM EVANS

The issue at stake

It has been a common experience in the early days of the reorganised NHS to hear unit managers proclaiming their unsureness as to what they are supposed to be doing. In part, clarity of the unit role depends upon the well formed identity and self-discipline of the DMT and that has often still been developing. The rhetoric is that of a 'strategically oriented DMT and semi-autonomous unit managers responsible for the operational management of their services'. But it may provide an unhappy combination of a seductive kernel of truth allied to a specification that is inadequate to resolve the inevitable confusions that arise in practice. The anxiety and uncertainty of unit managers have been exacerbated by the feeling that the original idea of decentralisation was right, but that what was given in principle has been taken back in practice.

No doubt the extended saga of implementing this reorganisation has contributed to the confusion. Certainly the experiences of many unit managers have been coloured by their inability to fill establishments of subordinates, or, at least, to do so with any confidence that they are making good appointments. It may be argued that this is a transient concern and that things will sort themselves out. This philosophy of 'It'll be alright on the night' underestimates both the complexity of the unit manager's task and the careful thought that is necessary to carry it out successfully.

This chapter approaches these problems by focussing on the manager of a unit and the choices of role and activity that he or she must make. Because I am considering the position of the individual unit manager I have written throughout of 'the manager' and what 'he' might do. It seemed clumsy to put 'he or she', and inappropriate to use the plural when specifically concerned with the individual director of nursing services or unit administrator. But, although addressing each unit manager's position so directly, this chapter is not prescriptive. That is to say, it does not recommend a 'best' or even a 'good' way for the manager to do his job. Rather it provides a framework to help the manager's own diagnosis of what is important in his situation, his analysis of his options and their consequences, and his appraisal of his own actions.

The variety of conditions facing unit managers responsible for units of radically different sizes and organisational complexity

would soon disprove any general prescriptive theory. The problems arising in a community unit will always have differences from those in an acute unit, and so on. However, the need for the manager to diagnose his own situational difficulties arises not merely from these kinds of factors. Even within units which are similar in size, complexity or service, differences will still arise from local characteristics of physical location, population, idiosyncracies of practice or personality. Successful management depends upon an adequate response to these local characteristics and hence requires a *situational diagnosis*. While this precludes a general prescriptive theory, my intentions in this chapter are even more modest than this suggests, in that differences between administrators and nurses are not considered explicitly.

My concern is to identify what is peculiar about a managerial job at unit level. Many additional refinements may be necessary. I emphasise the important contribution that principles can make to help managers understand their local situation and to develop an effective response. Though this chapter focuses on the unit manager and his choices, it recognises the importance of the organisational structures in which any manager operates. Principles of organisational design, at the level of the district as a whole, are dealt with in Chapter 2. However, the design of any organisational structure should still be responsive to the choices of those who operate within it and the emphases they bring to their managerial activities. There should be a continual interplay between the issues discussed here and the principles of organisational design.

As a final preliminary, I should make clear one important underlying assumption; namely, that the future role of unit managers is genuinely at stake. If the response of DMTs to the present confusions, and to the amorphous role of unit managers, is merely to revert to past practice, to run units with a firm involvement by chief officers, and hence to restrict the UMTs' discretion to administrative and operational matters, then many of the issues raised here will go by the board. My argument is concerned with the manager's choices of emphasis, whether as a nurse or administrator, and his need to establish dimensions of his role. His relegation to the status of an administrative serf would make managerial analysis of his function irrelevant. There is little doubt that, unless the unit role can be seen to be developing credibly and clearly, it will be subject in some places to precisely that type of relegation. However, there are enough senior managers in all disciplines who recognise the importance of delegating substantial discretion to unit level for the unit manager's role to survive the confusing and inelegant practice which will characterise it initially. In any case, the pressures of the problems facing the NHS will

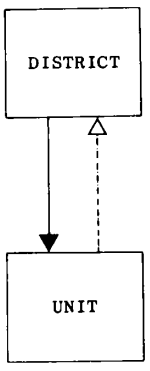
undermine those who seek to revert to simplistic, centralising management practices, and will reassert the importance of thinking carefully about management responsibilities at unit level.

A framework

The most transparent truth about unit management is that there is no simple model of the role. The argument of this chapter is that there are a number of legitimate competing demands on the attention of unit managers. However, these demands are presently incoherent, are partially in conflict, yet mutually reinforcing. They involve different balances of pressures from one managerial situation to another. The problem for the manager is to clarify and sort out these demands, and to build a set of responses which are mutually consistent and appropriate to the needs of his situation. The focus in this argument is on managerial choice – conceptualising, selecting and building packages of activities and roles, which reflect his sense of what is needed.

As a means of pursuing this argument, I suggest four types of involvement which the unit manager faces:

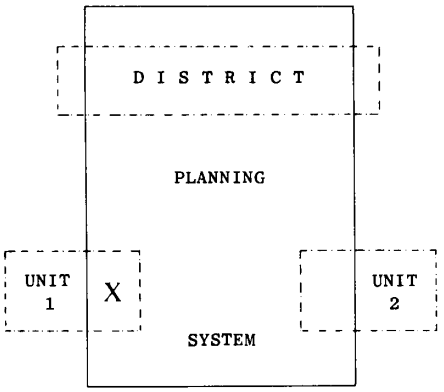
1 *Involvement in the implementation of policy*
One facet of the unit's responsibility is to carry out the policies of the DHA and the DMT in so far as they are relevant to its activities. In this sense there is a straightforward hierarchical relationship between the unit and the district level managers and members.



However, the relationship between policy making and implementation is not as clear cut as this suggests. The responsibility of the unit in implementation will vary with the nature of the policy, how closely it fits with local conditions, and the issues, often involving respecification of policy, that arise in the attempt to apply it. The processes of discussion and representation through which policy emerges should test its feasibility in implementation. But even so, the different perspectives of

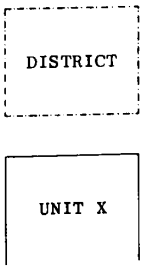
district and unit will be reflected in imperfect fits between policy specifications and their application. Moreover, much of the learning about the qualities of policies in practice will occur at unit level and will need to be refined and referred back to inform the policy making system. Factors such as these make the unit involvement in policy making and implementation worthy of reflection and analysis.

2 *Involvement in a system of planning*
Planning is difficult and is amorphous in concept (see Appendix 1). There are real choices to be made about its purpose, its organisation and its relationship to management. The dilemmas for the unit manager concern his own involvement in the planning system, the choice of purposes and methods, and the relationship of planning activities and routine managerial work within his unit.



The ownership of planning is clearly shared across the organisation. The unit manager X is at the conjunction of the planning system with the operational and management systems of his unit. What considerations should he have in mind? What should he be seeking to achieve?

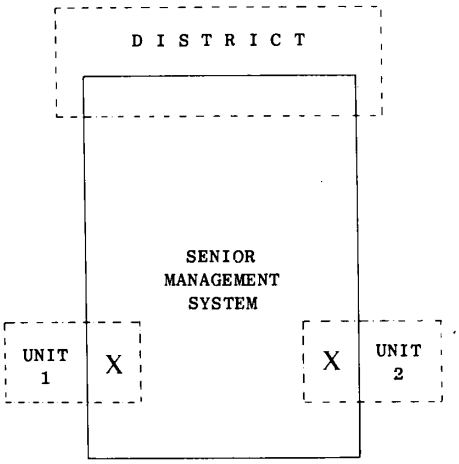
3 *Involvement as a top manager in the unit*
Perhaps the most distinctive facet of the unit manager's work is his overall responsibility for the bit of the organisation he runs, for its effective performance and its future development.



This is a 'last resort' responsibility in the sense that if he does not do it, the likelihood is that nobody will. It is also an intangible responsibility that is easily squeezed by his concern with the substantive activities of his unit. It embraces leadership, design and development of systems, and the development of the managers who work under him.

4 *Involvement as member of the senior management system of the district*

The unit manager is not only a line manager, he is also a member of the senior management cadre in the district.



The responsibility of this membership may or may not fit easily alongside his specific concerns as manager of his unit. The possible conflicts of interests in these two roles are well known in experience. Of course, the emphasis on and the integrity of the senior management system will depend on the predelictions of the chief officers and may vary widely between districts.

These four involvements are fairly obvious and highly interdependent. However, it is worth identifying them explicitly. Examining them individually gives rise to a number of issues which are less obvious. Exploring their inter-relationship highlights some problems for the unit manager in diagnosing what is useful in his situation and in avoiding the frustrations of the worst type of role conflict. At the end of this chapter, I shall discuss how the unit manager might seek to balance his approach to, and priorities between, these involvements to produce a coherent and evolving posture for himself.

Needless to say, these four instances are not intended to be definitive; the manager may think of more and better. They are

intended to suggest the kinds of things he must consider and the problem of balancing his activities.

Policy and its implementation – the unit involvement

In casting one facet of the relationship between district and unit as that of policy making and implementation, some refinement of the naive dichotomy between the two is necessary. To begin with, implementation at the level with which we are concerned involves substantial discretion. It is not the mechanical application of a comprehensive and detailed specification received from above. For the UMT, the problem is to exercise discretion in a way which is faithful to policy, which meets operational requirements, but which highlights any mismatch between the assumptions on which the original policy was drawn and what appears in the process of its application. Of course, in practice, policy making and implementation are not simply sequential. A good deal of testing of feasibility goes into the initial formulation of policy. Nevertheless, policy formation with only an outline of its properties in implementation is a sufficiently common experience in the NHS to warrant their notional separation.

The nature and problems of implementation will depend on the type of policy and the way it is specified. It is clear from even the most casual inspection that policy is not a homogeneous commodity. There are various forms of policy which provide differing specifications for the implementor. Again, without wishing to be definitive, we may recognise three types of policy:

> *an outline decision* as to what is to be done, which requires a number of subsequent decisions to bring it to the level of operational application;
> *statements of concern* about particular activities, which do not in themselves involve a decision for action and which are often relatively amorphous as guidance for implementation;
> *objectives for management processes* which are intended to be applied across all the authority's activities, for instance, the aspiration to be a good employer.

Though there may be value in defining other categories of policy, I will use these three to serve to illustrate the range of implications for implementation.

The first type of policy – *an outline decision requiring particularisation* – is common and widely understood. An example of this kind of policy is the recent exploration in one London district of the possibility of amalgamating two sizeable obstetrics departments

from different hospitals. This idea was triggered in part by the needs of a wider rationalisation of services, but it was also conceived as the first example of the integration of services between the two hospitals. Both departments had poor physical facilities in need of substantial modernisation. Both reflected occupancy rates below the average for units of their size. Demand was from a wide geographic area, but, in some cases, there were particular medical reasons for this. One of the hospitals had 76 obstetric beds and also housed the regional neonatal unit; the other hospital had 38 obstetric beds.

The proposal was to base the combined unit in the hospital which already had the larger department. To simplify slightly, the first question was to decide whether to provide 95 beds or 75 beds. The smaller size would be adequate to meet the needs of local demand and the neonatal unit, but the larger could continue to meet the existing workload with its geographically widespread origins. Some improvement in physical environment would be an intrinsic part of creating either unit, though more would be essential rather than discretionary for the 95 bed option than for the 75 bed option. Other qualitative improvements, such as dedicated ultra-sound, could be included in the project but are clearly not essential to the basic conversion process. So the question of quality improvement, how much is essential to the conversion as opposed to desirable in improving the service, is difficult to identify clearly.

These bare bones of description indicate a fairly orthodox policy implementation problem. Typically, the health authority or its DMT will decide the general lines of the policy they want pursued; the unit managers will be expected to accept the broad brush decision, substantiate and refine it and create a workable version which is consistent with what the policy makers are trying to achieve. In the obstetric unit example, the UMT will need to work through at least the following stages:

1 Defining the options in a way which distinguishes the different bed-number solutions and the element of quality improvement.
2 The attribution of costs and savings, differentiating, for example, between the various options and the marginal capital and revenue costs.
3 Testing the context of the project with the region, comparing the opportunity costs and benefits of other schemes and so on.
4 Negotiating with critical interests, the obstetricians, nurses and midwives, and the community.
5 Presenting critical issues that arise to the policy makers in a real time flow.
6 Planning the physical implementation.

None of this is very novel even if the scheme is a large one. The art lies in undertaking these tasks in parallel so that the intentions of policy makers are transformed into detailed proposals which make sense to those who must practice within them and that the further involvement of policy makers is efficiently based and focused on the issues that are turning out to be important. To do that effectively is not easy.

The second type of policy, *the statement of broad concern*, represents a different set of problems in implementation and can be illustrated by another aspect of the obstetric case. The HA was very concerned that the amalgamation would not be just a 'bricks and mortar' exercise. The planning of the project should also be the opportunity to review the quality and philosophy of obstetric care. Among the issues raised were the question of consumer choice in birth practice, how to preserve the variety of approach in the amalgamated unit that there had been in the two, how to ensure that there was continuity of care to enable mothers to elect for early discharge, and so on. Many of these questions are politically contentious. Obstetrics provides an interesting test case of the relationship between public interest and clinical judgment and this is referred to again in Chapter 5. Moreover, while there were some clear strands to the Authority's concern, the issues were not well defined. Clearly, the implementor's responsibility in this instance consists largely of helping policy makers to clarify their concerns, and to understand their implications in the operating system. But it is also to represent those concerns to practitioners whose behaviour may be affected by them. This responsibility calls partly for analytic skills, but the kernel of it is transactive – developing both the ability and the relationships to enable such qualitative issues to be explored and to be made significant in guiding the delivery of services.

The third type of policy, *objectives for management processes*, falls somewhere between the first two. The aspiration, for example, to be a good employer can often be rhetorical. Managers may deal firmly with any example of discriminatory or unfair practices, but still not make the routine achievement of good practices a positive and important component of their management systems. Equal opportunity policy, for instance, would command support in most authorities without having any great significance in subsequent action. Making such concerns competitive for management time, being prepared to inspect existing practices in the light of equal opportunity and where necessary to renegotiate them, establishing systems for monitoring subsequent practice, are all essential to making policy in this area stick. None of them is easy and in many a case it is the unit manager who carries the load. Once again the

question of implementation requires the fashioning of policy in a meaningful and useful form which enables a positive implementation to be undertaken and controlled.

Particularly in this third type of policy, the dynamics of how policy comes up for consideration are important. I recall sitting on a members' panel, hearing an appeal against dismissal for unprofessional conduct. It was clear from the evidence that the employee had a very unsatisfactory work record over a long period of time but that his managers had felt unable to dismiss him until the charge of unprofessional conduct was brought. It was possible, as a result of that hearing, for the Authority to make a clear policy statement that it would have wished for dismissal on the broader grounds of employment record and that, in future, where this had been properly pursued, the Authority would support the action. This is an example of how policy makers can gain an insight into management practice and develop an appropriate response. Regrettably, reliance on mechanisms such as appeals is not very systematic, so the responsibility of the implementor for raising questions for policy consideration is important. The creation of mechanisms for doing so is a serious problem.

What implications does this diversity of policy have for the manager as implementor? First, in a relatively placid world in which issues are well understood from the start, the parameters for implementation will be clear. But in a world of uncertainty and innovation, the straightforward link will be broken. Policies will be developed on one set of understandings which may or may not correspond to what is revealed in implementation. Innovative policies are inevitably more ambiguous and create greater surprise in implementation. This has a special significance at times of change. The first proposition therefore is that managers must increasingly prepare themselves to implement policies which are less clear, less structured, more in need of conceptual clarification. These are the policies which demand more transactive ability to make them stick, and rely more heavily on implementation through process than through executive action.

Second, the manager needs to develop some ability to diagnose what kind of implementation problem he is faced with, how it should be handled and what kinds of risks are involved. This is one of the skills that managers learn by practice, but can be improved by having a systematic personal check list to test out any particular situation. Managers should be cautious because the implementation of the outline decision type of policy is the most common and best understood. This carries two dangers: that it is the type of policy which receives all the attention; and that statements of policies about 'broad concerns' and those 'setting objectives for

management processes' will be implemented as if they were outline decisions.

Third, it is unlikely that for any manager the capacity for diagnosis and the implementation of different types of policy will be as good as it could be. Hence, there is the opportunity of monitoring how policy was implemented, of evaluating how well it was done and of learning systematically how to do it better. The problem is sufficiently complicated to warrant some conscious effort in evaluation and learning.

Finally, this area of implementation is one aspect of an important role, that of *intersect manager*. In any organisation, those people who are at the junction of the policy or guidance system and the operational system are critical to its effectiveness. This is even more important in health services where there is no simple hierarchical relationship between the manager and those delivering much of the service. Management and service delivery are different but equally legitimate perspectives, often based upon different concerns, initial assumptions and values. It is an important role for the intersect manager to facilitate the dialogue between these two perspectives and to enable each to influence the other. In the implementation of all types of policy, this facilitation will influence both the effectiveness and relevance of policy.

These roles of implementor and intersect manager have been applied only generally to the unit manager. The intention is to help the unit manager to understand more fully what he is doing and thereby focus upon the dilemmas in his role.

The unit manager's involvement in planning

Where the nature of planning is straightforward and its practice merely a matter of procedure and cycles, the involvement of unit managers in the planning system would be that of the implementation of that practice within their part of the organisation. In Appendix I, Gordon Best and I argue why that cannot be so. Planning is, itself, an uncertain idea compounded by dilemmas about what it is trying to do, about how successful it can be in forecasting and analysing the complex, uncertain and turbulent world in which we live, and about how we may judge its effectiveness in an organisation. We identify two major strands in planning ideas: an orthodox *rational* model of planning which relies on analysis and clear objectives to define 'best' decisions, and a *learning* model, which accepts the planners' inability to resolve uncertainty and complexity, is more exploratory and seeks, above all, to facilitate learning. While these two strands are slight caricatures, they identify a major difference in perspective in planning

literature. Though it may be little comfort to those who struggle with planning in the NHS, much of the private sector experience of corporate planning has led to scepticism about what the orthodox approach can achieve and to experiments with alternative methods. The difficulties experienced in industry are compounded in social planning generally, and certainly in health service planning.

Anyway, the long and short of the issue is that the concept of planning is not sufficiently coherent and specific to provide a clear cut basis of practice in health organisations. Questions about the intent of planning, its optimal organisation and procedures, and its relationship to other activities are not clearly answered by any existing concept of planning itself. The answers are matters of managerial choice. The relationship of unit managers to the planning system may include helping to exercise those choices. That relationship certainly will be affected by the choices that are made.

However, this discretion and the need for deliberate selection of roles for planning are obscured in the NHS by four major pathologies which have dominated practice:*

Planning as ritual: a system defined mainly by procedures and timetables.

Planning as picture painting: a snapshot of the future with little reference to securing the change through which it may be achieved.

Aggregating decisions: planning as a means through which decisions are assembled and presented rather than influenced.

Focus on the supply side: in which there is little emphasis on demand, values and the major issues of social planning.

The ease with which these pathologies have been accepted as the reality of planning betrays the lack of a critical model. But once recognised, these characteristics of practice together with the ambiguity of the underlying concepts, ensure that planning cannot be seen as a mature and stable system. To become effective, unit managers must explore and develop from the failures of their own practice. However, progress is not to be seen in terms of the unveiling of a better model of planning. It will result partly from the critical assessment of existing forms of planning and what it does, and partly from the creation of a model with which to structure choices about planning and its development.

A pragmatic approach to improve planning performance

As an example of the more pragmatic approach, let me summarise the approach adopted in an area authority with which I was once

* See Appendix I for a more detailed discussion.

involved. After a period of predominantly ritualistic planning in which the strategic element was largely absent, three major objectives were identified:

1 Linking operational proposals to criteria for choice. Operational planning seemed to consist largely of a shopping list of proposals which were not justified in terms of any explicit criteria, even where radically different types of justification were implied. The impression was that such criteria were not an important factor in the development of the proposals. The first task seemed to be to ensure that all proposals could be related to some explicit criteria.
2 Founding these criteria in a coherent strategy. While several criteria could be involved, some could be interpreted as contributing to strategic goals whereas others were ends in themselves, possibly to be pursued at some cost to the strategic goals.
3 Building a monitoring and control capability. Given criteria against which proposals were justified, outturns should be monitored to see whether the proposal did indeed achieve the expected benefit on whatever criteria had been cited.

The following categories of criteria were agreed:

a the need for rationalisation of facilities or resource use, giving rise to revenue savings;
b supporting desirable developments, particularly of a research and developmental nature;
c replacement of obsolescent assets;
d implementation of strategic priorities, such as emphasis on specific care groups, or explicit strategies;
e meeting short-term budget constraints;
f remedying 'black spots' in the service;
g remedying temporary cuts;
h logistical requirements of operations.

While these criteria were not novel, their application forced advocates to be specific about their proposals and their expectations of what would happen if the proposals were implemented. It also compelled an assessment of how far these criteria were merely proxies for the overall strategy, and this helped to illuminate the strategy and its limitations.

At the time of which I write, there was also a background concern with the purely incremental nature of the planning system. The vast majority of the Authority's work went without evaluation or even inspection. There was some interest expressed in the development of a zero-based or mixed scanning approach, but this

was regarded very much as a development which could be awaited. In consequence, the pragmatic approach I have outlined was adopted and found to be useful.

Managing planning

This quick sketch indicates how one authority assessed its planning activity. The emphasis was on monitoring and learning, rather than on any dramatic innovation in method. However, the approach to deciding what needed to be done with planning was fairly intuitive. It may be that a rather more systematic review of the organisation's planning capacity and needs could have provided an alternative focus for developing planning. That might be achieved by an explicit approach to the choices and dilemmas in *managing planning*.* If the substance of planning is largely intractable, then the advantage grows of focussing instead on the management of planning as a means of structuring the choices and judgments involved. A simple model of managing planning would involve:

Audit: a review and assessment of the problems facing the organisation to which planning might contribute, and of the currently available resources, systems and skills.
Purposes: the identification and selection of appropriate purposes and missions for planning.
Strategy: the approach to be taken to planning, its relationships, roles and analytic base.
Implementation: design of the practice of planning, its organisation, system, procedures, methods and personnel.
Evaluation: assessing the effectiveness of planning in the light of its espoused objectives, learning and improvement.

The literature on planning contains very little discussion and few reports of the experience of managing planning. There is a clear need to apply to the activity of planning the same standards of explicit appraisal that planners seek to apply to the activities of the organisation. At the end of the day, however, the issue is one of managerial judgment; in this case, the judgment of those responsible for planning. The purpose of the focus on managing planning is to emphasise the role of diagnosis and judgment in assessing and guiding planning.

What, then, does all this imply for the unit manager in his planning role?

The very ambiguity of the nature of planning and the need to

* See Appendix I for more detailed discussion.

choose its purpose and form, should eliminate any possibility of the unit manager being a compliant cog within a planning system. He must be involved actively in both the system's design and development. However obvious this may be in terms of logic, its adoption would mark a radical departure from NHS practice.

The unit manager is in a unique position to contribute the assessment and understanding necessary to several aspects of the management of planning; particularly in audit, implementation and evaluation, his information and perspective cannot be contributed by district managers. At the same time, he represents a valuable test for district purposes and strategy, for unless the intents and choices embodied in planning are congruent with the way he intends to manage his unit, then both will be ineffective.

Finally, the unit manager has a dual 'membership' of both the district planning system and of his unit and must expect conflicts and stresses to result. The two sets of interests may not appear consistent. There is no simple way of avoiding this. Its worst manifestations are avoidable by fostering trust and tolerance in the two systems.

The involvement that results from being top manager of the unit

Perhaps the most familiar role for the unit manager derives from his direct responsibility for a complete range of services and personnel in his unit. Here I should emphasise his responsibility for the quality with which his unit is managed. This is not a responsibility that could easily be exercised by anyone else. Moreover, as a relatively intangible concern, it can easily be forgone in favour of more pressing activities. Consequently, it requires a good deal of self-discipline if there is to be any systematic review and evaluation of the quality of management within the unit. Such a review has two elements:

Diagnosis and audit: to establish the present situation, the managerial strengths and weaknesses of the organisation and to relate these to the problems and challenges the organisation is facing.
Evaluation and development: to identify gaps in the quality of management, to design and undertake development where necessary.

These two elements of review need, in turn, to be applied to four factors:

The systems through which the organisation is managed, particularly planning, information and control systems.

The organisation and its performance.

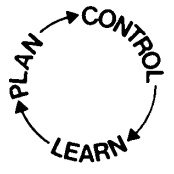
The managers who work within it.

The unit manager himself as a 'top' manager.

1 *Systems*

The recent interest in information in the NHS, while long overdue, still represents a fairly crude stab at the development of management information systems. An effective information system is about matching the demand for and supply of information while balancing the cost of information provision with its value in use. When the use of information is discussed, it usually tends to be in terms of information in top level decision-making by authorities or DMTs. While this is no doubt a high value use for information, it is also a high cost use in that it is one-off and requires special packages of information. In the first instance it would probably be better to concentrate on the provision of information for programmed use, where it is required continually in consistent form. This is more likely to focus on information for management control, a much neglected concept in the NHS. The development of integrated information and control systems is a useful and feasible initial objective.

Management control is the process of establishing targets or expectations for the organisation's activities, of examining the gap between expectations and outcome (the 'variance'), and of attributing that variance to causative factors, identifying whether or not they were subject to the determination of managers. By this means we can establish whether failure to achieve what was intended was due to unanticipated events or poor managerial action. Though best known in the context of budgeting, the control process can be applied to any other facet of the organisation's work – unit costs, activity rates, service levels, and so on. The concept of control is the cornerstone of any systematic management geared to learning and the improvement of performance.



In the short run, the development of a strong management control orientation linked with the information systems to sustain it, would be a major achievement. In the longer term, the task is to develop planning systems as the context for control. It

is not enough to control to any expectations of outcome – these expectations or targets must themselves be justifiable in the intents and priorities of the organisation; that is one of the purposes of planning. Control is then one element in a cycle.

The linkage between planning and control provides a context for the provision of information, though the more strategic and ill-structured the level of planning-control the more imprecise (and probably expensive) are the information needs. Guiding his organisation through its assessment of the existing state of systems and the available strategies for their development is a critical responsibility of the top manager. It is not a job which can be done in abstract generalities, so the combination of a rigorous overall view with a good empirical sense of system provision and use is essential.

2 *Organisation*

The main concern is to assess and improve the performance and effectiveness of the organisation. It is worth distinguishing between substantive and quality (or process) approaches to assessing performance and organisational effectiveness.

The substantive approach to the question of how well the organisation is doing is about measuring, against some indicators, such as:

its performance relative to other organisations;

its achievement of objectives or targets it has set itself;

its meeting of relevant environmental demands which it could reasonably be expected to know about.

Since the ground is well trodden in other chapters, let me content myself with two observations. First, substantive performance assessment is about control, that is it is a matter of attributing the variance. Only that shortfall which is caused by factors under managerial control can reasonably be cited as poor performance. Second, there is no chance of attributing the variance in overall indicators unless there is a sub-structure of control systems in the organisation to explain the component variances.

The qualitative or process approach raises a different set of issues. Here the organisation's performance is set by the quality and appropriateness of management activity and systems. Poor performance at its most gross, such as when no relevant managerial information is being provided at all, is easily dealt with. But usually, a conscientious effort is needed to assess any aspect

of quality in the context of the whole organisation's priorities for improvement.

Organisational effectiveness may relate to wider characteristics compared to the challenges of its environment. For example, a rapidly changing environment may lead to adaptiveness being regarded as a major criterion of organisational effectiveness. Or the changing nature of the problems facing the organisation may place a high premium on a form of learning which enables the organisation to address radically different types of problems rather than regarding all new problems as mere extensions of old ones.

It should be clear that the assessment of organisational performance and effectiveness requires considerable conceptual and diagnostic skills from the successful top manager.

3 *Managers who are subordinates*

The quality of subordinate managers is clearly a major concern. Among factors to be taken into account are:

their skills, analytic, conceptual and personal;

their attitudes, to their job, to responsibility, to risk and innovation;

their models of themselves as managers, both as a guide to their practice and as a framework for their learning;

their understanding of their roles and their capacity to accept new or innovative roles;

their capacity to learn from experience and from others.

Over and above the need to be concerned with these personal qualities of subordinate managers, there is the issue of what facilities exist for their professional development and how the top manager should encourage their use. The culture of the NHS provides little supportive career planning. It is full of discontinuities, with huge career leaps alternating with static prospects. Both the provision and use of management development opportunities are primitive and mechanistic.

All in all the assessment and development of subordinate managers is one of these areas in which the imagination and commitment of unit and other top managers is most tested, particularly since the investment of time and energy has an apparently high opportunity cost when measured against important short-term pressures.

4 *Self as top manager*

Perhaps the most difficult assessment to perform is that of self. As an aid to that tortuous process, here are some structuring questions.

Do you have and use good models of management?
Do you have clear strategies of what you are trying to do with your organisation, its systems and your managers?
Do you see yourself as having a responsibility to absorb uncertainty from your environment, to buffer your subordinates from that uncertainty and to create space for them to work? Do you do it?
Do you see yourself as directing or enabling your subordinates?
What are your attitudes to the creation of discretion for your subordinates? How do they use it?
Do you encourage or discourage the taking of risk by your subordinates?
What is your attitude to deviant ideas coming from your subordinates?
What do you think are your major responsibilities as a unit manager?

