KING EDWARD'S HOSPITAL FUND FOR LONDON

KING'S FUND COLLEGE

REPORT OF SEMINARS FOR CHAIRMEN OF NEW DISTRICT HEALTH AUTHORITIES

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

INTRODUCTION

Perhaps it was inevitable, when the King's Fund came to consider its contribution to the preparations for re-organisation of the NHS, that it should alight on the Chairmen of new DHA's as the prime focus. The spirit of the reorganisation emphasised the importance of their role. Their leadership would be critical in developing a management style and strategy in the new Authorities at a time when the challenges facing the NHS were becoming increasingly complex. For many Chairmen, it was anticipated, the experience would be novel. Indeed, some would have no experience even as members of previous Authorities though many would have a substantial background in other forms of enterprise. Furthermore there were manageable numbers of Chairmen, at least within the five Regions traditionally associated with the King's Fund College. For all these reasons, Chairmen seemed to be a fertile and useful focus for the Fund's efforts.

In the event, the sessions proved very valuable. We have every reason to believe that most Chairmen found them useful. They established our contact with a substantial number of people whose behaviour and attitudes will be critical to the succsssful operation of the reorganised NHS. They focussed the problems and perspectives of Chairmen in a way which has stood us in good stead subsequently in running workshops for Chief Officers and others. We are grateful to those who spared the two days to take part in this venture with us.

These reports on the workshops can do no more than act as an aide memoire to participants and a rough indicator of the issues raised to those who were not there. However, they do offer some record of an important event. We have not attempted to produce any comparisons of the discussions in the four workshops. Both the consistency of concerns and the varying directions in which the sessions developed are readily apparent from reading the four reports. Hopefully, the reports on the workshops which an individual Chairman did not attend will be suggestive of additional issues which may be considered.

Two possible means were suggested of following up these seminars. First, a number of Chairmen were interested in specific briefings on particular topics, most obviously finance. Second, many Chairmen suggested that another series of sessions in twelve months time might be a useful way of taking stock of the experience gained so far and of defining directions of further development. We should welcome comments as Chairmen become clearer of their needs.

In the meantime, may I wish our participants well in their important and demanding task.

Tom Evans
Director

King's Fund staff involved in the Seminars

Alison de Metz BSc(Econ)	Project Coordinator Thwaites Project
Maureen Dixon BA MPhil	Associate Director King Edward's Hospital Fund for London
Tom Evans MSc(Econ)	Director King's Fund College
Iden Wickings PhD LHA AMBIM	Project Coordinator CASPE Research Project

Report on a seminar for District Health Authority Chairmen
21 - 22 September 1981

INTRODUCTION

1. As part of the King's Fund response to the impending reorganisation of the NHS, a series of seminars for the newly appointed Chairmen of District Health Authorities is being organised at the King's Fund College. The first seminar was held on 21st and 22nd September 1981, the aim being to explore the interests and concerns of the new Chairmen. The seminar was attended by nine Chairmen, most of whom had previous experience of health authority membership, drawn from the five Regions for which this series of seminars is being provided - the four Thames Regions and Wessex.

2. This Working Paper reports on the major issues identified and the formulations developed at the seminar. It is not intended to represent the individual views of those who attended but rather to explore some of the general issues concerning the future functioning of DHAs and the NHS.

TOPICS

3. The focus of the seminar was the role of DHA Chairmen and the early discussion sought to identify the matters of immediate concern to the participants. These included:

- establishing the DHA as an effective body: the role of Chairman; members' different experience, background and expectations; the development of individual members and the DHA as a working group; relationship to the public and the openness of DHA meetings; consultant contracts;
- appointment of chief officers and setting up the management structure: sources of advice; the selection process; organisational principles for establishing units; timing;

- activities before April 1982: dealing with problems inherited from AHAs; relations with existing AHAs, DMTs and other DHAs; key tasks before April 1982; inheritance of operational plans for 1982/83;
- organisation and financing of inter-district relationships and services: shared services; agency relationships; area services; relations with local authorities;
- finance: initial budgets; planning and control; resource allocation;
- priorities and the management of change: achieving reallocation of resources towards the Cinderella services; developing policies and priorities;
- assessing performance: evaluating the peformance of the DHA, its organisation and officers; development of objectives and self-assessment by the Chairman.

4. Some general contextual issues were raised in order to place these topics in historical perspective. These included:

- the emphasis in this reorganisation on decentralisation and local variation, reflected in the limited central guidance given on questions of organisation and process. (A list of selected official reports and documents relevant to reorganisation was made available and is attached to this Working Paper). It seems particularly important therefore that the changes be based on a critical and clear understanding of the existing situation and that the new district organisations are devised according to clear and articulated principles;
- the trend of the last fifteen years or so towards greater identity and sovereignty on the part of the major health professions and the consequent development of management teams with a multi-disciplinary membership;

- the nature of the NHS organisation and the prevailing managerial culture, pointing out the tendency to emphasise the administrative and procedural components of management rather than the opportunities for innovation.

ESTABLISHING AN EFFECTIVE DHA

The Role of Chairman

5. The central guidance so far given on the Chairman's role is concerned with formal meetings of the DHA[1] and the Chairman's threefold tasks of acting as spokesman and leader of the DHA and adviser to the chief officers. It is anticipated that the time commitment of the Chairman might be ten to twelve days a month during and outside normal working hours.[2] In the seminar it was suggested that the Chairmen will have a wide choice as to how they interpret these broad guidelines, ranging from being relatively detached and uninvolved to being more directive and influential in the work of the DHA. There was agreement that the activities of the Chairman should extend beyond those associated with the purely formal business of the Authority as manifested in its meetings. It was felt that the chosen style of indidivual Chairmen will be a major factor in determining the style of their DHAs and the speed with which effective organisations are established.

6. A major aspect of the style of the DHA is how it chooses to handle its relationships to the public, the Community Health Council, the press and a variety of local organisations and institutions. Concern was expressed by some that the presence of the public and press at DHA meetings might be an inhibiting factor. Others felt that it is vital that the DHA works in as open a way as possible and establishes a real sense of relationship to its community. While recognising that the DHA cannot be, in the normal sense of the word, accountable to the community, there was agreement that the

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1 HC(81)6

2 Note on the Constitution of Health Authorities in England and the Duties of District Health Authority Chairmen.

DHA is responsible for taking community concerns into account and that the Chairman has a special responsibility to ensure that community interests are identified and represented in the work of the DHA.

7. The whole question of the emphasis on decentralisation was discussed; that is, to what extent is the notion of relatively 'autonomous' DHAs consistent with explicit expectations about the accountability of the DHAs (and the Chairmen) to Regions and/or to the Secretary of State? With regard to the DHA-RHA relationship, it was generally recognised that the RHA will carry authority, financial and other, to affect the DHAs but it was suggested that the quality of this relationship will differ from Region to Region. The duality of the Chairman's accountability - to Secretary of State and to RHA - was identified, as were the sanctions which exist in these relationships. There was stress on the consequent importance of the DHAs rapidly establishing a coherent view of the needs and priorities in their districts and being able to justify their proposals.

