Making
GENERAL MANAGEMENT
Work
in the National Health Service

A Guide to General Management
for NHS Managers

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ABBREVIATIONS:

Conventional abbreviations are used throughout and explained at their initial use. In general, the sense of the material should make the meaning clear, but the following list may be helpful for any readers less familiar with the NHS.

CMO = Chief Medical Officer
CNO = Chief Nursing Officer
DGH = District General Hospital
DGM = District General Manager
DHA = District Health Authority
DHSS = Department of Health and Social Security
DMB = District Management Board
DMO = District Medical Officer
DMT = District Management Team
DNA/O = District Nursing Adviser/Officer
DNE = Director of Nursing Education
DNS = Director of Nursing Services
DoH = Department of Health
DPH = Director of Public Health
FPC = Family Practitioner Committee
GM = General manager
HA = Health Authority
HQ = Headquarters
IHSM = Institute of Health Services Management
IPR = Individual Performance Review
LA = Local Authority
RGM = Regional General Manager
RHA = Regional Health Authority
RNO = Regional Nursing Officer
SCM = Specialist in Community Medicine
SN = Senior Nurse
UA = Unit Administrator
UGM = Unit General Manager
UMT = Unit Management Team

Pronouns
As a matter of convention only, the masculine pronoun is used to refer to both women and men.

Chapter 1

INTRODUCTION

Origin

This publication follows in a tradition of assistance to the National Health Service stretching back over twenty years. It aims to assist general managers in their task of designing and developing more effective and efficient structures and better management practices. It should also be useful for all other senior managers and health professionals with management responsibilities.

We unequivocally support the basic analysis and radical initiatives embodied in the Griffiths Report [1]. However, the possibilities for improvement unleashed by the implementation of general management have by no means been fully exploited. In many Districts, it is clear that little of substance has changed.* In some Districts, changes have been positively inappropriate or harmful. And even the most progressive Districts have a long way to go before their organisation and management can be regarded as truly satisfactory.

The material to be presented is based on long-term in-depth field consultancy, especially major organisation development projects in Newcastle DHA** and Exeter DHA prior to the introduction of general management, and York DHA, Leeds Western DHA and Yorkshire RHA subsequently. Solving the problems involved in establishing Units and introducing general management has led us to develop and test old and new concepts and models using a collaborative analytic research method [3,4; Box 1.1].

THE CONSULTANCY RESEARCH PROCESS

Our method is based on collaborative discussion and mutual understanding in which we assist managers by jointly analysing the problem, teasing out the underlying issues, clarifying the necessary concepts or models, and devising one or more appropriate arrangements. Implementing the changes is led by the general manager and supported by further consultancy as required.

The strongest test of our approach comes with determined implementation and long-term follow up. Here our view of validation is *pragmatic*. The key test is: does it work in the judgement of those involved? And if not, why not?

Box 1.1

The general applicability of findings from such consultancy has been examined and tested in a full programme of national workshops and conferences. Over the past five years, we have worked over the material in this Guide with some thousands of general managers, health professionals and other health service managers. In this process our ideas have been refined and generalized. And then they have been re-tested in the field situation, to check again that they really work.

Our ideas are presented with considerable confidence, but there are two caveats. First, although we have attempted to be as specific and concrete as possible, we must emphasize that this is no more than a Guide. We aim to offer a *usable framework* and *guiding principles*. Because there is no recipe or blueprint which can be mechanically followed, general managers must work out the detailed application of our ideas to their own particular situation. Many have done so successfully. The framework does not oppose pragmatic compromises, but indicates the price that has to be paid for such

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* An equally pessimistic conclusion is emerging from a project sponsored by the Economic and Social Research Council [2].

** For explanations of abbreviations, see list on p. 4.

compromise. The second caveat is a corollary of the first: *if it works, don't fix it.* In other words, the Guide should be used to help resolve problems or difficulties, and not regarded as a demand for perfection or as an excuse to tinker.

Problems and Challenges

The introduction of general management was driven, above all, by a desire that the NHS should cease being an organisation where management was low profile, manipulative, and dependent on balancing competing power groups; and one where leadership was diffuse, static and avoided thorny issues.

The new model was taken from large commercial and industrial firms where general managers have a high profile, manage directly, and are strongly oriented to results. This encourages leadership to be focused and dynamic.

Implementation of general management had one excellent rapid consequence. It led finally to the consolidation of poorly devised and staffed Units into effective entities with their own plans and budgets, along the lines suggested by us in 1982-3 [5].

However, the restructuring generated many new issues. Did general management signal the end of functional management? If not, how was functional management to be integrated with the new ethos? More to the point, was general management really about placing efficiency and economy before patients' needs? If not, how could concern for patients and quality of care be clearly demonstrated? In setting up general management, there were also questions about the most suitable disciplinary background for general managers, and what training they required.

CONSENSUS VS ?

'Consensus management' was the label used to describe the working of the old District Management and Unit Management Teams. It was to be replaced by the decisiveness of general management.

BUT

all management must in the end be based on consensus.

What was really needed was a move from a management style in which action emerged fitfully, if at all, from interminable debates between representatives of the power groups (nursing, medicine and finance principally), as arbitrated by the administrator.

Box 1.2

When general management was introduced, a number of statements were made about long-standing problems in the NHS which it was specifically supposed to overcome.* These problems included:

- ➡absence of individual accountability for poor or indifferent performance
- ➡inordinate delays in decision-making
- ➡uncontrolled spending
- ➡lack of strategic thinking and policy-making at the centre
- ➡failure to use objectives to drive developments
- ➡lack of concern for the actual effectiveness of service activities
- ➡failure to set explicit priorities and relate these to resource allocations
- ➡inadequate overall control of health professionals, especially doctors

To these must be added other chronic problems in NHS management which general managers have been explicitly or implicitly expected to tackle. These include:

- ➡failure to put the patient first
- ➡overload and demoralization of front-line staff
- ➡lack of usable financial and other information

* Griffiths was not the first to note these problems. Our own research [5], complementing that of many others using traditional methods [6], had documented such problems over many years. What was new in 1983 was the political will to tackle them and overcome entrenched positions and attitudes.

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➡inadequate administrative support for health professionals in management
➡confusion surrounding the nursing hierarchy
➡poor linkages between professional staff and support services

Scope and Limitations

In what follows, something will be said about each of the issues and problems just noted—and more. However, we have deliberately sacrificed the desirable goal of comprehensiveness for *a focus on those crucial matters of principle on which all else depends.** Although the bulk of our experience is with general management at District and Unit tiers, we offer analysis and suggestions also for general management at the higher tiers.**

The National level is unitary and the Regions in England are broadly similar. Districts, however, vary in their complexity and therefore must vary in their management and organisation. We have focused on what we have found to be a **typical District** with a budget between £35M and £85M***: which, in our view, is optimally-sized. Although the same basic principles apply to **mini-Districts** with budgets of the order of £10-20M, and **maxi-Districts** with budgets of the order of £150M+, these receive only limited attention in the text. Practical issues in such atypical Districts are noted but not worked out in detail.