Hopefully it will be seen that there are not simple 'good' answers to these questions, even to those that appear to invite you to be on the side of the angels. They are difficult issues to face, particularly if, as a manager, you accept responsibility for your subordinates' sins of omission as well as those of commission. It is equally possible to fail as a manager for what you do not do as well as for what you do. This is a sobering thought and another example of the wide and complex agenda that unit managers face.

Membership of the senior management cadre of the district

The unit manager's fourth involvement is as a part of the senior management of the district. The group of senior managers exercises a number of important though intangible influences within the organisation, including setting the tone and style of management practice, forming perceptions and values, and establishing the nature of managerial responsibility. These influences will reflect both the understandings and the style of the senior managers themselves. For instance, as the environment in which health service managers are operating becomes more intractable, generating problems which reach deeper down into the organisation,

expectations of the quality and roles of managers are being revised. It is clear that a traditional administrative model is inadequate. The manager is variously expected to be more active, more decisive, more entrepreneurial, more catalytic or whatever. The welding of a sense of managerial style and role that is both relevant and acceptable will depend on the example of the senior managers. Their behaviour and directions of commitment will set the climate and influence the sense of managerial purpose within the organisation of which the unit manager is an important element.

There are two areas in which the exhibited commitments of senior management will be most influential; (a) establishing an acceptable domain for managers and demonstrating the responsibilities that go with it, and b) developing a style of leadership.

In the NHS, the professional relationships within management, and between management and the delivery of care, remain in an emergent state. As the economic pressures on the service grow, the impact of the style of management on issues of service delivery becomes more pressing. For instance, at the ends of the spectrum, management which is entirely containing and restrictive contrasts with that which seeks to find ways in which the constraints may be overcome by active redefinition of the problems. This contrast between a controlling and an emancipating role for management is common in many organisations. It corresponds to radically different domains and methods of operating management and would need to be accepted as legitimate by others in the organisation, in our case, principally by clinicians. So, the questions of what managers are perceived as doing, their legitimacy in doing it, and the responsibilities they must accept are all interrelated and need to be built up as a coherent package by senior management.

If the manager is to be anything more than a provider of administrative support, then the idea of trusteeship or stewardship is central. The manager acts on behalf of others, balancing interests and concerns and seeking ways of reconciling conflicts. If management is to be active, seeking balance through the creation of opportunity, then a great deal of discretion and trust is involved. Two opposite but equally destructive pathologies arise. The first is where the right and legitimacy of managers to that discretion are assumed, not demonstrated. The second is where it is not granted and the positive functions of management are denied to the organisation.

However, these questions relate not merely to the exercise of the manager's discretion in choosing between competing demands on resources or facilities, but also to his responsibility for developing the organisation. A major feature of the manager's stewardship is to ensure a reasonable and well-directed investment in improvement

of the organisation, its management and the services it delivers. It is not enough just to leave it as you find it. For instance, there is little doubt that one of the characteristics of the management culture in the NHS that impedes change is the limited and predominantly administrative style of management that prevails. It maintains existing practice; it is not entrepreneurial in seeking actively to create opportunity; it is largely unconcerned with evaluation. All of these characteristics could be seen as limiting responses to the challenges NHS management must face. If this be so, it is a responsibility of senior management to influence and change the culture of the organisation.

The same argument applies to the style of leadership offered. Though each unit manager must determine his own leadership style, the senior management group should also establish dominant styles related to the predicament of the organisation and what the group is trying to do with it. Again the dominant assumptions which have prevailed in NHS management are worth challenging. It is at least arguable that the complexity of the problems the service faces and the substantial disruptions and changes with which it is having to cope require the liberation of the manager's full range of energies and imagination. This might be expressed in terms of attitudes to risk, or new ideas, or the emphasis to be given to experimentation and learning. Such a liberation certainly reflects a concept of leadership as enabling not directing, and an emphasis in senior management on clarifying and giving shape to problems rather than merely focusing on their resolution. This approach would see leaders as educators and extenders, and stresses their ability to conceptualise and to think about the forces which are shaping the destiny and style of the organisation. Perhaps most important is the capacity to imagine and give substance to images of the organisation which are not merely linear extensions of what it is already. As W B Yeats said: 'In dreams begins responsibility'.

While some might consider such images of leadership fanciful, there is increasing evidence to suggest that the problems of health organisations cannot be resolved just by more of the same, by increasingly intense application of existing solutions. Senior managers must envisage clearly the impasse of managerial assumptions, methods and imagination in which the NHS is lodged, and determine how they will by-pass or redefine it.

The unit manager plays an important part in the system of senior management not merely because he is its most visible representative in his part of the organisation; he is also a major source of its variety and hence its responsiveness. It is the most obvious of truisms about health service management that the context in which

it operates is complex and varied. The reconciliation of the perspectives and concerns of politics, the community, patients, doctors, nurses, paramedics, porters and so on is the very nature of managerial activity in the NHS. It is made the more difficult by the uncertainties and ambiguities in which these issues are structured. Ashley's concept of 'requisite variety' stresses the importance of internal variety if an organism is to perceive, understand and respond to the complexities of the world it is dealing with. So it is with the senior management of health authorities. The unit manager brings a different perspective and sense of pressures to bear from that of the district officers. He contributes to the variety of understandings and concerns shared amongst those colleagues who form the senior management and hence he extends its range of possible responses. If these differences are suppressed by the chief officers or under-represented by unit managers, the potential for exercising sensitive leadership throughout the organisation will be undermined.

Putting it together

The starting point of this chapter was that there is no simple, mechanistic role through which the unit manager can structure his work. He is inherently in the business of balancing a number of differing types of involvement, some tangible and pressing, some amorphous and easily ignored. His problem is to develop his sense of the content and importance of these involvements and to weld them into a package which makes sense to him. At all times he must judge his own position in the light of the objectives and purposes of his unit.

This will involve him in role development. It is unlikely that those around him will understand either his problem or his priorities in precisely the same way that he does. While it is not necessary that everybody should share his perceptions, it is helpful if role expectations can be created which are consistent with his own choices of activities and relationships. That will not happen by accident. It will require a good deal of sharing and discussion if colleagues are to understand his commitments, particularly to the intangible and developmental. So the unit manager's task is one of role creation to fit his diagnoses and selection of priorities.

Perhaps the most important consequence of the framework presented here, is the need for the unit manager to be able to analyse and assess his own predicament, his options and his responses. The emphasis throughout has been on his choices in structuring his activity and his need to develop himself and his role in the light of what he thinks important. This implies a level of

self-consciousness and analysis of himself as manager that comes only with deliberate effort. As with other managers who experience severe confusion of role due to poor institutional specifications, a 'Diagnostic → Audit → Development' approach to himself is essential. He will need to be able to diagnose and attach priorities to the problems he faces, to take stock of his own capacity, and to organise his own development in those areas where the greatest gaps are apparent. It may not solve his problems in the short run, but it provides some tools with which to handle the complexity he faces. Most significantly, it enables the manager to learn.

At the end of the day, a personal commitment to learning and improvement is the most important thing we can ask of him.

Gordon Best BArch MSc MSc(Econ)
King's Fund Fellow in Analytical Methods and Planning

Gordon Best is a planner and economist with fifteen years experience in the field of health services planning. He first qualified in architecture at the Rhode Island School of Design in the USA. Since that time, he has received Masters degrees first in industrial design technology (today, operational research) from the University of Manchester and, most recently, in economics from Birkbeck College, University of London. His previous posts include Lecturer in Architecture and Planning at University College, London; Lecturer and Research Associate at Guy's Hospital Medical School and Senior Management Analyst, University of Colorado Medical Center, USA. From 1978 until 1982 he acted as a freelance consultant to a number of private and public clients in the UK and overseas. Currently, he is Fellow in Analytical Methods and Planning at the King's Fund College. He is a member of the Haringey District Health Authority and the Special Health Authority for NHS Training.

CHAPTER FOUR

Performance indicators: a precautionary tale for unit managers

GORDON BEST

Introduction: the early steps in NHS performance appraisal

Few managers can have failed to notice the recent spate of activity surrounding the two closely related issues of improved NHS efficiency and better management accountability. In addition to the recently launched independent management inquiry under the direction of Mr Roy Griffiths, the last 18 months have seen the birth of performance (or accountability) reviews, the introduction of revenue reductions under the guise of 'efficiency savings' and official backing for privatisation as a means for improving NHS efficiency. Two key assumptions seem to pervade all of these developments. First, that the NHS is in a variety of ways an inefficient service; and second, one way of improving efficiency is to strengthen mechanisms of management accountability.

Central to these developments has been an increasing concern with devising ways in which the functional activities – or performance – of the NHS might be measured. This concern has given rise to the development of what are erroneously referred to as 'performance indicators'. The broad logic underpinning the desire to develop indicators of NHS performance is both sound and fairly obvious. It is felt that by quantifying various characteristics of NHS performance, the overall achievement level of an individual authority, unit or other functional sub-division of the service, can be cast in *comparative* perspective. As a consequence, differences in performance will be highlighted, giving rise to investigations of why these variations exist. Once performance has been described in measurable terms, expected performance can be systematically compared with actual performance – a comparison which is absolutely essential to the development of more rigorous forms of management accountability.

At present, performance indicators are at a preliminary stage of development with the first set of indicators having been tested during the 1982 round of regional performance reviews. The role of performance indicators in the regional reviews was summarised clearly in a paper prepared by the DHSS for a conference sponsored by the Institute of Health Service Administrators (1982):

> An additional element in the final seven reviews (in 1982) was the use of statistical performance indicators, covering clinical, finan-

> cial, manpower and estate management functions.
> A DHSS Working Group was set up last year to develop performance indicators as a means whereby objective statistical information may be used as an aid to the assessment of efficiency in the use of resource. The indicators have subsequently been developed in close collaboration with Northern Region.
> It has been recognised from the outset that no single factor indicator or combination of indicators could lead to a firm conclusion on whether the use of existing resources was 'efficient', 'good' or 'bad'. Their function is to point to areas which merit further investigation, and judgements can be reached only after detailed study of local circumstances. They will be used in the dialogues between RHAs and DHAs, but they are also intended to enable DHAs to reach views on the performance of their own services.
> Indicators are being introduced this year on an experimental basis. Any modifications seen as necessary will be incorporated in the list to be used in each of the 1983 reviews.

The general idea, therefore, would seem to be a hierarchical form of performance review with the DHSS looking at regions, regions at districts, districts at units and so on, in order to establish whether measurable differences in 'performance' merit further investigation. At present, therefore, the intended use of indicators would appear to be limited to that of 'diagnostic aids'.

As mentioned in the DHSS paper, the indicators under development are of four types: namely, clinical, financial, manpower and estate. Most of the clinical indicators are measures of bed 'throughput' such as average length of stay (LOS), or annual throughput per bed, although they also include indirect measures of inpatient workload such as waiting lists per thousand population. The financial indicators are made up of different categories of hospital costs, sometimes expressed in relation to hospital workload – for example, acute inpatient cost per case, and domestic and cleaning costs per unit of floor area. The manpower indicators relate to different categories of health service staff, again sometimes expressed in relation to workload – for example, midwifery staff per number of births and lab scientific officers per number of requests. The estate management indicators consist of measures such as building area per bed and maintenance and operating expenditure per unit of building development.

It is known that the DHSS has in hand a good deal of work developing more sophisticated indicators, but it still seems clear that most of the indicators are of one of three kinds: either they describe an NHS 'input' such as the number of staff of a particular

kind; or they describe an activity level or measure of workload – for example, annual throughput per bed; or, they consist either of a ratio of two inputs (for example, the ratio of nursing staff to doctors), or the ratio of an input to workload (for example, catering costs per inpatient day).

It is evident from even a cursory glance at the preliminary indicators, that they imply a fairly narrow definition of 'performance'. Others take a broader view. Robert Maxwell in a recent paper, for example, has argued that the measurable assessment of all social programmes and health services in particular should occur in at least six dimensions: i) relevance to need; ii) ease of access; iii) effectiveness; iv) fairness; v) social acceptability; and vi) efficiency and cost. It does not require a lengthy analysis to conclude that almost all the NHS performance indicators initially tested fell into the last of these six categories.

This observation suggests that the development of valid and useful performance indicators is unlikely to be a simple task. In addition, it is difficult to imagine longer-term circumstances in which the use of indicators will be limited to that of diagnostic aids. Indeed, if no attempt is to be made to influence or control NHS performance (as distinct from simply flagging up aberrant performance), there is no obvious reason to explain why so much effort should go into measuring and reviewing NHS inputs, activity levels and costs. Perhaps more to the point, when the development of performance indicators is set against the background of present government policy toward the NHS, there is every reason to suppose that it is only a matter of time until performance indicators are utilised both as a means of prescribing desired performance, and as tools for holding managers accountable for achieving that performance.

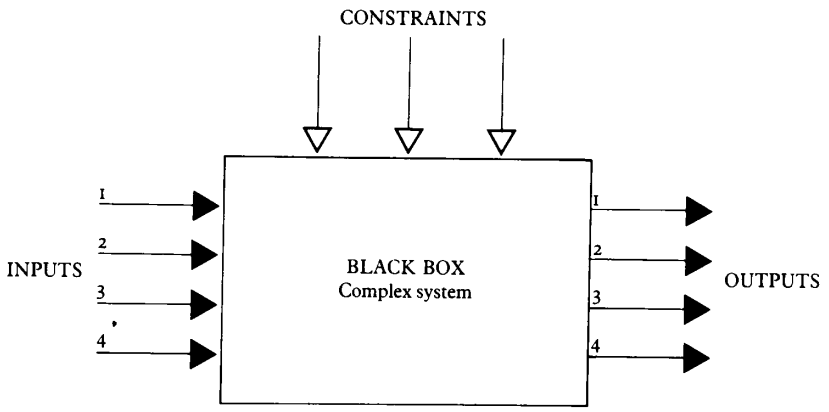
If performance indicators are eventually to be used for these purposes, it is quite clear that they will have to meet a number of fairly rigorous requirements, which, to date, do not seem to have figured in their development. In this chapter, therefore, we shall focus on the nature of these requirements and on some of the developments which are likely to occur if unsatisfactory indicators are prematurely utilised for management accountability purposes. The chapter is not, therefore, intended as a 'cook book' which will allow managers to construct valid performance indicators for their own units. Rather, it is intended primarily to enable unit managers to see how their managerial role is likely to be influenced by the increasing fashion for measurable performance assessment.

Performance indicators – a theoretical perspective

The preceding discussion made use of terms such as 'input', 'throughput' and 'output'. This kind of terminology is encountered increasingly in the literature on health services management, perhaps arising most frequently in discussing computer applications. The contemporary origins of such terms however are to be found in communications engineering and, later, general systems theory. Indeed, the analytical framework offered by general systems theory can lend considerable clarity to a discussion of performance indicators.

One of the theoretical constructs of general systems theory is the so-called 'black box' model of complex systems (Ashby 1956). The basic components of this kind of model are set out in Figure 1. Traditionally, the black box model has been used in an attempt to understand (and then to predict or control) the behaviour of complex systems. For example, psychologists have utilised such a framework in attempting to understand how the central nervous system works. Typically, systems investigated in this manner have been 'unobservable' in the sense there is no possibility of constructing a 'causal' explanation of their behaviour through observation of their 'inner' workings. Hence the term 'black (that is, opaque) box.'

Figure 1 'Black box' model of complex systems

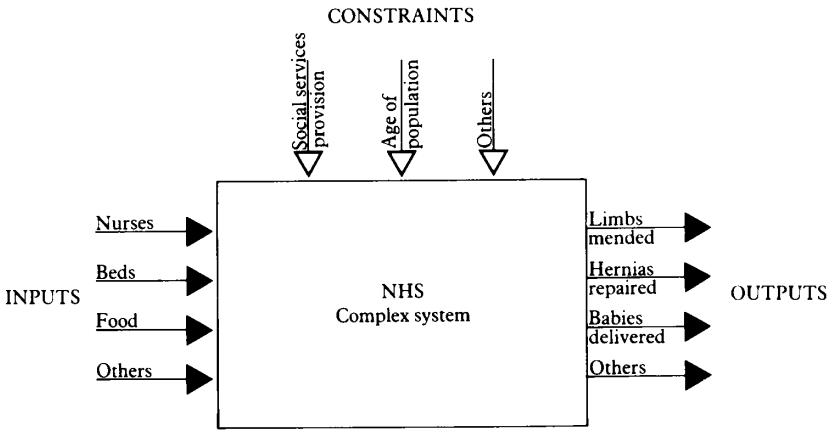


Within the black box framework, analysis must proceed on the basis of observation and measurement of whatever features of the system the external observer may be able to detect. In the case of the central nervous system, for example, psychologists are able to observe or detect many of the sensory inputs a person may receive from their environment, and then record how the person reacts to these in terms of their observable behaviour (that is, outputs). By

repeatedly observing and recording how such sensory *inputs* relate to behavioural *outputs* in different situations, the psychologist attempts to establish systematic relationships between the two. On this basis, an attempt is made to predict and/or 'explain' how certain sensory inputs lead to (or are transformed into) given behavioural responses.

As should be clear from Figure 2, it is possible to describe the NHS in the same way. Here, the health service is treated as a complex, imperfectly understood, system. Viewed like this, it is clear that the NHS utilises a variety of inputs which are then transformed into various outputs. For example, in order to function, the NHS requires the input of different types of professional and ancillary staff working time; it requires a variety of pharmaceuticals and surgical appliances; it requires beds, bed linen, food, electricity and so on. It is a relatively straightforward matter to enumerate and then measure many of the inputs which are essential to the successful operation of the NHS.

Figure 2 A black box portrayal of the NHS



Similarly, it is possible to enumerate and sometimes measure many of the outputs of the NHS. Traditionally, the outputs of the NHS are sub-divided into two types, namely: *intermediate outputs* which are usually measures of workload or activity levels, and *final outputs* which, it is held, relate more closely to the purposes or goals of the service. Intermediate outputs are usually just measures of how inputs are used and include such measures as beds occupied, pharmaceuticals dispensed and surgical appliances fitted. Examples of final outputs include broken limbs satisfactorily mended, hernias satisfactorily repaired and breech babies safely delivered.

There is often a systematic relationship between the inputs to, and outputs from, the NHS. For example, it is known that, other

things being equal, the more acute beds there are available (input), the greater the number of patients there will be to occupy them (intermediate output). In general, it is true to say that the higher the level of patient-related inputs, the higher the level of patient-related activity which can be used as a measure of intermediate output. These sorts of relationships between inputs and outputs are, however, not clear cut and, in particular, will change depending on certain 'external' influences which vary from one set of circumstances to the next. For instance, the inputs which will be needed to 'produce' a given level of output in different districts, will vary depending on such factors as the presence or absence of a medical teaching responsibility; the level of social services provision; the age structure of the district's population, and so on. In systems theory, such factors are sometimes referred to as *constraints* (Figure 1): that is, they are factors which are in some sense external to the system under study but which constrain how the system is able to transform inputs into outputs.

Within this type of framework considerable attention is given to the identification and measurement of the system's inputs and outputs. Effort is then directed to the task of trying to establish systematic relationships between the two in order to gain some insight into the way in which given inputs lead to, or are transformed into, particular outputs. At the same time, account is taken of 'external' constraints which may influence how inputs are transformed into outputs in differing circumstances.

It is worth noting that this perspective draws attention to certain aspects of the NHS which are very poorly understood. Thus, except in a few trivial instances, we simply do not understand how different inputs to the NHS are transformed into outputs. For example, no guidelines exist to suggest how, for a given diagnosis, we might combine clean bed linen, food and other inputs with the inputs of clinicians, nurses and ward orderlies to 'produce' a healthy and satisfied patient at discharge. Indeed, for most diagnoses, there is not even a consensus about how long a patient should remain in hospital. Yet since the quantity of inputs required to care for a patient varies with the time spent in hospital, it is hardly surprising to discover that there is no agreement about what inputs are required to 'produce' a given level of (inpatient) output. Similar confusion surrounds most other discussions of the appropriate relationship between NHS inputs and patient-related outputs.

In many respects then, the NHS resembles the theoretician's black box. Indeed, such a characterisation of the NHS provides a useful perspective from which to survey present attempts to construct indicators of NHS performance. The vast majority of

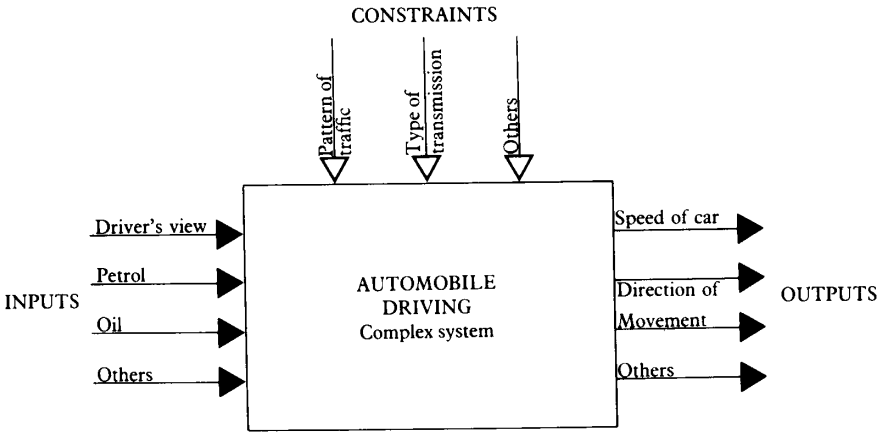
indicators presently under test simply relate inputs (for example, number of staff of different kinds, beds, and so on) to prevailing activity rates or measures of work done (for example, measures of intermediate outputs). Where differences in these ratios cannot be explained in terms of factors such as case mix or characteristics of the population being served (that is, the terms of externally imposed constraints on the black box), the implication is that these differences will be taken as indicative of differences in 'performance'.

Given that the NHS might reasonably be thought to qualify as an example of a complex system, this approach to the construction of performance indicators should not be lightly dismissed. Indeed, it is possible to utilise the black box framework to provide a fairly rigorous specification of those properties which we might expect such performance indicators to possess. This specification can then be used to examine present NHS initiatives.

Constructing valid performance indicators

To illustrate how the black box framework can be used to specify the properties of valid performance indicators, it is useful to begin with an analogy. For this purpose, Figure 3 attempts to portray the familiar act of motoring within the black box framework.

Figure 3 The black box model applied to motoring



In this case, the black box consists of a complex system made up of two principal sub-systems, namely: the driver's psychomotor system and the mechanical systems which determine how the automobile functions. The inputs to this black box are of two types. First, sensory inputs such as the driver's view of surrounding traffic conditions; information received from driving instruments such as the speedometer and fuel gauge; and other sensory

feedback such as that received via the 'feel' of the steering wheel. Second, there are inputs to the automobile's mechanical systems such as petrol, oil, air and so on.

What is clear from this portrayal is that the driver's psychomotor system and the vehicle's mechanical systems combine in a complex way to convert these inputs into a set of outputs which, themselves, constitute one of the 'purposes' of motoring. These outputs include the automobile's direction of movement; the speed with which it moves; the pattern of acceleration and deceleration, and so on. It is also clear that any relationship which we may detect between these outputs and the types of inputs above, will be influenced by a number of 'external' factors – or constraints. For example, these will vary with the surrounding traffic conditions; the state of repair of the road surface; the weather; the presence or otherwise of automatic transmission, and so on.

Keeping this black box model in mind, let us imagine that we are the owners of a fleet of such motor cars and that we employ a number of drivers to ferry cars between a number of destinations. Assume also that, as owners, we possess a number of records which describe certain aspects of each driver's performance. For example, we might possess records on the distance covered by each driver; the time taken to cover different distances; the oil and petrol used; and so on. In other words, we possess data on certain inputs, (for example, oil and petrol consumed), certain outputs, (for example, distance covered, average speed, and so on) which characterise the performance of a complex system, the detailed workings of which we do not fully understand.

Suppose also that, as owners, we wish to utilise this information to construct indicators of each driver's performance so as to improve driver efficiency, thereby reducing costs. To focus on a plausible and specific example, we might choose fleet running costs as measured by petrol consumption. For this purpose, we might examine available figures on each driver's petrol consumption as illustrated in Table 4.

Examination of these figures might suggest that, on average, drivers working the fleet routes should achieve a petrol consumption rate of not less than 30 miles per gallon of petrol used. After all, it might be reasoned, six of the fleet drivers already do better than 30 miles per gallon and if those getting less than 30 could achieve this minimum, savings in terms of fleet running costs would be considerable.

We might therefore establish a minimum fleet petrol consumption target of 30 miles per gallon. This target might be backed up with some incentive arrangement such as a bonus scheme favouring drivers achieving the target. Provided that the drivers had

Table 4 Petrol consumption: hypothetical figures for 10 fleet drivers

Driver	Average miles per gallon of petrol – last 12 months	Urban route?
A	34	No
B	26	Yes
C	30	No
D	24	Yes
E	32	No
F	31	No
G	25	Yes
H	33	No
J	36	No
K	22	Yes
Average	29.1	

access to the comparative figures contained in Table 4, we might at this point expect certain drivers to object to this scheme. In particular, those drivers with urban routes might point out that, on average, they stand a much poorer chance of achieving the 30 miles per gallon target than do drivers with non-urban routes. These drivers would be drawing attention to a constraint which influences the performance of the system of which they are a part (Figure 3), but over which they have no control. As such, it would be unreasonable to hold these drivers accountable for performance which – through no fault of their own – they would be unlikely to be able to achieve. As fleet owners we might therefore revise our performance targets to 30 miles per gallon for drivers on non-urban routes and 25 miles per gallon for urban drivers.

This example illustrates one way in which a knowledge of the input and output characteristics of a complex, imperfectly understood system might be used in an attempt to influence the behaviour or performance of that system. The specific illustration chosen was that of expressing the level of (one) output achieved (that is, route miles covered), per unit of input consumed (that is, per gallon of petrol), while controlling for one important external influence on system performance (that is, urban/non-urban driving conditions). Performance indicators which, like this one, express output per unit of input, are usually referred to as productivity or 'efficiency' indicators.* That is to say, while they may tell us something about the *efficiency* with which the system in question

* Efficiency as used here simply refers to the input 'cost' of producing a unit of output; it should not be confused with the broader concept of efficiency usually employed by economists. This latter concept incorporates not only the idea of productivity but also the appropriate allocation of inputs to different outputs.

operates, they tell us little about how *effective* the system is in achieving given objectives or in producing desired results.

Despite the fact that an indicator such as miles per gallon captures only the efficiency aspect of system performance, closer examination of its properties provides a number of insights into the difficulties of constructing valid performance indicators. In particular, the performance indicator in our illustration would seem to possess three properties which, at a minimum, all valid indicators must possess:

1 *The indicator must be performance calibrated*
This property is easier to affirm than it is to assess. In the context of indicators of efficiency, this will usually mean that some measure of output will be expressed in relation to the input or inputs required to produce that output. In our example, the measure miles per gallon, that is, output per unit of required input, was taken as *one* important indicator of fleet efficiency.

2 *A movement in the indicator must be subject to unambiguous interpretation*
This property implies that indicators are useful only in so far as an observed change in their value can be assigned a clear meaning in terms of performance. For example, other things being equal, an increase in the amount of petrol used per fleet mile travelled suggests a *decline* in fleet performance because fleet travel costs have increased. A decrease in petrol consumption clearly implies the converse. Thus, the direction in which the indicator is moving has unambiguous performance implications.

3 *Movement in the indicator must be subject to influence by those whose performance is being judged*
This critical feature of performance indicators implies that two conditions will be fulfilled before performance assessment takes place. First, factors which influence the value of the indicator but which are 'external' to the system, will be identified and their influence taken into account *before* performance is assessed. In our example, the fact that some drivers had urban and others non-urban routes, is an illustration of an external factor which influences system performance but over which drivers have no control. Secondly, in addition to controlling for the influence of external factors, it is necessary to ensure that any residual movement in the indicator is subject to the control of those whose performance is being assessed. Thus, in our example, in addition to controlling for the influence of such factors as an urban/non-urban route, it was also necessary to assume that by controlling foot pressure on the accelerator, by changing gears,

and by a variety of other means, each driver would be able to influence fuel economy.*

This last property of a performance indicator is of particular interest here because it highlights the relationship between management accountability and control. In particular, it makes clear that accountability *depends on* control in the sense that drivers (or managers) cannot be held accountable for performance over which they have no effective control. In our example, for instance, it would clearly have been counter-productive to have attempted to hold drivers accountable for aspects of fleet performance outside their control. It would be as if, as fleet owners, we had attempted to hold drivers accountable for the state of the road surface, or passengers in the back seat accountable for fuel economy.

NHS performance indicators

As noted in the introduction to this chapter, the indicators of performance being discussed in the present round of reviews are very much 'first generation' indicators. Nevertheless, while awaiting publication of the revised indicators, it may be useful to review some of those presently under discussion against the criteria set out in the previous section.