Relationship to DHA Members

8. There was some discussion of the need to spread the workload among the members so that all are involved, at the same time recognising that some members will have more pertinent skills and interests and more time than others. It was felt that it is the function of the Chairmen to ensure that each member makes the maximum contribution, to identify individual members' special skills and areas of interest, to ensure that members are provided with comprehensible information and to provide opportunities for members to develop and learn in their roles. The general feeling was that it is better to 'overuse' those members with relevant skills and knowledge than to allocate work to members in a uniform fashion.

9. One way of distributing the work among members is to create committees to take on specialised taks for the DHA. Members can thus develop special knowledge in specific areas and see that they are making a contribution. But the potential

disadvantages of the extensive use of committees was also mentioned: the loss of control on the part of the DHA itself and the consequent rubber-stamping nature of its decisions. It was generally felt that the use of committees would depend on local considerations and the make-up of the particular DHA. Where committees are established, they should not be delegated major, generic areas of work such as planning or resource allocation which are essentially concerns of the DHA as a whole.

10. Discussion crystallised around the question of the Chairman reviewing or assessing the performance of members. The sense was that such authority should not be formalised but left to the personal influence and style of the Chairman. Nevertheless, there is an explicit expectation that the Chairman will assess the performance of members and take appropriate action in the case of the member who is contributing little to the work of the DHA. It was emphasised that this responsibility does not mean that the Chairman should be assessing (or sanctioning) members' attitudes or political views.

Relationship to Officers

11. It is perhaps in the Chairman's relationship to officers, particularly those on the DMT, that there is the widest choice of style and approach. Should the Chairman behave as a de facto chief executive, devoting considerable time to monitoring individual performance and directing action? Or should the Chairman, at the other extreme, be mainly an arbiter in situations which are not resolved within the DMT? Recognising the importance of personal style and preference in this relationship, it was nevertheless agreed that the right approach lies somewhere between these two extremes. Although the DMT officers are formally accountable to the DHA as a whole, the Chairman has a particular responsibility in making appointments to the chief officer posts, in giving the DMT a coherent sense of DHA direction and in monitoring the effectiveness of the officers' performance. This will involve regular meetings between the Chairman and officers,

as a group and individually, to provide the opportunity for discussion of development and improvement in the functioning of the organisation.

12. It was felt that the DHA should not be seen as a body divorced from, or irrelevantto, the activities of the DMT. The Chairman and the Authority should examine the decision-making process of the DMT to establish the way in which team members work together, without undermining the confidence of the DMT as a group. It was seen as important that the DMT have a clearly identified coordinator who could ensure that as many decisions as possible are taken within the team, at the same time keeping the DHA in touch with issues in which it should be involved. There was some discussion of the desirability of the coordinator role being held on a rotating basis by different members of the team but most felt that a permanent coordinator would be preferable.

13. The question of consultants' contracts was touched on briefly. In the absence of a central decision on the level of NHS authority with which the contracts will be held, the general view of the Chairmen was that the emphasis on decentralisation of decision-making to the districts implies that the contracts should be held by the DHAs.

APPOINTMENT OF CHIEF OFFICERS AND SETTING UP THE MANAGEMENT STRUCTURE

14. There is considerable variation in the regional timetables and systems for the appointment of chief officers. In many districts the timing is clearly going to be difficult since decisions on the new management arrangements may have to be taken before all the DMT officers are in post. In other districts, the planning of the new management structures may be so well advanced that it will be difficult for the Chairman and the Authority to have any real impact on the overall design. An added problem for those Chairmen who have little or no experience of their districts will be how to obtain impartial information about the prospective candidates for posts.

15. In spite of these difficulties, there was a general view that the Chairman should be personally involved in making the appointments with two or three other members, and that the appointments should not be regarded as a fait accompli. The benefits to individuals and the organisation of keeping disruption to a minimum were recognised; on the other hand, it was felt that officers should be selected not only on the basis of competence in their own field but also on their ability to work together as a team. Other selection criteria which were mentioned included ability in initiating, in managing change and in relating to the Region. It was considered important that the DMT roles should be considered afresh and redefined rather than assuming that the roles would remain unchanged.

16. It follows that discussion and preparation that take place between now and April 1982 will be initiated by officers who may not be the new chief officers. The Chairmen considered it particularly important in this situation that they have access to reliable sources of advice on the optimal management arrangements for the future so that in this area also there should be at least the potential for change.

17. Discussion then turned to the definitions of units in the new management structures and an examination on the organisational principles which might be helpful in resolving this question locally. The proposed bases for units laid out in HC(80)8 were reviewed, together with other potential bases. It seems that in most districts the practical choice will be between:

- units based on a so-called functional differentiation of work - maternity, psychiatry, community, etc. - which is familiar in nursing management structures at present;
- a geographical/institutional differentiation - large hospital, a group of smaller hospitals, community services, etc. - often found in administrative structures.

Other possible bases for units were considered such as care groups (the elderly, mothers and children, the mentally ill, the mentally handicapped, and so on) and care levels (primary, secondary and tertiary care).

18. It was recognised that the bases for units which are likely to provide most flexibility of operation and match the needs of the community most closely may not be the ones most appealing to the professional groups in the NHS, concerned as they inevitably are with integrity of professional hierarchies and career structures. However, it was suggested that to the extent that the same type of definition is used for units within and across the different professional groups - principally in this connection nursing, administration and medicine - so the likelihood of confused accountability and territorial disputes will be minimised. Many of the Chairmen felt that this organisational principle was a counsel of perfection and that the best that could be aimed for, at least initially, was a structure which was based on the existing organisational arrangements and which would therefore embody geographical and functional and institutional components.

19. The emphasis on the notion of a unit 'team' was then explored, particularly in the context of increased delegation and discretion at the unit level, the concept of unit budgets and virement within allocated resources at the unit level. It was generally agreed that those emphases could be inconsistent with the accountability, managerial and financial, that the nurse and adminstrator at unit level will have to the district nursing officer and the district administrator respectively. It will clearly be important that the professional heads at unit level work closely together and with equal amounts of discretion delegated by their managers where these exist; but tension between the demands of the unit relationships and the managerial hierarchies will arise and should be recognised in the expectations of the unit managers' performance.

20. Alternative models for the management of service and staff functions were then analysed, concentrating on the relative benefits of centralisation and decentralisation. It was proposed that, in each case, there are three major criteria to be applied:

- Is there X level (unit, district, super-district) work to be done in the particular function?
- Is uniformity of policy and practice important or not in the particular function?
- Is there real economy of scale to be achieved in having a more centralised arrangement?