The focus is on general management, not on governance or on management in special areas. Little is therefore said about health authority governance because this topic requires its own conceptual framework and a recent publication is still relevant [7]. Relatively little is said about the details of nursing because a companion account of its organisation in the context of general management has just been published [8]. In the case of medical organisation, certain issues for general managers are briefly spelled out, and a fuller account is planned.

RELEVANT BRUNEL PUBLICATIONS

Currently available:
◆The District Health Authority: Tasks Organization and Relationships of the Governing Body (1986)
◆Stronger Nursing Organization (1987)

Forthcoming planned topics:
◆New Management Initiatives in the NHS: Budgetting Information &c
◆General Managers & the Health Authority: Handling Politicization
◆Managing Medical Consultants and Medical Services in the NHS

Box 1.3

As well as general management, the NHS has been subjected to a range of other management initiatives including management budgetting, information systems, quality assurance, performance review and performance-related pay. General management, if properly implemented, is the essential framework within which these initiatives can be pursued. Successful pursuit also depends, of course, on a proper understanding of the nature of the topic, but such analysis cannot be entered into here. Because performance review is so central to the integrity of the general management framework, some notes have been provided in Appendix II.

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* For brevity we have kept to a minimum the detailed evidence and justification for many of our propositions. The interested reader must refer to academic publications for further details.

** Our work has been mainly in England, but the principles derived there are general, and so our ideas may be applied with slight modifications to the NHS in Scotland, Wales and Northern Ireland.

*** All such figures are at 1986-87 values.

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Finally, **how will our proposals relate to any radical changes that may hit the NHS in the coming years?** Short of wholesale dismantling of the NHS, we believe that no development is likely to be so radical that the general picture to be offered becomes irrelevant. Indeed, field experience suggests that a vigorous application of our ideas will place general managers in a strong position to handle whatever may be thrown at them.

Structure of the Guide

Our prime aim has been to produce a compact and readable document for existing and aspiring general managers—a Guide which is both immediately useful and easily adaptable. However, the scope is broad, and complete reading from beginning to end is only mandatory for those aspiring to the highest jobs!

Chapters 1-3 are essential to get oriented. Thereafter, chapters may be read according to interest or need. Readers who are familiar with our ideas will be able to skip certain sections. A second reading from beginning to end might then follow to get the full picture. Boxes (see Box 1.4) are for browsing and are not summaries of the material.

> **BOXES**
> Boxes like this, numbered in the lower RH corner, have been inserted throughout the text. These boxes are not part of the flow of the main argument. They provide additional material, reflections on our findings, examples, emphases, or mini-debates on controversial points.
>
> *Box 1.4*

Chapter 1 (this one) introduces the Working Paper and aims to *orient* the reader.

Chapter 2 sets out the *principal ideas* to be used: levels of work, types of manager, and the elements of managing. (The last refers to a new set of helpful ideas not previously reported to the NHS.) Personal work capability and the distinction between governance and executive duties are also briefly examined.

Chapter 3 overviews the *responsibilities of general managers* at National, Regional, District and Unit tiers of the NHS. Part of this material elaborates earlier proposals using levels-of-work ideas which have stood the test of time excellently [5].

Chapter 4 briefly explains the need for Regions, describes the work of the *Regional General Manager* (RGM), comments on top organisation at Region, and notes what is needed for an effective National-Regional-District axis.

Chapter 5 considers *general management at District-level.* It covers such issues as the detailed work of the District General Manager (DGM), associated top management posts, necessary teams and meetings, and the handling of cross-Unit matters.

Chapter 6 examines *general management at Unit-level* and the essentials of the Unit infrastructure. The need is affirmed and clarified for the Unit General Manager (UGM) to maintain a simultaneous concern with functional management and facility management, as well as a focus on patients.

Chapter 7 clarifies issues for general managers in their dealings with *health professionals:* medical consultants, nurses, and paramedical professionals.

Chapter 8 brings all the previous ideas together to describe what is required for the *operation of the system of NHS general management as a whole.*

Chapter 9 concludes by *summarizing the nature of this Guide,* and the possibilities for action that flow from it.

Two Appendices are provided. The first is a one-page *handy reference to the levels of work framework* comprising short definitions and examples. The second examines misconceptions and realities in *appraising personal performance.*

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References are detailed in relation to bracketed numbers in the text. No attempt has been made to provide a full bibliography.

The Overall Message

The Griffiths revolution is absolutely right in principle, but it is not being properly and effectively implemented in practice. Some of the important changes in practice identified in this Guide include: appointing an effective Director-General at the top who is outside the civil service but subject to Ministerial governance; reorganising internal structures and processes within Regions to ensure that more effective dialogues take place with Districts; developing more and better support roles for general managers within Districts; and strengthening functional management, particularly within the specialist management disciplines and the health professions. There needs to be greater recognition of how radically size of District and Unit affects general management. There also needs to be a stronger appreciation that achievement depends on organizing and managing simultaneously in three distinct dimensions—health-care needs planning, resource provision and operational activities—a 'matrix' principle.

The move to general management, together with the development of effective Units, provides without doubt the needed organisational base for an effectively managed NHS. However turning these ideas from concept to living reality is not easy. Many general managers have not fully faced up to what is required. Action urgently needs to be taken locally, whatever new centrally-driven initiatives emerge.

HANDLING THE NEXT REORGANISATION

Many managers, health professionals, lobbyists, and even academics (who should know better) say that the NHS cannot stand more reorganisation. In fact the opposite is the case: general managers should be continually reorganising.

What needs to be relegated to the history books is the avoidance of necessary structural improvements by local top managers. Such avoidance forces periodic, massive, uniform and simultaneous reorganisation imposed by politicians and orchestrated by civil servants.

What the NHS needs is more reorganising not less—but now principally within Districts. Reorganisation by top District managers, like demands for cost-improvements, should be seen simply as part of the routine of organisational life. Correspondingly, centrally-orchestrated restructuring could then become less frequent.

For example, from the next Chapter, it will be clear that Unit definitions are still unsatisfactory in many Districts; and in later Chapters serious deficiencies in Unit infrastructure and functional structures will be highlighted.

Remember: structural deficiencies—confused roles, unworkable responsibilities, insufficient authority, deficient arrangements for accountability, proliferating committees, clumsy procedures—cannot be put right by goodwill, better information, IPRs or anything other than better structures.

Box 1.5

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Chapter 2

IDEAS FOR MANAGING

In discussing the implementation of general management, it is impossible to avoid the use of phrases like 'degree of responsibility', 'line-manager' and 'managing'. However such notions cannot be applied properly unless they are clearly understood. For example, people's perceptions about responsibilities, higher or lower, are usually conveyed by resort to terms like 'top management', 'policy-making', 'operational' and so on. But these are imprecise and ultimately confusing terms often causing rather than solving problems. For example, top management in a £5 million community Unit is clearly different from that in a £50 million 900-bed teaching hospital Unit. And, similarly, both RGMs and UGMs should be expected 'to make policies and allocate resources', but of a markedly differing scope and content in each case. Much the same problem exists in relation to describing the work or authority of managers as supporting, or advising, or instructing, or commanding: different types of managers perform these functions with markedly different implications for the recipient. Managing itself remains a mysterious activity—sometimes regarded as beyond definition, but more usually defined in a far too limited or too general way.

