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KING'S FUND CENTRE

ROLES AND RELATIONSHIPS IN SERVICE PLANNING

A report of a workshop held at the King's Fund Centre
on 6 September 1978

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1. THE STRUCTURE OF THE WORKSHOP

1.1. The Background

One of the issues which has emerged during the introduction of the NHS Planning System is the question of 'who does what?' in relation to service planning. Although the responsibilities of the various professions involved in the planning process have been broadly sketched, it seems on examination that there is considerable variation in practice and some degree of overlap between the perceived responsibilities of those involved. Related to this is the broader problem of trying to define what 'Service Planning' actually is. Is it part of the function of everyone in the NHS with some kind of managerial responsibility, or is it a developing specialist function which would be better fulfilled by people specifically trained to do it? Either way, what educational preparation or training is required for each of the professions involved to ensure that the function is effectively discharged?

1.2. The Means

These are among the issues which are currently being considered by the Roles Sub-Group of the DHSS Standing Group on Planning and it was decided that the debate might usefully be furthered by bringing together a small number of informed individuals from different health service professions at a day workshop, to discuss both the present position and ideas for development in the future.

1.3. The Goals

1.3.1. The stated objectives of the workshop were:

1. To discover and discuss the extent and range of service planning work currently being undertaken by each of the disciplines represented.
2. To examine ideas for future development of the role of each discipline in relation to planning in the service.
3. To consider the educational implications of any developments proposed.

1.3.2. Professor Willcocks, in his background paper, elaborated these objectives and listed more specific tasks to which he hoped the Workshop would address itself:

1. List the skills required in service planning and decide how these skills should be deployed within the structure of District, Area and Region.
2. Attempt a catalogue of what is currently being done, which skills are currently being used and by whom, and compare these to those listed under (1).
3. Discuss whether there is a role for a specialist planner or whether planning should be a part-time, part-career activity for many disciplines.
4. In either case, discuss what skills should be given to the specialist planner or added to the professional training of the non-specialist planner.
5. Consider the question that if planning is inevitably a multidisciplinary activity, then who is and who should be the leader, the initiator of the planning team? Should the relationship between the various members of a planning team be left to their own discretion? Or should there be guidance and perhaps even the creation of a specific planning team leader role?

1.4. The Process

1.4.1. Invitations were issued by the King's Fund Centre to a range of personnel in the health service. Those accepting the invitation included ten administrators, six clinicians, eight community physicians, five nurses, eight finance officers and three others. The participants are listed in Appendix A.

1.4.2. The following papers were circulated prior to the workshop, as background reading:

1. 'The Involvement and Role of Officers in Planning' (SGP (78) 15)
   Regional and Central Planning Division (2)
2. 'Roles and Relationships in Service Planning'
   Professor Willcocks
3. 'The Role of the Treasurer in the NHS Planning System'
   Mr Rippington
4. 'Planning in the NHS'
   Mr Rippington

5. 'Realistic Planning'

Mr T Rippington

6. 'Joint Approaches to Community Care'

Dr P Jeffreys

7. 'The Family Practitioner Committee and the NHS Planning System'.

Mr B Smith

8. 'Some Thoughts on the Roles and Skills of Officers Concerned with Planning".

Mr B Smith

9. 'A Summary of Comments submitted by individuals'

Dr P Begley, Miss J Moore, Ms D Lloyd, Mr J Roberts and Mr D Joines

1.4.3. The workshop opened with an introduction from Mr D M Hands, who welcomed participants to the King's Fund Centre and reminded them of the objectives of the workshop.

1.4.4. Mr R Venning, a Principal from RCP(2) (DHSS) spoke to the draft report submitted to the SGP Roles Sub-Group (SGP (78) 15) and made the point that planning practice at the moment followed very much an inherited pattern of work from pre-reorganisation days and depended very much on where the planners were and with whom they worked.

Since SGP (78) 15 had been written RCP(2) had received comments to the effect that there was a distinction to be drawn between the task of <u>leading</u> a planning team (which may well vary with the subject under discussion) and the continuing task of 'co-ordinating' the work of a planning team. As for the central question of whether there is a need for a specialist planning role, the SGP Sub-Group had not yet reached a firm decision. This would be the subject of ongoing discussions.