As a starting point, we might turn our attention to one of the more familiar 'clinical indicators', length of (bed) stay. This candidate indicator is frequently cited as one measure of bed 'throughput' – or, intensity of bed use. And although its use as a performance indicator is always hedged with a number of qualifications, it is widely discussed and cited as one measure for identifying districts or units whose bed throughput deviates significantly from normal practice. In this respect, length of stay (LOS) is usually calculated for a given specialty or case type and all units or districts with beds of this type are compared to see if their LOS differs from 'normal practice'. The clear implication of this kind of comparison is that where a district or unit differs significantly from the norm, this difference needs to be 'explained'.

This kind of approach to performance assessment is not new, growing out of a school of management thought often referred to as 'management by exception'. The broad idea behind this approach

* Fulfilment of this last condition implies that the driver (or manager) has access to that information which is necessary to make judgments about performance. In our analogy, this is equivalent to assuming that the fleet driver has an accurate speedometer as well as a knowledge of how much petrol is being used. In the NHS, the question of what information is necessary to make judgments about performance is one which the Körner Working Group and a number of others are presently trying to answer. In a logical world, of course, this work would precede the construction of performance indicators.

to performance assessment is that organisations (or managers) whose performance is in some way exceptional by comparison with similar organisations (or managers) elsewhere, are exceptional for one or more of three reasons:

1 They are *innovating*: that is to say, the organisation or manager in question has evolved or discovered a new way of discharging their responsibilities.
2 They are in some sense *failing* (for example, they are making inefficient use of resources). In this case, the organisation's performance appears to be exceptional because they are falling below the standards of performance achieved by similar organisations.
3 They are in some sense *idiosyncratic* (for example, they have a peculiar workload). In this case, the aberrant performance is attributed to some (usually) local idiosyncracy which may or may not provide justification for the observed performance.

The theoretical rationale for management by exception grows from the recognition that those who find themselves in the position of trying to monitor and assess the performance of others, should: a) identify and then decide whether to foster innovation; b) identify and inhibit failure; and c) identify those 'local' circumstances which justify deviations from normal performance.

It is easy to see how comparative measures of district or unit bed throughput fit into such a framework. For example, a unit with a particularly short LOS in a given specialty might, on the face of it, be thought to be relatively efficient and therefore 'innovating' in a way that might be copied by other, less efficient units. Equally, those with a particularly long length of stay might be thought to be relatively inefficient and making use of resources in a way which should be discouraged. And, of course, a particularly long or short LOS could simply result from certain local conditions which would require justification in their own right (for example, a complex case mix or high levels of day surgery).

To date, no attempt has been made to utilise indices of bed throughput to arrive at judgments such as these. Rather, such indices have been used simply as one means of identifying regions, districts or units whose pattern of bed usage deviates significantly from the norm. Like LOS, however, a number of the clinical indicators presently under review (for example, annual case throughput per bed, turnover of inpatient population, and so on), are little more than readily available but partial measures of *intensity* of bed use. As such, the use of such measures to identify deviations from normal practice can be expected to focus attention on regions, districts and units whose pattern of bed use is sig-

nificantly more or less intense than the norm.

In so far as presently available measures of bed throughput do highlight differences in intensity of bed use, their inclusion in performance reviews has clear 'efficiency' overtones. Moreover, given the present preoccupation with NHS efficiency, it will require a determined effort to resist the temptation of making the (apparently) short conceptual leap from the notion of '*intensity* of bed use', to the notion of '*efficiency* of bed use'. Such a shift in emphasis, however, immediately removes a measure such as LOS from the realm of one useful indicator for identifying exceptions to a general rule, and confers upon it the status of a performance (that is, efficiency) indicator in the sense that we have been using that term here.

The possibility that indices such as LOS may be used as rough and ready indicators of bed use 'efficiency' seems real enough. If the results of such an application are to be fruitful, however, these indices will need to be valid performance measures in the sense described earlier. To demonstrate why this is the case, it is helpful to examine how well an indicator such as LOS meets the three criteria set out in the previous section (page 71).

1 *Performance calibrated*

Although LOS might be thought of as one rough and ready indicator of how efficiently inpatient resources are being utilised, its status as an efficiency indicator in the output-per-unit-of-input sense is, at best, dubious. For example, a reduction in LOS for a given diagnosis could be accompanied by an increase in patient readmissions for that diagnosis; equally, a shorter length of stay might occur at the expense of bed occupancy if the reduction is accompanied by an increase in the turnover interval between cases; or, a reduction in LOS could lead to a shift in patient workload onto the outpatient department, community services and/or social services. In all three cases, the belief that resources are somehow more efficiently used, or that performance has somehow been improved, is, at best, dubious.

2 *Movement interpretable*

For the reasons just cited (and others), it is often unclear as to whether a reduction (or increase) in LOS represents an improvement (or decline) in performance. For example, a reduction in average length of stay is often accompanied by an increase in hospital activity rates and hospital costs per occupied bed day. This is because the decline in length of stay, unless accompanied by a lower bed occupancy rate, almost always increases the pressure on operating theatres and other departments. Readmis-

sion rates and quality of care arguments aside, it is unclear at best as to whether this represents an 'improvement' in efficiency.

3 *Movement subject to influence*
Even if it were to be accepted that LOS represented one valid measure of performance and that, on the whole, a shorter LOS represented an improvement in the efficiency with which inpatient resources were used, its use as a valid performance indicator would fall at this last hurdle. Consider for a moment why LOS may vary from one unit to another. The reasons for such variations are numerous, often interrelated and themselves varied. For example, differing LOSs might reflect, or be influenced by, characteristics of the population being served; complexities of case mix; levels of social service provision in the community; day surgery rates; bed occupancy rates; readmission rates; differences in clinical practice or judgment; and so on. As should be clear from our discussion in the previous section of this chapter, LOS could not therefore be used as a valid indicator of performance until the influence of all of these various factors had been disentangled, and variations in LOS attributed to their component causes. The importance of undertaking such an exercise is twofold: first, it would provide responsible managers with that information which would be necessary to make judgments about how their 'performance' is influenced by each factor; and, secondly, it would ensure that managers were held accountable for reducing (or altering) LOS *only if* the observed variations could be traced to factors over which they had effective control.

There is thus quite a wide gulf between the rather general notion that exceptional lengths of stay are intrinsically interesting and require explanation, and the more rigorous requirements which would have to be met if measures of bed throughput are to be used in assessing how efficiently inpatient resources are being utilised. Indeed, in the light of the foregoing, it is perhaps not surprising to discover that the present round of reviews would appear to be much more circumspect in their approach to performance assessment. In particular, while LOS is being used as one indicator to compare different districts and regions, it is but one of a number of clinical activity indicators being used in this way.

The selection of a good many of the clinical indicators being used in the present round of reviews would appear to grow out of the work of John Yates (1982). What would seem to be intended, if Yates's work is an accurate guide, is the use of a 'cluster' of interrelated indicators which, it is felt, bear on some dimension of performance such as 'efficiency of bed use'. In his work, Yates has

shown how, by carefully examining the interrelationship between different measures of bed use, it is possible to identify differences in utilisation which have clear resource implications. For example, by examining the interrelationship between four measures (namely, LOS; bed occupancy; case throughput; and case turnover interval), it is possible to gain some insights into the reasons for differences in a *single* index such as LOS, and to trace these differences to their origins in clinical and administrative policies (Yates 1982, pages 53–87).

In work along very similar lines to Yates, my colleague Iden Wickings has developed an array of indicators related to estate management (Wickings and Coles 1982). Using a technique called cluster analysis, Wickings has shown how health authorities can be grouped according to measures of their land holdings, building stock, building services expenditure, and so on, and then compared in terms of a number of interrelated 'performance' dimensions. On the basis of this array, he shows how health authorities can make more informed assessments of their comparative performance position as well as more informed choices of estate management policies for the future. Like Yates's work, this approach relies on the systematic investigation of the *interrelationships between* a number of indicators which, it is felt, bear on an important 'dimension' of performance.

On the face of it, work along these lines would appear to hold out considerable promise for at least gaining some useful insights into how various NHS resources can be utilised more efficiently. These hopeful signs notwithstanding, it remains true to say that, to date, the majority of work on performance indicators is characterised by a common theme; namely, a preoccupation with efficiency of resource use and, in particular, variations in resource utilisation rates between different authorities and units.

Performance reviews: efficiency versus effectiveness

Implicit in much of the current work on performance indicators, therefore, is the notion that questions of 'good' and 'bad' performance can sometimes, if not frequently, be reinterpreted as questions of how efficiently resources are being utilised. Thus, the strong emphasis on input measures in relation to activity levels, and throughput measures in relation to workload. And while it is clear that the efficient use of resources is *one* important aspect of performance it is equally clear that a performance review based solely on this aspect could go badly wrong.

To see this, we can once again consider the problem faced by our fleet owner. In this case, performance review was based on the

notion that drivers should be able to get more output (that is, route-distance covered) for each unit of input (that is, per gallon of petrol) – an idea exactly analogous to trying to improve NHS productivity. From this perspective an improvement in fuel economy, because it lowers fleet running costs, represents an improvement in fleet performance. However, the problem is not this simple. If, for example, the fleet of cars was owned by a company wishing to market its products, and the drivers were salesmen, this 'improvement' could render the business bankrupt. That is to say, if to achieve better fuel consumption drivers were forced to travel at a lower average speed, it is quite possible that they would visit fewer customers per unit time with the consequence that sales volume would fall. Obviously, if the fall in sales were to more than cancel out the savings in running costs, the former 'improvement' in performance would no longer qualify as an improvement. In other words, it is quite possible that the desire to increase fleet efficiency could come into conflict with the drivers' ability to pursue the overall purpose for which the fleet exists.

There is a clear sense, then, in which the pursuit of efficiency can conflict with the effectiveness with which an organisation can pursue certain objectives and produce certain results. Indeed, beyond a certain point, there will almost always be a trade-off between further increases in efficiency and the effectiveness with which it is possible to pursue certain goals. The earlier example of achieving a reduction in LOS at the expense of an increase in the readmission rate is an illustration of this kind of conflict within the NHS. It is difficult, therefore, to see how valid performance indicators can be developed without first addressing the problem of what the performance in question is intended to achieve.

Clearly the company owning the fleet of cars is *not* in business to maximise the route distance covered per unit of petrol consumed: it is in business to sell its products. Therefore the objective of improving fuel consumption can only be pursued *subject to* the proviso that this does not interfere with the company's ability to pursue its overall goal. In this case, the trade-off between efficiency and effectiveness in the pursuit of certain results is clear enough. It is obvious that improvements in fuel consumption are desirable for as long as sales are on the increase, static, or falling so slowly that the lost revenue is more than offset by the savings in travel costs.

Unfortunately, the trade-offs between efficiency and effectiveness in the context of the NHS – while just as real as in the case of our hypothetical fleet of cars – are much less easy to identify. There can be little doubt, however, that just as with the fleet of cars the pursuit of efficiency can often occur at the expense of effectiveness. An example will perhaps make this point clear.

Table 5 lists a set of interrelated efficiency and activity indicators which relate to the provision of preventive primary care services for children. Given data on each of these indicators for (say) all of the districts in a region, the present approach to performance assessment would suggest that districts appearing 'exceptional' on one or more of these measures were worthy of further investigation. Such an approach might result in the identification of a district with (say) a considerably higher than average number of child health officers per 1000 under-fives. At the same time, there may be no evidence on any of the activity level indicators to suggest that this district is coping with a greater workload. In other words, as far as it is possible to tell from the indicators available, the district in question would appear to be less efficient than most other districts in the output-per-unit-of-input sense.

Table 5 Possible efficiency and activity level indicators relating to the provision of preventative primary care services for the under-fives (A = Activity indicator; E = Efficiency indicator)

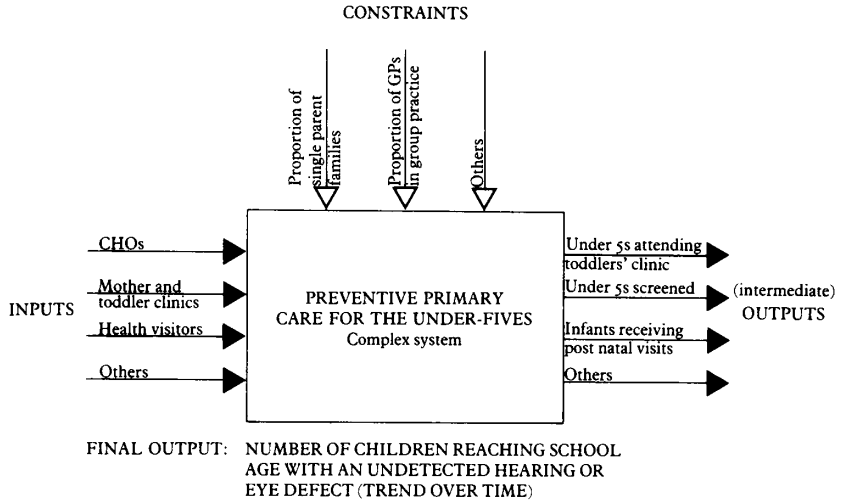
1 Proportion of under-fives visiting mother and toddler clinics	A
2 Proportion of under-fives receiving clinic 'screening' investigations	A
3 Number of clinic GPs/1000 under-fives (or under-fives visits)	E
4 Number of clinic/nurses/1000 under-fives (or under-fives visits)	E
5 Number of child health officers (CHOs) per 1000 under fives	E
6 Number of post-natal health visits/1000 births	A
7 Number of district nurses/1000 births (or under-fives)	E

Although no performance review has as yet gone as far as we are about to suggest, it is quite easy to see how the above observations could lead us to adopt a strategy not unlike that of the fleet owner. We would know for example, that most districts were capable of discharging a given level of workload for every child health officer (CHO) employed. Equally, we would know that one district seemed to require a larger number of CHOs to do the same work. On this basis, and like the fleet owner, we might be tempted to set a performance target of, say, so many CHOs per 1000 under-fives. This would be done, remember, in the knowledge that many districts were already doing better than the target with no apparent

sacrifice in terms of workload. Moreover, if all districts were able to achieve the target (rather than one or two being over the target), this would constitute a more productive use of resources.

Figure 4 uses the black box framework introduced earlier to set out what would almost certainly be a preferable approach to performance assessment in these circumstances.

Figure 4 Application of the black box framework to the construction of performance indicators for primary care services for the under-fives



In this case, the same set of interrelated efficiency indicators are seen for what they are; namely, a description of some of the input, throughput, and intermediate outputs of a system which exists not *primarily* to be efficient but rather to facilitate improvements in child health. In other words, Figure 4 introduces a measure of one *final* output of the NHS as a means of assessing how *effectively* the child health resources in question are being deployed. In addition to introducing a measure of final output into performance appraisal, this framework also draws attention to a number of constraints, for example, the number of single parent families in the district, which might influence how a district is able to deploy its child health resources. The salient characteristics of this approach to performance assessment are threefold:

1 It makes use of valid efficiency indicators possessing all of the properties set out earlier in this chapter.
2 It attempts to assess performance by examining the interrelationship between a number of indicators all arguably related to a common performance dimension (that is, preventing ill-health and facilitating improved health in children).

3 It relates the cluster of efficiency indicators to a measure of final output in an attempt to avoid the trap of improving efficiency at the expense of effectiveness.

Within this kind of framework, then, performance assessment can proceed while taking account of some of the more likely trade-offs between efficiency and effectiveness, as well as local idiosyncrasies which might influence what can be achieved in any particular set of circumstances. Obviously, given the same or very similar constraints on districts, a district obtaining more intermediate outputs per unit of input (for example, having fewer CHOs/1000 under-fives receiving clinic examinations), could be said to be making better use of their child health resources *provided that this was not associated with an upward movement in the indicator of final output*, that is, in the number of children reaching school age with an undetected hearing or eye defect. Once again, I am making use of a hypothetical example to illustrate the argument. As such, the above illustration over-simplifies; for example, it is not yet possible to obtain all of the data necessary to develop the measure shown in Figure 4, nor can the use of the child health resources included in the figure be simply and neatly associated with a single measure of final output. Nevertheless, the example is primarily intended to illustrate one approach to performance appraisal which may have some promise as a model for the future development of performance indicators.

Conclusions: some implications for unit management

This chapter, while intended as something of an antidote to the present fashion for NHS performance indicators, should not be interpreted as a wholesale dismissal of efforts in this direction. In principle, there is every reason to applaud attempts to be more explicit about how the NHS is performing and to hold managers responsible for maintaining and improving performance. Equally, there is nothing intrinsically objectionable about utilising quantitative information – or indicators – in attempting to achieve these objectives. *The single most important point to be made here is that these are extremely difficult tasks to do well and an uncritical approach to the construction of performance indicators can easily do more harm than good.*

In order to be as clear as possible about this point, it is perhaps appropriate to provide a brief summary of the essential argument developed in this chapter. What we have suggested is that the majority of performance indicators presently being developed within the NHS ought more appropriately to be called 'productivity' or 'efficiency' indicators. This is because most of such indica-

tors fall into one of three categories: either they are measures of an input to the NHS, an intermediate output (or activity level) of the NHS, or some index of the relationship between an input and an intermediate output (or another input). As such, these indicators focus attention on differences in performance which tend to raise the question, 'How much output is being obtained for a given level of input?' – that is, they tend to highlight differences in productivity or efficiency.

Clearly, if such indicators do focus attention on *genuine* differences in productivity, they may well have utility as a means whereby responsible managers can be held accountable for maintaining or improving *this* aspect of NHS performance. Performance – or efficiency – indicators constructed for this purpose, however, must possess a number of properties: first, they must be *performance calibrated* in the sense described earlier; second, a change in the value of an indicator must be susceptible to *unambiguous interpretation*; and, third, if the indicator is to be used for management accountability, the *managers in question must be able to exert an influence* over those factors which cause the indicator to change value.

As illustrated earlier, however, even measures which fulfil these three conditions do not necessarily constitute valid tools for improving NHS performance. Rather, there is a very real danger that the casual use of productivity or efficiency indicators will lead to a situation in which managers will be encouraged to pursue efficiency at the expense of effectiveness in obtaining desired results. In other words, in constructing performance indicators to promote efficiency we must be willing to pose the question, 'Efficient at what?'. And the answer to this question can only be expressed in relation to the *final* outputs of the NHS – that is, those outcomes which directly or indirectly lead to the avoidance or the reduction of pain, handicap and suffering. In this respect, we have suggested that a cluster of interrelated performance measures intended to focus attention on effectiveness in achieving one or a small number of desired results may provide one way forward.

As implied in the introduction to this chapter, unit managers would be well advised to take a close interest in the development of performance indicators and their eventual use in performance reviews. The crucial 'interface' role of the UMT suggests that unit managers are likely to find themselves in pivotal roles if and when performance indicators are introduced as tools of management accountability. In concluding this chapter, therefore, it seems appropriate to provide one or two illustrations of how unit managers could well come face to face with performance indicators in the not-too-distant future.

Effective unit management

One of the key interface roles identified by Tom Evans in his chapter is that between policy and implementation. In this role, the unit manager assumes an 'implementing relationship' with a higher, policy-making authority – usually the DMT or DHA. At present, many unit managers in RAWP-losing districts are finding themselves in just such a relationship with respect to so-called 'efficiency savings' policies that are decided at district level. Typically, district authorities subject to regionally-imposed revenue reductions are passing these along to units with the expectation that unit revenue requirements for the forthcoming financial year will be reduced by some percentage of the total unit budget.

In most districts where this is happening, the size of the reductions is arbitrary, reflecting the 'efficiency cut' imposed on the district by region. Also, the manner in which the reduction will be effected is usually left to the discretion of unit management in consultation with the DMT. With the advent of performance reviews at unit level, however, all of this could change in quite dramatic ways.

A likely development is the use of performance indicators in determining the size of efficiency savings to be passed on to each unit. In this case, savings imposed on the district could well be passed on to units in accordance with their 'performance' as measured by these indicators. Indeed, in at least one region such a policy is already under active consideration as a means of allocating efficiency savings to districts, and were it to be adopted at unit level, one of the dangers highlighted earlier in this chapter would surely become a reality.

For example, were the size of the reductions to be imposed on each unit to be determined in accordance with relative performance on such indicators as LOS or nursing staff per FTE doctor, there is no guarantee that the size of the reductions would bear any relationship *to the scope each UMT would have for implementing them*. Indeed, while the use of such indicators would surely create the expectation of increased efficiency, there is a distinct possibility that the factors making the unit appear inefficient would not only be obscure but, worse, be beyond the influence of the UMT. Besides almost certainly being counter-productive, this situation would provide a clear example of one of the dangers stressed earlier: namely, a failure to recognise that managers can only be held accountable for performance over which they have some degree of control.

The role of the unit manager in the context of strategic planning is another interface role which receives some attention in Tom Evans' chapter and in Appendix I. If, as suggested in Appendix I, planning evolves from a concern with creating blueprints for the

future to a concern with providing senior management with an on-going strategic direction for shorter term decisions, then performance reviews could well become an important input to the planning process. For example, the annual pattern of efficiencies and inefficiencies identified at district reviews could well influence district priorities in respect of unit development. In this case, the importance of linking efficiency indicators to measures of final output would be paramount. The alternative of relying solely on efficiency indicators could well lead to priorities framed primarily in terms of unit productivity – quite possibly to the detriment of the district's overall effectiveness in producing service results.

It may be, of course, that none of this will happen. It may be that performance indicators will be painstakingly developed and refined and only used when all of their present shortcomings have been overcome. Alternatively, the fashion for performance indicators may pass and they may never be used except in the very broad, non-prescriptive manner presently advocated by the Department of Health. It may be, in short, that performance indicators will simply go away. A second view is that the notions of performance review and improved public sector efficiency dovetail so neatly and rest so comfortably with the other dimensions of current government policy, that performance indicators are unlikely to go away. Unit managers who choose to believe that they will, do so at their peril.

June Huntington BSc PhD
King's Fund Fellow in Organisational and Professional Studies

Dr June Huntington graduated in sociology from the University of London and became a Lecturer at Brunel University. Three years later she returned to Bedford College, London to develop industrial sociology, specialising in the sociology of occupations. Before leaving London for Sydney in 1972 she became involved in the post-experience training of general practitioners, social workers and health visitors for inter-professional collaboration. She continued this interest in Sydney, conducting an Australian government-funded project to evaluate the effects of social work attachment to general practice. Her book *Social Work and General Medical Practice: Collaboration or Conflict?* was published by George Allen & Unwin in 1981. She is particularly interested in the management of human services and has acted as a trainer and consultant to several health and social service organisations in Britain and Australia. She took up her present post at the King's Fund College in September 1982.

CHAPTER FIVE

The social context for units

JUNE HUNTINGTON

Social pressures on groups

The social context of the 1982 reorganisation includes five components which will impact powerfully on unit management.

1 Government identification of 'priority care groups' in the old, the mentally ill, the physically, mentally and sensorily handicapped (DHSS 1981b).
2 Its determination that services to these groups should be financed not from a resource increase, but from a resource shift both within the NHS and from the NHS to the personal social services.
3 An accompanying assumption that these populations can and should be cared for in the community, and that a significant proportion of those now cared for in institutions should be returned to the community (DHSS 1981c).
4 Government commitment to self-help in health care, with the assumption that 'we all have a personal responsibility for our own health' (Jenkin 1981), and that self-help and voluntary effort must be more directly encouraged by the NHS.
5 In some areas of the service, for example that of maternity services, the emergence of increasingly articulate, organised and vociferous consumer groups which are demanding radical changes in service delivery.

This list highlights a major difference between the NHS and most industrial or commercial organisations. The NHS is not just an organisation in which certain types of work get done. It is also a national symbol which evokes powerful emotions both inside and outside the organisation. Its establishment symbolised the political victory of one set of values over another in our society at a particular point in time. From the moment of its inception, the NHS, because of its symbolic nature, has been a political football, kicked and dribbled by political parties and pressure groups outside and by sectional staff interests inside.

The NHS is an open system: changes in the political environment outside provoke shifts in the internal political environment, producing at times an organisational climate of hostility and competitiveness rather than one of trust and cooperation between different staff groupings. Alliances may be formed across the

organisational boundary as, for example, between consumers and researchers outside and minority groups within the professions inside the organisation who seek to challenge the current pattern of service.

In this chapter, I shall explore these components of the social and political context of unit management so that managers may assess their own and their unit's current response to the intensity of external and internal pressures upon them and the ways in which they might wish to change that response.

The priority care groups

The priority care groups comprise those for whom becoming a patient and receiving all the treatment which medical science and technology can muster, results not in cure or in immediate death but in entering a condition accompanied by varying degrees of dependency. Cure being unavailable, these people need care. Who is to offer it and where?

For most of this century, those whose degree of disability or handicap has been severe and who had no relatives able or willing to look after them have been housed in institutions. Whether they have been cared for is another question. Many of the long-stay institutions of our health, welfare and penal services are in the nature of Everest: they are 'there', and that is function enough so far as society is concerned (Nokes 1967). It is significant that the in-house term for some of them is 'bins', for many were set up to take those the rest of society regarded as refuse.

As a result, the primary task or objective of these institutions remains clouded in confusion and denial (Miller and Gwynne 1974). Their clientele has little or no political clout and seldom produces organised and vociferous consumer groups. Significantly, these clients are rarely if ever referred to as consumers, a term which assumes the capacity to express satisfaction or dissatisfaction with the service either directly or at the ballot box. They have had to depend either on the representation of relatives who have themselves been too ambivalent about institutionalising their nearest and dearest to challenge the quality of care they receive, or more usually on the outrage of staff who find work in the worst of these institutions an affront to their own humanity, let alone that of their patients. (Association for the Protection of Patients and Staff 1983).

To define these people as 'priority care groups' is one thing. To mobilise sufficient concern, commitment and resources to translate policy into practice is quite another. The status and prestige of professions and organisations relates directly to that of their clientele. Unit management staff who have accepted responsibility for

the development and delivery of service to the priority care groups will not find it suddenly easier to influence their colleagues in the more prestigious sectors of the NHS, especially when their aim is to secure a shift of resources in their own direction. It may well be that a significant shift of concern, commitment and resources within the NHS will result only from successful alliances built across its boundaries with consumer groups, external researchers and consultants, and other statutory and voluntary organisations.

Implicit in the government's intention that services to the priority care groups be financed not from a resource increase but from a resource shift, is the assumption that 'most people who need long-term care can and should be looked after in the community' (DHSS 1981c). In recent years, the cost of performing even the most basic 'warehousing' function of long-stay institutions, as well as the hotel function of acute units, has risen dramatically. This economic reality, together with mounting evidence of the dehumanising effects of institutions and the government's self-help philosophy of life, has reinforced the political commitment to 'community care' as the resource-conscious, ideologically fitting solution to the ills of both the priority care groups and the NHS.

Community care

'Community' is a flag word, one that provokes feeling rather than thought. Bob Pinker, Professor of Social Work Studies at the London School of Economics, suggests that 'when our policy-makers reach an intellectual impasse they cover their embarrassment with the figleaf of community' (Pinker 1982). One of his Australian colleagues was just as near the mark when he termed 'community' the 'aerosol word of the 1970s because of the hopeful way it is sprayed over deteriorating institutions' (Jones 1981).

Both motives for use of the word 'community' can be ascribed to recent British governments. That 'the community' exists is taken as fact rather than hypothesis, while the term 'community care' evades the all-important choice between two prepositions: is 'community care' to be understood as care *in* the community or care *by* the community?

As the problems associated with institutional life are now common currency, a statement like 'most people who need long-term care can and should be looked after in the community' is presumably uncontroversial. The location of care is clear and acceptable. The location of responsibility for that care is neither. That the government in 1981 intended care *in* the community to mean care *by* the community is implied in the salutary warnings contained in the report of a study of community care (DHSS 1981d) which acknowledged that:

There was little doubt that early discharge from hospital after acute treatment, day surgery and out-patient treatment when used as alternatives to in-patient care, and the emphasis on avoiding long-term institutional care for the elderly, mentally ill and mentally handicapped wherever appropriate, all depend for their success on a high level of commitment from informal carers – family, neighbours, and volunteers.

The cost-effectiveness of community care packages often depends on not putting a financial value on the contribution of these informal carers who may in fact shoulder considerable financial, social and emotional burdens.

Early discharge and day surgery schemes work only if they are backed up by adequate staff support in the community from district nurses, general practitioners, health visitors, home helps, social workers, and laundry services.

Care *in* the community can become a reality only if those in hospitals and institutions are returned to a community-based but adequately staffed service. If care *in* the community means care *by* the community, and 'community' is taken to mean informal carers, the result is a cynical shift of responsibility onto people who have neither the requisite skills nor, more importantly, the resources to assume that responsibility. More fundamentally, in many areas of the country it is a shift of responsibility onto a figment of policy-makers' imagination, for 'community' as they envisage it may no longer be there.