21. Taking the personnel function as illustrative, the Chairmen felt that there is district level personnel work to be done, that uniformity of personnel policy and practice across the district is important and that since experienced personnel specialists in the NHS are scarce the most desirable model is a centralised district personnel function providing support to line managers in the units. This model, where personnel staff might be outposted to the units but would remain under the managerial control of the district personnel manager, was preferred to the model of each unit having its own personnel function. It was also suggested that in other functions, where in some cases efficient area-based services already exist, a single district could provide services on an agency basis to its neighbours.

FINANCE, PRIORITIES AND PERFORMANCE ASSESSMENT

22. The whole question of finance and resource allocation within the new districts was touched upon, particularly from the point of view of achieving a significant reallocation of resources. Inhibiting factors such as the dependence upon functional budgeting and the relatively unimaginative use of financial systems were identified. But it was stressed that even within the present financial system there is room for manoeuvre which may not always be exploited. It therefore seems important that the Chairman and the DHA as a whole provide a critical assessment of financial planning. To do

this, the DHA will have to be clear about its priorities and also be able to understand and question the financial reports made to it. It was suggested that the Chairman has a special responsibility in this area and should have close contact with the district finance officer when necessary.

23. There was concern that even when a DHA has carefully considered its priorities and made these generally known, there will still be great difficulty in achieving any real redistribution of resources towards the high priority areas of service. With the called-for 10% reduction in management costs and the usually smaller scale of financial operation at district level, there will be considerable pressure to maintain the status quo. However, it was suggested that even under these constrained circumstances, identification of areas of comparative over-spending and use of changes in the flow of funding can provide some financial leeway. Budgets and plans should be drawn up on the basis of justification of current expenditure, the cost implications of possible changes and the monitoring of the effectiveness of changes once introduced.

24. The importance of the DHA having an overall strategy was also discussed, particularly regarding its stance vis-a-vis its public, patients and patients' families. In the absence of such a strategy, planning can become a rather ritual exercise with little possibility of measuring success or failure. The DHA Chairmen will need to have a clear personal sense of direction too, establishing priorities for themselves, if they are not to be swamped by the range and complexity of issues that will arise.

Report on a seminar for District Health Authority Chairmen
8 - 9 October 1981

INTRODUCTION

1. The King's Fund College held a series of seminars during September and October 1981 for newly appointed Chairmen of the future District Health Authorities. The objective was to assist Chairmen in developing their roles in the build up to and aftermath of reorganisation. The seminar on the 8th/9th October was the second to be held and was attended by twelve Chairmen from the Thames and Wessex Regions. Some of the participants had extensive experience of the NHS, while others were new to Health Service activities.

2. The main themes, issues and problems discussed at the seminar are documented in this report, which outlines the major debates but does not represent the views of any individuals.

TOPICS

3. Participants were asked what they saw as the major problems facing them, both in the short and in the longer term. Seven main problem areas emerged, a structure which subsequent discussion in the seminars largely followed. They were:

- Reorganisation (the pressing time scale for many decisions, management structure, developing relationships between the DMT and the Authority)

- The Region (its monitoring role, strategy, control of capital projects, procedures for sale of assets)

- Finance (the initial budget, capital planning mechanisms, revenue, control of clinically induced expenditure, virement and carry forward, joint financing, use of assets)

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- The interim (policies ongoing from the present AHA, status of the District Plan, communication and consultation with CHC's,staff and union issues, disciplinary codes, joint staff committees)

- The Authority (training new members, roles of Chairmen and DHA, relationship with DMT, committees, meetings, visiting, monitoring especially of long stay hospitals)

- Priorities (identification, changes in priorities, growth and no growth, process innovations, information for change and performance assessment, value for money, performance review, audit)

- Relationships with other organisations (other DHA's, shared services, local authorities, CHC's, MP's, DHSS, public patients and clients, FPC's health education)

REORGANISATION

Initial decisions

4. Key factors in the immediate future were the pressing time scale and the procedures for Chief Officers appointments. Some Chairmen anticipated pressures to err in the direction of existing officers. The general view, however, was that, though the short term inconvenience of failing to appoint on the first round was substantial, it was to be preferred to appointing Chief Officers whose insufficiences or lack of sympathy with the direction taken by the Authority would prove a longer term embarassment. There was considerable apprehension as to how the qualities of potential officers could be appraised. Almost all sources of information carried their own hidden agenda, it should be possible to determine, at least, which candidates were widely respected.

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5. There would also be a severe time table for decisions on unit and management structure, which might prevent any fundamental review. These pressures of time scale would be amplified if the DMT were seriously incomplete after the first round. But the fear was also expressed that a DMT consisting largely of the present officers may equally be a factor inhibiting a new look at assumptions about management structure. These issues and the overall requirement of a 10% cut in management costs made the clarity of the Chairman's mind on these immediate decisions all the more important.

Management structures

6. It is likely that the pressures towards continuity of structure in any district would be substantial. However, there are aspects of the guidance on the nature of units and their management which require some fresh thought even if the basic structure were to remain the same. While recognising that no definitive prescriptions are available, the seminar looked at alternative bases for the definition of units. HC(80)8 suggests several examples of possible units but offers no identifiable alternatives for choice. The commonly cited bases are:

- a "functional" division (maternity, psychiatry, community, etc.) which reflects the way some professional skills and managements (particularly nursing) are structured.

- a "geographic/institutional" division, which reflects the major hospital, or groups of hospitals, refined by any local geographical constraints.

The most radical alternative to these dominant views is that of "client care groups" - the elderly, the mentally ill, the mentally handicapped, etc. The advantages of this alternative were recognised, particularly in the context of budgeting and cost control, but the inevitable intricacies of this approach were not developed at any length.

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7. Discussion centred on the insufficiency of any simple approach relating to the complexity of the services provided. Ambiguities, such as occur with psychiatric wards in a DGH, were accepted as unavoidable. We cannot ask for perfect solutions in structuring service activities. But we can avoid the most obvious mistakes and we can focus attention on those areas, in whichever form of structure is adopted, at which the stress or ambiguity is greatest. Several participants emphasised the importance of avoiding situations in which the distribution of responsibility or lines of accountability would be blurred by a mixing of the bases for defining structure. Staff could be left effectively unmanaged. Others might encounter complex lines of accountability, as could be the case for the psychiatric nurse in the DGH. In general, it was considered important to inspect any proposed approach to unit structures for the problems it might generate, rather than to rely merely on its overall appeal.

8. The emphasis in reorganisation on decentralisation and unit responsibility raises the interesting question of whether the idea of a management team could or should be replicated at unit level. This would imply some multi-professional group with a responsibility for the effective performance of the unit as a whole. If each of the members of this team is held accountable in a line relationship to his own professional superior in the DMT, it is difficult to see how lateral accountability of a team relationship could be sustained. This will, in turn, affect other aspects of their mutual responsibility such as unit budgets, with an appreciable degree of virement between different expenditure heads within the unit's area of responsibility. However, it was suggested that it may be opportune for other reasons, notably the strategic role of the DMT, that strict line accountability of individual unit managers might be loosened. This would enhance the feasibility of team accountability at unit level, though the general weaknesses of the concept of accountability of a "team" would still remain.