As it is necessary to have a clear way of talking about such fundamental issues, we have developed our own approach to levels of work or responsibility, authority relations, and the principal aspects of managing. All the ideas have been validated and, in many cases, worked out with NHS staff who have found them helpful in resolving practical problems. Here, we provide no more than an introduction: all the ideas will be further explained when they are brought into the discussions in later Chapters. To aid the reader, a one-page summary of the framework is provided in Appendix I for easy reference while reading the Guide.

Levels of Work

Over the years, and from work in many organisations as well as the NHS, a useful and precise method of describing and differentiating levels of work (or responsibility) has been developed at Brunel University. It does not rely on overt or covert references to numbers of heads or beds or even size of budget, but attempts to capture and convey the very nature of the work itself, its output, complexity, and time-span. Detailed accounts have been provided for the management literature [9-11].

Proper recognition of levels of work is absolutely fundamental in organisational design, planning, budgetting, cost-control, standards, information systems, training, recruitment and appraisal, and most other (if not all) aspects of management.

The framework reveals that in all large-scale organisations, including health services, there are seven levels of work to be done, each sharply different in quality. There are five levels of operational responsibility, and two higher levels of responsibility concerned with orienting services and providing resources.

REMEMBER!

Recognition of the different levels of work is essential if general management is to work with maximum effectiveness.

The ideas are based on research in many countries, and with many organisations in the public and private sector over decades.

Confirmations of predictions based on levels of work have been frequent; and its good sense and practical usefulness have produced a sustained positive response in NHS fieldwork and from general managers and others at workshops.

Box 2.1

Work at a particular level shows important similarities within any public service, any commercial firm or any voluntary agency. As the levels are ascended in any field of work, the scale and complexity of objectives to be achieved on the one hand, and the range of environmental circumstances to be taken into account on the other, broaden and deepen. Giving examples of levels in particular roles or jobs is often contentious and may be misleading. Nevertheless a brief introduction to the seven levels with illustrations from the NHS is now offered. We expect the ideas to become clearer when they are explored and applied in the Chapters to follow. Levels 1 and 2, though little discussed in this Guide, are relevant if general managers are to understand front-line work in the NHS, and they are therefore included.

Level 1: Prescribed Output (Responding to Concrete Demands)

Here, the end-product can be concretely specified beforehand as far as is at all significant. Clear examples are portering, typing, repairing a machine, and helping with nursing care. Tasks are taken one at a time, and work is done on demand. The time scale of tasks is of the order of hours, days or weeks with a probable maximum of three months. Insofar as any work is completely routine—e.g. basic physical care of people, tasks exactly as prescribed by others, procedures learned in training—it could be performed at this level. Although the output is precisely described, significant skill, judgement and knowledge may be required in carrying out Level 1 tasks, for example in technical work. The possession of appropriate attitudes and sensitivity may also be important, for example in receptionist or nursing aide work.

Level 2: Situational Response (Assessing Concrete Needs)

Here, precise objectives have to be determined by assessing the real needs of each particular case as it is dealt with. Tasks are still concrete, but many may be handled simultaneously; and the time scale may be as long as 3 months to 1 year. Examples are: handling the breakdown of a complicated arrangement; assessment of the care needs of an individual patient; dealing with anxious or distressed relatives; coping with tricky staff problems like negligence due to illness; medical diagnosis. Such tasks are required in most forms of professional practice and in first-line management. For example we have found that running a ward calls for Level 2 work [8].

Level 3: Systematic Provision (Handling Concrete Systems)

Here, the requirement is to make and develop systematic provision of services shaped to a changing flow of needs or cases which present themselves. This implies handling a socio-technical system: deciding exact programmes, methods, procedures and quality standards. By this criterion, medical consultants are expected to operate here. The key control task in general is to manage available staff and other specific facilities or resources so as to handle presenting demand, taking into account inevitable fluctuations both in workload and staffing, and higher level priorities. Examples of typical Level 3 tasks include: providing rotas for continuous cover through the year; developing a new complex procedure for dealing with a group of illness conditions; ensuring that all needed arrangements in an outpatient department exist and mesh properly; and implementing in practice the actual changes generated by long-term plans or broad policies. Analysing such situations, developing a new system, negotiating its introduction and ironing out problems lead to a typical time scale of up to 1-2 years.

Level 4: Comprehensive Provision (Balancing Multiple Services)

Here, the requirement is to comprehensively balance and develop a range of services which meet the needs of some social territory. This work therefore calls for a response to needs that are not currently being met as well as those that are; and the time scale for planning, implementing and evaluating extends to 2 to 5 years. As new services are added, older ones must often be reduced. The key control task is to match long-term plans for changes in services to budget, and implement these changes within agreed and detailed budgets. Such development in the NHS is always associated with restructuring of services and roles and hence changes in many associated disciplines. In other words, it is *general* in nature. This, therefore, is where general management

commences. Here is the output of typical NHS Units, and hence the expectation of the UGM role. Other roles may also be set up with an expectation of work at Level 4 e.g. the Director of Nursing who must develop and maintain a comprehensive nursing service for a typical District general hospital, or the Director of Personnel who must provide a given range of personnel services for a typical District.

Level 5: Field Coverage (Shaping Overall Operations)

Here, the requirement is to provide services in some specified field of need, like 'health care' in some given social territory by responding in the most fundamental way possible within given definitions of the nature of these needs and services. Overall operational shaping implies defining the exact ranges of services to be provided (negotiating with other agencies where appropriate) and structuring the field of activity. Financial constraints and possibilities must be managed, but detailed budgetting is not required for such work. This type of responsibility characterizes the typical District in the NHS, whose neighbouring agencies include other DHAs, private sector firms, voluntary bodies and local authority agencies. The DGM must define the changing nature of health-care problems, services, and needs in a practical fashion and provide an impetus for their handling. The principal tasks have a lengthy time scale of 5 to 10 years. Most Directors in RHAs need to work at this level.

Levels 6: Multi-Field Coverage (Framing Operational Fields)

Here, the requirement is to manage by overseeing a cluster of discrete operating agencies ensuring their operations mesh and boundary issues are decided. The operating agencies may cover different fields within the same social territory or a single field in multiple territories. The bridge between basic definitions and operations is provided by developing frameworks and guidelines for local application which, in the NHS, point to a realization of the given conceptions of needs and services devised at Level 7, as modified by an awareness of practical realities. Such work is implicit in the Regional organisation of health services in England, industrial conglomerates, and the largest local authorities. Deputy permanent secretaries in the DoH and certain top specialist staff people are expected to work at this level.

Levels 7: Total Coverage (Defining Basic Parameters)

Here, the requirement is to cover a total and unbounded field by deciding what is to be regarded as acceptable or given or agreed at any or all lower levels. Basic parameter definition involves providing the definitions of needs to be met, services to be provided, problems to be tackled, and methods to be used—and ensuring that these are comprehensively institutionalized. The structure of Level 6 and Level 5 agencies must be created, and overall priorities, policies and constraints for their operation must be decided. This management task is performed in the NHS by politicians, the Secretary of State for Health and his Ministers. Assistance is provided within the current Department of Health by a Permanent Secretary and Chief Medical Officer who work at Level 7, and by the NHS management board. The multi-national is an obvious example outside the NHS: these are organised with a 'holding' company (L-7), and 'group' companies (L-6) dividing up the world as convenient, with each group having 'operating subsidiaries' (L-5) in the various countries.