1.4.5. Professor Willcocks then spoke of his paper and drew out some of the key points from the other background papers. Elaborating upon the distinction made in SGP (78) 15 between specialist planners and those officers for whom planning is one duty amongst several, he drew a cross-cutting dichotomy between those who have a continuing interest in planning and those whose interest in planning is episodic, thus developing the following matrix - which could have particular relevance to training requirements.

TIME SCALE

	Episodic Involvement	Ongoing Involvement
Posts with a planning component amongst other tasks	eg Service Managers, Consultants	eg DCPs, Chief Administrators
Specialist Planning posts	eg O.R. Sections	eg Planning Administrators

He also posed the question of how far experience as opposed to formal training contributed to or constituted a planning skill and how far it is possible to distil the lessons of experience. There were further questions to be asked about 'planning skills'. In his paper, Professor Willcocks had split planning tasks into three categories:

1. setting goals and deciding the future pattern of services.
2. choosing the methods or means to reach the goals
3. operating the planning system.

Different skills are required for each of these functions, but are they of a kind that can be encompassed in one person or are there more specialized skills separately possessed by differently specialized people which should be accessible to the health service? If the notion of a 'planning profession' was discarded, what skills would the different disciplines who have a continuing interest in planning need to acquire in order to plan? Professor Willcocks also stressed the need to improve communications skills (especially where statistics were used) and he raised the issue of how to train authority members - and maybe even the public - to play their role in planning health services. He warned of the stultifying effects when planning of always thinking of stereotyped professionals by their traditional title, rather than of arrays of needs and needed services for individual patients or groups of patients. He commended the treasurers' contribution in warning those involved in planning against rigidity. As Mr Rippington had pointed out in his papers there is a need to develop a planning system which is sufficiently robust and flexible to withstand changes in the economic (and by implication, the political) environment.

1.4.6. There followed a general discussion amongst all the participants, on issues arising from the circulated papers and from the initial speakers' comments. The points made ranged widely across a number of issues - the nature of leadership; the need for NHS planning to make use of the

forgotten skills of economists, political scientists and medical sociologists; the relative merits of training and experience; the different sort of planning skills required at different levels of the service; the importance of involving those who will be implementing plans, in their planning; the notion of a career in NHS planning; the difficulties in managing resources commanded by clinicians and also the possibility of NHS planners identifying solutions to health care problems which lie outside the NHS and then pushing for the requisite changes.

1.4.7. After this general free-ranging discussion, the participants split into small uni-disciplinary groups to discuss the nature of their own discipline's contribution to planning and their expectations of other disciplines. Each unidisciplinary group reported back to the plenary session in the afternoon and that session ended with Mr Venning and Professor Willcocks summarizing the main points arising from the days discussion.

2. KEY ISSUES ARISING FROM THE DISCUSSION

2.1. Introduction

This section of the paper summarizes, under subject headings, the main issues arising from the morning's general discussion and from the report-back session in the afternoon. The discussion can be categorized under two headings. On the one hand there was a consideration of the specific contribution to planning from each of the different disciplines represented at the workshop. On the other, there were the wider issues - the skills required for planning, the necessity, or not, for a specialised NHS planning profession, and the training requirements of specialist and non-specialist planners. Obviously these topics overlapped and it is difficult to draw distinct boundaries around issues. It is perhaps easiest to begin with a summary of the points made about the role of each discipline present; points made not only by that discipline itself but also by the other members of the workshop.

2.2. The Role of Each Discipline

2.2.1. Community Physicians

The community physicians were concerned to identify the essence of their role in planning. None of them disputed that others, even non-doctors,

could perform much of their task. However they felt that their training in community medicine gave them a broad perspective and their contribution to planning was to encourage others to take a broad look across services. Their medical training and experience helped them to understand, to be understood by, and interpret the viewpoint of medical staff. This view was later questioned by a non-medical participant who said that in his experience community physicians tended to be mistrusted by clinicians, who seemed to think that they had no understanding of the hospital setting. The two DCPs who answered this point, acknowledged that this mistrust had existed immediately after Reorganisation but argued that the situation had changed since 1974 and gradually the consultants' reluctance seemed to be disappearing as they realised that the DCP was not a threat.