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9. There was some discussion of how many levels of management there needed to be between unit and first-line managers. In particular, there may be little relationship between what might be desirable managerially and the constraints likely to be imposed by Whitley salary scales. In terms of organisation design there may be an argument for wider salary bandings to allow for career progression within each banding, but this was likely to be in conflict with the concerns underlying Whitley negotiations.

10. Each District will also have to place a number of service or staff functions e.g. personnel, supplies, works, etc. Different functions may require different treatment depending on whether district wide policies are thought to be important (e.g. personnel), whether economies of scale matter (e.g. supplies) or whether specialised services are easily and reliably available from outside the organisation (e.g. legal or architectural advice). Perhaps the two most important structuring questions would be:

- Is there district level work to be done ?

- Is uniformity in policy important ?

If district level work is identified or uniformity in policy matters, both of which were regarded as true for personnel, then there remains a dilemma of how to organise the function. A presence at district level does not imply that all of the particular function should be placed at district. For instance, personnel may need not merely assist in the formulation and promulgation of district policies, but also to influence managers and their practice. Generally, participants favoured the view that, in the case of the personnel function, contact with managers could be maintained from a district based team.

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11. The question was raised of whether these detailed criteria for design of structure ought not to yield to rather broader insights based on perceptions of where the DHA wants the organisation to go. If it were possible to define some clear directions of development, whether in the innovation of particular management systems or in coping with specific challenges, then these may identify priorities in organisation structure.

FINANCE

12. A number of points were raised in the description and analysis of the financial system in the NHS and of financial information. Among the issues discussed in describing the system were cash limits, RAWP, RCCS, virement, capital, major and minor and virement with revenue, earmarking. The observation was made that, though RAWP remains a force to be contended with in current allocations, the achievement of equal resources according to its formula was a distant prospect.

13. However, most of the discussion concerned the use of financial information. Attention was drawn to the work of John Yates at Birmingham University, who had used a series of resource indicators to predict those long stay hospitals which were at high risk of failure, and to the evidence of Dr Forsyth on the failure to achieve any major increase in the relative shares of Cinderella services in expenditure. These were examples of the diagnostic and evaluative use of financial indicators.

14. Several different approaches have been adopted to budgeting in the NHS. These were outlined and compared in the seminars. The path from functional budgeting (based on grouping people and resources of like type e.g. nurses, drugs) to speciality costing and clinical budgeting (concerned to analyse the expenditure of individual specialities or the resource consumption of individual clinical teams) was explored.

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Simply to attach budgets to units can be confusing and can result in no increase in usable information unless those units reflect some policy relevant criterion such as client care groups. Certainly the establishment of units on functional or institutional grounds could inhibit the development of budgeting and resource allocation systems in which clear policy objectives could be pursued. At the moment the NHS tended to use budgetry structures which did not provide information needed for policy purposes. It was likened to "steering the ship by watching the wake over the stern".

15. This gave rise to a discussion of the different uses of financial information - for reporting, for control and for decision-making. A further distinction was made between management financial information and "boardroom" financial information. It was agreed that the purposes to which financial information in the NHS was directed had become confused, and that, in particular, the Authority was not provided with information useful for the assessment of performance or for policy-making. If active priorities are to be pursued, it would be necessary to develop management systems to sustain it. There is a real choice between resolving to be in the driving seat and embracing the need to develop the requisite management systems or accepting a more passive role of witnessing the delivery of health care but influencing it only spasmodically and ineffectively.

16. Other facets of current procedures were identified. For instance, the capital led nature of strategic planning was cited. The issue should be expressed more in terms of what services do we wish to provide, for which capital requirements are derived.

THE INTERIM

17. There appeared to be a substantial variation between Regions as to the clarity and nature of arrangements for the period till the new DHA's takeover, though it was recognised that these were still early days.

Where an individual DHA comprised an existing District or was entirely contained within an existing area, many of the problems of transition would be lessened. However, a DHA which involved the grafting together of two sets of plans, or management procedures would be likely to encounter difficulties. For instance, developing a mechanism for disciplinary and appeals procedures from two such procedures, already established, could be an arduous task. This example sparked a general discussion of the nature of member panels in hearing appeals against disciplinary action. The essential principle is that of another tier of management considering whether correct procedure had been followed and whether management action was reasonable, not whether the panel agreed with the outcome.

18. It was not generally considered that relationships with the existing Authority would be too dificult. In the particular, case whether there was a substantial turnover among Chief Officers, there may be some logistical problems of who would be working where, but these should not be severe.

THE AUTHORITY

19. There was substantial discussion of a range of issues about the roles of the Authority and of the Chairman, and how they might ensure the effective conduct of those roles. There is a general problem of the DMT producing unified and single recommendations for the consideration of the Authority or even of the Chairman. It should be possible for the Chairman to become involved in the major choices which underpin DMT recommendations, but it is much more difficult to ensure that the Authority considers its policies and actions in the light of a range of reasonable options.

20. There was agreement that the role of the Chairman was not that of a Chief Executive, but beyond that it remained somewhat amorphous. The spirit of an active Chairman, with freedom of involvement in the work of the DMT, was strongly endorsed. But it was clear that the way in which the

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Chairman should establish ground rules of what issues should be referred to him or her, at what stage of deliberation, and with what degree of pre-structuring would be a matter for each Chairman to determine as a matter of personal style.

21. There remained an outstanding fear that the consensus philisophy of the DMT might operate to exclude debates that ought properly to take place in the Authority. Indeed, there may even be a tendency to present the Chairman with a single strongly argued view. It is important to identify the dimensions of the alternatives early in the debate, since once a consensus view has formed in the DMT, the alternatives are likely to be represented only nominally if at all. However, if the Chairman meets regularly, both formally and informally, with the DMT and individual chief officers these problems can be avoided at least as far as the Chairman is concerned. Moreover, such meetings, together with information from lower in the organisation, could be useful in judging the performance of chief officers and the effectiveness of the DMT in helping the Authority to achieve its objectives. It is likely that the Chairman is in a unique position to judge effectiveness in this sense and to undertake whatever counselling or change might be necessary. It was felt that this responsibility is an important one for the Chairman to keep actively in mind, since it is easy to lapse into an acceptance of the status quo in this critical area.

22. The Chairman is accountable to the Secretary of State, though the interpretation of this accountability varied from that for the broad conduct of the Authority's affairs to an obligation to implement the policies and priorities advanced by the Government. The significance of this accountability is obscured further by the responsibilities the Chairman has to other groups, the Authority, patients, the public, employees,for example. Again it is for each Chairman to balance these responsibilities with his interpretation of his accountability to those who have appointed him.