Calibre and Career Progression

It appears that the capacity to do useful and effective work at any particular work level, whatever the discipline or domain, varies markedly from person to person. Work capacity develops at different rates throughout the careers of different people: some people, for example, show no obvious ability to move beyond Level 1 work at any stage of their life; others become able, at successive points in their careers, to tackle work at L-2, L-3, L-4, or beyond. Plotting career development against age therefore results in a series of curves as in Fig. 2.1. It is possible to use these curves to analyse potential [9,12]. For example, the career of high-fliers—those in responsible jobs at a young age who are destined for greater things—can be broadly predicted.

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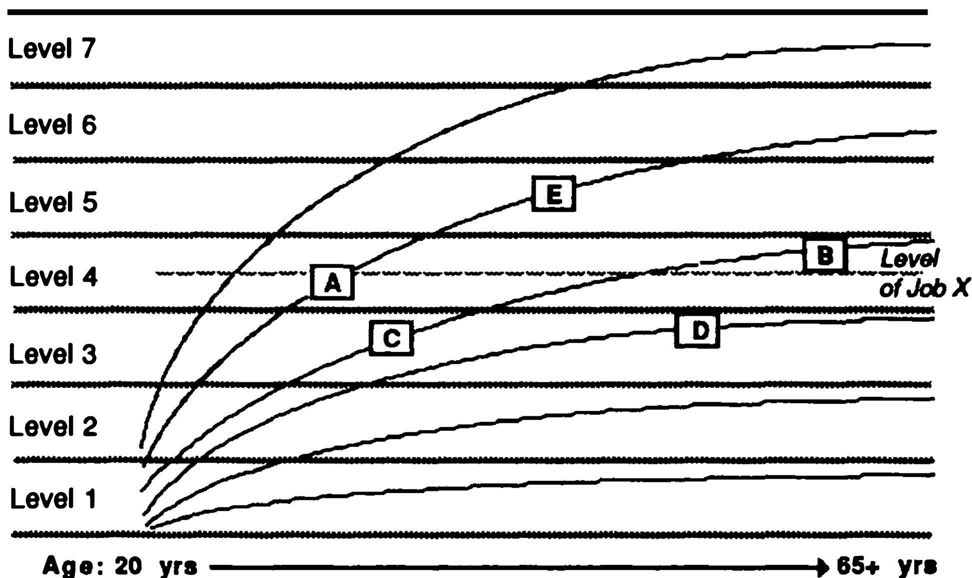
Figure 2.1: Some Career Progression Curves
A, B, C, D and E represent individuals who might be attempting job X.
[A & E might also be taken to refer to the same person at a different point in his career. This also applies to C & B. See Box 2.2 for explanation.]



At any point in a working lifetime, it is desirable that the work expectation on a person and his work capacity are in equilibrium. In complex organisations, this equilibrium is not automatically achieved because typically *both the work to be done and the people doing it are changing*. Matching of staff to work is therefore a continuous and difficult management task. Managers must realize that if people are not properly matched to their job both people and the organisation suffer. Attempting work at a level beyond a person's capacity leads to failure and ill-health. The reverse situation frustrates the individual, wastes talent, and sometimes disrupts the organisation.

The times in a career when the person moves from posts at one work-level to posts at another, as opposed to periods of progression through grades within the same work-level, appear to be particularly testing. This is because each work-level demands a different outlook on achievement, different patterns of relationships, different styles of operating, different modes of thinking and so on. It is likely that focused management education can develop a person *within* a work-level, or prepare him for his natural progression to the next work-level; but training cannot move an individual *across* work-levels at will. (See Box 2.2)

THREE VARIETIES OF UNSATISFACTORY PERFORMANCE

If an individual is failing to perform satisfactorily (eg in Job X, Fig. 2.1) and personal or social causes are excluded, three cases must be distinguished. The individual's general level of ability may be:

1: *Broadly matched to the desired level of work*
in which case settling in, role reshaping, further training or special experience may be required to assist. Individuals **A** and **B** in Fig. 2.1

2: *Below the desired level of work*
in which case no amount of training or role reshaping will help. It is important to assess whether or not the person has the potential *ever* to operate at this level. In Fig. 2.1, individual **C** does and **D** does not.

3: *Above the desired level of work*
in which case the individual may be better placed in a different higher-ranked job within the organisation or outside it. Individual **E** in Fig. 2.1

Box 2.2

Types of Manager

The term 'manager', often as opposed to 'administrator', has now become established in the NHS. However this has been associated with many erroneous assumptions such as that there is only one type of manager, that all people called managers operate in the same way, that all managers are now general managers, and that administrators do not manage. Nothing could be further from the truth.

There are five main types of manager which must be recognized:

- **main line-manager**
- **staff officer**
- **coordinator**
- **supervisor**
- **monitor**

MANAGERS & TITLES

Titles used for jobs are very important. Ideally, they should be both short and immediately meaningful. Managers in the NHS have often gone astray here.

The first component in the title should indicate the kind of *work to be done*; and the second component should say something about the kind of *authority*
eg medical policy adviser
special projects manager
cancer care coordinator
outpatient department supervisor
[The label 'manager' can be used in a wide variety of titles. But remember that its meaning may vary greatly.]

Principal, superintendent and *head* are titles often used for L-3 managers; and*director* and *general manager* for L-4, L-5 and L-6 managers.

Box 2.3

Main Line-Managers have 'total' responsibility for results, and so they are dependent on the work-output of their subordinates. They must therefore be able to set general policies and standards, judge the abilities and potentialities of each of their staff, assess the training and development needs of each accordingly, and assign general responsibilities and specific tasks for each accordingly. For the same reason, they also require the authority to join in selection of their own staff with the power of veto, to initiate de-selection (e.g. by promotion, transfer or dismissal), and to zoom into any detail of any work of a subordinate at any time to query or alter what is being done.

The system of main line-managers is the back-bone of an organisation. *The strongest and most straightforward organisational structure is designed with main line-managerial relations which cross one work level only.* Naturally, general managers are main line-managers.

Coordinators are essential to integrate work within and across hierarchies, or even across Agencies. In a multiple hierarchy service like the NHS, coordinators are of particular importance. Their main responsibilities usually involve meeting with those to be coordinated; convening and chairing working groups; preparing and issuing detailed plans to forward agreed objectives; keeping informed of actual progress; and attempting to overcome obstacles. Such work involves giving instructions, but does *not* imply authority to set new directions, to override sustained disagreements, or to appraise and develop personal performance. Coordinators typically operate with others working at the same work level, or at one or even two work-levels below. Although it is often convenient for coordinators to be of equal or greater seniority to those being coordinated, this is not a requirement, and they may be expected to handle staff graded more senior and at higher levels of work.