Their use of the term is often synonymous with that of 'neighbourhood' which in turn implies a geographically defined place within the boundaries of which people engage in 'neighbouring': popping in and out of each other's homes, reciprocally assisting with shopping, child-minding, taking and collecting children to and from school, and so on. We all like to believe that this kind of community exists in our society. English people in particular, whose way of life has been, and to some extent continues to be, dominated by the image of the village, cherish the belief that community still exists.

If we are to be honest, we must acknowledge that certain social trends which have increased throughout this century continue to erode community. Rapidity of transport has extended the distance between home and school or work, families have become more private and vulnerable to breakdown, producing increasing numbers of one-parent families and individuals who experience chronic social isolation, while bureaucratisation of educational, health, welfare and recreational institutions has intensified. Housing policies for inner cities have not only militated against the formation of

'community', but have deliberately severed the shared identification with a place and its culture which motivated human beings to care for each other. Similarly, the current pattern of unemployment impels many to abandon communities in which they may well have spent most of their lives in order to seek work elsewhere, while industries and firms which employed whole families through generations are disappearing or have already gone.

More women than ever who are wives and mothers also work full-time outside the home, and more who return to work after having children expect to work until retirement. Even the DHSS admitted that 'social and demographic changes may reduce the number of those people who have traditionally provided the mainstay of informal care' (DHSS 1981d).

Community care will not come cheap and will depend on whether those employed in the NHS and the personal social services can, through their pattern of service provision, create, sustain, or re-create 'community' or more accurately 'communities' in a mobile, highly differentiated society. They can do this only if their organisations model a genuinely caring human environment in the way that NHS staff relate not simply to patients but to each other and to those outside their immediate organisation who share in the provision of service.

'Care' and the NHS

When the objective of the NHS is said to be the provision of health care, or that of the medical or nursing professions to be the provision of medical or nursing care, the term is being used in one of its dictionary definitions, that of 'oversight with a view to protection, preservation, or guidance' (Onions 1973). This kind of care is usually provided as part of a contractual obligation, the recipient being entitled to receive the care that the organisation or professional is obliged to provide. Fulfilment of the obligation does not necessarily require that the provider 'care for' the recipient in the sense of 'feeling concern or interest' or 'having regard or liking for' (Onions 1973).

Once the word 'care' is used as a verb, affective or feeling components emerge. When we say a nurse 'genuinely cares for her patients', we imply that in providing the service she also feels concern for them. Our use of the possessive adjective 'her' implies a degree of personal investment or involvement in their welfare.

In making these observations about the nurse we impute feelings to her on the basis of behaviours we have witnessed. What has she done to make us think she 'cares'? Usually she has demonstrated the capacity to respond sensitively to her patients' needs, appearing at times to anticipate them. She appears able to 'say the right thing

at the right time' and to 'be there' when needed. The source of this capacity lies in her empathic response: she is able to put herself in each patient's shoes, and to do this as if she *were* the patient.

This empathic response does not derive wholly from feeling. To be effective it must have a cognitive as well as an affective component. In addition to 'concern and regard for' there must be 'serious mental attention to' (Onions 1973). Empathic responses which result in the recipient feeling cared for or cared about derive from the responder having *actively listened* to him, having given 'serious mental attention to' how he perceives and defines his current situation.

This blend of 'concern and regard for' and 'serious mental attention to' constitutes care at both the interpersonal level of the individual nurse, doctor, or porter and patient, and at the organisational level of a unit and its clientele. The nurse, doctor or porter, in the way they physically handle the patient, will convey to him immediately whether or not they 'care'. It is difficult to feign care if you have to touch people: touch is more telling than talk.

Similarly, the organisation conveys whether it 'cares' by its physical environment, its procedures and its overall climate. If, for example management and staff of maternity services felt 'concern and regard for' and paid 'serious mental attention to' women from the lower strata of our society and those from its large and varied ethnic groups, more use might be made of their services by these women. Discussions of non-use are too often couched in terms of the 'failure' of working-class or Asian women 'to take up' antenatal services, rather than the failure of those services to attract these women. 'Serious mental attention to' the way of life and the needs of these women and to the current pattern of service provision would reveal the mismatch between the two. Some maternity units have engaged in such exercises and modified their pattern of service accordingly.

I use the above example to suggest that the structure of the service offered – where it is offered, at what times, in what kind of setting, by what kind of staff – conveys care or lack of it to the potential patient. *The British Way of Birth* (Boyd and Sellers 1982), a report of a survey of a self-selected sample of 6000 women, acknowledged to be skewed towards the more highly educated, identifies the message many antenatal clinics convey to many women. Waiting times, lack of facilities for toddlers to play, for pregnant women to sit comfortably and to enjoy privacy while they undress, absence of refreshments, distance from the clinic to pathology laboratories, all these convey to women their lack of entitlement, their lack of value in the eyes of those who run the service.

Procedures also convey care or lack of it on the part of the organisation. Procedures emerge or are created initially by individuals or groups in the organisation, but are then institutionalised, converted into routines the continuance of which is then independent of the initiator(s).

At a recent one-day conference held at the King's Fund Centre to discuss *Maternity Care in Action* (DHSS 1982), Caroline Flint, the Antenatal Clinic Sister at St George's Hospital, London, spoke of her clinic's objective of enabling the pregnant woman to make a friend who would see her all the way through the confinement and beyond. The friend might be a midwife or other professional, or another woman who is going through the same experience. She and colleagues at the hospital had been giving 'serious mental attention' to the creation of a climate in the clinic which would achieve this objective. She is also trying to attract women from those groups who are said to 'fail' to take up antenatal care.

This 'serious mental attention' for Caroline Flint involved:

> Trying to think how we would greet an honoured guest in our own home. We would phone her and say 'looking forward to seeing you, here's how you get here, this is what will happen'. When she comes we would offer her a cup of coffee or tea. We would then sit down and devote time to getting to know her and allowing her to get to know us.

Sister Flint, mindful of the need to attract women into antenatal care, also gave 'serious mental attention' to how she introduced herself:

> Who do we say we are? – 'I'm Sister Flint'. Or do I say 'I'm Caroline Flint, I'm a midwife?' We ask her what name she would like us to call her.

Sister Flint has given 'serious mental attention' to the total environment of her clinic – physical, psychological, and social. From this are emerging new policies and procedures which hopefully will result in greater takeup of care.

A further example of a procedure which conveys care derives from a geriatric unit. In a recent course on management skills in geriatric medicine held at the King's Fund College, Peter Horrocks, a consultant geriatrician in Hull, described his unit's system of care which combines lower bed occupancy with high throughput. His system aims to maintain the elderly in the community. He argues that this is more possible if relatives and GPs responsible for long-term care can depend on the unit to arrange

immediate admission or readmission of the elderly person in their care. Readmissions are an inevitable and planned part of the system, part of readmission procedure being that, *as a routine*, the elderly person will usually return to the ward to which she was previously admitted, so that the physical and personal environment is familiar to her.

These two examples of organisational procedures which suggest that the organisation cares are the result of an empathy with the patient that is based on both concern for *her* as a person in her situation and the serious cognitive effort of thinking through that situation and the ways in which the organisation can best make a response to it. Responses of this type are made only when the providers of care, be they individual professionals or whole organisations, recognise and affirm in both their individual work behaviours and organisational procedures the patient's fundamental entitlement to the service and his entitlement to be treated as a whole person rather than simply the carrier of a disease.

Medical education's emphasis on the physical sciences and the acute setting has traditionally produced practitioners who cannot see the person for the patient. In challenging and combating the disease the person is by-passed. Yet a growing research literature in psychosomatic medicine and social psychiatry suggests a subtle and complex interrelationship of physiological, psychological and sociological factors in illness.

Significantly, the most vociferous consumer criticisms of quality of care currently directed at the NHS have emerged in maternity services.

What could be done? An example in maternity care units

Ann Oakley's work (1979, 1980) and *The British Way of Birth* survey testify to the way in which the orientation to seek out and combat pathology and in so doing to maximise the use of medical technology has been extended into the care of healthy women. Obstetric staff defend their practice by referring to their key performance indicators – maternal, infant and perinatal mortality and morbidity statistics. These may be indicators of performance (see Chapter 4) but they are not sufficient indicators of 'care'. Many women on the receiving end of maternity services feel distinctly uncared for. They do not even feel that staff are simply indifferent, which is the dictionary's suggested antonym of 'care'. Many mothers have experienced maternity 'care' as an assault on even their basic humanness. Terms like 'cattlemarket', 'animals', 'slabs of meat' and 'herded' appear frequently in descriptions of their experience, an experience that is problematic for women who do not see themselves as ill and who therefore reject the patient role.

Faced with people who resist patienthood, staff may proceed to deny these women's entitlement to be perceived as persons. Staff may insist on alienating the woman's body from the rest of her, and again I use the term in one of its dictionary meanings: 'the action of transferring ownership to another' (Onions, 1973). Staff may focus exclusively on the woman's physiological functioning and on their own definition of what this should be.

Pregnant and labouring women are then alienated from their bodies at precisely the time they need to work with their bodies rather than against them. Our sense of potency begins with our bodies. The stretching and reaching out of the infant, the crawling, standing, walking, running, and jumping of the toddler and young child, the control over bowel and bladder: these are the earliest experiences of potency and self-esteem.

As they grow up, females become particularly sensitive to the potency of their own bodies – in attracting men. As Oakley shows, the threat to self-esteem that is inherent in pregnancy and childbirth in our type of society begins for some women just when their bodies start to take on the pregnant shape. Some women experience these body changes and, later, the changed reactions of men and women towards them once they become mothers, as a severe loss of sexual identity and self-esteem.

Given the demands of raising small children, women need all the self-esteem they can get. One of the objectives of maternity care should be that of enhancing existing self-esteem and trying to create opportunities in which its seeds can be sown where they appear to be lacking. But how many unit managers feel that achieving such an objective is a critical part of their role?

The physical environment and procedures of the service and the orientation of staff are all important: *Maternity Care in Action* has set out a checklist against which antenatal services can assess whether they are providing good quality maternity care.

Despite official advice, consumer studies of obstetric 'care' suggest that some maternity units work to the 'warehousing' model of institutions described by Miller and Gwynne (1974).

> The emphasis on physical care may be carried to such extremes that there is opportunity for only the most circumscribed activity of any kind. With very few exceptions, inmates are continually forced into a dependent role . . . The body is cared for, but any manifestation of individuality is treated as trouble-making and disciplinary measures are introduced to deal with the offender.

To be 'entitled' is to be regarded as 'the agent of' something, the one who acts to bring something about. Many women are now

demanding 'active birth' in which they are entitled to be the agent of their own delivery.

Oakley has shown that contrary to popular assumption contemporary women suffer considerable loss in making the physiological, psychological and sociological transition to motherhood. Loss of work, financial independence, freedom, sexual and personal identity are major threats to self-esteem. If the organisational and professional procedures of maternity services deny the woman's entitlement to be perceived as a person, curtailing her choice and control of where and how she shall give birth, providing minimal or misleading information, then they infantilise her at precisely the point in her development when she is entering the most demanding adult role of her life.

The objective of the service should be not simply a reduction of mortality and morbidity statistics nor the birth of a live healthy child, but also the discharge from hospital of a mother who feels her self-esteem and competence are not only intact, but preferably enhanced by her experience of the service.

Some of the earlier evidence I have quoted was acknowledged to be particularly representative of the views of more highly educated women, but the promotion and support of self-esteem is even more important in the maternity care of working class women. Melville (1983) recently reported the findings of the Family Research Unit at the London Hospital which has been researching the interrelationships of depression in mothers and behaviour disturbances in their young children. Their sample was predominantly working class. Melville reports that even prior to delivery, during pregnancy, one in eight of their sample of 131 women was too depressed to be able to cope, and three and a half years later this proportion had risen to nearly a quarter. A further quarter were depressed but still able to function. Significantly for this chapter concentrating on care in the NHS, during pregnancy these women were in contact with medical and other services but their depression was rarely recognised, and professionals seldom questioned whether help was needed or was feasible.

The research demonstrated that pregnancy and childbirth caused definite stress, especially in women who had had some form of psychiatric disturbance before they became pregnant. These women became depressed during pregnancy and postnatally, a finding which can be linked to Oakley's on postnatal depression which she found to be significantly affected by the amount of medical technology used, the routinisation of surgical procedures such as episiotomy, a low degree of maternal control over the birth process and dissatisfaction with management of the birth.

These studies suggest that a major objective of maternity ser-

vices could well be that of assisting women in making the transition to motherhood, a transition that is as much social and emotional as physical. To do this, the services would need to recognise women's need for support, particularly if they are without a pair-bond or 'confidante' relationship.

The London Hospital study produced a graphic account of 36 such women who had been admitted to local authority care during their own childhoods. They were said to have got on badly with their parents; if they were married, their husbands showed little interest and involvement in their pregnancies; and their relationship to their parents remained poor. 'So at a very vulnerable time in their lives, these women who needed more support than most were getting less.' (Melville 1983)

Subsequent to the birth, these women's relationship to their infants was poor, with little talking, touching and holding. The social worker with the project suggested that these women still needed nurturing themselves, and that having become pregnant the care they received was 'not as sensitive as it could be, given that they are particularly vulnerable to insensitivity from staff'.

This social worker underlined the complexity of the task facing the NHS if it is to take up the challenge of caring for these women.

> Professionals can try to help, but they cannot give lasting support in the same way as a relation or friend. Yet this is one of the things these women have lacked all their life. I think that the services should somehow try to uphold whatever vestiges of natural support there are, but make sure it's the right sort of intervention. We need to find the sort of help *they* need and want. Ante-natal care at home, for instance, is effective [italics in original]. (Melville 1983)

Stephen Wolkind, Director of the Family Research Unit, suggests that 'the whole process of ante- and post-natal care should be geared into the emotional level – finding out what individual women want.' (Melville 1983)

Although not such an 'at risk' population, the women in Oakley's and Boyd and Sellers' surveys previously referred to, expressed a marked desire for continuity of care as embodied in a particular person who would acknowledge and affirm their entitlement to consistent and accurate information, to an understanding of their uncertainties and anxieties rather than ridicule or dismissal, and to some emotional support.

These needs are shared by most patients in the health service. When people face major changes for the worse in their bodily functions, mysterious symptoms, uncertainty of diagnosis or prog-

nosis, surgery, or terminal illness, especially in the hospital context where they are confined to bed and their bodily functions attended to by others, they may experience overwhelming anxiety and feel a deep need for emotional support.

Loss of a body part through accident or surgery, diagnosis of an illness condition which can only be contained and not cured, demand a radical shift in the person's concept of self and life style. They threaten his psychosocial equilibrium and provoke anxiety and a need to talk and be with someone who will listen and just 'be there' for him. The function of staff willing to respond to these needs is that of metaphorically, and sometimes physically, 'holding' the patient through his experience, of helping him to separate fantasy from reality and to assess the appropriateness of inner fears to outer threats, to accept his grieving in the face of losses which are real, and to assert hope when the patient may feel despair. The capacity to respond in this way depends on a capacity for empathy, but more especially in situations in which the patient is very distressed, a capacity to 'stay with' the patient emotionally, to be flexible enough to take in the patient's experience but to know that one's own ego boundaries are secure enough not to be incorporated by it.

These demands are frequently made on staff in acute units and there can be little doubt that the quality of care is judged by patients according to the nature of the staff's response. They are not made so overtly perhaps in other units, but that is not to say that they are not made at all. Studies of pregnant women quoted previously suggest the need for emotional support from staff is widespread. They contain many comments from women who felt 'abandoned' by staff, especially during labour. These studies suggest that first birth in particular arouses great anxiety and activates needs for attachment, needs to be metaphorically 'held' through the experience by someone who is both knowledgeable and sensitive.

Many women do not receive this kind of response from staff in maternity units. This may be related to their ambiguous status as patients and to the primitive emotions that birth as well as death arouses, particularly the emotion of envy. Whether staff can respond caringly will also depend on whether their managers define such a response as a legitimate, indeed inalienable, part of their role, and on whether the staff themselves feel cared for by their organisation. This is an issue I shall take up later.

Mothers often need emotional support when giving birth. Bowlby has emphasised the situations in adulthood, as well as in child care, which activate attachment behaviour directed exclusively towards the 'attachment figure'. Research suggests

that the woman's sexual partner is usually the person most able to meet the needs expressed by her attachment behaviour.

As in the paediatric situation to which I refer later, hospital staff find that encouraging the woman's partner to take an active part in labour and delivery produces in most cases a more cooperative patient, providing they themselves define the process as a partnership. Unfortunately, some units still insist on the partner leaving the room if complications arise, which is precisely the point when the woman's fears increase and when, correspondingly, her needs to feel attached are raised.

A more important reason for maternity services to acknowledge and affirm the couple relationship lies in the fact that the transition to parenthood is a crisis point for the marital relationship (Oakley 1979, 1980; Clulow 1982). Contemporary research challenges the old assumption that children make a marriage. The evidence, at least in contemporary Britain and the United States, is that pregnancy, and more particularly the postnatal period, is a vulnerable time for couples. As their marital roles become more segregated, their level of satisfaction with the marriage decreases. This is particularly apparent when external stressors of poor housing, financial problems and social isolation are also present.

In these circumstances, it is vital that the maternity services do not add to these stressors, and that, preferably, they are designed and delivered to support and enhance the couple relationship.

A 'husbands-in' policy must, of course, never be imposed, for it may not be congruent with the personality needs of either partner, with the dynamic of their relationship, or its cultural background. Henley (1979) warns maternity staff that they may think they are helping to support family relationships by engaging the husband, whereas the pregnant Asian woman might find this an insult.

In obstetrics, acknowledgement and affirmation of the patient's primary relationship must be considered in its other sense, that of the bonding of the mother to her infant. There is evidence to show that the formation of this relationship is a delicate process, whose development can be arrested or damaged by thoughtless external intervention (Klaus and Kennell 1976). The woman must be allowed to 'take possession of' her infant.

Two final examples convey the contrast between 'care' and lack of it in this context. In *The British Way of Birth* study one woman was allowed to hold her son but wanted also to feed him straight away. The midwife said 'my mothers' babies wait till they're washed' and took almost two hours to clean him up and give him back to the mother. By contrast, a woman whose baby had to be taken to the residential nursery for sick children came out of anaesthetic to find the sister showing her a polaroid photograph of

the infant in his incubator. This nurse showed great empathy with this mother's need to 'claim' her infant. Unless a mother can do this, she will be unable to bond with the child. Maternity units need to pay particular attention to their procedures with regard to children born prematurely, or with handicap, disease or malformation, as separation of the infant from the mother inhibits bonding and the mother's sense of possession. Which leads us to the care of children.

What could be done? An example for those with paediatric units

Paradoxically, staff may find it easier to acknowledge and affirm the patient's entitlement to emotional support from them than to acknowledge and affirm his entitlement to sustain his own primary relationships while he is in the unit. This is seen clearly in paediatrics, where some units continue to resist the introduction of open visiting and 'mothers-in' policies.

For the young child, especially when under five years of age, the mother is an 'attachment figure' in the sense that:

> . . . in the company of his mother he is cheerful, relaxed, and inclined to explore and play. When alone with strangers he is apt to become acutely distressed: he protests his mother's absence and strives to regain contact with her. These responses are at a maximum during the second and third years of life and then diminish slowly. Thenceforward, although attachment behaviour is less evident in both the frequency of its occurrence and its intensity, it nonetheless persists as an important part of man's behavioural equipment, not only during later childhood but during adolescence and adult life as well. In adults it is especially evident when a person is distressed, ill, or afraid. (Bowlby 1975)

Young children are still learning to come to terms with their bodies. They frequently entertain primitive fantasies about bodily function and about attacks on their bodies. Even in adults, any threat to the body signals danger and usually provokes anxiety. The need for surgery arouses primitive anxiety, as we would normally fight or flee from a situation in which our bodies were to be cut open and pieces removed. We submit ourselves to surgery because we convince ourselves that it will, or might, make us better. The ego, that part of us which perceives and makes sense of external reality, asserts itself against the impulse to fight off or flee from the threatened assault on the body. Adults are usually able to

tolerate the conflicts and anxieties aroused by the need for surgery; children find this very difficult and frequently impossible.

The body threat posed by medical procedures and surgery arouse instinctual terror in the young child, a terror which threatens to engulf him. In such a state he is beyond the reach of reassurance or consolation from strangers. His own mother will find it difficult enough to 'get through'. The threat mobilises intense attachment behaviour which is directed to his 'attachment figure', usually his mother. He cries for her, clings to her, and will not let her out of his sight. Her presence spells safety and protection. She takes over his temporarily disrupted ego function which is, in normal circumstances, much less developed than that of an adult, and 'holds' him through the experience.

Most paediatric units now recognise the value of maintaining the child's access to his primary relationship while he is in the unit. There remain pockets of resistance to unrestricted visiting, while some units which espouse the policy ensure that their environment and procedures subvert it, there being no space or comfortable seating for mothers, no refreshment or sleeping facilities. There is little doubt that mothers, for whom the hospitalisation of their children is also stressful, feel that the unit 'cares' when they are welcomed on paediatric wards. There is also little doubt that unrestricted visiting is usually in the best interests of the emotional health of the child.

Collaboration in caring

Significant improvement of care in the priority services will depend on the quantity and quality of collaboration both among different professions and organisations within the NHS and across its boundary with different professions, statutory and voluntary organisations outside. Experience and research suggest, however, that improvement of inter-professional and inter-organisational collaboration is notoriously elusive.

One reason is that individuals are reluctant openly to confront differences in work groups, particularly when they know there *are* differences but do not know others in the group well as individuals. It is natural, especially in the early period of a relationship, to try to avoid conflict. People are busy trying to make a good impression, to appear open, trusting and ready to collaborate. The norm of niceness is quickly established in such groups, especially if they meet only briefly and sporadically.

To risk conflict, a group needs to know it has the time, goodwill and social skills to work through and resolve it. Without these qualities, people will avoid confrontation, perhaps by covertly agreeing to alter the nature of the difference. A difference of

objective may be reduced to one of technical detail, while a problem rooted in major structural difference between the individuals' professions or organisations may be converted into one of interpersonal communication.

The tendency to reduce major issues to problems of interpersonal communication is rife in collaboration in the health and welfare services. As I demonstrated in my own study of social work and general medical practice (Huntington 1981) major inhibitors of collaboration were not inter-personal but inter-professional differences. Professions and indeed organisations are distinct cultures: systems of values, work orientation and focus, language and technology. Most of these cultural differences are also underpinned by major structural differences: the sex, age, and social class structure of the profession, its typical work settings, type and level of income, and clientele.

Professions differ in their capacity to confront conflict. Doctors, used to medical dominance in most settings in which they work, have less need to develop skills in conflict confrontation and resolution. If they are aware of inter-professional differences in a situation, their power and status usually enable them to impose their own definition of the situation. Others then comply, while possibly festering with resentment. Significantly, however, doctors are frequently loath to confront and resolve differences within their own professional group.

General practitioners, for example, are notoriously reluctant to do this in their partnerships. As a result, partnerships are often vulnerable to breakdown and ineffective with regard to both operational and strategic management of the practice. Differences of objective and strategy are inevitable in such small and professionally autonomous organisations, and unless these differences are acknowledged and consciously worked through the organisation is weakened in its capacity for creative innovation.

In my own social work attachment project, the social worker was constantly frustrated by the GPs' resistance to facing obvious differences in their professional objectives and strategies and in hers. They feared that confrontation would threaten not only their inter-professional relationship with her, but their intra-professional relationship with each other. Unit administrators and directors of nursing services will be well aware of this dynamic in their own relationships with doctors, especially in the unit management team.

Experiencing frustration in inter-professional and inter-organisational collaboration, people may resort to a search for the 'ideal' structural solution: 'If only we can get our roles and accountabilities straight, or our professional boundaries defined,

we'll be OK'. Today, the complexity of care provision in the NHS and personal social services defies one hundred per cent clarification of roles and accountabilities. Whether people can work within a less tightly prescribed structure depends not only on their personalities – that is on how far they can tolerate ambiguity and blurring of role boundaries – but on the degree to which the culture of the overall system of care is shared.

If individual workers and organisations involved in the system feel at one with its 'mission' – that organisational goals reflect their own individual values – they will tolerate a far greater degree of role blurring and flexibility. (Dockar-Drysdale 1968)

This can be seen frequently in primary health care. If attached nurses and social workers feel their commitment to better patient care is shared by the GPs, they are happy to work in a very flexible manner. If this shared commitment is lacking – if the GP is in it for the money, the health visitor for the hours, and the social worker to develop expertise in family therapy – then inter-professional conflicts will always result in demands to tighten up structures, role prescriptions and accountabilities.

It is not that definition and embodiment of tasks and accountability for their completion in a clearly articulated organisational structure is undesirable or unnecessary, but rather that a precipitate resort to structural solutions may close off opportunities for more innovative and creative ways of working. Innovations will be essential if services for the priority care groups are to be improved at a time of financial constraint. Those involved in inter-professional and inter-organisational collaboration must be able to persist with the innovations, painful as this may be, for some considerable time.

To do this involves the development of a comprehensive map of the system of provision available for their care group. A profile will be required of the total population, indicating those who are receiving service, who need it but do not get it, and who will need it in the future. This profile will list all statutory and voluntary organisations, professionals and volunteers already involved or available, and also show the actual and potential informal carers who are available. If collaboration at authority, officer and practitioner level is to be improved, everyone will need to increase their knowledge of the structure and culture of the different organisations and professions involved.

UMT cooperation with social services departments and general practitioners

If unit managers in the health service wish to collaborate more closely and effectively with social services departments, they will

need to understand their intense political environment. I began this chapter with reference to the political environment of the NHS, especially at national level. At local level, social services departments work in an environment of even greater political intensity, with local councillors putting direct, face-to-face pressure on social workers and their managers. Joint care planning teams are bedevilled by the difficulty NHS staff have in understanding the constraints placed upon their social services department colleagues by the council to which they are accountable. Satyamurti (1981) offers an excellent description of the political environment of social services departments.

The Rising Tide report (NHS Health Advisory Service 1982) suggests the reason for good service development in the south coast areas of England lies in the high proportion of elderly in the population 'forcing the developments earlier than elsewhere'. Certainly this is a push factor to service provision, but district health authorities may not secure the collaboration they want from social services departments if in addition to elderly there are high numbers of families and children at risk in the population. The political pressures on these departments, especially those focused on the deaths of children in care which have occurred over the past fifteen years, have produced a primary and, in some departments, an almost exclusive preoccupation with families and children at risk.

In addressing the problems of the priority care groups, the NHS cannot expect too much of the personal social services. There is ample evidence that social services departments are experiencing a crisis of management more serious than the NHS. Recent articles in *Community Care* and *Health and Social Services Journal* point to the considerable number of directors' posts recently vacated, the difficulty some authorities are having in making appointments, and the alleged lack of good quality management training at chief officer level. For unit managers who must collaborate closely with social services departments, useful descriptions and analyses of their organisational structures and managerial problems are offered by Stevenson and Parsloe (1978), Mattinson and Sinclair (1979), Satyamurti (1981), Lishman (1982) and Bamford (1982).

Unit managers find it difficult to collaborate with general medical practitioners. GPs are an idiosyncratic group with whom any unit manager concerned with the quality of care must come to terms. In my own book (Huntington 1981), I tried to interpret general practice as a profession to social workers, who have often been frustrated in their attempts to collaborate with GPs. The interpretation may prove useful to unit managers, as may my analysis of social work in the same publication. Indeed, the

perspective developed in the book can be used to explore any inter-professional relationship.

GPs aim to offer primary, continuing and comprehensive care. Although the experiences of unit managers in inner London might sometimes lead them to doubt this in practice, most GPs take pains to meet these objectives. The content, focus, and rhythm of their work, the type of relationship to patients in which it involves them, and their relative independence of other professional groups and organisations, are quite different from those of most hospital consultants. Similarly, general practice as an organisation is different from other organisations in the NHS. Yet collaboration with GPs as professionals and with general practices as organisations is vital to the success of priority care group and community provision. Useful reference is made to this on pages 40–50 of *The Rising Tide*. Like the family of the elderly mentally infirm patient, the GP may be persuaded to carry onerous responsibilities provided he is assured of the accessibility and availability of back-up specialist services when he needs them. This accessibility and availability must be psychological as well as physical; that is, willingly offered from a sense of trust in the GP's own judgment.

Trust and reciprocal autonomy of judgment must of course be two sided. Some GPs are concerned only with what they can get or dump, rather than what they can offer. But there are other organisations and professionals who use the GP in this way.

One way to promote trusting, rather than suspicious, collaboration with GPs is to involve them in the planning of service provision for a particular group, especially when this will involve a large number of professionals and organisations. GPs are often loath to attend meetings outside their own organisations, so it is necessary to ensure that these are held at times and places reasonably convenient to them. Monday mornings are simply not on for most GPs, this being the heaviest surgery of the week. Of all professionals they are the ones most wedded to the personal approach, and to the spoken rather than the written word. They abhor bureaucracy and will resist it mightily. When they commit themselves to meetings outside the practice they have usually arranged for cover by their partners. If the meeting is then cancelled at short notice they become justifiably irate.