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23. Though the Authority consists of members recruited from a variety of interests and sources, the intention is that it should operate as a corporate entity. However, participants were pessimistic that this quality would be achieved at all easily. It is clearly the Chairmen's responsibility to be concerned with the development of the Authority and with welding it into a working group. This may well recognise diversity of interests and time commitments of members. But it should also be concerned with developing these interests and skills to evolve a more effectively functioning Authority. The Chairman is also the point of sanction or, at least, of counselling for those Authority members whose performance falls substantially below expectations.

24. Some suspicion was expressed over the role of committees. There is a danger that these could become too specialist or powerful, relegating the Authority to the status of 'rubber stamping'. Specialisation of members could lead to a lack of balance in the more general functions of the Authority. On the other hand, it was recognised that some issues are impenetrable to members unless particular effort is devoted to them. An alternative which was canvassed was that of "ad hoc" committees set up to perform a single task or with a limited horizon, with the Authority monitoring progress closely.

PRIORITIES

25. The national priorities laid down in Care in Action may or may not correspond to the needs or opportunities in any particular situation. This will depend on existing levels of provision of various services in the locality and the opportunities for shifting resources which can be identified. Abstract statements of priorities are unlikely to offer such guidance. Real choices will often prove inconsistent with them. Nevertheless, some consistency might be achieved by comparing the implied priorities in successive decisions.

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26. Shifting resources to priority areas inevitably involves innovation and change. These resources may be made available by growth, cutting waste or moving resources between alternative, but effective uses. It is unlikely that the first two sources will contribute enough to allow substantial shifts towards priority areas. The third, on the other hand, is difficult to achieve at all systematically. To do so will involve a number of critical 'process innovations':

- planning which is evaluative, affects what managers do, and exposes options

- budgeting which is not merely incremental and historically based

- system of resource accountability which identifies expenditure by its use and locates high cost practice

- information systems which are about information and its use,not just data

- a commitment to monitoring and control

RELATIONSHIPS WITH OTHER ORGANISATIONS

27. Relationships with Regions, FPC's, other DHA's, Local Authorities was a topic which attracted substantial but inconclusive discussion. It was clear that in this re-organisation the role of Region and how it might develop were critical. At this stage, how various Regions would interpret their powers and seek to manage their relationships with DHA's was a matter of conjecture. This was particularly true in issues like initial funding, strategy and planning, monitoring, approval of management arrangements, regional specialities. However, there was clearly a strategic dilemma for DHA's in how to approach the relationship from their side. Once again, the Chairman was the principal instrument together with his officers.

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Yet the larger number of DHA's in each Region militated a favour of officer contact or of Chairman-Regional Officer contact. Reservations were expressed about this There was also specific discussion of relationships with Local Authorities and joint funding, in particular. It was felt that this had been confused by differing expectations on the two sides and by the difficulty Local Authorities experienced in assuming responsibility for revenue expenditure in due course. Nevertheless, it was felt that mechanisms could be devised to ease these problems and to make joint funding a more useful and significant mechanism.

28. In dealing with the public and the DHA's clients, the Chairman is inevitably thrust to the fore. This is particularly true of complaints or mishaps. There was some discussion of the procedures and dilemmas involved in accidents within a hospital and of the problems of ensuring a proper investigation together with just treatment of relatives of the victim. This broadened into a consideration of the dilemmas arising from conflicts of clinical practice and the represented interests of some patients, as arise, for instance, in high technology practices in obstetrics. As with most topics in the seminar, no clear guidelines resulted from this discussion, but issues of this quality and the Chairman's responsibility to guide judgements on them were clearly recognised throughout.

Report on a seminar for District Health Authority Chairmen
19 - 20 October 1981

INTRODUCTION

1. The King's Fund College held a series of seminars during September and October 1981 for newly appointed Chairmen of the future District Health Authorities. The objective of the seminars was to assist Chairmen in developing their roles in the build up to and aftermath of reorganisation. The seminar on 19 - 20 October was the third to be held and was attended by twelve Chairmen from the four Thames Regions and Wessex. Some of the participants had considerable experience of health authority membership; others were new to the NHS.

2. The main themes, issues and problems discussed are documented in this report, which serves to outline major debates and does not represent the views of any one individual.

TOPICS

3. Some of the problem areas that Chairmen could foresee are listed below:
   - The Authority (relationship of Chairman to members and officers, role of Chairman, role of the DMT and DHA, monitoring of officers, Authority and Chairman, committees and public meetings)
   - The build up to reorganisation (management structure, appointments, consultative machinery, area services)
   - Relationships with other organisations (region, DHSS, local authorities, other districts, CHCs, FPCs, the public)
   - Management issues (financial management, resource allocation, priorities, planning and strategy, IR, management style).

Time constraints meant that only some of these problems could be discussed but avenues for further investigations were opened.

THE AUTHORITY

Role of the Chairman.

4. It was recognised that each Chairman will have a choice as to how to interpret the role, the extremes being a laissez-faire approach on the one hand and the approach of a chief executive on the other. The Chairmen agreed that the ideal approach lies somewhere between these two extremes. For example, although the Chairman will need to relate closely to the DMT, this relationship should not exclude the Authority as a whole. Similarly, the Chairman should not be taking overriding decisions when there is disagreement within the Authority.

5. Although the Chairman is directly accountable to the Secretary of State, the relationship with the Region was also seen to be important since the RHA allocates resources and monitors performance. It was recognised that the nature of the DHA-RHA relationship will vary from Region to Region but it was felt that this is an uncertain area which should be studied further as experience is gained.

6. With regard to the Authority members, the Chairman should be a spokesman and leader and as such has a responsibility to assess the performance of members and take appropriate action in the case of a member who is contributing little to the work of the DHA. The Chairman should also provide opportunities for members to obtain training and development in their roles.

Role of Members

7. The corporate nature of the DHA was discussed, particularly the need for individual members to stand by the decisions of the Authority. Members will wish to put forward the view of external groups or particular sections of the

community but once a decision has been taken in the Authority it should be binding on the membership.

8. The need to involve all members in the work of the Authority was emphasised; even though the members will have different skills and areas of interest, they should be encouraged to take part in activities such as visiting and conducting appeals. It was felt that it is the function of the Chairman to identify individual members' special skills and areas of interest and to ensure that each member makes the maximum contribution.

9. Another question discussed in this context was the desirability of creating committees to take on specialised tasks for the DHA. The practical advantages of committees were identified - committees enable more work to be done more thoroughly and quickly, they encourage members to develop knowledge in special areas and they promote members' sense of contribution. However, it was also pointed out that if committees become too powerful, the Authority can become fragmented and lose control. It was also suggested that where committees are established they should not be given major, generic areas of work such as planning or resource allocation since these should be considered by the Authority itself.

Relationship between the DHA and Officers

10. It was agreed that, although the chief officers are accountable to the DHA as a whole, the Chairman has a special responsibility to give the officers a coherent sense of DHA direction and to monitor the effectiveness of their performance. This will probably require the Chairman to have regular meetings and working sessions with the officers and to establish criteria for judging the effectiveness of the officers' performance in both their professional and corporate spheres.