Staff Officers are assistants to line-managers, helping them by contributing to development of policies or projects in particular fields like personnel, planning, information, and budgetting, or resolving problems which cross the responsibilities of several or all operational subordinates. To do this they act as *monitors* and *coordinators* as described here. Line-managers at Levels 7, 6, 5, 4 and 3 usually require staff assistance. Staff officers work best when one level below their line-manager, and may themselves require direct subordinates. It is commonly, but

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mistakenly, assumed that staff assistants automatically require higher grading than operational subordinates. Grading should be determined by an analysis of the actual work expected. (Note that even if a staff officer 'acts up' or deputizes for a period, this does not automatically, or even usually, mean performing the higher level of work.)

Supervisors take charge solely for the period in question, see that all necessary work is handled, and deal with immediate problems. Sometimes they are described as 'acting up' or deputizing. They are typically operational subordinates rather than staff assistants, and are usually required at Levels 1 and 2 (e.g. among junior doctors; and in nursing, paramedical, portering, and domestic work) where they assist by: inducting, giving technical instruction, assigning tasks, checking performance, and helping with difficulties which present. Supervisors usually are at the same work level as those they are supervising, but in a more senior grade.

Monitors may operate at any level of work. Like coordinators, they can cross occupational boundaries in pre-specified areas of concern; and they may deal with staff at both higher and lower work levels. They are used to ensure that activities of staff conform to satisfactory standards in one or more particular respects and where line-managerial, supervisory and staff officer relationships need supplementing. Monitors must be able to check or otherwise keep informed of activity in the given area, warn of deficiencies and advise corrective action, discuss possible improvements with the person concerned or his superiors, and recommend new polices or standards. Monitors do not have the authority to judge the appropriateness of breaches, to set policies or standards, to give instructions or to appraise personal performance. If deficiencies are found during monitoring, they require to be reported to the line-manager who authorized the monitoring and who is responsible for taking the matter further.

TOO COMPLICATED?

"These detailed academic theories are too much for down-to-earth busy people like me" says a pragmatic general manager. *"I tell people what to do and expect them to cooperate sensibly with each other."*

If only life were so simple!! The ideas presented here have developed from finding people landed in chaotic messes characterized by many conflicting expectations, misunderstandings, failures of achievement, duplication and delay in decisions, mutual criticism and general overall demoralization.

Even when these ideas are not applied across the board, they may be useful where difficulties persist despite exhortation of staff to be more sensitive and reasonable.

Box 2.4

Q: Can a person be more than one type of manager?

A: Yes (& No)
Multiple roles are usual, because the type of manager-role must be based on what authority is needed for the particular task assigned. For example, a main line-manager is often a natural site coordinator; and managers of all types are natural monitors in their area of responsibility. There is a combination which must be avoided if at all possible, and that is expecting a person to be both a line-manager of part of the main operation and a staff officer. This error has been prominent in nursing hierarchies. And it has also been seen in general management roles!

Q: Surely managerial style is what really counts?

A: Yes & No.
Work style is important. It has already been noted that general management was about moving away from an ad hoc and power-broking style of managing; and we have elsewhere developed a comprehensive account of managerial styles which confirms that these affect successful achievement [13]. However, although assertion of formal authority rarely solves problems generated by an unsuitable work style, clarity about legitimated authority is essential in large organisations to ease interpersonal interactions and speed decision-making.

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Managing Across the Levels

One of the commonest concerns about the above framework of levels of work and types of manager is that it all appears too precise and rigid to be practical. Rigidity is of course never desirable. But precision about responsibility, authority and accountability is almost invariably preferable to muddle. Even so, the necessarily sharp divisions between kinds and levels of work and authority must somehow be bridged.

Recent research has revealed the various different processes of management that promote this essential bridging by crossing or grouping adjacent levels. For a detailed account, the reader is referred elsewhere [14]. Here the principal bridging activities and arrangements are briefly described. They will be taken up in more detail as appropriate in the various Chapters, especially Ch. 8.

Getting action depends on a dialogue which always crosses **two** adjacent work levels. All decisions must be overviewed and oriented by policies or criteria at the higher level, and put into practice at the lower. Put another way, any action or programme must take into account wider requirements decided by the higher level, as well as being finely tuned to practical realities being faced at the lower level. If general managers are to have an action orientation and objectives are to mean something, creating genuine policy-focussed dialogue between adjacent tiers becomes of the utmost importance.

Dealing with change in large organisations always crosses **three** consecutive work levels. The manager in the topmost level must organise for it systematically and provide the impetus, the manager in the middle level must devise detailed feasible specifications, and the manager in the lowest level must put the change into being as specified irrespective of his own views of its priority. So those in the lowest level of a given triad are closest to the realities and disruption of change, and those in the middle level need to respond by explaining the situation to the topmost level and by taking account of realities in their specifications. As will be seen, general managers within Districts find themselves handling all three of these types of responsibility for change.

Providing functions is essential. The introduction of general management and wild claims that functional management is dead have led us to make a closer analysis of functions. Functions are primarily about standardization of specialized skills, procedures and outputs and are intrinsic to recruitment, training, methods and standards. 'Occupation' 'discipline' and 'profession' are therefore cognate terms. So functions cannot die! Nor be fully controlled! Our researches indicate that functions ramify over **four** consecutive work levels. Four types of function therefore exist according to the lowest level which specifies what basics are to be standardized within that function. High level work outside the function itself and developments outside the organisation shape the function. General managers depend heavily upon the functions and must both provide them and support them.

Pursuing achievement depends on making simultaneous progress in three different dimensions, *planning for health-care needs, provision of resources and supporting facilities,* and *operational activities.* In each case, achievement demands integration of work across **five** levels. Hence control resides respectively at L-7 (National tier), L-6 (Regional tier) and L-5 (District tier). General managers need to ensure that all three approaches to achievement are pursued simultaneously by developing matrix organisation suitable to their own level of work. At present, GMs tend to confuse these dimensions or attempt to use one as a substitute for all.

Establishing leadership depends on both the *exertion* of leadership and the *accordance* of leadership. Staff must be properly integrated into the NHS and their efforts supported and led. They must also accept such direction. Each form of involvement extends over **six** levels. Leading and following is what all the other

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processes depend on for their realization in practice. Because all general managers are expected to excel as leaders but behave as loyal followers simultaneously, tensions are inevitable.

Participating in the mission of the NHS is fundamental. Participation here refers above all to the decision to work in the NHS, and this applies across all **seven** levels. The choice to participate must be constantly renewed implicitly if not explicitly if there is to be anything or anyone to lead. In the NHS, the staff's desire to provide health services is not problematic, but such goodwill can be overstrained. In this respect, general managers must look to their own needs and commitment before developing mechanisms for others. There is an area of great importance here, but since it has not fully surfaced in the current development of general management, we do not intend to explore it in detail.

Executive Work and Governance Work

Managers often ask what level of work is expected of governing bodies like the DHA. The answer is complex.* The levels of work schema applies to *executive* work, that is to say to actual transformation of concrete realities. General managers are part of the executive structure and can, indeed must, have a level of work assigned. The DHA, however, performs *governance* work and is part of a three tier governance structure (Secretary of State–RHA–DHA). Governance duties and the governance hierarchy are therefore sharply distinct from executive duties and the executive hierarchy. Governance and specialized governing bodies are essential and distinct in all organisations [15,16]. The work of NHS governance primarily concerns safeguarding progress, maintenance of accountability to the community, resolution of controversial issues and assignment of main priorities or criteria for action.