Inter-professional collaboration at service delivery level in the NHS and personal social services is usually inter-organisational as well. The organisations involved, being major public bureaucracies, manifest several levels of responsibility. In these circumstances, collaboration in the field is vulnerable to sabotage through lack of it in the higher reaches of the organisations or to failure due to lack of support from above.

Conversely, Satyamurti (1981) warns that not much can be expected of attempts to enhance inter-organisational cooperation through setting up top level meetings. She suggests that these are of less value in promoting cooperation than more informal relationships at field worker level, since top level discussions tend to be characterised by the avoidance of conflict or discussion of specifics and the mentioning of names, and are confined to general principles and airing of shared grievances against third parties.

The Rising Tide report argued that

> . . . the most harmonious services make joint strategies at Authority level, plan together at officer level, and work closely together at the point of delivering the service.

I wonder, however, whether this lateral collaboration at each level is sufficient, or whether maximum feasible collaboration results only when the corresponding vertical collaboration is also assured?

In an ideal world, inter-professional and inter-organisational collaboration would be undertaken by staff whose own ego boundaries were flexible, those who were comfortable with ambiguity, openness, and uncertainty. The NHS today is not an ideal world and some personalities will find themselves in parts of the organision which are bearing the brunt of radical change. They will be threatened by insufficient structure and will put up defences. Alternatively, they will collude with colleagues to convert the organisation into a defensive social system which functions to contain their own anxieties rather than to care for patients or clients. (Menzies 1970)

Defensive postures will close off individuals, organisations and professions from the influence of others. Their over-riding concern will be to maximise control of their own neck of the woods, to ensure that their own work is tolerable and predictable, and to export troublesome and onerous tasks to those beyond their own tightly observed boundary. In such a climate, individuals, professions and organisations interacting with others aim to secure maximum advantages for themselves. Political questions predominate: who gets what, when, how, how much, and with how little cost to themselves? An external climate of severe resource constraint only intensifies such parochialism.

The policies and practices of an organisation which operates as a closed defensive system may sabotage other performances. Unilateral introduction of a high turnover, rapid discharge policy by a new consultant in a geriatric hospital unit without consulting those responsible for geriatric care in the community, will wreck their achievement of their own objectives and control over their own

flow of work. Organisational and professional unilateralism is guaranteed to prevent high quality health care, and more especially in the priority services. The recipients of these services will experience patchy, inconsistent and discontinuous provision, if they experience any provision at all. They will not even experience 'oversight with a view to protection, preservation, or guidance' which I deemed to be the weaker or minimum definition of 'care'.

If consumers are to experience this weaker definition of care or, more desirably, its stronger definition as a combination of 'concern and regard for' and 'serious mental attention to', service providers must feel concern and regard for each other and think seriously about each other's internal and external organisational environment. The courtesy and understanding shown to patients by professionals and organisations in the NHS must be extended to everyone who contributes to the total system of service provision. This will make possible a more caring service to the patient because it allows each profession and organisation to anticipate the impact of its policies and practices on other professions and organisations, and to negotiate the inter-relationship of each other's contribution to a system of care that offers continuity and consistency to the user.

Managerial implications of caring for our clients

Many people who choose to work in human service organisations do so not simply out of the need to earn a living, but also out of a desire to work in an organisation that expresses certain values absent in others. By working in such an organisation the individual hopes to express his own values and beliefs about human nature and about the nature of human relationships.

Joining human service organisations is often an expression of hope. It may be fantasy-based, grounded in the individual's need to find 'ideal' persons and social groupings outside himself; or it may be reality-based, grounded in a capacity to appraise himself and to recognise that he has certain strengths, energies and resources which will be used more effectively in an organisation whose primary task reflects, rather than counters, his personal values.

A person's hope and commitment can only be used effectively, however, if they are recognised by the organisation and its management. If they are dismissed as irrelevant, or rejected as inappropriate, hope will be replaced by cynicism or despair and energetic commitment by passivity, apathy, destructive attacks on the organisation and its clientele, on other workers or on the self.

The importance of creating a supportive environment for unit staff

My first educational task at the King's Fund College was to run an administrators' development course for young NHS administrators, many of them with low morale. I assumed initially that this might relate to the uncertainties generated by reorganisation and by the government's commitment to privatisation of public services. Closer contact suggested a more fundamental reason, which lay in a lack of clear objectives and any management appraisal of their performance. Many of them found it difficult, if not impossible, to tackle their managers about this; yet the unit administrators of tomorrow will be drawn from this group of people. One of them is already administering a new community-based unit where there is maximum uncertainty about objectives.

Responsibility for inter-organisational collaboration falls heavily on community unit administrators and puts them in boundary roles with maximum stress (Kahn et al 1964). I envisage particular problems for those placed in such roles at a time when the boundaries of their own organisational task have not been adequately defined by senior management.

In such circumstances these staff, particularly the young and inexperienced, risk being swamped by the unlimited needs and demands of those beyond, as well as within, their own organisational boundaries.

Unless these young people are helped by senior management, and by further training, to define their own, and the organisation's, objectives, they will continue to be uncertain about their performance. A no feedback situation is a deadly experience for anyone who is trying to grow. They cannot become the strategic managers of tomorrow unless they become confident today. Confidence comes from being able to meet objectives and achieve valued goals. Although I am referring particularly to young administrators, I have no reason to think that nurses have a much better understanding of their objectives and their power.

Community-based units, particularly those charged with care of the priority groups, will find themselves, like social services departments, in a situation of unlimited demand quite unmatched by resources. Organisations such as community health councils and consumer groups have varied and conflicting expectations of the unit's role and tasks, and may confuse and inhibit the manager by defining unfamiliar objectives and measures of performance. Nonetheless, managers of community-based units must build effective alliances with outside organisations if resources are to be shifted from acute to non-acute sectors. They will be unable to do

this if they react too defensively to the pressures emanating from these organisations.

Some units have been created specifically to meet the government's objectives as spelled out in *Care in Action*. As such they are innovatory. Miller, in an article entitled *The Psychology of Innovation in an Industrial Setting*, writes:

> One of the first tasks of a new organisation is to identify itself in some special way, either consciously or unconsciously. This implies a psychological constellation both in relating the organisation to the outside world and in establishing structures and processes internal to the organisation. The allegedly "new" ways of doing things may relate to the development of new technology, new social and organisational arrangements concerning work, or whatever. Part of the psychology of such a venture will be to harness shared social fantasies around the nature of this 'new' work . . . The organisers of such a venture are not likely to see themselves as establishing just another plant, but to see it as an improvement on all existing arrangements and a primary source of hope for the future. (Miller 1979)

If unit managers are to harness both the social fantasies of their staff and their commitment to improved care, they will need to demonstrate their awareness of the emotional demands caring makes on them. In the current political climate, many staff who are highly motivated to care, and who have the capacity to be caring, will continually experience a gap between their ideal way of working and what can really be achieved with very limited resources. This experience may, on occasions, produce despair rather than hope and provoke feelings of ambivalence and guilt towards the recipients of their care which staff, committed to help others, find difficult to tolerate.

In such circumstances, staff cannot continue to care for patients unless they themselves feel cared for. They too must feel that they are recognised and affirmed as whole persons and not simply as bundles of skills or organisational resources to be spent – and accounted for – by their managers. Of course, staff constitute resources which must be deployed to best advantage, but in human service organisations they are also individuals who must accept and respond to the distress and dependency of others.

Organisational structure and climate tend to manifest the management's assumptions about human motivation. It is important to question whether your unit's structure and climate motivate your staff to care.

Iden Wickings PhD
King's Fund Fellow in Health Service Systems and Policy

Dr Iden Wickings is the Director of the DHSS funded CASPE Research Unit which is exploring Clinical Accountability, Service Planning and Evaluation in the NHS. His health service career started at the Paddington Group Hospital Management Committee and, after short periods there, and at King's College Hospital, he joined Westminster Hospital in 1961. He worked in a variety of posts but his interest in research began while he was Deputy House Governor. He left during the reorganisation of the NHS in 1974 to become District Administrator of the Brent Health District. He left Brent to found the CASPE Research Unit in 1979. While at Brent he was a postgraduate student at Brunel University where he obtained his PhD. He is now an Honorary Senior Research Fellow at the Brunel Institute of Organisation and Social Studies and an Associate Fellow at the Warwick University Centre for Industrial, Economic and Business Research. He was appointed part-time Fellow in Health Service Systems and Policy at the College in 1982.

CHAPTER SIX

Finance in units

IDEN WICKINGS

Too little and too late?

An avowed intention of the 1982 reorganisation was to strengthen unit management. HC(80)8 (DHSS 1980b) stated:

> The early establishment of unit budgets is an essential element in increasing local responsibility and accountability . . . District treasurers should provide advice to the budget holder at unit level through improved financial information systems.

The authority to grant or withhold resources is a genuine power; the duty merely to keep within bounds set by others, to 'do what you are told', does not confer power but restricts it. Since the national intention was to strengthen unit management, this chapter considers how different budgeting systems could contribute to that achievement. But let me first quote some actual examples, taken from three different health authorities, of the standing financial instructions given to unit managers:

> UMTs have a duty to investigate the expenditure being incurred on the services they manage and to identify areas of savings without reducing the level or standards of service being provided.
>
> . . . any sum in excess of £5000 will revert to the DMT.
>
> The DMT will agree at intervals each UMT's main objectives including planned virement within budget heads. Virement outside these agreements above a level to be fixed will be subject to DMT approval.

In my experience, the above quotations are fairly typical. It is, of course, essential for UMTs to manage their allocated resources efficiently and prudently; but in financial matters, just as in other aspects of unit management, health authorities and their chief officers will usually get the performances that they deserve. If the context for unit managers is restrictive, and delegation provides little more financial power than the disbursement of the unit's small change, then DMT members will be pulled down into unit affairs. The inevitable consequences are that high-level district

work does not get done and UMTs will be by-passed regularly by those wanting decisions.

An alternative financial strategy is, of course, open to any health authority: to build up the strength of its UMTs. This allows quicker decisions to be reached and frees the DMT members for those more difficult tasks that only they can perform. Strengthening unit management cannot be achieved solely by good financial practices, but it cannot be achieved without them.

The standing financial instructions I have quoted exemplify the fears and doubts with which many authorities viewed their units of management in 1982. The opportunity still exists for changes to be made, and I shall describe some practical steps later. However, an important question about budgetary management underlies, at least in some cases, the decision of many health authorities to talk of unit management 'groups' instead of UMTs.

Unit management teams or groups?

Throughout this book, we have used the term 'unit management teams' (UMTs) although we are aware that practice varies. No particular term was used in HC(80)8 where there was a simple statement to the effect that all units of management would need an administrator and a director of nursing services, each accountable to the appropriate DMT manager, and a representative of medical opinion. In Chapter 7 Max Rendall explores the role of such a representative, but many commentators have made the point best expressed in the University of Birmingham Health Services Management Centre's Handbook No 16 (1982) that such a doctor

> . . . can take a full part in major and difficult decisions on finance, staffing, development, etc., for which substantial responsibilities are expected to be delegated to unit level. In such circumstances the profession would lose a great deal of influence on local issues if it did not take part: *but would be very concerned if major responsibilities were not delegated in the event* [my emphasis]

Because this chapter is concerned with financial management, any distinction between 'UMTs' and 'UMGs' is relevant only if:

1 the terms convey different working modes which will affect financial management, and
2 more financial authority will usually be associated with one title than with the other.

In fact only the first proposition is substantially correct. The term 'group' is more all-embracing than 'team'. There is an immense

Effective unit management

sociological literature about groups, their characteristics and working constraints. Those familiar with the literature will know that the term is ultimately too all-encompassing to convey an exact meaning and most authorities have produced many sub-categorisations.

On the other hand, while a 'team' is a type of 'group', the reverse is not true. A team has some recognisable characteristics, including the general notion that there are expectations that its members will consciously try to harmonise their individual performances. Dictionary definitions of teams often include words like 'cooperation'.

In matters of financial management, the term 'group' might be thought appropriate for those responsible for the distribution of a shared resource, such as an equipment allocation, or for those engaged upon some special project. However, when unit management is the primary function with which we are concerned, cooperative and mutually supportive activity should be the hall mark. HC(80)8 asserted that an administrator, nurse and medical representative would be the minimum requirement. Obviously these roles are not interchangeable, and each is separately accountable to his or her manager or the medical electorate. As Maureen Dixon showed in Chapter 2, the inevitable result is decision taking by consensus. Majority voting would be unacceptable as long as it is laid down that 'the unit nurse should be given responsibility for control of the nursing budget (allocated as part of the district nursing budget)'. Circular HC(80)8 also makes similar recommendations about the administrative services budget. The NHS experience since 1974 with district management teams employing consensus decision-making about budgetary and other matters has been broadly successful and a number of enquiries have found that it continues to be supported by the majority of team members, who appreciate the strength they gain from it. (Association of Chief Administrators of Health Authorities 1975; Royal Commission on the NHS 1979). It is difficult to force a change upon a resistant and united DMT who, over time, build up shared practices and methods of overcoming financial and other problems.

It seems likely that the term UMT was often avoided where health authorities feared the creation of powerful, mutually supportive teams of unit managers, taking decisions by consensus. Yet it is precisely this type of unit management team that we hope that this book will help to develop, and which was encouraged by HC(80)8.

Developing UMT strength through delegation of financial powers

In my view, the widespread concentration over the last few years on levels of virement for UMTs has been entirely misplaced. Many health authorities have issued standing financial instructions which exemplify contortions that would have been admired by Houdini, in the inevitably doomed attempt both to delegate boldly to their UMTs while in fact restricting financial authority to the minimum. As I suggested earlier, the power to grant or withhold resources is very significant and UMTs need to be encouraged to use it if they are to be effective, influential and capable of attracting an authoritative medical representative into their membership.

Delegating financial authority to UMTs does not mean giving them carte blanche. In particular UMTs would need to have their financial plans approved at least by the DMT and to demonstrate that they knew how to achieve these plans and not drift into irretrievable overspending. But it is of specific importance that the delegation must not consist of the DMT designing and approving each of the unit budgets (with their administrative and nursing components bounded by an impermeable membrane) and instructing their UMTs to stick to 'their' budget.

At this point, some definitions will help. In an earlier article (Wickings, 1980) I used the following linked definitions, which should help to clarify what could be meant by financial delegation to UMTs. The definitions were:

> *Plan:* objectives attainable within the limits imposed by the resources available.
> *Resources:* people, materials, buildings, systems and processes available within a specified period of time.
> *Budget:* financial statement of resources to carry out a plan.

I would like to add to the above three linked definitions the following:

> *Allocation:* a financial sum provided for unspecified uses within defined limits. (This should be contrasted with a budget, where the precise uses – the resources to be used – are already specified.)

In the DMT/UMT context, and using these definitions, the sequence would be that DMTs, after gaining a sense of the health authority's strategic policies, could announce to each of their unit management teams a provisional revenue *allocation* and agree or

specify the unit's *objectives*. Each UMT, supported by the financial advice urged in HC(80)8, would then be responsible for preparing its own *budget proposals* for DMT or health authority approval. It would be a test of UMT skills to show the extent to which the authority's overall objectives could realistically be incorporated in the *plan* which, when finally approved, would be expressed as a financial statement: the *budget*.

It will be appreciated that the preparation of their own budget proposals would be a demonstrable power for UMTs to wield, just as the clarification of service objectives for units would contribute to developing the planning strategies described by Best and Evans in Appendix I. A unique responsibility for DMT members is the provision of the support necessary to allow their health authority to develop its sense of corporate direction and its own strategic objectives. Strengthening the UMT role allows DMTs more time to provide this support. Appendix I emphasises the contribution that the learning model of planning can make to these processes, through the specification of corporate objectives, by improving analytical skills, relating planning to management control and the subsequent evaluation of how effective previous choices turn out to be. Budget preparation, in the manner I have described can, therefore, usefully contribute to strengthening unit management while driving forward more powerfully the strategic development of the district.

It is, of course, essential that budgetary practices follow organisational reality and UMTs must be sensed by their staff and colleagues to have the capacity and authority to wield these powers. I refer later to some problems which face health authorities in this respect. It is also essential that budget holders are named individuals, and not collectives. Consequently, each UMT's budget proposals must identify the parts of the whole for which different managers will be responsible. But the significance of having authority to make budgetary proposals about the distribution of an allocation is that, within the allocation's defined limits, the territory is clear. The UMT can use all its skill and judgment in the formulation of its own proposals. The DMT or health authority may, of course, not accept these proposals and require changes. But the position is quite different from that which applies when UMT members are simply expected to stay within a set of budgets handed down to them.

As a final comment on the process described, it will be seen why virement becomes less of an issue. Every year, the UMT will be expected to consider all parts of their organisation's spending patterns when making their plans, which in turn become budget proposals. Once the budget has been approved for the year, they

will be expected to implement the plan for which the budget is the financial statement. The UMT may judge, at any time, that they would like their plans changed – temporarily or permanently – and then must make proposals accordingly. This is quite different from setting an arbitrary limit of, say, £5000, as in the earlier example, which effectively restricts the UMT's 'financial territory' to that sum.

Allocations and priority care groups

Secretaries of State have regularly congratulated NHS treasurers on the skill they have shown in achieving an end-of-year outturn that matches the allocations passed down from the DHSS. This achievement compares very favourably with many other big spenders on behalf of HM Government, where effective control has been less evident, particularly before the introduction of cash limits.

It must be admitted, however, that in other respects the traditional styles of NHS financial management have not worked so well. Many commentators were dissatisfied for years with the failure both nationally and within regions to shift resources in real terms into the less well-provided parts of the country. It took the implementation of the RAWP methodology (DHSS 1976) to begin to achieve significant change – change which should probably be welcomed on grounds of equity despite the justifiable concerns expressed by Max Rendall in Chapter 7. It may be noted that the RAWP methodology involves changing allocations and requires local managers to adjust their budgets to match. Yet, although there has been some success in national resource redistribution, there has been a consistent failure to achieve a sufficient movement of resources, within authorities, from the acute care services to the priority groups. This is despite the fact that it has been official policy for many years. Richard Crossman drew upon his experiences as Secretary of State when he gave long-stay care as an example:

> In fact, we are running a two class system in the Service. We are treating patients in these long stay hospitals . . . as second class citizens. (Crossman 1972)

Yet little change has resulted. Malcolm Forsythe, Regional Medical Officer SE Thames RHA, for example, has noted that the national objectives articulated since Crossman's time have not been met. An example he quoted was that the total share of NHS resources devoted to inpatient mental illness care had actually

fallen, while the share spent on community care had only remained constant (Forsythe 1981). More recent analyses offer some better results (DHSS 1983) but the improvement is not impressive. The feature which I want to emphasise here is the absolute success that the Service has demonstrated in the matter of staying within its allocations overall, and the relative failure to switch resources within the allocations. This may well be due to existing NHS budgetary practices and, as suggested in Chapter 2, to organisational arrangements which reinforce the status quo. If authorities were to use the principle of making allocations to care groups and requiring the UMTs to produce budget proposals to show how they will use these allocations, then more powerful resource shifts could be achieved. Appendix II shows that very many units of management align closely to care groups that would allow such national priorities to be easily recognised. A mental illness or community care UMT could be told, for example, that they should plan for one per cent per annum increase in their share of the health authority's total allocation while another UMT might be told the opposite. This requirement upon UMTs to plan accordingly during their budgetary preparations would not only help to achieve the resource shift but would strengthen the UMTs' local position.

Could UMTs cope with such an expanded role?

It must be admitted that there are some difficulties to be faced in envisaging the type of expanded role for UMTs that I have outlined. Commitment would be needed at all levels to bring about the changes. Except in the very biggest units, the directors of nursing services and the administrators have not had any experience in preparing budgets, or facing up to the rigours of cash-limited allocations. Lack of experience can, however, be overcome by time and appropriate management education. Such a development would also impose fresh demands on finance departments. Unless strengthening unit management is an important objective in the health authority concerned, other financial activities will take precedence and leave us with DMTs who are too busy on minor matters to develop their strategic roles. Given the appropriate commitment, however, these particular difficulties could be overcome in any health authority within two years.

It is less easy to see how to overcome the difficulties caused by UMTs, and individual UMT members, who have different 'capacities'. I am using the word capacity to embrace both the idea of organisational work strata, as discussed by Maureen Dixon in Chapter 2, and to incorporate ideas of the personal capacity of individuals – a related but distinct matter. Without covering this

territory in depth, it would be widely accepted, I think, that the managerial capacity at any moment will usually be different for a Scale 9 and a Scale 32 unit administrator. Similarly a DNS VI would not be expected to have the same managerial capacity as a DNS I+.

As a consequence, and in terms of managerial capacity, it will usually be the case that a large unit (with a scale 27 administrator and a DNS I, say) will have more managerial skills and, probably, experience than a small unit with managers on relatively low grades. I emphasise here that I am speaking of 'managerial' rather than 'human' capacity, and that often individuals develop a greater personal capacity as time passes. But it would be a manifest nonsense to pretend that all individuals and all UMTs have equal capacities. Those interested in pursuing this topic further may wish to read Rowbottom and Billis (1978) Jaques (1976) Kinston (1982a) Jaques (1982) as well as Maureen Dixon in Chapter 2.

A frequent dilemma for health authorities and their DMTs is that the 'work level', of their various UMTs will be different. The type of budgetary and service planning proposals that UMTs will then make will vary according to their working mode.

In summary, UMTs working at stratum 4 can be expected to have wider ranging responsibilities, think in longer time spans, and be ready and willing to achieve better services by redeploying resources – trading off the less valuable service for the more valuable. Stratum 3 teams can be expected to respond to concrete situations and identify and cope with changed demand levels for services of a consistent kind. Their time perspectives will be shorter; they will feel unhappy if expected to decide upon trade-offs between the uncertain benefits of redeployment towards new developments and the certain costs to those existing services that might be forced to cede resources.

The financial management of such different types of team will not be the same, and yet each may purport to have the same relationship to the DMT. Furthermore, some DMTs may themselves feel happiest working at stratum 4 and thus seek to contain their UMTs within stratum 3 boundaries. The first quotation I included earlier for the terms of reference for UMTs will be recalled:

> UMTs have a duty to investigate the expenditure being incurred on the service they manage and to identify areas of saving *without reducing the level of standards of service being provided.* [my emphasis]

Table 6 Work strata and budgets

Features	UMT working at stratum 3	UMT working at stratum 4
Characteristics of work	Systematic service provision with a 2 year time perspective; responsible for analysing current trends and responding to a series of concrete situations that presents itself	Comprehensive service provision, usually of a range of related activities, with a 5 year time perspective; responsible for identifying shortfalls or new developments needed in the service(s), and expected to reallocate resources to meet conceived shortfalls or to achieve developments within managed services
Boundary conditions	Not expected to decide upon the reallocation of resources to meet as yet unmanifested needs for the service managed	Not expected to decide to reallocate resources to or from other unrelated kinds of services

HC(80)8 asserted that unit management was to be strengthened, that more power was needed at that level. This, if it is to mean anything, implies that DMTs must seek to widen and lengthen their own perspectives, thus giving UMTs 'room to grow'. I know of some DMTs which are already concerned with capital/revenue trade-offs, exercises involving the major financial restructuring of services, perhaps using the RHA as a 'banker', or working with local authorities, or with neighbouring districts, universities and medical schools, and so on. In many cases, the benefits from such activities will not be apparent for five, ten or even more years. But unless this work is going ahead, these benefits will never materialise and I see many DMTs taking no part in such strategic thinking. DMTs that allow themselves to be pulled down into stratum 4 unit affairs will be doing their health authorities, and the community that both serve, a signal disservice.

Unit management and experiments in financial techniques

There are several new developments in financial management techniques that will soon affect many UMTs. They share the common element that the expenditure is recorded in relation to the way clinical care is provided but in other respects there are differences. These differences can be appreciated from Table 7, which shows how different ways of recording the same total expenditures are being used variously in (W) functional budgeting (X) specialty budgeting and costing (Y) consultant budgeting and costing and (Z) patient costing. Research into these systems is now in progress both within single units and across all the units in several health authorities.

Patient costing is still a long way off in the NHS, whereas something similar can be achieved easily in those countries where financial accounts are submitted to insurers. When it can be achieved, it allows costs to be aggregated by diagnosis, by clinician, by hospital and so on. Such costs can be incorporated in epidemiological analyses designed to explore the comparative costs and benefits of different health care programmes. The disadvantages, at present, are that it is very expensive in administrative labour to cost each patient's care and many apportionments of departmental expenditures have to be used.

Specialty costing is much less expensive to install and one system is being widely tested in the UK. (Magee 1981). Under such a system, the costs of a unit of management are divided as shown in Table 7 and are then compared with those of similar units in other authorities. Such costings are of considerable use to managers, because without such data there is little evidence upon which to base judgments about comparative levels of over- or under-provision. However, as I and colleagues have argued elsewhere (Wickings and others 1983) the evidence to date suggests that changes in clinical behaviour are more likely to result from clinical budgeting than from costing alone.

It seems probable that some system of clinical budgeting must be adopted in the NHS because ultimately it is unacceptable for finite, cash-limited resources to be used up on a first come, first served basis. The same problems did not exist in the early decades of the NHS because real resources were steadily growing; indeed, in real terms NHS spending has more than trebled since 1948. During these early decades, NHS managers were resource *distributors*, adding resources first here, then there, in response to various pressures. In future, however, NHS financial management must be characterised by being *redistributive*.

The case for redistributive management becoming common is

Table 7 Illustrative table of functional and clinical matrix*

Clinical headings	Functional headings					Total of departments shown (£)	
	X ray (£)	Pathology (£)	Nursing (£)	Pharmacy (£)	etc (£)		
Surgeon Mr A							
Patient Mrs P	7	2	30	10		49	
Patient Miss Q	15	7	25	18		65	(Z)
Patient Mr R	2	5	45	0		52	
Other patients	720	390	3200	540		4850	
Total for Mr A	744	404	3300	568		5016	
Total for Mr B	890	444	3750	485		5569	(Y)
Total for Mr C	960	218	3800	960		5938	
Total for general surgery	2594	1066	10850	2013		16523	
Total for general medicine	3000	3750	14950	3600		25300	(X)
Total for geriatrics	1500	1890	19250	2600		25240	
Total for psychiatry	300	150	11000	900		12350	
Total for other specialties	1000	500	5000	1000		7500	
Total for hospital or group	8394	7356	61050	10113(W)		86913	

* Data for illustration only and to represent nominal financial units.
(W) = Functional budgets and/or expenditure.
(X) = Specialty budgets and/or expenditure.
(Y) = Clinical consultant budgets and/or expenditure.
(Z) = Patient costs.

based upon the need to judge competing clinical priorities. It has come to be widely accepted that caring doctors and nurses will invariably be able to see, or discover, new ways of helping their patients. These new ways will usually cost more and often be supplements to existing practices. Increasingly, the resulting pressures will force resource managers to decide what limits must be placed upon one service to accommodate an improvement in another. Hiatt (1975) and Kinston (1982b) have demonstrated the unavoidable inefficiencies which result from doctors sharing pooled resources. As it becomes harder to fund developments, such inefficiencies will become less tolerable and budgeting systems will be adopted throughout the clinical arena. The precise systems will vary, depending upon the methods used to fund health care. In the USA, for instance, experiments are in progress with 'health maintenance organisations' (North Carolina 1980) 'decentralised budgets' (Solomons 1979) and with 'diagnostic related groups' (Fetter and others 1977). Elsewhere Bally (1982) has reported on experiments in Scandinavia and France. Other experiments are in progress in Holland, West Germany and Australia, and in Britain (Wickings 1977; Wickings and others 1983).

The longer term effect on UMTs of these costing and budgetary developments is difficult to see clearly. Certainly, if UMTs begin to prepare their own budget proposals in the manner I am advocating, they will need to reach prior agreements with their clinical colleagues. Much of the discussion will be about the comparative advantages of different health care options, and UMTs will need all their skills of redistributive financial management. I find it hard to believe that UMTs, working in the extrapolatory mode described earlier as typical of stratum 3, will be equipped to handle such discussions.

Capacity differences within UMTs

I have suggested that strengthening unit management will necessitate the introduction of new financial practices, and that the increasingly harsh financial climate will bring other pressures to bear upon the consensus operating UMTs. Each member will have unique responsibilities and yet each will need to become part of a cohesive team.

In this climate, one must note with concern two of Catherine Shaw's findings quoted in Appendix II. Firstly, the gradings of the members of UMTs and also, one must expect, their personal capacities, vary widely even in units where the administrative and nursing boundaries are identical. For instance, Catherine Shaw has found a number of community units where the officer members of

the UMT consist of a DNS I and a Scale 9 unit administrator. Such disparities will doubtless impose additional pressures on UMTs that are, in any event, going to be severely tested over the next few years. The second feature of concern is that those UMTs working in the priority sectors – mental handicap and illness, the care of the elderly and so on – often have lower gradings than their colleagues in the acute units. This is most marked with the unit administrators. Over time, there must be disadvantages for units with weaker senior managers and this will not be felt least in the competition for scarce resources.