THE BUILD UP TO REORGANISATION

Management Structure

11. It is likely that the pressure in each district will be towards causing minimum disruption by changing the management structure and the people in the roles as little as possible. This approach has obvious virtues in terms of maintaining morale and maintaining continuity of operation. On the other hand, it was suggested that the opportunity should be taken to eliminate obvious anomalies in the present organisation and to create a structure more suited to the needs of the community.

12. The present structures tend to place emphasis on hospital care and the acute sector. It follows that the choice which is being debated in most districts for the future is between:

- units based on a so-called functional differentiation of work (maternity, psychiatry, community, etc.) which is the basis of many nursing management hierarchies at present;
- a geographical/institutional differentiation (a large hospital, a group of smaller hospitals, community services, etc.) which is often the basis for administrative structures.

Some other bases for units were discussed and analysed, in particular the basis of care groups - the elderly, the mentally ill, the mentally handicapped, and so on. The care group basis for units was seen to have some appeal in that it breaks down the traditional organisational and professional barriers. But some Chairmen felt that such a structure would result in an unacceptable splitting up of responsibility within the district general hospital with a possible drop in standards of hospital management as a consequence. It was also recognised that a care group basis for units is unlikely to appeal to the major professional groups in the NHS, since they are understandably concerned with the integrity of professional hierarchies and career structures.

13. In general, it was felt that it would be impossible to think through and implement a radical change in the management structure in the time available. Nevertheless, the opportunity should be taken to create structures which are consistent with the long term objectives of the Authority and which allow adaptations to be made over the next few years.

14. Another aspect of unit organisation is the question of the unit management team as identified in HC(80)8 and elsewhere. It will clearly be important that the professional heads at unit level work closely together and with equal amounts of discretion delegated by their managers at district level. The relationship between these professional heads and a doctor or doctors at unit level will also be an important element. However, it was suggested that it may not be necessary to reproduce this nurse-administrator-doctor triad in each unit. For example, some units may not need a full-time administrative presence; in other units there may not be a single doctor who is in a position to represent the views of the medical staff. It seems therefore that the notion of a unit management team is a flexible one which will have to be interpreted on the basis of local circumstances.

15. Discussion then turned to the question of how many levels of management there should be between the unit and first line managers. It was suggested that the number of management levels should be kept as few as possible and that within each level there should be a wide range of salary. It would thus be possible to reflect length of service and special expertise in higher salaries rather than in artifical promotion to the next management level. There was concern that the Whitley salary scales, when announced, would not allow for this flexibility.

16. Alternative models for the management of service and staff functions were then analysed, concentrating on the relative benefits of centralisation and decentralisation.

It was proposed that, in each case, there are three major criteria to be applied:

- Is there work to be done in the particular function at unit, district or supra-district level?
- Is uniformity of policy and practice important or not in the particular function?
- Is there real economy of scale to be achieved in having a more centralised arrangement?

17. Depending on the answer to these questions, any one of the three following models could be appropriate for particular functions:

- Two or more districts sharing a service. The management responsibility could lie with one of the districts which would provide services to the others. Alternatively, a particular service might be regionally based or be contracted out. Such relatively centralised arrangements may be necessary in functions where the particular expertise is in short supply or where there are particular economies of scale to be achieved;
- Basing the function at district level, with the functional manager accountable to a member of the DMT. Specialist staff in the function might be outposted to units but would remain under the managerial control of the district functional manager. This model was felt to be appropriate in functions where uniformity of policy and practice across the district is important e.g. in personnel;
- Basing the function at unit level, with the functional manager accountable to a unit manager. This model allows for maximum flexibility to suit local circumstances but is expensive both in terms of staff and duplication of effort.

18. There was considerable discussion of the application of these alternative models to different functions. In general, it was felt that the operational services in the district should be as decentralised as possible whereas many of the support functions could be centralised at district or supra-district levels.

RELATIONSHIPS WITH OTHER ORGANISATIONS

19. Concern was expressed about the future relationships of DHAs with local authorities, particularly in the area of joint funding. In the past it has not been easy to establish effective joint funding schemes and it may be even more difficult in future when in general districts will be smaller. However, it was generally agreed that joint funding should be pursued wherever possible and that DHAs might consider cooperating in order to obtain funding for larger schemes.

20. With regard to the DHAs' relationship to the public, it was suggested that it will be important for each DHA to discuss and identify its preferred approach. Clear policies should be developed on matters such as access to information, handling of complaints and other matters with potentially legal implications and these policies should be made known within the organisation so that managers understand what is expected of them.

MANAGEMENT ISSUES

Financial Management

21. The whole question of controlling costs within the NHS was discussed, particularly the need for the budget holders to be provided with relevant and up-to-date information. It has been demonstrated that savings are more likely to be made if the budget holders can see the financial impact of their decisions and if some incentive can be introduced such as the ability to retain some of the savings within the budget category. The general view was that none of the types of audit currently carried out in the NHS is directed to suggesting more efficient use of resources. In this connection, some research into comparison of unit costs to highlight areas of possible inefficiency was mentioned.

22. The relationship between capital and revenue expenditure was discussed at some length and various suggestions were made on how to achieve greater flexibility between the two.

These included leasing equipment, the sale and return leasing of land and buildings and renting out utilities and services.

23. On the question of budgeting, the importance of an agreed and well developed budgeting system was underlined. The budgetary system and the organisational structure should be complementary and budget holders should be involved in developing the budget and the limitations upon it. This was seen to be particularly important with regard to clinical medical staff who on the whole are unaware of the financial significance of their clinical decisions.

Planning and Priorities

24. There was concern that even where a DHA has carefully considered its priorities and made these generally known, there will still be great difficulty in achieving any real redistribution of resources towards the high priority areas of service. With the 10% reduction in management costs and the usually smaller scale of operation at the district level in the future, a change in direction will be particularly difficult to achieve. Nontheless, it was felt important that the needs and demands in the community should be examined and evaluated and that innovative solutions should be pursued.

Report on a seminar for District Health Authority Chairmen
22 - 23 October 1981

INTRODUCTION

1. The King's Fund College held a series of seminars during September and October 1981 for newly appointed Chairmen of District Health Authorities. The objective was to assist Chairmen in developing their roles in the build up to and aftermath of reorganisation. The seminar on 22nd/23rd October was the last of the series and was attended by eleven Chairmen from the Thames and Wessex Regions.

2. The main themes, issues and problems discussed at the seminar are documented in this report. It outlines the major debates but does not seek to represent the views of any individual.

TOPICS

3. Participants were asked what they saw as the major problems facing them, both in the short and in the long term. These were grouped into three main categories:

- Management of the mature Authority: the role of the Chairman and the relationships with officers and members, the role of the member, committees and specialisation of members, finance and budgeting, clinicians and their use of resources, priorities, planning and development.

- The interim: issues of management structure, selection of chief officers, shared services.