The clinicians at the workshop were also preoccupied with the role of the community physician. It was obvious that they saw the DCP as the key planning role at District, although they expected that he/she would have strong administrative support in this role. They felt that the DCP would have to have planning expertise, such as knowing how to use the skills of other disciplines and also to understand about the process of consultation. The community physicians themselves felt they had a leadership role in helping to initiate plans and putting information out.

Another attribute which one of the administrators said he had found invaluable, was the sensitized political antennae which community physicians with local government experience had brought to NHS planning, although presumably this is not an inherent skill of the profession. Nor will it be possessed by new entrants to community medicine.

2.2.2. Clinicians

The clinicians felt that the consultation system for doctors was too complex and they were concerned about how to get a good medical input into planning. They themselves acknowledged that clinicians sometimes had too much of a say in planning. There was some debate about which specialties contributed most to planning but, as one of the clinicians pointed out, consultants in psychiatry and geriatrics, for instance, stood a better chance of securing development money, than, say, an obstetrician and therefore saw more of an incentive to involve themselves in planning. Moreover, it was argued, their working patterns helped them to appreciate the approach of planning

for the needs of the community rather than the individual.

The question was also raised as to where the clinician could most usefully make his/her input into planning - as a member of a DMT, on a planning team, through a pressure group or by cultivating CHCs.

There were differing views from the other groups about the best way to obtain this input from clinicians. One treasurer argued that they had had much better results by presenting a scenario to clinicians and asking them to comment rather than waiting for them to put up their own ideas, but several other participants argued that this depended very much on the specialty and location. Indeed an example was cited, where it was felt that HCPTs had proved far more innovative and creative when the guidelines from above were kept to a bare minimum.

Although there were no GPs present at the workshop, their input into planning occasioned considerable discussion. An administrator said that he was sure that the GPs and community nurses could be most cogent commentators on the provision of secondary care but at the moment their input is patchy. It was felt that the LMCs, whose main concerns lay with conditions of service, did not provide the best forum for idscussions on planning issues. It was recognised that it is difficult to organize a coherent and ongoing contribution from GPs because of their geographical dispersal and their position as independent contractors, but in one district they appear to have had considerable success with a GP planning committee quite separate from the LMC.

2.2.3. Administrators

Most of the groups identified the need for a planning coordinator and there seemed to be an underlying assumption that in all likelihood this coordinator would be an administrator. Where this assumption became most obvious was in the discussions about career prospects for planners and the links between planning and general administration. For instance, the point was made that with the current crop of young chief administrators, there was a need to provide new career options, close to the decision-making process for the next generation of administrators and perhaps planning provided such an outlet. On the other hand, there was a fear (although not universally shared) that planning could become a 'dead end', such a higly specialized job that it would be extremely difficult for 'the planner' to break back into

general administration.

Several people identified the sort of task that they would expect such a planning co-ordinator to undertake. He/she would need to be able to involve a wide range of people in planning; to identify those people who are able to put forward ideas; to write up the plans and to test ideas for negative reaction. Such a co-ordinator would have to have a knowledge of skills and resources available to planning and know how to draw upon them.

The general agreement on the need for co-ordinators of the planning process did not extend to the qualifications required of people filling this role. Many participants thought that planning co-ordinators would probably be administrators - reflecting perhaps the similarities between the tasks listed above and those which administrators have traditionally carried out. Others, however felt that the planning co-ordinator could come from any discipline, providing he/she had the skills and personality to fulfill this role.

In addition to the discussion of the role of planning co-ordinator, a plea was made to acknowledge the contribution of hospital and sector administrators and to allow them to make a meaningful input into the planning process. They often had an extremely keen appreciation of the problems and also the likely impact of proposals at ground level.