What can be done?

There is a considerable danger that many of the present financial arrangements for UMTs accepted by health authorities will negate the national intention to strengthen unit management. If significant powers are not devolved to UMTs then it will be difficult to persuade authoritive medical representatives to serve. If the UMTs are not strengthened, DMTs will be drawn into unit affairs with the consequence that higher levels of managerial activity will be neglected.

One way to reverse this depressing sequence is to expect UMTs to become the true managers of their services and to accept the responsibility of preparing their own budgetary proposals for DMT and health authority consideration. Such 'higher level' UMT behaviour would free DMTs to spend more time on strategic policy formulation with their health authorities and, in relation to financial management, undertake those tasks concerned with capital/revenue trade-offs, the major financial restructuring of services, cooperative project financing with other health districts, local authorities, universities and so on. There is, of course, a matching range of higher level DMT work in their non-financial activities, but that is beyond the scope of this chapter.

To enable UMTs to carry out more responsible financial management, they will require good information services from the finance department and, indeed, elsewhere. This was envisaged in HC(80)8, but it will only be achieved if it is a priority within the health authority concerned.

These are the problems. Some UMTs are unlikely to have the capacity, collectively or as individual members, to cope with the 'redistributive management and service planning' which has now become an essential requirement. This shortfall is a matter of concern for management educationalists as well as those responsible for recruiting managers to the Service. However, the way ahead is reasonably clear: health authorities and their DMTs must take

the bold step of creating managerial space which their UMTs can learn to occupy. It will take time, but it will never happen if the potential development of UMTs is restricted by well meaning but inhibiting minor regulations. It has been customary to encourage the idea of delegation in the NHS for many years, but the creation of UMTs affords a major opportunity to practice what has been preached.

As I commented earlier in this chapter, strengthening unit management cannot be achieved solely by good financial practices, but it cannot be achieved without them.

Max Rendall BA MB BChir FRCS
King's Fund Fellow in Clinical Studies

Max Rendall read medicine at Cambridge University and the Middlesex Hospital Medical School. He is a consultant general surgeon at Guy's Hospital, where he was appointed Clinical Superintendent in 1981 and is now the medical representative on the Acute Services UMT. He has a long standing interest in many aspects of the organisation and administration of hospitals, including particularly medical audit and issues of quality assurance and medical records. He has been the part-time Fellow in Clinical Studies at the King's Fund College since 1978, helping to run the management courses for groups of clinicians. He divides his time about equally between clinical work and managerial matters.

CHAPTER SEVEN

Medical care and units

MAX RENDALL

The central concern of all health care, in whatever context it is provided, is to help and comfort a patient at a time of need and vulnerability. The illness or *dis-ease* may prove to be clearly organic or to be largely emotional, or often some combination of the two, but it may require the help of unique skills of several health professions. As yet, however, it is still accepted that a doctor has a special place in this process, which will vary greatly from case to case, but which is of prime importance. In the exercise of this role he will take decisions which either cost money directly, or commit the time and energies of others. In some situations, such as single-handed general practice, the consequences of this are readily understood, but in large hospitals there are many doctors, who, as a group, have a singular effect on determining the directions in which organisations dedicated to the care of patients should move, setting priorities, and deciding how money is spent.

This chapter examines some of the issues which follow from and contribute to this unique position. Historically doctors have had an astonishingly free hand in these respects, and maybe rightly so; but it is unlikely that this state of affairs can persist indefinitely. This is not because clinical freedom is thought to be undesirable, but because we can no longer pay for decisions taken without careful consideration of cost. The profession is a victim of its own success in treating ever iller patients with hitherto unmanageable problems, but at a cost which can no longer be borne. This dilemma forces upon us the necessity to make choices, and the medical profession must take its rightful part in this process.

The need for doctors to share in today's decision-making

Not all decisions taken by doctors have a direct bearing on the treatment of a patient – indeed far from it. But there is a wide range of questions to which doctors as professionals should make an often crucial contribution; on many other issues the health authority, DMT or unit management team will wish to consult medical opinion in recognition of the collective wisdom which it may bring to bear, and the power that it can wield; and there are yet other matters which must be presented to clinicians not for a decision, but for information.

The need for a formal structure within which such discussion

can take place and be minuted for future reference has long been recognised. That is not to say that informal consultation or lobbying is not permitted or is ineffective. Both are legitimate and essential, and an understanding of how and when to use each mechanism is a prerequisite of effective management.

The history of medical involvement in what may loosely be called management decision-making is very mixed. On the one hand stand the medical superintendents of the past – autocratic and powerful figures clothed in frock coats; on the other are today's consultants, drawn or drafted, often with great reluctance, into the process of management. A consultant's presence here may owe more to the fact that the arrangements dictate that a clinician must be involved than that the individual concerned recognises what opportunities are presented, and what influence he can have on the way things are done. Of course the world has changed out of all recognition from the times of our archetypal medical superintendent. The size and complexity of today's hospitals, and the technical and interventional nature of medicine today would amaze him; he would have scant regard for the problems of industrial relations, work study, clinical budgeting, or any of the other trials and tools of today's manager. The reluctance to become involved in such matters expressed by his modern counterpart is understandable. Doctors spend years training to look after patients as effectively as the knowledge and facilities of the moment permit. They have no professional managerial competence, and are uneasy taking decisions which may have the effect of restricting their colleagues' clinical freedom. While, as medical representatives, they may work with other managers, they fear that their colleagues will regard them as having become 'one of them'. It is a difficult role, but one of great importance, and I will return to it in the last part of this chapter.

Doctors are by nature entrepreneurial and independent-minded achievers who are used to taking decisions for themselves. As scientists they are trained to weigh up the available evidence, and to change their practice in the light of new or contradictory information if it is substantiated. Clinical decisions of this kind are taken many times a day. Doctors rightly prize very highly the clinical freedom to take decisions as they see fit in the interests of their patients, and resent or resist any attempt to limit or circumscribe it. In such circumstances it is understandable if, from time to time, clinical decisions might seem to an outsider to be autocratic or intuitive, and there is perhaps a case to answer.

The need for the participation of doctors in the management of their own organisation has grown steadily. It is clear that today the senior medical staff, and the juniors for whom they are responsible,

are the most influential group in determining those policies and practices which have a direct influence on how a great deal of money is spent – on drugs, investigations, and other forms of treatment. Almost all the services upon which they call are increasingly labour intensive, and in many cases have high initial capital costs as well. Even if there were no other reasons, the need to commit money as effectively as possible would be sufficient to demand medical participation, and the further need to ensure that the services, once established, are run as efficiently as possible inevitably involves medical cooperation and commitment.

The realisation that we can no longer count on a steady annual growth in the money at our disposal has given a new urgency and a finer focus to medical participation in the decisions of management. Not only are we concerned now with the very best value for money in the non-clinical parts of our organisations, but we are facing the unpleasant reality of examining clinical practices by the same criteria – a matter which hitherto we have shrunk from as being too delicate and too dangerous. Issues of clinical freedom are indeed under a new scrutiny. In the 'good old days' so recently passed, most desirable developments in the services offered were sooner or later funded by new money. Although at the time we still felt very constrained by shortage of money, such days look attractive indeed in retrospect, for today in many parts of the country developments can only be funded at the expense of reductions in existing services. It is of course highly questionable if it was ever the intention of the Resource Allocation Working Party (RAWP) that certain parts of the country should have to suffer actual cuts in financial support. The philosophy was one of differential growth, and, given the extraordinary variability in services up and down the country, it was a principle which was hard to resist. However the extension of RAWP methodology to the districts within some of the 'best provided' regions has lead to actual cuts being imposed on the 'above target' districts. This has produced a totally new situation with consequences quite alien to the original intention. In this bleak climate some very hard and unpalatable choices will have to be made which may even prove to be unacceptable to significant numbers of those who work in the hospital service. Consensus management and acquiescence in the views of the majority may well be in for a very rocky time, and the medical staff may indeed find themselves to be front-line troops in the fight to maintain standards. It will require very clear and unemotional thinking, a preparedness to experiment and take risks, and an unusual degree of leadership.

Never before, therefore, has there been a clearer need for medical involvement in decision-making. How this should be

organised and channelled is an important matter which is the central theme of this chapter. But first we must look at some of the ways in which hospitals differ from most other organisations.

The special features of medical organisations

It has long been fashionable to criticise the administration of hospitals in this country, and much of this opprobium has come from doctors. Some of it is undoubtedly fair comment, but much of it is not, merely serving to perpetuate the divisions in a service in which all those who work ought to be striving together to overcome our common difficulties.

That there are deficiencies in the administration of our hospitals and other medical organisations should not be surprising. On the one hand you tend to get what you pay for, and the NHS does not always offer rewards which are competitive with comparable posts in industry and commerce. On the other hand there are a number of special features which make the running of medical organisations formidably difficult by any standards. They do not share many of the basic assumptions which the manager of a commercial organisation would recognise as being fundamental to good practice, and yet they are increasingly being subjected to purely financial control. It will be helpful to look briefly at some of these sources of difficulty.

First and foremost it is essential to be able to define the objective of any complex organisation, so that it is possible to judge the overall success of the enterprise and to make decisions about the contributions of its various parts. The profit motive may be regarded as inappropriate in medicine, but where it can be used it provides a very good discipline, it is easy to understand, and there can be little argument about success or failure. There are of course many secondary objectives in a commercial organisation, but they are all subservient to the need to make a profit, or to yield a satisfactory return on the capital invested. Medical organisations can only define their objectives very loosely, which does not permit critical and unequivocal judgments of success or failure to be made. To provide the best care possible within the constraints of a limited budget, against a background of almost limitless demand and an inexorable increase in what is possible and what it costs, is very difficult to express as an objective, and proves even more difficult when it comes to measuring success.

If that were not bad enough, two of the fundamental quantifiables of any commercial process – the input and the output – can neither be controlled nor measured in health care. The extent to which any acute hospital can control its workload is very limited,

though not negligible. Year upon year the emergency work and the case mix will not change greatly, but in the short term there can be considerable variability. It can be argued that in the NHS, where funding is not related in any direct way to output, quantification is unimportant. It would nevertheless be very helpful indeed when making comparisons, or in discussions on issues of the quality of care, if output could be measured. There have been many attempts to do this, but with little success so far, and indeed the problems are probably insurmountable. How, for example, would one compare a patient with brain damage from a severe head injury who survives as a consequence of skilful medical care and dedicated nursing, with the unexpected death from a pulmonary embolus of a patient after a mastectomy for a carcinoma of the breast?

There are other important ways in which variables cannot be controlled in our institutions. Clinical developments, frequently led by research, are constantly changing current practice, and, with very few exceptions, it is impossible to predict or anticipate the new directions in which they will take us. These will in turn create a demand for new facilities, new machines, more people, different sterile goods, or other drugs. Some of these developments are clearly cost effective, but others are much more questionable, and they are all ultimately expensive.

Another way in which unpredictable growth in a medical organisation may occur, which is in many ways wholly desirable but may nevertheless pose problems, is the creation of departments by energetic and ambitious individuals who offer services far beyond what was expected of them. Consequently patients benefit but the DMT has to meet unplanned expenditure. The last source of difficulty – and the most troublesome – is changes in national policy, often associated with changes in government, mediated by the Department of Health and Social Security or the regional health authority. Doubtless some changes are unavoidable, but the examples of inefficiencies in nationalised industries caused by radical changes of policy have been largely ignored and, in consequence, the NHS has had to suffer the paralysis brought about by two reorganisations.

There are, too, some unique financial features of medical organisations in the NHS. Whilst the cash limit system has proved remarkably successful in limiting overall health care spending, it may also be seen to encourage the less energetic and to stifle enterprise. As has been hinted previously, cash limited allocations are not directly work related, and certainly provide little in the way of incentives. It is of course regrettable that only a real shortage of money has concentrated the mind adequately on efficiency, and it seems that the profession and our patients will have to pay a heavy

price for it. Nevertheless, this process cannot go on indefinitely without inflicting serious damage on the service. Given some system of built-in incentives it is likely that more could be achieved with available resources, but present funding arrangements do little to encourage enterprise and harness enthusiasm.

Another strange feature of hospitals is the reversal of the usual trade-off between capital expenditure and revenue saving. Almost invariably in hospitals capital projects cost more to run, be they new buildings or a body scanner. Perhaps this is related to the fact that hospitals are not allowed to borrow money. The requirement to pay back loans for capital projects constrains extravagance in commercial enterprises. Is it surprising that some critics compare the NHS unfavourably with commercial enterprises?

Finally, and very importantly, the usual pattern of management and workforce, with all the mechanisms and relationships which have evolved between them in any conventional business, has had to accommodate in hospitals a group of powerful and independent-minded individuals who remain outside the usual lines of responsibility and accountability in the organisation. The senior medical staff of a hospital are, in the main, a self-regulating peer group, but their influence on all aspects of the way the hospital is run is crucial. They do however, particularly as individuals, pose serious problems for the administrators. There are some obvious reasons for this, most notably that many of the administrative staff in contact with consultants are young and relatively inexperienced, which, almost by definition, consultants are not. Coupled with the traditional but out-moded notion of the subservient administrator and the all-powerful and omniscient consultant, this places the young administrator at a severe disadvantage and perhaps fosters the well known adage about the NHS – that it is 'over-administered and under-managed'. The difference between doctors and administrators is important and not simply one of degree. As money becomes even scarcer the need to manage rather than administer will become more apparent. These circumstances could provide common ground for doctors and administrators to join in confronting the over-riding problem in the health service – the provision of high quality care at a realistic cost.

Clinical autonomy, and doctors as resource managers

In a civilised society all freedom must lie within the law. Any calling which can lay claim to being a profession will have a discrete body of knowledge which it calls its own, with a well regulated training and a closely controlled entrance qualification. It will have carefully nurtured professional standards and codes of behaviour,

and mechanisms for self-imposed discipline for those who transgress these limits. In many cases there will be statutory bodies which reinforce and guarantee some of these features and provide a degree of protection to the public at large. These features are common to many professions but doctors have certain unique privileges – the ability to prescribe drugs, a recognised and respected place in society, and freedom to practice within this professional framework. There are still other limitations, of which the most important are such explicit policies as may from time to time be introduced in the NHS, the available resources, and generally acceptable standards of behaviour in society.

Clinical freedom, perhaps better called clinical autonomy, means that a doctor is free to investigate and treat his patients in whatever way he feels to be in their best interest. It is a feature of practice in the NHS which is universally regarded by doctors as essential, and its continued guarantee has been a major factor in persuading medical men and women to cooperate with government in setting up the NHS, and in subsequent attempts to reorganise it. It remains today the cornerstone of practice in Britain. It is a genuine freedom which is, of course, circumscribed by law.

Clinical autonomy can be said to lie in the fact that the decisions of a doctor when treating a patient are not subject to managerial control. In this respect there is an important difference between, for example, a managerial decision that a certain drug should not be available on the grounds of cost, and a decision, arrived at by a majority of informed colleagues, that the drug should only be prescribed if certain clinical criteria are satisfied. This kind of self-regulation is increasingly necessary to ensure that the money available is spent as effectively as possible. In this sense, the doctor is autonomous rather than free, and clinical autonomy more accurately describes the notion which we are examining. No matter how tight constraints become, clinical autonomy must be preserved, but within a realistic framework determined by the available resources, be they money, people or facilities. Discussions which touch on this sensitive issue will be difficult and will only reach acceptable conclusions if the majority of clinicians are persuaded by the case being put.

There has been a school of thought which advocated the notion that clinical autonomy sprang directly from the unique nature of medicine and the need for doctors to retain their professional dignity and self-importance, which made it entirely inappropriate to subject them to binding managerial decisions. This rather nineteenth century conclusion seems muddle-headed, and it may have sprung from the practical difficulties of imposing any other basis for practice. However, clinical autonomy can hardly have

been a real issue in the days when medicine was relatively impotent and comparatively cheap, social attitudes different, and the need for decisive managerial action very limited. A more cogent argument, put forward by the Brunel Health Services Organisation Research Unit (Jaques 1978), is that clinical autonomy was the direct consequence of the decision to provide an individual and personal health service in which there was to be a confidential relationship between the patient and a particular doctor. This was a specific item of social policy which obviously had a far-reaching effect on how the service would be organised, since such a relationship cannot, by its nature, be managed in the formal sense. Thus, GPs and consultants only enjoy this autonomy if they continue to provide a personal service. Doctors practising in other settings will not necessarily share this autonomy, but may be organised in the traditional managerial hierarchy. The belief underlying the decision that the NHS would provide personal clinical care was that this pattern of practice was the most effective way of helping an individual to cope with all aspects and consequences of an illness. If this justification is accepted, any change from a one-to-one relationship with a known doctor would presumably carry with it a threat to clinical autonomy. A general practitioner deputising service is an example of such a change, since it can obviously be a managed service. It will be interesting to see if these and similar variations continue to enjoy clinical autonomy.

The concept of clinical autonomy is, however, very complex and, in effect, its operation is not totally restricted to those doctors who have a one-to-one relationship with a patient. It is to some degree enjoyed by pathologists and radiologists, and is increasingly being laid claim to by certain nurses, physiotherapists and similar professionals. In an effort to elucidate the matter more fully, the Brunel Unit has identified at least four components of clinical autonomy. First is the most obvious, that a practitioner can exercise professional judgment without having to submit to the scrutiny of others. This they have called 'independent practice'. Second, the patient has a theoretical right to choose his doctor, and the doctor has the right to accept or reject the patient. This 'right to choose' is clearly essential if the relationship of confidence and trust upon which the service is founded is to be anything more than a hollow promise. Third is what has become known as 'prime responsibility' which acknowledges that the doctor is in a unique position to deploy whichever of the available treatments or resources of the NHS he feels to be most appropriate for his patient. He is, in this respect, the conductor of an orchestra. Fourth, only doctors are expected to coordinate the care of other professions on behalf of each patient, so the medical profession alone is said to

have 'primacy'. Doubtless others will lay claim to prime responsibility and to primacy in due time, but to date the only group which can reasonably claim all four elements, and hence enjoy true clinical autonomy, is the medical profession.

So much then for the concept of clinical autonomy. The next issue which arises is to what extent the role of a doctor as a committer of expenditure or as a manager of resources is compatible with clinical autonomy. In an ideal world, doctors would be inspired managers as well as impeccable clinicians who would treat patients as they wished in the confident knowledge that their management was the most effective and the cheapest available. Given that neither the world nor the doctors are ideal and that medicine at its best is rapidly becoming too expensive for any nation, more and more attention is being focussed on expenditure. It therefore becomes inevitable that doctors, especially those in hospital who are responsible for the expenditure of huge sums of money, must, at a time of severe restraint, make choices and, consequently, manage what is at their disposal. Far from being incompatible with clinical autonomy, such involvement is the best defence we can offer against those who will otherwise make much more arbitrary and damaging decisions.

Provided we continue to finance medicine from public funds, the sums available for health care will be determined by the politicians of the day, but we will do well to remember that those who make this decision will be conscious of society's willingness to pay the bill. We are now in a time when we cannot expect to finance new developments with new money. If we are committed to practising and providing up-to-date care, as we are, we must finance innovations by increased efficiency and by trimming back less desirable services.

At the present time we are seeking new ways of making these very difficult and unpalatable choices. The philosophy upon which medical men are brought up is totally incompatible with the idea, now being widely discussed, that criteria other than medical need should determine whether a patient is treated, and how. The only sensible way to avoid having these criteria forced upon them is for clinicians to exercise a degree of constraint, discipline and self-control hitherto unknown to them. The most promising practical way forward is to devolve to clinicians responsibility for the control of spending without proscribing freedom of choice. This can be in a budget, with their agreement in advance to the incentives for success and penalties for overspending. Although there are manifold difficulties in this approach, there is evidence that doctors can work in this way, and that it gives them certain worthwhile advantages. The role of the consultant member of a DMT or UMT

in this overall process of resource management is different and it will now be discussed.

Medical representation in the new units

The 1982 reorganisation abolished the area health authorities, and introduced the notion of units to organise and manage the services. Some units are concerned with client groups and others with the management of services on a particular site. The former may well ignore the traditional demarcation between hospital care and care in the community and seek to provide an integrated and effective service for the group of patients concerned, be they the mentally ill, the mentally handicapped, the young, the elderly, or those having maternity care. Units concerned with the management of services on a particular site are very often having to deal with acute services based on one or more hospital sites.

The membership of unit management teams (UMTs) is usually a senior administrator, a director of nursing services and a clinician, but some may include a representative of the district treasurer. It is important to recognise that the doctor alone on a UMT is not directly accountable to his counterpart on the DMT. Medical representatives are answerable to those who elect them, their colleagues, and it is not a relationship such as that of a manager to his subordinate. Because other members of a UMT could be instructed to carry out a policy which will be unacceptable to the clinician, it is essential to understand the strains these different relationships can impose.

The special position of the doctor on the UMT underlines the need for him to be able to consult and report to his colleagues. In the case of units based on client care groups, the Cogwheel division or divisions concerned provide a ready made forum in which the views of all grades of medical staff, can be made known. If there is no community services division, there may well be other meetings of the staff concerned which could fulfill this role. A great problem arises where there are large acute service units, particularly if there is more than one in a district. In these circumstances, a large number of senior clinicians may wish to take part in discussions but meetings of the main medical advisory committee could become too parochial. Other means of obtaining advice would then have to be found. In some cases the informal approach might work, although that would have its dangers for the individual concerned. Unit Medical Advisory Committees (UMACs) might be considered, but most consultants feel that there are too many committees already. Nevertheless, if UMACs can command attendance they are an obvious solution. An alternative is to use an existing

forum. Some districts have a general purpose committee which, with alterations to its constitution and membership, might serve this purpose.

The extent to which the management of services in the NHS is being devolved to units differs considerably up and down the country, but, whatever form they take, they offer new opportunities for imagination and innovation. It also means, however, that the unique position of the clinician could lead him into serious and even damaging conflicts of loyalty. His best defence is to have a close and realistic relationship with his colleagues, enabling him to listen to their advice and to take his problems to them while explaining the problems of the organisation which he serves.

The historic development of medical advisory systems in the NHS

The development of the National Health Service brought with it a uniformity of structures hitherto unknown, making it possible for the then Ministry of Health in the 1960s to initiate the setting up of medical advisory committees in all hospitals. These had an elected membership drawn largely from the consultant body, with the specific task of advising the hospital management committee (HMC) 'on matters of legitimate concern'. The Ministry of Health at the time felt that there were extensions of the traditional advisory role which should be taken on by these committees – what might today be called monitoring activities – but these suggestions were largely ignored. These new committees, in many but not all cases, took over the functions of the medical staff committee, which consisted of the entire consultant body. They began to develop expertise and generally to raise the level of debate and concern amongst doctors for matters hitherto regarded as strictly administrative.

The increasing costliness and organisational complexity of hospital treatment, and hence the difficult decisions needed, led to the publication of the three Cogwheel Reports in 1967, 1973 and 1974. Consultant numbers had greatly increased and a less unwieldly, yet truly representative, mechanism was needed. The Cogwheel reports introduced a structure which made it quite unavoidable that clinicians should become more deeply involved in consultation and decision-making on a wide range of issues. The efficient use of resources was one of the matters singled out for specific mention, and the essential involvement of junior medical, nursing and ancillary staff in discussions which led to properly considered advice was formalised. Most important of all, though, was the decision that clinicians should for the first time have a statutory role

in the affairs of the district and its hospitals. This marked the coming of age of medical advisory machinery, but the clinicians were to come to the party as reluctant guests.

The full impact of the Cogwheel system coincided with the changes brought by the 1974 reorganisation of the NHS. Rooted in the belief that services should be organised on a district-wide basis, with much greater integration of primary care and public health services with the hospitals, the complexity and range of issues to be considered became even wider. As if to mark the distance travelled from the all-powerful chief executive of the pre-war voluntary hospitals, consensus management came to the health service. Somewhat surprisingly, it has worked remarkably well. It has fostered a freedom of expression in discussion which might not have been heard if there were a constant likelihood of being out-voted. It ensures that, once a decision is taken, there is a real commitment to making it work.

The Cogwheel structure of the various divisions, all represented by their chairmen on the medical committee executive (MCE), is designed specifically to offer advice from the medical staff to the district management team, and more often than not the team's chief officers attend its deliberations. However, the executive is not in a position to speak for the general practitioners of the district as originally proposed. The 1974 reorganisation envisaged the district medical committee (DMC) as the senior source of medical advice to the DMT, since it brought together members from the three branches of the service – general practitioners, hospital consultants, and doctors in the community medical service – in a form which enabled each group to put forward its views, which could then be moulded into an integrated consensus. With few exceptions, however, the DMCs have not prospered, and, since the findings of the Yellowlees Committee, districts are no longer required to set them up. Other mechanisms for putting forward the views of primary care are being tried, most commonly perhaps the introduction of a division of primary care, which takes its place beside the other Cogwheel divisions with its chairman on the MCE. The GP member of the DMT is, of course, also very well placed to speak for the interests of the general practitioner services, and ensure that their voice is heard. Very important though the primary care services may be, the majority of problems which beset DMTs are much more concerned with the hospitals and the containment of their costs.

A point of great importance, which is not often fully appreciated, must be made before we leave the subject of medical decision making and advisory machinery. The purpose of all the mechanisms we have been discussing is to represent the views of the

medical staff to the DMT and to the UMTs. They serve as representative or advisory bodies and are not either suitable for, or intended to undertake, a managerial function. For example, the day to day problems of managing a particular pathology laboratory are not a matter for which the division of pathology can be held accountable although, naturally, it would be interested in advising on what changes in service the laboratories could offer. For the efficient management of the financial and other resources of such a service the head of the diagnostic department can properly be held accountable to the unit administrator, or, in smaller authorities, to a nominated chief officer on the DMT. These officers are whole-time managers who can mobilise the necessary assistance to deal with problems in a timely fashion if the departmental head cannot. It should be emphasised, though, that this accountability is for the department head's managerial role and not for medical decisions, which remain the consultant's personal responsibility.

The role of the doctor on the UMT

As noted earlier, the clinician on a UMT is in a significantly different position to others on the team. The unit administrator and director of nursing services, and indeed any other non-medical member, have an in-line relationship with a superior – probably on the DMT. The doctor has not. Perhaps echoing the position of the senior medical staff as a whole in the organisation, he is outside any traditional hierarchy. He is in an obvious sense responsible to his consultant colleagues, whose confidence he must retain, but he is not their delegate.

The 'medical representative' has unusually wide powers and duties. He is expected to lead, negotiate and make many judgments on behalf of his colleagues. He is their nominee to serve on those groups which must confront problems collectively and decide how best they may be dealt with. In this process the clinician will put forward clearly and forcefully the views of the medical staff. These will be of paramount importance on some issues, and less compelling on others. To be effective he must recognise issues of principle; he must know where consensus lies and how fast, and how far, it can be pushed. To do this he must maintain good communications with his colleagues and know how and when and where to apply informal pressure. He must be aware of who forms and influences opinion and who does not, and he must be prepared to negotiate with a clear view of what he can give up to achieve his objectives. In short he must be a politician. It is in the exercise of informal personal qualities that his effectiveness will lie, not in his position.

Bearing in mind the directly accountable relationship of the majority of members of a UMT to the DMT, it is likely that a UMT will, from time to time, be instructed to implement a policy decision which the team finds damaging to the interests of those it serves, or is in some other way undesirable. Clearly DMTs will be at pains to avoid these problems if at all possible, but it seems likely that some will be unavoidable in the financial climate in which we now live. This will place the clinician on the UMT in a very difficult position, because he may find himself party to a decision which his colleagues cannot accept. Such issues will stretch his political skills to the utmost, and success will depend as much on his ability to explain to his colleagues the reasons which have led to the conclusion reached as on his adroitness in selling a fait accompli. He must always remember that there may be an issue on which he might not be able to carry his colleagues and it is his duty and responsibility to know where the frontier lies, and to make sure that he states the position clearly in the discussions in the UMT. If he is unable to deliver he must say so or he will have to resign. Otherwise, his colleagues will be certain to make it impossible for him to continue to act as their nominee.

In difficult times when unpleasant decisions must be implemented, there is obviously a danger that the unit doctor could acquire the reputation for being 'one of them', for collaborating with the administration in the pejorative sense of that word. It is a danger which has to be accepted, but there are ways in which the risk can be lessened. I have written of the importance of skilful and sensitive communication, which is fundamental. Close contact with the consultant member of the DMT will also pay dividends. The DMT consultant must be aware of the anxieties and priorities of the medical members of his constituent units; they help him to shape his own views and allow him to give early warning of problems coming down to the units. Most important of all, the UMTs should try to solve some long-running problems; successes of this sort will build up capital for them on which they can draw in less happy circumstances in the future. There is nothing that will command the respect of a consultant more than the ability to solve intractable problems quickly and efficiently, and he will be prepared to repay the debt when necessary.