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- Relationships with other organisations: local authorities, Region, public, patients, CHC's, unions and employees, other DHA's.

THE AUTHORITY

4. The key factor in the forthcoming reorganisation is the extent of the local discretion that is intended. The constraints and pressures on Authorities are substantial but often unclear. Perhaps the most important aspect of the Chairman's role is to ensure the consistent and coherent exercise of the Authority's discretion. It is important for the Chairmen to identify the pressures and demands to which he must respond and to evolve working arrangements with members and officers.

5. It might be tempting for those Chairmen who can commit sufficient time to see the role as that of a Chief Executive. However, the attempt to be an executive in the same sense as the officers would certainly confuse their role, particularly that of the administrator, and would result in isolation of the Chairman from the Authority. But the Chairman has distinctive responsibilities, particularly in assessing how the DMT, the Authority and the relationships between them are working out. It is likely that no simple and convincing analogue to the DHA Chairmen can be used to define the role and each Chairman will have to determine his own approach pragmatically. Certainly, the Chairman must have access to DMT meetings and should be involved in issues before a consensus view has become rigidly established. More ambiguous is the responsibility for taking remedial action in response to shortcomings in the senior management. In the last resort, the responsibility is his, but in most practical situations it will be more a matter of mutual adjustment in the DMT.

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6. General concern was expressed about the medical members of the DMT. On occasion, the consultant member may feel himself to have privileged access to the Chairman where he feels the interests he represents might be threatened. This possibility requires sensitive treatment by the Chairman to avoid undermining the collective relationship with other members of the DMT. The position and contribution of the District Medical Officer was raised. The difficulties of the several inherited activities and the general ambiguity surrounding community medicine were appreciated by participants. Some stress was laid on the involvement of the DMO in planning,though practice was very uneven. Reported experience reflected the variation in ability and interests of practitioners of community medicine, but, from those whose experience had been good, there was considerable optimism about the possible contribution,with the caveat that it depended critically on the qualities of the individual involved. The initial scepticism with which the topic was introduced yielded to this conditional enthusiasm. There was further discussion of the organisation of community medicine in a DHA and the peculiarities of status and relationships of SCM's.

7. In discussing the role of the Authority, the question of committees was raised. Particularly noted as advantages were the ability to involve members in detail at an earlier stage of determination of issues, the use of members' specialised knowledge and the limiting, through the division of labour, of the number of issues which had to be dealt with for ratification or broad inspection in the full Authority. The disadvantages were all variants of the fear that committees might become exclusive, controlling bodies which would undermine the role of general and public discussion in the Authority meetings. To some extent the involvement of the Chairman in the committees might limit this tendency. Some Chairmen felt that the enhanced specialist knowledge of the members might increase the confidence of officers in discussion in general meetings and could contribute to a healthier flow of information to the Authority.

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8. There are, in any case, varieties of specialised interests and knowledge in the Authority and there may be problems of welding these into a corporately functioning body. To varying degrees, doctors, nurses, local authority members or trade union nominees may speak from special interest or may even participate in the Authority's affairs selectively. It is important to realise that individual members are not representatives, but exercise a more general trusteeship role for the affairs of the Authority as a whole. Neither the formal specification of sources of members nor the process of their nomination is very helpful in securing understanding of this role. It represents a major problem for Chairmen. It may be accentuated where political or community divisions are important in a particular Authority.

9. It was agreed that the Chairman was in a difficult position with regard to Authority members who were not fulfilling their duties. Experience suggested that over time the involvement of some memberswould decline or be reduced to a limited or highly delineated contribution. There might be, as a consequence, a problem of finding sufficient members to discharge the general functions of the Authority. Experience also suggested that consultant, GP and local authority members were the most susceptible in this regard. The Chairman's capacity to deal with this situation may be inhibited by the fact that he is appointed not elected. More importantly, he has few sanctions apart from seeking to influence reappointment and must rely on persuasion or on stimulating the members' interest.

FINANCE AND BUDGETING

10. This seminar discussed finance and budgeting at greater length and in more detail than any other. In particular, the development of innovative forms of budgeting and their relationship with organisational structure received considerable attention.

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11. To begin with there was a short explanation of sources of revenue for the NHS and how it was controlled and spent, including a brief assessment of the RAWP mechanism. RAWP only determines the allocations of additional sources, so the process of equalisation is inevitably slower than would be the case if direct redistribution were permitted.

12. Recent changes in the adjustment of cash limits to cope with inflation greater than expected were also discussed. Whereas, in the past, some compensation could be expected from the Government for wage and price increases which exceeded the estimates built into the cash limit, this would no longer be the case. As a result, there would be a significant shift of risk to the DHA, which would have to be more conscious of such factors in the management of resources, and, particularly, in its use of reserves. Poor management would lead to the need for sudden economies with all of the disruption and conflict that implies.

13. It is clear that some familiarity with financial issues within the Authority is an important piece of the Chairman's armoury. This involves not merely trust in the technical skills of the Finance Officer, but an ability to put in context the financial issues that arise. The qualities and approach of the Finance Officer will be important, but the Chairman may have to push strongly for briefing which provides context and not just technical detail.

14. It was suggested that more attention might be given to asset accounting. At present attention is concentrated almost entirely on revenue flows. A variety of approaches to more effective use of assets might be possible, including sale and lease-back, or selling the services of excess capacity e.g. of boilers. This novel area would be likely to break some established conventions and problems might be encountered in establishing particular practices. Nevertheless, serious investigation of the use of assets might provide substantial contributions to the revenue account.

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15. Specific consideration was given to budgeting and resource allocation and control. Although increasing the share of the Cinderella services appears to have a major commitment of many in the allocation of resources, some evidence had suggested that such a shift of emphasis had not taken place. The question was raised of how far the purposive allocation of resources was enhanced or inhibited by the management systems in operation. The dominant mode of budgeting, based on 'functional' criteria allocates by grouping like resources - nurses, administration, clinicians, drugs, etc. Within such a budgeting system, there is no clear statement of the purposes or areas of activity in which these resources have been used. So it would be impossible to identify the extent of resources committed to, say, psychiatry or surgery, and how this might have varied over time. Equally, budgetary control - the analysis of the variance of actual from targeted expenditure - is limited to identifying factors concerning the availability and deployment of inputs. Changes in volume of services provided could not easily be related to observed changes in expenditure. Alternative types of budgeting systems were discussed. One obvious variant is to create budget centres corresponding to units. However, overlap between units might make it difficult to ensure that all budget holders have clear responsibility for the expenditure incurred. Moreover, unit budgets would replicate the problems of functional budgeting in relating expenditure to output except where the unit was coincident with a single care group.

16. Somewhat more radical alternatives are to be found in 'specialty costing' and 'clinical budgeting'. The former identifies expenditures on all resources by the clinical speciality which they serve. It involves the allocation of inputs to specialities and encounters common accounting problems such as joint costs. The latter breaks expenditure down further to identify the resource use of individual clinical firms with the potential for comparison and control of resource use by like firms.