2.2.4. Nurses

The nurses' group felt that nurse planners were at a disadvantage because many posts identified at Reorganisation had not been implemented and there were now very few nurses employed solely on service planning. There was also a need to give thought to the career aspirations of nurse specialists.

Expenditure on nursing forms a major part of any NHS budget and there is therefore a need for better information and for better interpretations of the manpower implications of all plans especially or often decisions on the use of nurse manpower are implicitly taken by other disciplines. Indeed it is necessary to identify staffing requirements at least three years ahead in order to determine training needs.

An administrator commented that although he thought nurses do have special skills and abilities which they can bring to planning, there is no reason why manpower planning has to be done by nurses. It was then

suggested that nurses bring an important qualitative approach to planning, a subjective knowledge of the local situation, based on line feedback, up the Salmon ladder, plus a more general knowledge of current trends in caring practice.

2.2.5. Treasurers

The treasurers group maintained that it was fundamental that plans should be costed and costings presented in a comprehensible format. Finance is the common factor of all resources (manpower, land and buildings, and supplies) and treasurers should be able, by manipulating the financial system and exploiting any flexibility between capital and revenue, to suggest the best use of resources. On the other hand, it is also the treasurers role to ensure that plans are financially realistic.

This provoked the comment from an administrator, throwing doubt on the notion that treasurers have cornered the market in "realism" and pointing out that "political realism" was as important as "financial realism" in planning. There came the riposte that although that might be true, the responsibility for keeping within a budget is usually laid at the finance officers' door and therefore they are bound to be 'financially realistic'. At least one of the administrators however was prepared to admit that the climate is changing and that, in his experience, treasurers are now prepared to put forward qualified financial projections.

Professor Willcocks raised the dilemma that finance officers face in making a basically innumerate health service population understand statistics without treating them with awe. Elaborating on this point, concern was expressed from more than one quarter about the lack of capability amongst most people from other disciplines to expose pseudo-scientific projections or reconciliations which sometimes prove to be very shakey.

2.3. The Identification of Skills for Planning

Any discussion on the skills required for planning was fairly general and certainly the workshop did not achieve the goal of setting out a list of such skills. A plea was made to make use of the skills of economists - and political scientists and medical sociologists - in NHS planning; and one of the clinicians stressed the importance of

community physicians carrying out epidemiological studies to show the implications of a policy. Otherwise there was little discussion of specific skills. One did sense however, underlying some of the discussion, the idea that a professional health service planner would simply have mastered a set of technical skills which he/she would then feel constrained to employ regardless of the organizational or political climate. Against this it was argued that planner should be a person of political nous but there was little suggestion that professional training in itself could alert would be planners to political undercurrents, or develop their negotiating skills or their understanding of group dynamics.

It was also implicit in the discussion that NHS planners would be drawn from within the NHS. The notion that planners might be recruited from people with experience of planning in industry, local and central government was not discussed. One can only assume from this omission that it is taken for granted that a primary qualification for anyone involved in NHS planning is a good working knowledge of the service.

2.4. A Specialist Planning Profession ?

The issue which recurred most often during the day's discussion was whether or not it is necessary to develop a specialized health planning profession in the NHS.

It is interesting that the community physicians, the clinicians, the nurses and the treasurers all disagreed with the concept of a "super-specialist" planner, who they feared would assume a completely separate role from management. They did however agree that it is important to identify a co-ordinator of the planning process, and, as mentioned earlier, there seemed to be an assumption that such a co-ordinator would probably be an administrator. The administrators, although wary of an additional 'specialist', acknowledged a role for the specialist planner - "the numerate philosopher", the "planning king" - a person who would be aware of the resources available and who could "play the orchestra of skills". They felt that the requirements of such a role were more to do with personality and aptitudes than disciplinary training. They were not particularly concerned which discipline the person who assumed the baton came from, but they did stress the need for continuity and good administrative back up.