THE GM VS THE AUTHORITY
WHO IS THE BOSS?

∗*Strong general management does not do away with the need for the Health Authority or strong political control* (as some GMs imagine)—but it does demand more effective functioning from those entrusted with governance.

∗*The general manager is not a straightforward subordinate of the Health Authority or Minister and is not simply delegated work* (as some HA members imagine)—however GMs are expected to serve their governing body conscientiously and defer to its views on matters of value.

Box 2.5

The duties of the GM and the governing body are complementary. Hence understanding governance work and handling the political demands that flow from it are essential for general managers. The conceptual framework required is distinct from that presented in this Chapter and the reader is therefore referred elsewhere [7,16]. An abbreviated account of the respective requirements of the DGM and the DHA is provided in Ch. 5. This is the basis on which effective mechanisms required for their joint work can be developed. The same general principles are applicable at Regional and National levels.

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* The question about expected level of work needs to be re-interpreted as a question about calibre. All DHA members must be able to assess situations, hence presumably be able to work at L-2 at a minimum. Some DHA members, including the Chairman, should be able to consider the District comprehensively and hence be able to work at least at L-4. However, as argued in the text, it must be kept in mind that the distinctive skills required are political, not executive.

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Questions about Levels of Work

Q: Surely this system of work levels represents the sort of rigid hierarchical thinking that has already done irreparable damage to the NHS?

A: A hierarchy of work and responsibility is intrinsic to complex organisation. The levels are often recognized intuitively, and parts of the hierarchy are repeatedly rediscovered by managers, committees of inquiry and academics. The hierarchy simply cannot be avoided. The same can be said of authority. The question is how the work and authority is divided and allocated to posts, and whether the hierarchy is well or poorly designed. The NHS has indeed been (and still is) damaged by inappropriate hierarchical arrangements. Structure must be differentiated from style: of course, rigidities of thought, obsession with status, or authoritarian styles of management cannot be defended. Moreover, as described above, there must be structures and processes which systematically bridge or join levels.

Q: Is it possible to work at more than one level?

A: Ideally jobs should be arranged to operate at one level only, because this is what people prefer. It also minimizes confusions of responsibility. Very occasionally it may be necessary for a post-holder to do two jobs: one at Level X and another at the level above. However posts should never be described in a way that leaves it uncertain which work level the post-holder is expected to operate at. There are grades within levels, but there is no such thing as a Level X-and-a-half post. This is a recipe for muddle.

Q: But surely staff at higher levels deal with concrete situations like handling a missed appointment (L-2) and may perform simple tasks like taking notes at a meeting (L-1)?

A: Yes, those at higher work levels do some work at lower levels, but if this becomes excessive they seek assistants or resolve the problem in some other way. They also regularly 'zoom' down into the problems at lower levels in the organisation. However if they are truly able to work at the higher level assigned to them, they then zoom up again, carrying the broader implications of the low level problems into successively higher levels of response.

Q: Is it possible to work at higher levels, say, during planning meetings?

A: Any notion of 'zooming up' beyond one's true level-of-work capacity at any point of time is a self-contradictory one within this approach. The work levels relate to the ability to carry *full and sole* responsibility for making decisions and seeing them through, and so for being able to be held accountable for the end result. This does not mean however that those at lower work levels should not be involved in work at higher levels by contributing to working discussions (like planning meetings) or putting up ideas or proposals spontaneously. As noted, participation in work is based on the idea that all levels are relevant to all staff in terms of their commitment to the NHS.

Q: What administrative or nursing gradings correspond to these levels of work?

A: Some approximate correspondences can be offered. These are not definitive and do not refer to individuals. There is also a problem of 'grading drift' in which posts are regraded upwards to keep staff, increase pay or maintain pay comparability unofficially. In administration, scales 1, 4, 9 are typically L-2; scales 14, 18, 23 are typically L-3; scales 27, 29, 31 are typically L-4. In nursing, the new clinical grading suggests that A-C are L-1, D-G are L-2, H & I are ambiguous; SN8 & 7 are L-2; SN6 is ambiguous; SN5-3 are L-3; SN2 & 1 are L-4; DNS V & IV are L-3; DNS III - I are L-4.

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Chapter 3

GENERAL MANAGEMENT IN OVERVIEW

The Issue

If a general manager is to be able to move forward positively, he must be clear about the extent of his freedom to act. The NHS has however been bedevilled by struggles between the DHSS and Regions, between Regions and Districts, and between Districts and Units. In each case, those in the upper tier express discontent with the performance of the tier below and tend to take over their work, while those in the tier below accuse the tier above of intruding and interfering.

To resolve such issues, the exact responsibility to be carried by the general manager in each tier must first be clarified. The level of work framework presented in Ch. 2 will be used because it is the only available way to distinguish and describe general responsibilities precisely. The variety of Districts and Units within the NHS means that more than one option may exist, and hence alternative patterns of responsibility will be formulated in this Chapter. As the analysis unfolds, it will become clear what occurs when the needed level of work is not performed (also see Appendix II).

In determining the work to be done at each tier, it is necessary to consider both what is *explicit in official policy* (or seems to be implicitly desired), and what is *naturally emergent* or thrown up by the complexity of existing institutions and services. Sometimes these two analyses coincide, and then the decision about expected level of responsibility is easy. When expectations and realities do not align, hard choices must be made, and conflict and dysfunction may be difficult to avoid.

Level of Responsibility of the NHS Management Board

In 1974 our colleagues put forward a view which we reiterated in 1983 [5], and do so now again. *There is the need for a top level of management for the NHS headed up by a Director-General and working to the Minister, but outside the Department of Health.* The Director-General would work to Ministers just as the RGM and DGM should work to the RHA and DHA respectively. This top level of management would have to be concerned with institutionalizing new conceptions of health services and their management. In other words, the Director-General must be capable of performing L-7 work (as defined in Ch. 2). All such developments are inherently controversial and highly sensitive, and therefore ministerial governance must lead to the setting of political aims and main priorities, and sanctioning all management strategies [16].

Managing as a Director-General. In accord with the L-7 responsibility, any Director-General would develop prescriptions for what is to be taken as given and agreed at all lower levels, i.e. the basic parameters. He would develop a response to situations which call for new concepts of needs or service; he would systematically remodel service operations and NHS organisation; he would comprehensively develop the operation of general management and see that all other functions are comprehensively provided; he would definitively shape health-needs planning; he would provide distinctive leadership; and would participate in all aspects and issues which are fundamental to the NHS. None of these tasks would be delegated.

Such a Director-General could give a unified lead to RGMs and DGMs. This would create a sense of unity in the organisation, and focus its energies. The Director-General would lead a small top executive group with staff working at L-6 to handle feasibility and resource issues and certain specialist topics. Managers at L-5 would shape the operation of policy, and be supported by managers at L-4 and L-3 to cover

specific programmes. Most (if not all) posts would be for staff wishing to be identified with the NHS and its success, and therefore not suitable for career civil servants.