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The informational and accounting aspects of these approaches are developing in a number of experimental authorities. However, this bare statement of approach leaves open the question of how they would be used in budgeting and resource allocation. They would inevitably involve clinicians in both expenditure control and budgeting. The motivation for this might well derive from the prospect of nil growth in real expenditure on a particular specialty and the need for resources for development to be found from savings within that specialty. These issues and corresponding questions of clinical autonomy, the role of the Authority given such budgeting systems, the need for a different emphasis in management information, and the impact of these systems in enhancing a planning perspective were all discussed. The detail of how such budgeting systems might work depends intimately on the organisational structure employed. It was felt that these issues were not separable and that consistency with innovations in budgeting and control might be a major criterion for the design of management structure.

MANAGEMENT STRUCTURE

17. The basis for the organisation of districts below chief officer level was a major concern. Two conflicting pressures were identified. First, it was recognised that most professional groups would want little change and disruption. In particular, there would be pressure to maintain the professional hierarchies that had been established under the previous reorganisation. Moreover, the schedule for deciding management structures would be extremely constrained. The status quo would inevitably be more feasible than an extensive review and redesign. Second, reorganisation could be regarded as an opportunity to make some radical changes and refinements. Some changes would be necessary to achieve the target reductions in management costs.

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18. Different ways of differentiating work below district level were explored. Functional, with divisions which approximate to nursing structures and specialties, and institutional or geographical, which tend to be favoured by administrators, both tend largely to reinforce the status quo. Obvious confusions and overlaps are possible which could result in obscured responsibilities and lines of accountability .

19. The logic of the discussion of budgeting led inexorably to a focus on client care groups as the basis of organisation structure. This approach would include group activities which served classes of patients or potential patients which were relatively homogeneous in their needs, regardless of whether these activities were operated within the same institutions or based in the community. It allows comparison and substitution of activities which were alternative ways of serving that client group. It also focuses on the relative balance of resources devoted to different client groups and therefore corresponds directly with the general policy concern with priorities and how allocations can be changed over time. Finally, it links with the specialty costing and clinical budgeting approaches.

20. Some technical problems result which were explored in detail. Most obviously, it might not be sensible to break all of a hospital's activities down and attribute them to the various care groups which are served. Nobody would then be responsible for the hospitals as a whole. It might be better to define a hospital infrastructure (including maintenance, porters, cleaning, laundry, catering) as a separate unit or portion of a unit which provides services to the care group units. In the most sophisticated version, the client care group units might be notionally charged a transfer price which represented the cost of hospital infrastructure and services used and which therefore contributed to the real expenditure of that care group's activities.

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So, they may be notionally charged for theatre space, share of cleaning, provision of food and so on. The hospital infrastructure unit would then be required to break even, i.e. to attribute to the user units the total costs of running the hospital. Such a format, though difficult, would provide a basis for explicit statements of all costs and a motivation for more efficient use of facilities.

19. This broad approach to management structure and systems produced a response varying from considerable interest and commitment to scepticism and wariness. It was pointed out that such changes could be made over longer periods. In practice, local conditions might dictate a variety of styles. But it was critical to realise that decisions made now about management structure could inhibit such innovations in the future.

20. The notion of a unit 'team' was explored and some substantial difficulties identified. Direct line responsibility to the individual members of the DMT could inhibit inter-professional 'teamness' at unit level. This would depend on how the DMT interpreted the requirement for substantial discretion at unit level, and poses the issue of the role of the DMT itself. It was felt that the professional representation in unit management would require careful attention and should be flexibly interpreted in the light of the characteristics of each unit.

21. Discussion then turned to the sub-unit structure. Traditionally, there has been a large number of management levels between wards and units. This arrangement gives little opportunity for merit increments, delegation, room to work or to reflect seniority at one particular level and is also costly and wasteful. Ideally, wage bandings should fit the management structure, but, in reality, the process is reversed. It was argued that Authorities should aim for a 'flatter' pyramid in the organisation especially in times of financial constraints, but this implies a heavy use of staff and service functions, discussed below.

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22. For each staff and service function two main questions should be asked:

- is there district/unit level work to be done ?
- does uniformity in the district matter ?

It was agreed that the answer to these questions will be different for each function and, in some cases, financial considerations will have to be borne in mind as well. For example, economies of scale will apply to the 'purchasing' functions (supplies, catering) and the total cost of employing many specialists will have to be borne by the district as a whole. For some functions it was not thought necessary to have a permanent specialist but instead to hire services when necessary. However, consistency in the application of structures is crucial, for example, if a district specialist is appointed, then their duties and responsibilities should cut across all professional boundaries.

RELATIONSHIPS WITH OTHER ORGANISATIONS

23. Relations with unions and employees will be a central concern for most Authorities, particularly given the pressures on resources expected in the immediate future. Several aspects of this were discussed. The handling of disputes, disciplinary procedures and appeals were considered specifically. It is important to establish clearly in members' minds the status and remit of appeals panels. They constitute the top level of management for the purpose of hearing disciplinary cases, and as such are concerned to establish that proper procedures and reasonable judgement have been used rather than to judge the merits of the case. It is an area in which member panels, acting in an undisciplined way, can create dissonance and confusion among officers. On the other hand, appeal hearings can be an important source of insight into the practice of management within the Authority and of policy guidelines for the future behaviour of managers.

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This is a precarious and complex field, in which new and difficult issues arise unheralded. Members need a clear remit and training for this task. The problem is that it is often regarded solely as a mundane chore.

24. Other aspects of Authority policy in the field of employment were also noted. In what terms and to what degree does the Authority wish to be a "good" employer? For instance, in the areas of equal opportunity and youth employment, what standards should the DHA set for its officers and how should they be monitored? There were mixed responses to these issues, some feeling strongly that they were of no greater concern to the NHS than to other employers. However, it was also pointed out that in many areas the NHS probably lagged behind progressive private sector employers in this field. There was dispute over whether scarcity of resources should be a determining factor of policy in these issues.

25. The seminar members felt that the relationship with the Regions might cause problems. If area services are taken over by the Regions, Districts will be left with little room for initiative and manoeuvre in spite of the stress of the 1982 reorganisation on delegation, autonomy and flexibility to meet local needs. Some fundamental questions about the need for a Regional view, strategic planning and coordination were raised in view of the implied restrictions imposed on Districts. A further difficulty is the fact that each District Chairman will have to compete with many other Chairmen when making demands, negotiating and liaising with the Region. However, strategic considerations should not be solely the prerogative of Region. DHA officers should also be in the strategic role. This would necessarily involve the responsibility for evaluating the performance of the DHA, developing management information and guiding changes in competence and attitude within the Authority.

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26. This last point raised the issue of management development for chief officers and Chairmen agreed on the importance of the Authority and the chief officers understanding and working towards the same goals.