The main difference in the reaction to the concept of "planning king" seemed to centre on the issue of leadership. Simplifying the debate, perhaps, the doctors, nurses and treasurers were opposed to the development of any "professional planner" who would have the advantage of special skills and who would be <u>seen</u> to be directing the planning effort but they acknowledged the need for a co-ordinator who, it seemed, was conceptualized as the servant of the multidisciplinary team. Again, the assumption that a specialized planner would probably be an administrator, is relevant here. The administrators, on the other hand, were much less concerned about who is the apparent leader of the planning effort, the 'front man', so long as there is consistency, continuity and strong coordination. Perhaps this reflects a different perception of where power lies in the system.

2.5. Education for Planning

There were very few specific points made about the advantages of, or the content of training courses for planning, whether for the specialist with a full-time commitment to planning or the person with a more episodic involvement. Most of the comments related to training were of a much more general order.

One of the participants, in putting an argument for a specialist to organize the planning process, said that such a person would have to have an understanding of the analytical tools and more important, an ability to judge what contribution those tools can make - i.e. the extent to which an analytical exercise is likely to further the debate - and this, it was maintained, would require some fairly high level training.

An administrator argued that experience improved one's judgement about what is possible and acceptable but also recognized that training could make people more alert to trends and better at interpreting their experience. On the other hand, he was uneasy about the idea that there is a ready made training kit for planners. What they required was a knowledge of the skills and resources that are available and where these could be found. Another view was that the 'education' of planners (as opposed to 'training') should be concerned with sensitizing them to key issues and undercurrents.

3. A COMMENTARY

This section brings together some reflection on the day's proceedings - a few suggestions about issues which perhaps deserve further exploration.

3.1. The Insularity of the NHS

It was noticeable that virtually no consideration was given to the possibility that people trained to plan in other contexts could usefully apply their planning skills in the NHS. Perhaps this stems from the failure to list the technical and analytical skills which participants would want to see used in health service planning. A logical next question, would then have been to ask where such skills exist at present and how the NHS can acquire them.

3.2. The Nature of Innovation and Creativity

Another aspect of planning skills which received scant reference was the nature of innovation and creativity. There are many questions to be asked here. Is creativity necessary at a local level in a nationally based planning system such as that of the NHS? What conditions and experience foster, or conversely stifle, creative flair? Does the creative drive grow stale after too many years in the same routine? And is it therefore necessary to ensure an influx of new blood every so often? How easy is it to communicate and implement innovations in an inherently conservative organization like the NHS?

3.3. Interdisciplinary Authority

Allied to this issue of creativity, is the question of how willing 'non-experts' will be to contribute ideas in a multidisciplinary forum. Are nurses, or finance officers, for instance, going to be hesitant to put forward ideas about medical services when a doctor is present? Here, the skills and sympathies of the chairperson, as well as any planning co-ordinator, are likely to assume importance.

3.4. The Hierarchical Dimension

Although the concept of the planning co-ordinator's role, as a career-grade post, was discussed at some length, the issue of his/her authority was hardly mentioned. If responsibility for co-ordinating the planning process is given to a second or third-in-line officer, that person will have the task of ensuring that more senior officers, many from different disciplines, pull their weight in the planning

effort and this can be a problem. There is a hierarchical, as well as an interdisciplinary and inter-tier, dimension to the debate on roles and relationships and it is perhaps only because the majority of participants in the workshop were chief officers, that this was not seen as an issue for discussion. It may be however, that the ability to persuade and cajole is the most important skill that a career-grade planning co-ordinator requires.

3.5. Planning for Planning

Following on from this point, is the need, in a complex organization such as the NHS, to plan the planning activities themselves, and, most important, to ensure that those who will be involved are aware of and involved in this plan. It is important that they know what will be required of them, when, and with whom. This is true not only within but also between tiers. Inter-professional and inter-tier rivalries can be exacerbated by a failure to understand how the process is being organized and the concomitant fear of being ignored.