The Present Situation. The new NHS Management Board appears to be muddled, and the above work is not being carried out in full there or elsewhere. The appointment of a Minister as Chairman of the Board (in effect the Director-General), recognized the political dimension at the cost of emasculating the management dimension. The Chief Nursing Officer (CNO) and Chief Medical Officer (CMO) are members but other policy staff and health professional staff are separated off. It is not clear how L-6 support for the Minister in regard to management initiatives, which is after all the crucial step in implementing government policy, is provided by the Board or other civil service division. At any event, civil servants, untouched in general by management experience or personal accountability, still devise and distribute large numbers of specific management instructions to the NHS, most of which are not politically sensitive in any special way.

A striking phenomenon has been the way that most of the new management initiatives (e.g. quality, information, management budgetting) have been correct in principle, but unsatisfactory in practice. It is also noticeable that significant and genuine dialogue between the Management Board and GMs has not developed. As a consequence, the Board has been the subject of much open criticism by the GMs. Problems of dialogue and direction are to be expected from a civil service leadership, but not from a Director-General leading a properly functioning Top Management Group.

POLITICAL RESPONSIBILITIES

Politicians are slowly realizing that they, themselves, cannot develop and pursue complex strategies for their many public services. They are increasingly aware that the civil service cannot do so either.

Politicians do have wide political responsibilities which may not be delegated. For example, in relation to health, they must be concerned to develop value positions on issues like work, pollution, accidents, and immigration. Support for this work is necessary and so a health ministry with a core of top level civil servants is certainly required.

This distinction between political work (with its support) and executive management has recently been endorsed by the Prime Minister's review of the civil service [17].

Box 3.1

Level of Responsibility of the Regional General Manager

Official policy implies performance of L-6 work by the Regional General Manager (RGM). Region has always been expected to coordinate and review Districts in the light of national policy initiatives, and not to provide operational services itself—a role confirmed as necessary and appropriate by the Royal Commission [18].

The level of work naturally emergent in a Region is also L-6. There is no Region so small that the RGM could delve where necessary into the smallest operating detail as is required by the head of an L-5 agency. Within Region, a small hierarchy of staff needs to be established with posts at L-5, L-4, and lower, which support the development and implementation of the RGM's L-6 output.

It must be emphasized that *an effective L-6 output depends on the RGM actually working mentally with the appropriate degree of abstraction, and socially with appropriate relationships to Regional and District staff.* L-7 initiatives and L-6 National programmes must be processed to produce practical guidelines and frameworks which can be applied in all the Districts of the cluster, whatever their actual operational situation. Simply processing DoH paperwork, or rubber-stamping and disseminating documents devised by lower level staff at Region is not enough. The RGM's detailed responsibilities and the organisation of Region will be examined further in Ch.4 and Ch.8. Here we reaffirm that there is supra-operational work to be done at this tier.

An L-6 output from Region overviews and recognizes the main differences amongst Districts within that Region. Too often, however, Districts are provided with an L-5 type of policy from Region which, in its nature, is rigidly geared to an artificial or standardized conception of a District. The result is discontent, dissension and distrust in the Region-District relation. Occasionally, Region provides L-4 policies which are little more than a set of specific desirable programmes of activity for the Districts. The result of such input is a loss of respect for Region by District staff.

However well or poorly the responsibilities at Region may be fulfilled, the expected level is unambiguous: a situation not to be found in the lower territorial tiers.

Level of Responsibility of the District General Manager

Official policy here is reasonably explicit. Districts are expected to provide comprehensive health care services. These services are not to be taken as self-evident or pre-defined, but must be made maximally responsive to the local community. The District is expected to consider new needs emerging in the community service, the use of new forms of hospital or community care, the balance of preventive and curative work, and the boundaries between health and welfare or educational services. In pursuing these tasks, the DGM is expected to develop and implement 5-10 years plans. *All these qualities unambiguously characterize L-5 output.*

By contrast, when we turn to examine what level of work emerges from the task of managing the various institutions and services as they currently exist in NHS Districts, we find that some Districts seem too small and some too big to be run at L-5. In short, *expectations and reality do not always match.*

A **typical District** has, as a minimum, a large general hospital (or equivalent) and a range of community services. The hospital would generate L-4 work in so far as that institution must maintain and develop a given comprehensive range of services to meet the changing needs of the community. Running the community services involves a quite different kind of work, but usually the same level of response is essential to prevent stagnation. Therefore, the DGM must perform L-5 work if he is to manage overall and alter the shape and ranges of provision.

However there are Districts which are extremely small, often lacking a general hospital, or having little else. In terms of both complexity and size of budget, the whole District may be smaller than many a general hospital. In such **mini-Districts**, it seems unlikely that decisions about specific developments will be taken by anyone other than the DGM—who will therefore be performing the L-4 work (as well as the L-5 work if the capability and the time exists).

In other Districts, there may be several large teaching hospitals, or perhaps one giant international referral and research centre. In these, the subdivisions of the District autonomously generate L-5 work. In such **maxi-Districts**, the DGM must at least operate at L-5, but could, in principle, operate at L-6. An obvious example would be the Greater Glasgow Health Board with a budget approaching that of the whole East Anglian Region.

THE FUTURE FOR DISTRICTS: A GAP IN NATIONAL POLICY

At present Districts vary in their degree of complexity. At least three major types may be identified:

mini-	L-4
typical	L-5
maxi-	L-6

Should such a mix of Districts be accepted as permanent?
OR
Should Districts be fused, enlarged or divided so that they can run at L-5?

The existence of DGMs at different levels of work affects the relationship between Regions and Districts. The RGM must moderate his expectations of L-4 DGMs; and must also ensure that in assisting the L-4 DGMs to perform L-5 work, L-5 DGMs are not constrained. The RGM will have difficulty controlling L-6 DGMs.

Box 3.2

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One way or another, decisions about the level of work required of the DGM need to be taken. In the large majority of cases, the DGM will naturally opt for L-5. Some will have a choice of operating at either L-5 or L-4. A few will be forced to operate at L-4. A few will have the option of operating at L-6.

Level of Responsibility of the Unit General Manager

The official policy appears to be to expect the performance of L-4 work by UGMs. Griffiths recommended the appointment of general managers down to Unit level, and, as indicated in Ch. 2, L-4 is where the label 'general' becomes appropriate.

However, whereas Regions and District are territories overseen by Health Authorities and defined under legislation, *Units are no more than conveniently clumped sets of services*. The level of work emergent will therefore depend on exactly what services are to be provided, and what degree of development is likely to be generated by them. What this means is that Units can be designed by general managers in a way that Districts and Regions cannot be.

DHSS guidelines were clear that Units should have managers in control of budgets and all staff, and that they should be near to the patient but only 'one level down' from District [19]. 'One level down' should have been taken to mean one level of work down. If that had occurred in 1982, we might not have general managers today! As it was, *most Units were not deliberately designed to work at L-4, or were inadvertently blocked from doing so* (see Box 3.3).

Too many health service managers at the time claimed that Unit difficulties were teething problems. They were not. The sorry situation post-1982 could not last. Griffiths came along. In a stroke, the L-4 chaos was identified and resolved. Henceforth there would be one person who would be accountable in the Units as well as in the Districts. Once this became clear, Units were finally restructured, and most (but by no means all) have been set up to enable the UGM to perform at L-4.