The role of the clinician on a UMT will, of course, vary greatly from unit to unit and from hospital to hospital. Some units will make modest demands on time and energy and others will be close to a full-time occupation. It goes without saying that the clinician will need the help of an efficient secretary. The job will demand the skills of a tight-rope walker at times, but the opportunities have

never been greater and it would be sad if consultants did not respond to them.

Effective medical representation in units – four important points

1 *Credibility for the medical representative*
Maureen Dixon's chapter listed the wide variety of units of management. Some form natural units from the clinical standpoint, and particularly where there are only one or two consultants involved – for instance in some mental handicap units – there is no question about the choice or role of the medical representative. In other cases there can be problems. A frequent difficulty arises where the health authority's resources and internal politics are dominated by one large district general hospital. Distinguishing between the roles of the UMT and DMT consultants can be difficult. Another situation which poses problems comes about when a group of clinical specialities in a unit make sense from the viewpoint of administration and nursing yet fail to provide a logical basis for the clinicians. A 'priority care group unit', for example, which incorporates community services, midwifery, mental illness, mental handicap and geriatrics, provides no natural grouping to throw up a clinician for the UMT. By definition, he cannot represent all his colleagues with equal experience or insight, although he must strive to do so.

2 *The power delegated to UMTs*
It should be obvious that if DMTs delegate little authority to UMTs the medical representative's role in the unit will be seen as a waste of time. Unless significant and effective decisions can be made by the UMTs, the medical staff will insist on dealing directly with the DMT. This in turn will create powerless unit managers.

3 *Doctors on the health authority*
It is important to emphasise that consultants or general practitioners who are health authority members are not representatives of their colleagues and should not be asked to act as such. A medical representative on one of the management teams has to judge which of his colleagues to listen to and which to ignore. If doctors on the authority are treated as representatives, the doctors on management teams will be faced with an impossible balancing act.

4 *The conveyor of unwelcome tidings*
Sometimes it is inevitable that the representative has to convey unwelcome tidings to either his UMT or his medical colleagues.

It is important that both sets of colleagues realise that his independent viewpoint is a highly prized asset and, if he is thought to have lost it, it will become much harder to get a broadly based consensus amongst the doctors. In particular, this means that other members of the UMT may be well advised to explain major difficulties or unpopular health authority policies to the medical staff rather than expect the clinician to put forward views which may be inimical to those of his medical colleagues.

CHAPTER EIGHT

Conclusions and an action outline

IDEN WICKINGS

What are units of management?

It is relevant to question whether 'units' are, in fact, anything new. The notion that the cooperation of a doctor, a nurse and an administrator should form the essential basis for the management of a general hospital has been well established since the sixties, although such triumvirates have sometimes been called hospital, or sector, or service management teams. Perhaps this was to avoid the ugly, quasi-military term 'unit' which the NHS now seems determined to use.

Outside the acute hospitals, however, the composition of management teams has varied in the past, and some have included psychologists, therapists and social workers. Other teams have incorporated several doctors or several nurses in order that different parts of a comprehensive service could be represented. A financial adviser could be found working with many of these teams and sometimes this role had been elevated to full membership. So the current emphasis on the three members of unit teams does represent something of a change outside the general hospitals.

Since the implementation of HC(80)8 began, however, some complications have emerged, even though the wider adoption of the deceptively obvious 'triumvirate' had been expected to simplify arrangements. In many so-called unit posts there is no alignment between the nursing and administrative roles. For example, it is common to find districts in which the acute hospital unit administrator is expected to cooperate with several directors of nursing services who variously cover the acute, midwifery, psychiatric, and child health/community nursing 'units'. In such circumstances the acute unit administrator will not usually be the administrator of the last two units mentioned above. Furthermore, the elected doctors on these other 'units' may be unfamiliar with the acute unit. The various medical representatives may belong to committee systems which are, at best, poorly integrated, such as the separate committees for general practitioners and consultants. It is, of course, not only the administrators and doctors who are so enmeshed by these complexities. The nursing unit managers principally providing community based or longer-stay care often have very uncertain powers in the associated wards and clinics in the acute hospitals although these areas may be included in the list of their

responsibilities. It is questionable whether 'units' exist in a meaningful sense when the administrative, nursing and medical zones of influence are very poorly aligned.

Any outsider looking in must regard the whole pattern, or lack of it, as the product of a design conference held during that famous tea party when Alice asked, very appropriately, 'Is that the way you manage?'.

General management in units

We cannot complain if an outside observer of unit management today concludes that the overwhelming need is to simplify it, particularly if the DHSS has reaffirmed the aim expressed in HC(80)8 that units should be strengthened. While this book was being prepared, the members of the NHS Management Inquiry chaired by Mr Roy Griffiths have let it be known that they have some sympathy with the concept of a general manager. It is not difficult to see why, and most large organisations have one. Even in other health care systems there are many examples of general management roles, although it is always important to discover precisely what powers these managers can, and cannot, exercise. Such de facto authority has been wielded less frequently in the past by nurses than by doctors or general administrators but many nurses manage their own convalescent homes in the UK, and in developing countries mission hospitals are often directed by nurses. Medical directors control many hospitals around the world and quite recently Britain also had community and preventative services solely under medical management. True, in developed countries, there has been a widespread growth during recent years in the proportion of hospitals coordinated by non-medical general administrators, but no discipline can claim a proprietary right to a general manager's chair. But if there were to be such an office in NHS units, what might this mean? Is general management the same thing as having a chief executive ?.

It is worth clarifying what might be meant by such concepts in relation to NHS units. A chief executive elsewhere has full managerial authority over 'his' staff and can require this compliance, but NHS clinicians have both the duty and the right to treat their own patients in the manner they consider best within the constraints described by Max Rendall in Chapter 7. We can be certain that this aspect of the clinician's role will remain unchanged, not because of the power of the medical lobby, but because of the need for confidentiality in doctor/patient relationships. If a clinician's judgment about the treatment needed by an individual patient was open to managerial review then the clinical data and social details about

that patient would need to be available to the higher authority. Such a change would not only flout clinical autonomy but would negate the principle that patients can rely upon their clinical and personal data remaining confidential to their own doctor. We can be certain that such a change would be unacceptable to our society and so the concept of an overall chief executive can be put aside.

However, the same difficulties need not necessarily affect the hierarchically organised professions and there are many examples of nurses and others being managed by non-nurses. Nurses, psychologists, therapists of various types and others such as works professionals increasingly demonstrate that their professional development has reached the stage at which management *at the operational level* by members of other disciplines is not truly satisfactory. The same cannot be said about higher level management where the professional knowledge base is less important than general managerial skills and an understanding of policy. The issue is that at some point managerial responsibility must be integrated into something that becomes 'general'.

Returning to our outside observer, Halpern (1983) has reported that Mr Roy Griffiths, the chairman of the NHS Management Inquiry Team, had 'not talked specifically about the concept of a chief executive' but wanted 'to develop a general management concept to establish who is exercising the overall responsibility for matching resources to the results which are . . . to be achieved'. This seems entirely compatible with the points made above.

The general managerial responsibility could therefore be allocated by a health authority to the most appropriate person who is managerially accountable to them and who can exercise the necessary authority over the managed staff in other professions. This probably excludes the medical representatives who are, ultimately, accountable to their electorate and not the authority. As Max Rendall put it in Chapter 7, the financial climate has changed so dramatically that some clinicians are realising that 'choices will have to be made which may even prove to be unacceptable to significant numbers of those who work in the hospital service. Consensus management and acquiescence in the views of the majority may well be in for a very rocky time, and the medical staff may indeed find themselves to be front-line troops in the fight to maintain standards. It will require very clear and unemotional thinking . . .' Health authorities will also, of course, need to think clearly and unemotionally but they must be capable, finally, of instructing their general managers. This cannot apply to a medical representative who is unable to represent his colleagues if he is being instructed to behave in a way that is inimical to their interests. It therefore seems that the retention of clinical autonomy

by general practitioners and consultants effectively excludes the medically elected representatives from roles with the responsibility for general management on behalf of the health authority. Other ways have to be found, as have been described in earlier chapters, to inter-relate the responsibilities of the clinicians to their own patients, and the responsibilities of the managed hierarchies to the health authorities and, ultimately, to the Secretary of State and Parliament. The general management of units is quite feasible but it excludes the clinicians from its grip. To reconcile the legitimate objectives of clinicians and authorities, some form of consensus mechanism seems inevitable.

Action proposals for health authorities

The unit structures introduced as a result of HC(80)8 were often compromises and were selected in the light of various pressures which affected health authorities at that time. Some of these pressures have been referred to earlier, such as when the perceived need to attract or keep able staff forced health authorities to 'cobble together' units that would be large enough to justify senior gradings. Other forces at work included a determination by some authorities to have units that were care group based while their neighbouring authorities perhaps held entirely different views. In many instances decisions on these matters had to be reached very rapidly and Appendix II reveals the complexity of some units and the grading anomalies that affect some unit managers' posts. It is time for the structures and gradings to be carefully reviewed. Are they optimally designed to achieve the authority's objectives? Do the structures give unit managers a proper opportunity to build powerful UMTs or are they being forced to grapple with needless difficulties? Can the unit managers establish effective working relationships with their doctors?

Max Rendall wrote in Chapter 7: 'Another situation which poses problems comes about when a group of clinical specialities in a unit make sense from the viewpoint of administration and nursing yet fail to provide a logical basis for the clinicians. A "priority care group unit", for example, which incorporates community services, midwifery, mental illness, mental handicap and geriatrics.' Units of this type will have great difficult in finding a suitable medical representative to serve on the UMT. Where the UMT does not seem a logical focus for senior doctors to raise important issues with managers representing the health authority then they will by-pass the UMT and seek to deal with the DMT directly. Nonetheless the choice of unit structures will often have to be a compromise and no one aspect is conclusive. Despite the difficulty concerning medical

representation on such unit teams, these units may, as Max Rendall puts it, make administrative and nursing sense. Presumably the term 'priority care groups' means those which the authority has decided need to be developed and improved. The effective achievement of such developments is dependent upon managers with the personal capacity to envisage the way forward, the skill to turn their ideas into practical proposals, and the competence to make the changes.

The proposed developments must be competitive with other bids for improvements arising in the district, and, once approved, they must be implemented in the complex world described by Tom Evans in Chapter 3. If the priority care groups do not have unit managers with the capacity to meet these demands, then the proposed developments will be inhibited. Maureen Dixon earlier described such requirements in terms of work levels and emphasised that those managers who habitually operate in a systematic way, principally responding to sequences of concrete situations and perceiving their world in one to two year time spans, are unlikely to be the most suitable in the developmental role. In this light, there must be some concern at Catherine Shaw's conclusion in Appendix II that 'as a general rule, the gradings accorded to unit administrators working in the priority care groups compare less favourably with [those] in the acute units.' She also noted that the administrative gradings in a number of units compared unfavourably with those of the unit DNSs. It is, of course, true that changing gradings and altering the composition of units will not necessarily produce unit managers with the capacity to undertake the demanding, developmental roles that I have described. However, it may well be timely for authorities and their DMTs to review their unit structures and gradings to ensure that the original designs offer the best chance of achieving the required objectives. In particular, it is unlikely that the cause of 'priority' groups, and especially the cause of those complex units with boundary roles impacting upon other authorities, will be best served by having the lowest graded unit administrators working in them.

The next major step that could help to strengthen UMTs would be to have the managerial arrangements simplified where possible. This certainly includes the clarification of the general management responsibility mentioned by Mr Roy Griffiths, but also means avoiding the 'dual accountability' situations and other needless complexities described by Maureen Dixon. If accountability is confused, then it is almost inevitable that poor performances will result.

Finally, authorities could strengthen unit management by re-

quiring their UMTs to make their own budget proposals, as described in Chapter 6. It is a relatively simple step, although it imposes some extra demands upon the financial staff. It is, however, quite different from handing a pre-determined budget down to the UMTs which effectively weakens rather than strengthens their roles. It also means that health authorities would need to determine the allocations and the objectives for their units and neither will prove to be a simple task. But if health authority members cannot handle the difficult issues involved, they have no right to expect their managers to handle them without guidance.

Action proposals for DMTs

It has been a repeated theme in this book that unit managers will only achieve their full potential when the context for their roles is well designed and when their powers and duties are made explicit. Unless these conditions are fulfilled, unit managers will often be forced to act indecisively. UMTs that cannot exercise significant delegated authority will find it difficult to attract an influential medical representative into membership. This lack of local grip will lead to the DMT members becoming involved in affairs more properly left to their subordinates. In turn, the DMT will be prevented from undertaking its own high level work. This underperforming sequence can be reversed by a conscious effort to delegate from DMT members, provided they have the support of their health authority. Inevitably there are initial risks while the unit managers are left alone to develop their individual and collective capacities, but the long term costs resulting from too little high level work being undertaken by the DMT are very significant. I quoted some examples from the financial scene in Chapter 6 but similar issues are raised by service planning, by the need to formulate criteria and strategies for district development and by the responsibility for the formal evaluation of existing services.

A significant responsibility for DMT members is to decide what should be done when one or more of their UMTs fails to cope with the expanded role outlined in this book. This is not simply in relation to those matters just described but also includes the UMT's capacity to contribute towards the achievement of a genuinely caring environment in the unit. June Huntington gave a number of clear examples in Chapter 5. Such an achievement, although principally the concern of the operational staff, can be fostered or hindered by unit managers. Members of DMTs need to be concerned to develop the personal and collective capacities of their unit

managers in this respect, particularly in those priority care units with responsibility for the most vulnerable clients – although the development of a caring environment is important in other units as well. It is not always easy for DMTs to give sufficient emphasis to this aspect of the unit managers' roles when their health authorities are beset by the need to achieve 'efficiency savings' and to contain expenditure within apparently reducing RAWP targets. But only the DMT members can give to UMTs an authoritative sense of where the balance of effort should lie.

These are, of course, only some of the areas in which the DMT members' actions are critically important if effective unit management is to be achieved. This is not intended to be a general management textbook and no general prescriptive theories are being advanced. There are, however, particular subtleties to the relationships between the teams at district and unit level. As described in Chapter 3, each unit manager faces a complex agenda and is also personally involved in policy implementation and in planning, while occupying distinctive roles as a top manager in the unit and as a member of the district's overall senior management system. Tom Evans concluded that the most important thing that can be expected of a unit manager is that he or she demonstrates a commitment to learning and to personal improvement. Such a commitment can be developed by the appropriate DMT member, provided the unit manager concerned is faced with a comprehensible task. But where the complexities of the structural relationships with unit colleagues are so severe that they effectively defy clarification any unit manager's personal commitment will be reduced. In these circumstances the DMT must act decisively to reconstruct the unit roles.

Action proposals for unit managers

Unit managers themselves can, of course, participate in many of the proposals already put forward, but in addition there are steps they can take independently. They can begin by undertaking their own 'situational diagnosis'. This means that they can review their existing position and powers within the organisation and decide whether changes would probably contribute to better unit performance. Tom Evans argued earlier that the future role of unit managers is at stake. If past practices are allowed to continue and units are run with a firm involvement by chief officers, then many of the issues we have raised will go by the board. To strengthen their role, UMTs will need to show that they can think ahead and they should have contingency plans prepared in case their current proposals prove to be over-optimistic. If unit management is really

to be strengthened, UMTs cannot rely on being bailed out when difficulties arise.

In this context unit managers must show that they can manage financial and other resources well. That includes developing their own skills in the preparation of budget proposals. Furthermore they will need to show their capacity as managers of their own commands, which requires the ability to develop their staff as well as themselves. As professional managers they will also have the opportunity to contribute to the wider, more strategically oriented district management system.

These are not trivial tasks, and many unit managers may elect to avoid such significant responsibilities through fear of criticism from authority members and senior officers. Unit managers working in the manner we have envisaged would be highly visible in the organisation. Many managers feel increasingly vulnerable in the NHS and the growing use of performance indicators and other methods of review has contributed to this. Yet effective unit management depends upon accountability being clear and, in the ultimate, no one benefits when these issues are fudged.

If unit managers are seen to be working in the way we have outlined the medical profession will want to play a full part. UMTs that have the benefit of a respected medical representative as a member should be able to achieve an effective grip upon the whole unit. A mutually supportive team can prove a powerful force, enabling each unit manager to achieve a great deal.

The King's Fund College's future work with NHS units

At some time in our lives most of us depend upon the NHS. Effective unit management forms an essential component in the delivery of effective patient care. Achieving excellence in unit management should become a major objective for the Service as a whole.

We hope that if this book achieves nothing else it will demonstrate the commitment shared by the College Faculty to the encouragement of unit management in practice as well as in concept. Many of the ideas in this book were explored in a series of workshops for members of UMTs and we would all like to acknowledge the contribution made by the members. The workshops have contributed to a redesigned package of activities at the College. In future, courses will have a greater emphasis on case studies and a heavier involvement by Faculty members. More time is to be spent in exploring issues raised by course members and there has been some reduction in the number of visiting lecturers attending for single sessions. These changes have not only affected

the specific courses for unit managers but are also reflected in the general Senior Management Development Course, and indeed in many other teaching activities. So far, these changes have been welcomed by course participants but the process of development is continuous.

The College has also expanded its activities in managerial development in other ways, most notably by process consultancy work in district locations with managers of various disciplines. We believe that College based courses have an essential part to play in managerial development but often it is better for College Fellows to work alongside professional managers in their own districts.

Postscript: Effective unit management and the report of the NHS Management Inquiry dated 6 October 1983 (The Griffiths Inquiry)

The Inquiry's report discusses the management and financial arrangements of units in several sections, principally in paragraphs 8.1–8.6 and paragraphs 17–21, and many of the views put forward are much the same as those in this book. The following quotations from the Inquiry's report are relevant:

> Units of management . . . provide the bed rock for the whole NHS management process (para 17).
>
> Most hospitals and Units are big enough in management terms to take all their own day-to-day management decisions. The onus should be on a higher management to argue away from this position . . . (para 18)
>
> We believe that urgent management action is required, if, Units are to fulfil their role and provide the most effective management of their resources. This particularly affects the doctors (whose) decisions largely dictate the use of all resources . . . This should be more explicitly recognised: . . . in constructing the system of management budgets . . . (para 19)
>
> District chairmen should . . . plan for all day-to-day *decisions* to be taken in the main hospitals and other Units of Management. (para 8.1) . . . See that each Unit of management has a total *budget* (para 8.4) . . . arrange for district *procedures* to spell out: the role of the Treasurer's department in providing management accountant support to Unit managers in the development of their budgets . . . (para 8.5.1) ensure that each Unit develops *management budgets* (para 8.6).

Many of the earlier chapters in this book – particularly 2, 3, 6 and

7 – provide some detailed suggestions which would achieve the same ends as those sought by the Inquiry team.

Where there are differences, they are more matters of degree than substance. For instance, although the Inquiry team was very critical of consensus decision taking, which this book suggests is essential in many instances, the Inquiry's detailed proposals state:

> A general manager should be identified . . . [and] we therefore propose the identification of a general manager to harness the best of the consensus management approach and avoid the worst of the problems it can present (para 15).

The general manager's role has been discussed earlier. Provided that general management begins above the operational level it is undoubtedly practical. But if unit general managers occupy different professional roles from those of their district general managers, problems could follow. This is because unit general managers would then be accountable to two chief officers and the difficulties that dual accountability causes are discussed in Chapter 2. Some existing units may also be too small to accommodate a general manager working above the operational level. The difficulties small units could face in handling an expanded financial role identical to that recommended by the Inquiry are described in Chapter 6. Nonetheless, provided health authorities carefully review their existing units and combine some units with others so that the unit's task and size is related to the role of a general manager, much would be gained.

We hope that this book will be able to 'flesh out' the skeleton for the stronger units of management that the NHS needs and the Griffiths' Inquiry recommends. The principal danger is that those working in the NHS will feel themselves subject to another reorganisation. Much will depend upon the sensitivity with which the changes envisaged are implemented. In the introduction to this book I wrote that 'The cost to the patients of further restructuring would be far too great.' It will present a considerable challenge to those with major responsibilities in the service if they are to achieve the undoubted benefits of effective unit management without increasing the costs to both patients and staff. Let us hope that they prove up to the task.

Appendix I

Planning

GORDON BEST and TOM EVANS

The idea of planning and its underlying difficulties

In Chapters 3 and 4, we referred to issues of planning in health services. In order to facilitate the flow of discussion, we have gathered together some notes on the concept and practice of planning which are intended to help the reader to understand better the concerns raised in those chapters. In addition, the notes are meant to be something of an antidote to the prevailing notion of planning within the NHS – a notion which tends to equate planning with the procedures set out in the NHS planning system.

Traditionally, planning has been singled out as a special kind of semi-autonomous management activity. Frequently, it is characterised as 'thinking rationally about the future'. Conceived like this, planning is fundamentally about two activities – prediction and preparation. It is the process of trying to predict what the future may hold and then attempting to prepare for the likeliest contingencies.

Thus, planning is seen as *future-orientated*. As such, it is sometimes contrasted with management which, it is held, is more concerned with immediate pressures, threats and opportunities which need to be addressed on a relatively short time scale. According to this view, the principal product of the planning activity is a *plan*. Plans can take two broad forms: either they consist of a specification of a more or less desirable future which management is concerned to bring about (as with most architectural plans); or they are 'frameworks' which are intended to endow relatively short term management decisions with a consistency of purpose in respect of certain agreed objectives (as with most corporate plans).

Sophisticated versions of this view of planning admit to three fundamental difficulties:

First, the all-pervasive presence of *uncertainty* about the future. To a greater or lesser extent, uncertainty undermines the prediction or forecasting of the future – an activity which is almost always central to traditional planning strategies.

Second, the recognition that most forms of real world planning involve high levels of *complexity* – or 'unknowability'. Thus, if we cannot know with confidence what is or is not possible, or

what will happen if we do this or that, our ability to think *rationally* about the future is undermined.

Third, the inevitability of changing *values and purposes*. To a greater or lesser extent, changing values undermine the notion of endowing decisions with a consistency of purpose over time. We cannot therefore decide in advance what will be desirable in the future.

These three difficulties threaten to undermine any notion of planning which is based on the premise that planning is *primarily* about giving shape to the future.

Two models of planning

Broadly speaking, there are two quite different sets of planning ideas which make contrary assumptions about how to deal with the problems of future uncertainty, complexity and changing values. At the same time, these two sets of ideas lead to different roles and styles of planning.

The first set of ideas emphasises the capacity of planners and senior managers to *analyse* their organisation's environment and problems. Its main aim is to provide a stable context for decision making through *forecasting* and *analysis*. It is relatively optimistic about the ability to forecast adequately; hence, coping with what is still seen as uncertain, although a problem, does not disrupt the main thrust of the analysis. In this 'orthodox' model of planning, purposes and goals are assumed to be given and accepted, and to remain relatively stable. The major concern is with finding the best actions and decisions to achieve those goals.

In addition, there is a strong emphasis on coordination and consistency. The actions and decisions of everyone within the organisation have to fit together consistently with each other and with the central choices which have been made. This approach has a *centralising effect*, focusing on central judgment in the allocation of resources and in directing innovation and change. It depends on a flow of information which summarises local management action and insight. The assumption is that given such an information flow the central decision makers have the wisdom and understanding to make the necessary choices. Learning is concentrated on improving analysis and information, and decision making can be concentrated at the centre. Finally, the mentality which tends to underpin this idea of planning invariably exhibits two salient characteristics. First, it is *instrumental* in the sense that its over-riding concern is with finding ways to achieve desired ends; second, it is *causal* in the sense that the major problems it recognises are those of estimating the consequences of proposed actions.

Fundamentally, this conception is of planning *as a means of control* – control over the future, over local management decisions, and over ultimate choice of purposes. Despite all the difficulties, this model of planning its often held to be an ideal – somewhat unattainable in practice, but worth aspiring to. The shortfall from the ideal and the difficulties that it encounters, are not seen to require a basic shift in the nature of planning. The limitations are held to be kept within acceptable bounds by doing as well as possible and seeking always to improve forecasting, analysis and planning methods. The alternative is seen to be a collection of short-term expedient decisions which, over time, will be found to have had little overall coherence or consistency of purpose.

The second set of ideas is much less sanguine about the resilience of planning analysis to the difficulties of uncertainty, complexity and changing values. Advocates of this school of thought would argue that these difficulties are so severe that the *nature* of planning itself must change in response. The apparent stability which forecasting and analysis introduce is chimerical, and it breaks down when actions turn out to be inappropriate for a changing world. What is more, social planning is inherently about conflicts in values, so a model of planning which assumes the opposite becomes a weapon used by the holders of one set of values against the others.

A central tenet within this second set of ideas is the recognition that there is a sense in which planning is *not* primarily about giving shape to the future. Rather, planning can be seen as a process of unveiling, analysing and then representing those strategic issues which provide the context for managerial action and choice. Seen from this perspective, while planning is *in part* about preparing for the future (because an improved understanding of strategic issues will necessarily colour our view of what is desirable and possible in the future), it is *primarily* concerned with relating individual actions to the *strategic context* within which those actions take place.

This second view, then, portrays planning as a *learning* activity. It recognises that those who are a party to the planning process must inevitably live with uncertainty and poorly understood complexity, and that the task of planning is to help them to do so effectively. It enables managers to be as strategic and purposive as possible while allowing them to account for the way in which they cope with uncertainty. In essence, it seeks to provide an evolving flow of strategic context for individual decisions.

This second approach recognises value conflicts explicitly and seeks to use planning in part as a means for clarifying differences and, hopefully, finding an acceptable way of resolving them. It recognises that the resolution of conflict is often temporary and, as

such, that planning must be a continuous activity facilitating the learning of everyone involved. Planning is enabling rather than directive, helping managers and other participants to cope better and to learn from their experience rather than seeking to coerce them into a common or consistent set of responses. The 'learning' model of planning does not assume a monopoly of wisdom at the centre, but respects a dispersal of wisdom which cannot be transmitted to the centre by information flow. Planning is not separate from management, but is a source of context and discipline for managers to help them relate to a meaningful strategy. It should help managers to cope with the remaining uncertainties and help them to *learn*.

It should be clear that the 'learning' approach is about process, influence and development. How things are considered and determined is important. Planning must influence understanding and action. It is not only how we do things now but how we invest in their future improvement and development that matters. Because of these factors, the 'learning' model of planning seeks to relate the substance of the strategy to the developing capacity of the organisation to manage change.

Though the 'control' and 'learning' models of planning have been somewhat idealised, they represent radically different views of what planning is about and how it might be effective. They give rise to different problems of concept. Most importantly, they suggest different directions in which the practice of planning in any organisation might be developed and improved.

NHS planning – a critique of practice

As noted earlier, planning within the NHS is often regarded as little more than a matter of conforming to the procedural arrangements laid down in the NHS planning system. As such, the practice of planning within the NHS might be said to be dominated by four 'pathologies'. These can be summarised as:

Planning as ritual. The NHS planning system is dominated by rituals of timetables and procedures. This emphasis has been reduced slightly in its most recent version. The fact that there is *one* NHS planning system laid down by circular, however, ensures that practice is dominated by the production of standard forms of plans to externally imposed timetables. This is necessary to some extent if planning is to be a means of communication between levels of the NHS, but the outcome is an emphasis on reporting, accountability and control rather than on learning and the *effective* management of change. There is little doubt that the procedures and mechanisms that characterise NHS planning reflect an emphasis on the hier-

archy of organisations and their control rather than on the needs of managers inside them.

Picture painting. The basic method of NHS planning is to produce a snapshot of the service at some future point. This relies primarily on forecasts of population and patient flows and on centrally stipulated bed norms. The shortcomings of this approach are well known; for example:

it is dominated by a concern with capital allocations;
it fails to link service planning with manpower and financial planning;
it discourages contingency planning, and, therefore, the exploration of choice;
it focuses attention on two points in time (that is, the present and the future) with little serious examination of how the picture of the future is to be achieved.

The question is – what is it really for? One must conclude, again, that it is about *control* in the hierarchy of organisations. Certainly, it offers little support, or help in the resolution of uncertainty, for managers in districts and units.

Aggregation of already determined decisions. Operational planning, which is where one might expect the implications for management to be most clearly felt, has often been a means through which decisions are assembled and presented, rather than one through which they are influenced. An acid test for planning would be how far it could be a source of different but usable criteria in the complex and politicised process through which development proposals are produced. Anecdotal evidence suggests that, on the whole, this has not been the case. In any case, it is doubtful if standard formats for plans allow different criteria to be developed which could be useful in that process.

Supply side planning. With its immense concentration on service profiles and facilities and its identification of demands or needs with bed norms, NHS planning has a strong supply side emphasis. The much more complex questions of social planning, concerning actual demand, priorities, consumer satisfaction, socio-economic effects, equality, and impact on the health status of the population, receive relatively little emphasis. In part, this is because these questions are especially difficult, but a supply side approach severely inhibits both the style and use of health service planning in its social context.

Managing planning

The existence of the four different pathologies we have identified has important consequences. If we cannot rely on a well established approach or set of procedures, then planning is a matter of dilemma and choice. What planning can contribute, what problems it could most usefully address, what organisation, role and method of analysis are appropriate, are all matters of judgment for those who are responsible for the planning activity. In order to tackle these questions systematically, we have to focus on the *management of planning*.