3.6. Education and Expectations

Although there were differing views about the value of training specialist health planners, it is perhaps worth making a general observation about specialized training. It is often the case that those who receive this sort of professional training expect to improve their status as a result. (Indded this is often inherent in the training). The very fact that a person spends time and energy acquiring knowledge is often seen as a sacrifice which deserves recognition and recompense. Clearly this was at the back of the mind of some of the professionals present at the workshop. The NHS is already an arena chock-a-block with different professions. There is a suspicion that specialized training of planners would lead to yet further jockeying for position, and anybody undertaking such a course needs to recognise that this suspicion exists and also be aware of their reasons for seeking such an education.

3.7. Those who were not there

Finally, a comment on who was not at the work-shop. There were no works officers, no dental or pharmaceutical officers or any representatives of the other professions who make contributions to service planning. There were no Authority or CHC members.

Although the workshop was a microcosm of some of the relationships which exist 'in the real world' it could not mirror the full complexity of the many roles which influence service-planning in practice.

Joy Reynolds
King's Fund Centre
January 1979

Further copies of this report, or additional information about this workshop may be obtained from David Hands, Assistant Director, at the King's Fund Centre. (telephone 01 267 6111)
Suggestions for follow-up or related activities would be welcomed.

Appendix 'A'

'Roles and Relationships in Service Planning' Workshop 6 September 1978

PARTICIPANTS

Administrators		
Mr A Wall	District Administrator	Bath H D
Mr R Dearden	District Administrator	Hereford H D
Miss D Lloyd	Planning Administrator	Buckinghamshire AHA
Mr R Hinton	Planning Administrator	Wessex RHA
Mr B Smith	Area Administrator	Lincolnshire AHA
Mr D Huscroft	Administrator Services Planning	South Western RHA
Dr J L Roberts	General Administrator	West Midlands
Mr R Crail	District Administrator	Norwich H D
Mr R Banks	Assistant Secretary	RCP2 DHSS
Mr R Venning	Principal	RCP2 DHSS
Community Physicians		
Dr M McCarthy	Research Associate	K F Centre
Dr P Begley	District Community Physician	Frenchay H D Avon AHA
Dr P Heath	Specialist Community Medicine	Sheffield AHA
Dr R Haward	District Community Physician	Beverley H D
Dr W Edgar	District Community Physician	West Berkshire H D
Dr D Hewitt	Specialist Community Medicine	Hampshire AHA
Dr E Vincent	Specialist Community Medicine	Merton Sutton Wandsworth AHA
Dr M Harper	Senior Medical Officer	DHSS
Nurses		
Miss J Moore	Divisional Nursing Officer	South District Ken, Chel West
Miss E Ensing	Area Nursing Officer	Brent & Harrow AHA
Miss J Smith	Divisional Nursing Officer	Bromley AHA
Miss E Watson	Area Nurse (Planning)	Lambeth Southwark & Lewisham
Mrs B Rivett	Nursing Officer	DHSS
Treasurers		
Mr D Pace	Area Treasurer	Ken, Chel & Westminister AHA
Mr R L Hillman	District Finance Officer	Southmead H D Avon AHA
Mr D Russell	District Finance Officer	City & East London AHA
Mr B Herbert	District Finance Officer	Ealing Hammersmith Hounslow
Mr D Joines	Regional Treasurer	N E Thames RHA
Mr T Rippington	Regional Treasurer	South Western RHA
Mr T A Tagg	Area Treasurer	Warwickshire AHA
Mr J L Dixon	Senior Assistant Treasurer	Yorkshire RHA
Clinicians		
Dr N Gunther	Consultant Geriatrician	North Surrey H D
Dr P Jeffreys	Consultant Psychiatrist	Northwick Park Hospital
Mr P Simpson	Senior Tutor	King's Fund College
Mr S Steele	Consultant Obstetrician & Gynae	Middlesex Hospital
Dr C Godber	Consultant Psychogeriatrician	Southampton
Mr F Murray	Consultant Obs & Gynae	St Mary's Hospital Portsmouth
Others		
Mr D M Hands	Assistant Director	King's Fund Centre (Chairman)
M/s J Reynolds	Research Assistant (Rapporteur)	Leed's University
Prof. A J Willcocks	Professor of Applied Social Science	University of Nottingham

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