To focus on the management *of* planning is to underline again the idea that planning is not in some sense a semi-autonomous activity which can be 'imported' into an organisation, but, rather, is a process which can take many forms and serve differing purposes depending upon the needs of, and opportunities facing, the organisation. Managing planning, then, is largely a matter of being systematic and explicit in deciding what form the planning process is to take, what purposes it is to serve, and how its results are to be assessed.

A model intended to assist in managing planning would aim to provide a framework within which these kinds of judgments and choices could be made explicit as a basis for organisational learning and improvement. Broadly, such a model would embrace the following aspects at least:

What problems should be addressed? That is, an *audit* of problems and capabilities.
What is planning intended to achieve? That is, the *purpose* and *missions* for planning.
What form should planning take? That is, *strategies* for planning.
How is planning to happen? That is, the *implementation* of planning.
What are the expected outcomes of planning and how are they to be assessed? That is, the *evaluation of the effectiveness* of planning.

Each is discussed briefly below.

Audit

Perhaps the most critical element in situations where planning roles are ambiguous and resources scarce is a perceptive diagnosis of what really matters. It is important that planning should address issues to which it might make a significant and effective contribution. It is equally important that the problems selected for attention

should be those that determine the performance of the organisation. Planning audit – involving a review of the planning environment and an evaluation of planning resources – seeks a basis of congruence between these two factors.

In so far as planning is concerned with the analysis and representation of strategic issues as a context for managerial action, an important aspect of planning audit will be the recognition of which issues are strategic. For example, in most 'social' organisations, such as the NHS, a decision or choice will tend to be strategic if it:

- fundamentally constrains what options the organisation will be able to pursue in the future (for example, major capital investments);
- or has an important impact on, or interacts with, the choices which other senior managers or organisations are able to make (for example, joint care initiatives);
- or represents a relatively irreversible 'assignment' of values in the sense that the needs or aspirations of one sub-group of the organisation (or population) are put before those of another (for example, care group priority choices).

One of the problems for planning – and one which begins with the planning audit – is how the strategic nature of such choices and decisions can be recognised, analysed and given significance.

Purposes

Our brief review indicates what is readily apparent from the planning literature, namely the wide variety of purposes which are given to planning activity. For example:

underpinning strategic choice;
promoting entrepreneurship and innovation;
being a medium of participative dialogue;
facilitating the updating of the 'dominant ideas' of the organisation;
fostering the capacity to change, to reconceptualise or to learn.

Some clarity about what planning is being asked to do matters greatly both in how we run it and how we assess its success or failure.

Strategies

Given the purposes toward which planning is to be directed, there follows the need for an explicit strategy for planning. At the very

least, adherence to either of the approaches outlined earlier in this Appendix would generate a distinctive strategy for planning. Some of the differences between strategies for planning arising from those two approaches would be:

The specification of corporate objectives: the contrast between establishing objectives for the organisation and increasing organisational purposiveness.
The use of analysis: the contrast between analysis as a tool for directing choice, as distinct from analysis as a means for enabling judgment to be brought to bear on choice.
The role of forecasting: an emphasis on prediction and buffering against uncertainty as distinct from environmental scanning and problem finding; that is, attempting to reduce rather than manage uncertainty.
The relationship of planning to management: control rather than learning, influence and development.
Strategic management: 'blueprints' for organisational development rather than developmental purposes and roles for planning to transform the capabilities for the organisation.

The concept of strategy for planning, therefore, envisages the welding together of purposes, roles, structures, modes of analysis and assumptions into some *coherent planning response to the organisation's need*. It assumes that this task can be undertaken *systematically* in identifying variants in response, their properties and resource needs; *evaluatively* in assessing choices among the variants; and *developmentally* in building planning experiences and skills which allow more effective responses in the future.

Implementation

The strategy adopted needs to be embodied in practice. The major concern of the implementation stage is the design of that practice. It will cover:

organisation for planning;
design and development of information and other systems and processes;
procedures and planning cycles;
selection of methods of analysis;
developing managers (and others) to use planning consistently with the strategy.

Though there is an enormous amount of specific material on these issues available in the planning literature, little of it is related to

purposes and strategies of planning. The problem is that, because this is the most tangible aspect of planning, there is a tendency to start here without reference to the earlier stages.

Evaluation

Perhaps the least addressed question in practice is whether planning is effective, and if not, why not? It should be clear that without an explicit audit, and a definition of the purpose and strategy of planning, this question is meaningless. Even with such specification, it is difficult. In what terms should we monitor the effectiveness of planning? The important thing is not to allow the best to become the enemy of the useful. Evaluation is about learning. It forces us to be explicit, no matter how crudely, about what is intended and expected in comparison with what happens. Few of the problems in planning can be resolved definitively. But we can be systematic in assessing the way we use whatever limited information or understanding is available and ensure that we progress through experience.

Catherine Shaw BA
King's Fund Research Assistant

After graduating from the University of East Anglia in European Studies, Catherine Shaw spent two years in industrial and social market research before joining the King's Fund College in 1981 as a research assistant. With Maureen Dixon she is currently studying why national trainees leave the NHS and whether the reasons are gender related.

Appendix II

Survey of units and the gradings of unit managers after the 1982 reorganisation

CATHERINE SHAW

Aims of the survey

Following the 1982 reorganisation of the NHS I undertook, on behalf of the College, a sample survey of health authorities (HAs) in the 14 regions in England. The brief for the survey was two-fold: firstly, to find out how units have been defined (that is, which service elements come under a unit of management) and secondly, to look at the gradings of the administrative and nursing managers in charge of the units. With the data collected, I hoped to elucidate the following aspects of unit management:

1 The number of units within districts and the bases upon which units have been established
2 The relative status of the different 'types' of unit
3 The relative status of administrative and nursing unit manager posts
4 Any geographical pattern in the gradings of unit managers.

Survey method

Initial consideration of how to choose a representative sample from the 192 health authorities* in England included such variables as population size and whether mainly urban or rural. However, there are difficulties in defining a 'rural' or an 'urban' HA as many combine both features within their boundaries. Even the calculation of population presents some difficulties in relation to catchment areas and cross-boundary flows. It was, therefore, decided to stratify the sample by region and then select the HAs at random. A letter was sent to every fourth HA in England asking for details of the number and types of their units and the gradings of the unit administrators (UAs) and directors of nursing services (DNSs). This method resulted in a range of between two and five HAs in each region being asked to participate.

Of the 48 HAs in England which were asked to participate, replies were received from 36 (75 per cent). Nineteen per cent of all HAs in England are therefore included in the survey results. The representativeness of the responding HAs by region is shown in Table 8.

* Liverpool East, and Central and Southern are counted as one HA. Any future reference to health authorities or districts will be based on this total.

Table 8 Representativeness of responses by region

Region	% of HAs in England (n = 192)	% of responding HAs (n = 36)	% difference
Northern	8.3	11.1	+2.8
Yorkshire	8.9	11.1	+2.2
Trent	6.3	5.6	−0.7
East Anglian	4.2	0.0	−4.2
North West Thames	7.8	11.1	+3.3
North East Thames	8.3	11.1	+2.8
South East Thames	7.8	5.6	−2.2
South West Thames	6.8	11.1	+4.3
Wessex	5.2	5.6	+0.4
Oxford	4.2	5.6	+1.4
South Western	5.7	5.6	−0.1
West Midlands	11.5	8.3	−3.2
Mersey	5.2	2.8	−2.4
North Western	9.9	5.6	−4.3
Total	100.1	100.2	

There is no clear geographical pattern evident in the representativeness of the responses, although three of the four Thames regions were over-represented. The imbalance in the representativeness overall and the small size of the sample made any geographical analyses of doubtful reference and so this aspect of the analysis has not been included.

In addition to any difference in regional representation, the variation in the detail of the replies imposed certain limitations on the data analysis. The exact responsibilities of the new post-holders were not always available as some of the HAs sent a standard job description to cover all their UAs and DNSs respectively. Information on unit budgets and the number of staff for which a manager is responsible was not available from every HA at the time of the research. All the information was collected in the first half of 1983. Since that time a few of the unit manager grades may have been reassessed.

Number and types of unit

HC(80)8 said health authorities 'should arrange their services into units of management, each with an administrator and a director of nursing services, directly accountable to the district administrator and district nursing officer respectively.' In the survey there was great variety in the number of UA and DNS posts. Out of the 36 districts there were only four where all the units had a matching

UA/DNS combination. Overall there was a total of 183 DNS posts which related to 136 UA posts. Across all the responding districts there were 81 units with matching DNS/UA roles. In the instances where the one UA to one DNS pattern was not applied, the following variations existed:

1 One UA covering the services of two or three DNSs and therefore relating to two or three DNSs. The DNSs for the additional units were given one 'administrative point of reference'.
2 Two UAs covering the services of three DNSs. The DNSs were each given one main 'administrative point of reference'.
3 Two or three UAs covering the services of three, four or five DNSs where the DNSs liaise with two or three UAs (that is, no 'administrative point of reference' specified).

Most of the additional nursing units were in geriatrics, mental handicap, mental illness and midwifery. There was a total of 31 separate midwifery units with no full-time administrative presence. The different organisational arrangements for UA and DNS posts have been variously interpreted by the districts. For example, two districts with the same pattern – three UA posts corresponding to six DNS posts – described themselves as having three and six units respectively.

In analysing the number of units in a district I have taken the existence of a DNS as indicative of a unit. It should be borne in mind that this classification hides a considerable variation in managerial relationships. There was great variety in the number of units in a district, the smallest being three and the largest nine, with an average of five. Although district population size appears to have had some effect on the number of units – the largest district had the most units – this was not consistently the case. Rather, it seems that the greater the complexity and range of services in a district, the larger the number of units established.

HC(80)8 gave examples of the types of units that could be formed below district level: a large single hospital, the community services of a district, client care units, maternity services, geographical units (hospital and community services for one location), a grouping of smaller hospitals. Our survey included all of these with the exception that there was no unit which could be considered wholly 'geographical', that is, providing all the hospital and community facilities for one particular locality in a district. There were, however, many units which could be termed 'geographical' in so far as neighbouring facilities of varying types had been grouped together under one unit.

The classification of type of units varies from district to district.

Some have named their units after patient groups, others after geographical location. It is impossible to assume, for example, that the institutional and service elements in one so-called 'acute' unit are the same as any other. The next section does, however, attempt to establish broad categories of 'type' of unit in order to compare unit manager gradings.

The relative status of different types of units

There are two questions of interest relating to the status of units. Firstly, any observed relationship between type and status of unit and secondly, any apparent differentials in UA/DNS gradings in the same unit. The second point is more fully explored in the next section which deals with the relative status of administrative and nursing unit manager posts.

For the purposes of this part of the analysis, I have assumed that post gradings are a proxy for the relative status of a unit. Due to the variety in the ways in which most districts have divided the service provision between UAs and DNSs, it was necessary to make a separate analysis for each. See Figures 5 and 6 respectively.

The broad types of service referred to were broken down as follows: 'community' refers to the UAs and DNSs in charge of the community services of a district. In some of these units there were small hospitals which had been allocated to the community unit managers. A few of the UAs in this category had additional responsibilities such as district general administrator or mental handicap unit responsibilities. Under 'mental illness, mental handicap and geriatric' are included all the units which provided one or more of these services. The 'acute based' services account for all the unit managers for whom the substantial component of their unit was the provision of acute services. Under 'other' have been included the unit managers with a function not commonly found amongst the other unit managers in the survey. For the DNSs, the 31 midwifery units are shown separately.

In Figures 5 and 6, it is quite striking how the managers of the priority service units (community, mental handicap, mental illness and geriatric) have been graded lower than the acute based units. In Figure 5 the number of UAs working in acute based units accounts for approximately 39 per cent of the total number of UAs. There were 25.5 per cent in the community units, 25.5 per cent in the mental illness, mental handicap and geriatric units and 10 per cent under other. The strongest contrast in the UA gradings is between the acute based UAs and the community UAs. Seventy-seven per cent of the acute based UAs were on a scale 23 or above whereas 91 per cent of the community UAs were on scale 18 and

Figure 5 Unit administrators' grades by type of unit

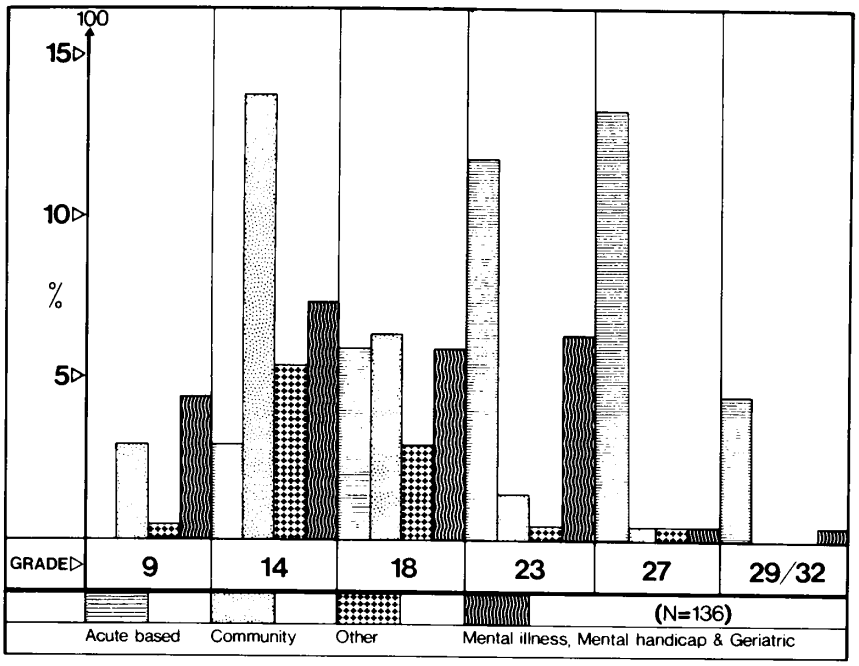
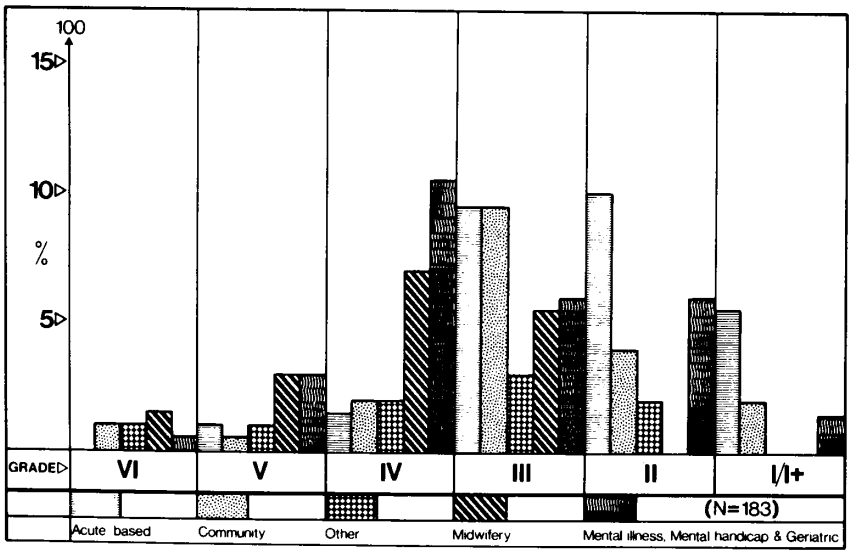


Figure 6 Directors of nursing services' grades by type of unit



below. The UAs in geriatrics, mental handicap and mental illness as a whole fared better than the community UAs with 69 per cent on grade 18 and below. However, within this broad category most of the higher grades (23 and above) were in the mental illness units. The UAs in the mental handicap units fared better than the UAs in geriatrics. In Figure 6, 27.5 per cent of the DNSs are in acute based

units, 19 per cent in community units, 27.5 per cent in mental illness, mental handicap and geriatric units, 17 per cent in midwifery units and 9 per cent under other. The contrast between the acute based and community units is not as marked as it was in the case of the UAs. Ninety per cent of the acute based DNSs were on grade III and above and 80 per cent of the DNSs in the community units were on grade III and above, whereas just 50 per cent of the DNSs in the mental illness, mental handicap and geriatric units were on grade III and above. In this latter category, the same pattern as the UAs was apparent: the higher grades were in the mental illness units, and the DNSs in mental handicap units were on higher grades than those in the geriatric units.

The relative status of administrative and nursing unit manager posts

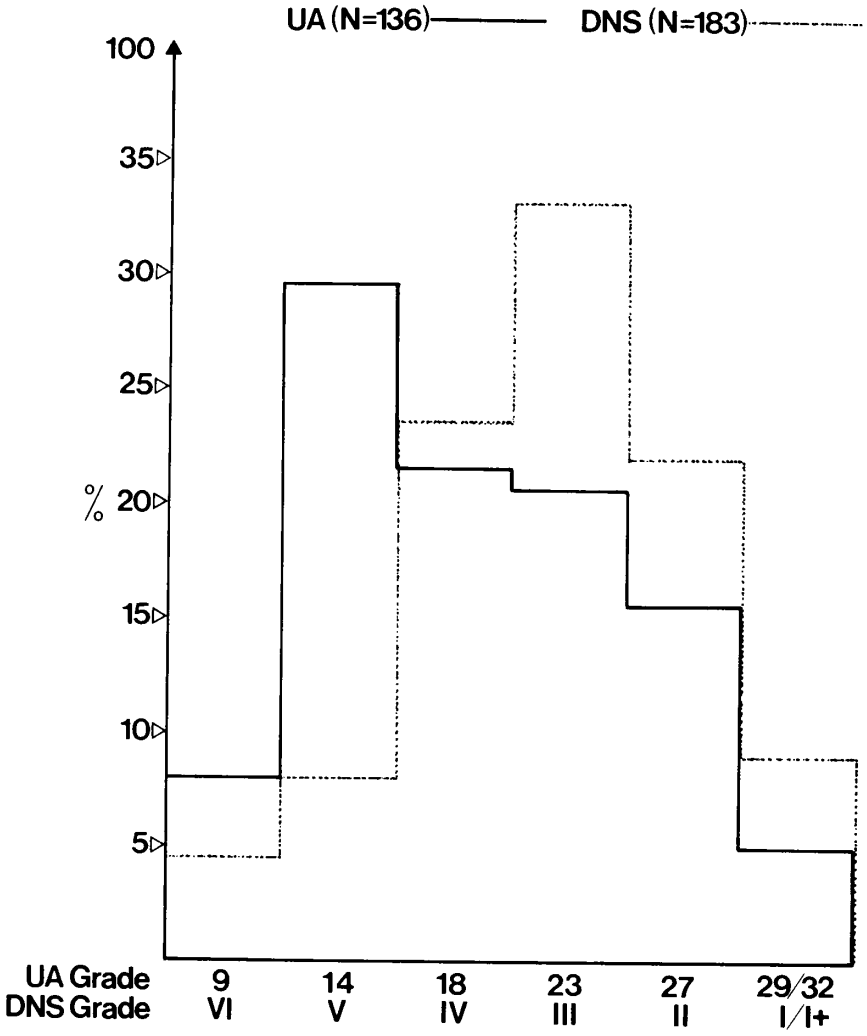
Before the comparative gradings of UAs and DNSs is discussed, it should be re-emphasised that in many instances the responsibilities of the UAs and DNSs in the same district vary considerably. In this survey, the 81 units where there appeared to be an exact match between the UA and DNS posts are called 'coterminous'. There were 37 instances where the UAs and DNSs appeared to cover the same services with the exception of midwifery services. In many of these instances there was a UA for, say, acute based services relating to the DNS for acute based services and the DNS for midwifery. The relationship between the remaining UA and DNS posts was more complex, there being for the most part two or three DNSs relating to one unit administrator.

For this part of the analysis I have assumed there to be a broad relationship between the UA and DNS grades as shown in Table 9. The mid points of the salary scale for DNS and UA grades reveal that UA grades 9, 14 and 18 compare closely with DNS grades VI, V and IV respectively. The UA salary mid points are slightly higher for grades 23, 27, 29 and 32 than the DNS equivalents.

Table 9 The equivalence assumed between UA and DNS gradings

UA grade	DNS grade
29/32	I/I+
27	II
23	III
18	IV
14	V
9	VI

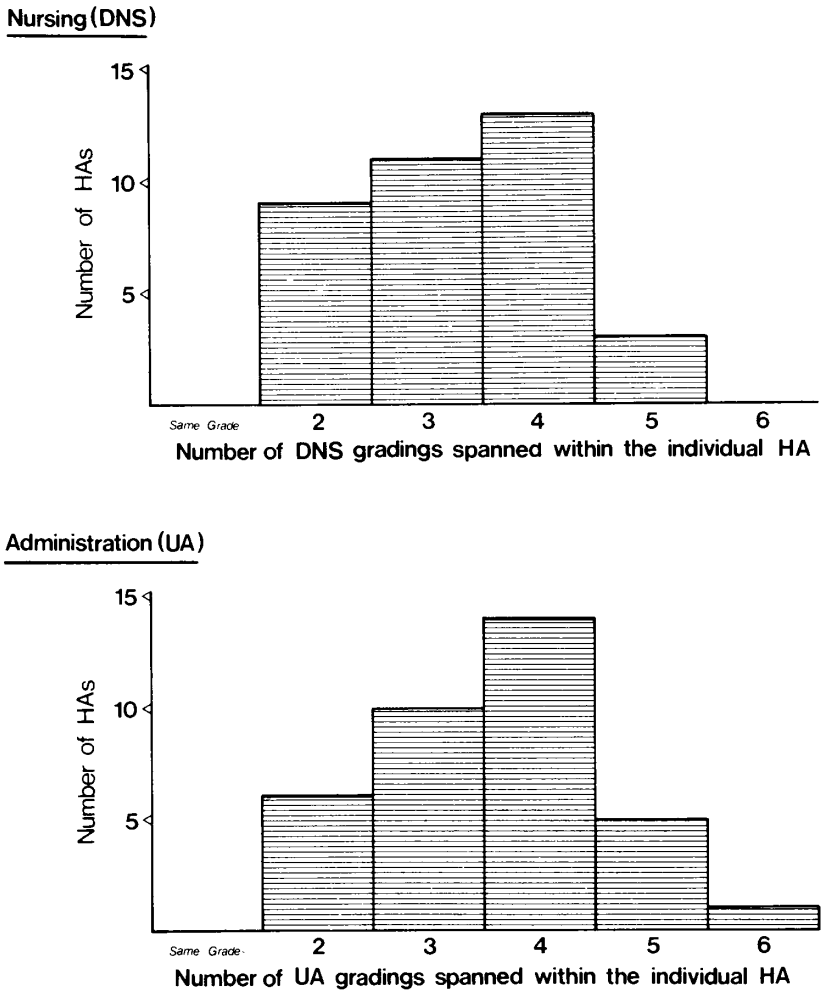
Figure 7 Comparison of UA and DNS grades in 36 HAs



The distribution of UAs and DNSs amongst the managerial grade bands is shown, in percentage terms, in Figure 7. The most striking pattern to emerge is that 64 per cent of the DNSs were on grade III and above, as compared with 41 per cent of the UAs who were on grade 23 and above. The most common grade for the DNSs was scale III, the number on this grade accounting for 33.5 per cent of the total. For the UAs, the most common grade was 14, there being approximately 29.5 per cent on this grade.

To test the number of different levels of management in operation amongst the DNSs and UAs by district, an analysis of the range of managerial gradings was carried out. Figure 8 shows the different levels of unit manager gradings in existence amongst the DNSs and UAs respectively. The number of gradings spanned has been calculated using Table 9 as follows. If, for example, a HA

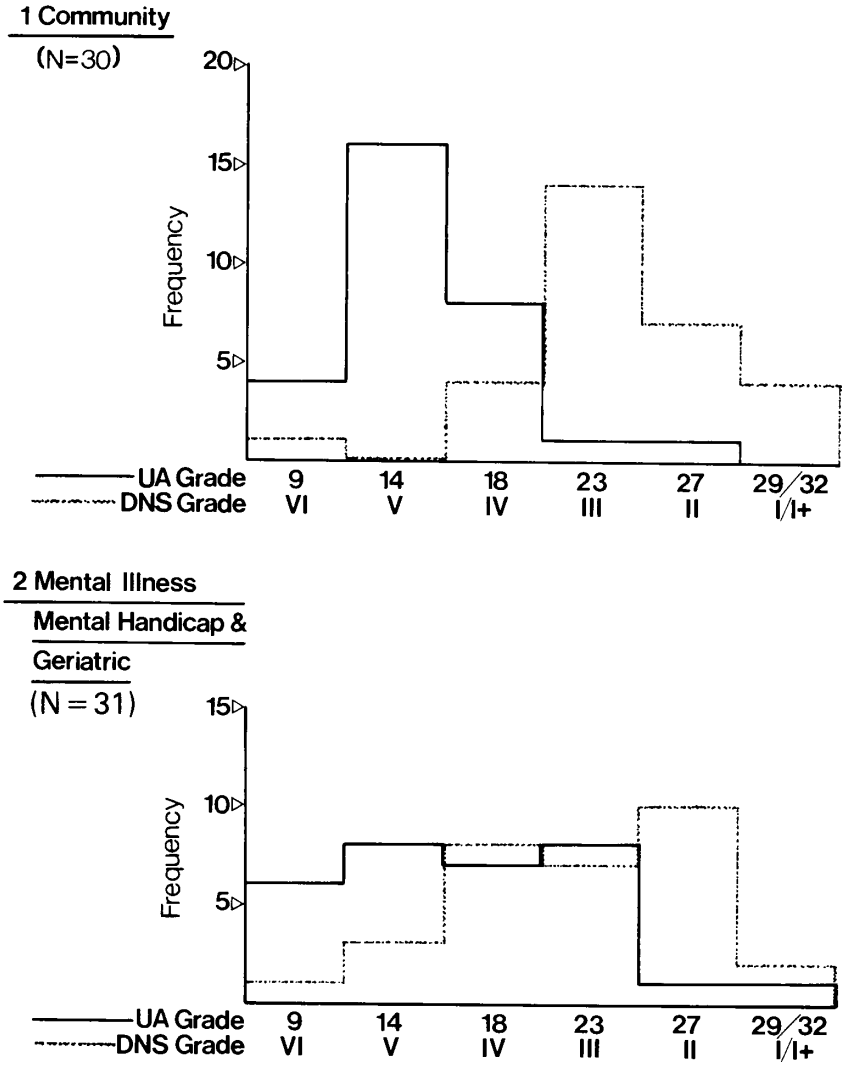
Figure 8 Span of management grades in 36 HAs *Appendix II*



had a total of three UAs on grades 9, 14 and 23 respectively, then this combination of levels of management was noted as spanning 4 grades (by-passing grade 18). The most frequent span of grades in both the administration and nursing units was found to be four, but one HA had UAs in all six possible categories. The implications for the unit managers' relationships with each other, with the district chief officers and for financial managers has been discussed more fully in Chapters 2 and 6.

In comparing the status of UAs and DNSs within units I have used only the 81 'coterminous' units. Using the grade equivalents identified in Table 9, a quite obvious pattern of differentials between nursing and administration grades in the *same* unit appears. Of the 81 'coterminous' units, only 13 had 'equal' gradings for the DNSs and UAs. There was only one unit in which the

Figure 9 Coterminous units. Comparison of UA and DNS grades in 1) the community units and 2) the mental illness, mental handicap and geriatric units



UA was graded higher than the DNS counterpart; as it happens this UA also acts as district general administrator. In the remaining 67 units, the DNS was graded higher than the UA counterparts. In 31 of these cases the nurse was one grade higher than the administrator, in 27 instances two grades higher, and in nine cases three grades higher.

Thirty (37 per cent) of the coterminous units were community units and 31 (38 per cent) were mental illness, mental handicap and geriatric units. The other 20 units (25 per cent) consisted of DGH

units, DGH and long stay, mixed long stay and specialist hospitals. An analysis of the first two categories can be seen in Figure 9. In both instances the DNSs appear to be more highly graded than their UA counterparts, the contrast being most striking in the community histogram.

Conclusions from the survey

1 There are many HAs where the district services have been divided differently between UAs and DNSs. Only four of the 36 responding HAs had matching UA/DNS units.
2 There is great variety in the bases upon which units have been established. Some cater for one client care group, others appear to be based on geographic convenience. More DNS than UA units are based on client care groups.
3 There are substantially more DNS posts than UA posts. Some UAs will be working with up to three DNSs and, in fewer instances, the DNS will be relating to more than one UA.
4 The survey demonstrated great variety in the grading of unit managers in most HAs. As a general rule, the gradings accorded to UAs working in the priority care groups compare less favourably with UAs in the acute units. The DNSs in the acute units tended to be on higher grades than other DNSs, though the contrast was not as marked as with the UAs.
5 The DNS gradings in the coterminous units were often higher than their UA counterparts. The greatest difference was in the community units.
6 Relationships between UMTs and within UMTs may be complicated by the variation in gradings.

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