The issue of the *kind of work* performed in the Unit, which so preoccupied commentators in 1982 in preference to *level of work*, has now faded into the background. However *both kind and level are important*. As we explained at the time, once the need for all Units to operate at L-4 is understood, the specific kinds of services to be included in each of the Units in a District must be created in a *pragmatic* fashion. Their definition must be guided by the need to create a viable entity for comprehensive provision and detailed

1982 MISTAKES
[Many of these mistakes in the creation of Units still persist!]

A: Too many Units were created that were too small for comprehensive development.
B: Some Units were incoherent e.g. a general hospital would be almost arbitrarily divided into two parts.
C: Some Units were conceptually confused e.g. a 'services for the elderly' Unit might be only a 200 bed hospital and would not include most services for the elderly.
D: Some Units, though of sufficient size, were not staffed by personnel capable of working at L-4.
E: Units were set up at different levels within the District and intrusion by District HQ was inevitable.
F: Units at L-4 were often stymied by the District officer's refusal to delegate control of the budget or permit service planning.
G: Units at L-4 were not provided with the necessary staff support in functions like finance, planning and personnel.
H: District Heads in nursing, administration or works unilaterally disrupted and countermanded Unit team decisions.

The result of all the above was that District agendas became overlong; HQ struggled ineffectively to cope with L-5 and L-4 work; and decisions about developments got made in a spaghetti junction of committees, meetings and project groups involving numerous District and Unit staff. L-4 work got done—but ever so laboriously and ineffectively. L-5 work was pushed out and neither expenditure nor workload could be effectively controlled.

Box 3.3

systematic development of the specified services. In general, each Unit should be devised so as to serve the entire population of the District. Simple geographical subdivision of the District into territorial Units is therefore usually untenable. (The basic territory is the District because many specialized skills and technologies can only be planned and provided economically for District-sized populations.) General hospitals demand Unit management. But smaller hospitals, community services, mental handicap and mental illness services may be organised within Units in a variety of ways. Boxes 3.3 and 3.5 provide some further details. Given the current management climate, typical Districts will require 3-4 Units, certainly not less than two and rarely more than five or six.

Our main message is stark and simple:
if Units are set up in a faulty way, only re-structuring them will solve the problem—however drastic, difficult, and undesirable this may seem.

Many **mini-Districts** have (correctly) set themselves up as 'single Unit Districts' to maintain the L-4 meaning of the term 'Unit'. Others have called the District's subdivisions Units, but have implicitly ensured that they operate at L-3 (and therefore should not, in our view, be led by someone called a 'general manager'). In the **maxi-Districts**, the prime subdivisions have tended to be large and generate L-5 work. Such L-5 entities would need further subdivision into L-4 entities. Perhaps, to maintain comparability with the rest of the NHS, the secondary subdivisions should be labelled as 'Units', not the primary. In any case, there would be three levels of general management within such Districts.

The very large and famous teaching hospitals represent an anomaly in the system which has not always been squarely faced. In these cases, the hospital as an institution completely dwarfs the rest of the District's services. Where a Special Health Authority has been set up, this position has been officially recognized. Such international centres of research and practice must operate at least at L-5 if not higher. Some medical staff within them are almost certainly working at L-6 and L-7 in their specialism. In some cases, it may be natural for the DGM to act as the L-5 manager for the institution, as well as being L-5 manager of the District. It is never appropriate to pretend that these gigantic institutions are L-4 entities to be managed by one L-4 UGM (see Box 3.5).

Various District-Unit Patterns

Three unequivocally different models for Districts may be identified in relation to the level of responsibility of the general managers: the L-6 DGM with L-5 UGMs, the L-5 DGM with L-4 UGMs, and the L-4 DGM with L-3 UGMs (see Fig. 3.1). These models correspond to our labels of maxi-, typical and mini-Districts respectively. The differences for achievement and the experience of work in the different types of District are enormous.

In addition to the above patterns, two further 'in-between' models may be noted (but will not be further discussed):
Small maxi-Districts: These teaching hospital Districts with budgets in the £100-£200 million range might operate with an L-5 DGM working with L-5 UGMs. Although workable, marked tensions may develop between the DGM and UGMs.
Large mini-Districts: These Districts might operate with an L-4 DGM working with L-4 UGMs. This is particularly unsatisfactory and probably not workable. The clash between DGM and UGMs is likely to be severe.

In the typical District, the DGM post must be set up to work at L-5, and the UGM posts must be set up at L-4. What this means will be examined in detail in Chapters 5 and 6 respectively. Here we merely orient the reader in a way which we assume will be generally familiar and unexceptionable.

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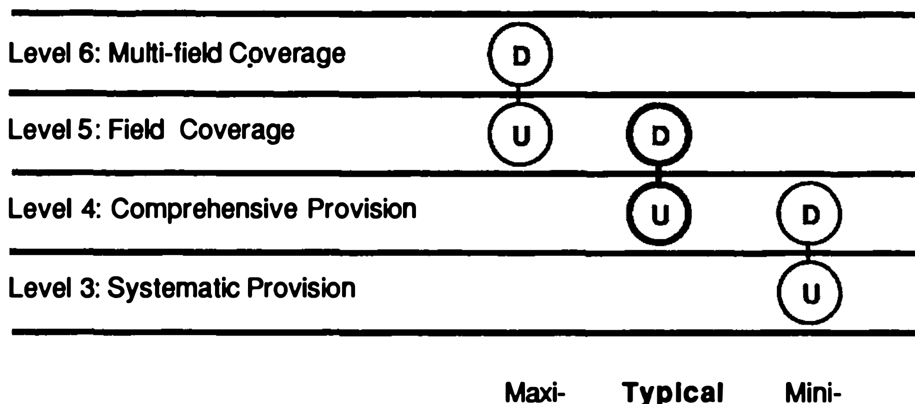
Figure 3.1: Patterns of responsibility in different NHS Districts
D = Expectation of DGM; U = Expectation of UGM



Maxi- **Typical** Mini-

In brief, the typical DGM must comprehend the totality of the services offered, and broadly shape their development. He must determine with the Health Authority the main policies and priorities for the District in relation to any particular operational matter, and develop strategies for their implementation. In order to grip the whole field of operation, the DGM must define ranges of services and needs to be met, HQ and Unit structures, budgetary structure and financial strategy, and frameworks and criteria for operational plans. The DGM must mastermind relationships with higher levels in the NHS and set the boundaries with related agencies in local government, private and voluntary sectors.

The detailed programming, planning, and costing of these initiatives is the responsibility of staff at L-4. As will be elaborated, the DGM does have headquarters staff working at L-4 to help him, but *detailed development of the services to be implemented and delivered in the Units must be worked out and owned by Unit staff.*

The UGM therefore has the task of working out his own plans, of examining options and costings, of negotiating and consulting with staff involved, and of ensuring implementation of plans if they are sanctioned. The UGM must keep a multiplicity of services in balance and has an on-going task of filling gaps in provision. In the present financial climate, expanding or starting services usually entails reducing other services and reallocating posts and resources.

THE COMMONEST CRITICISM

"These models are all very well in theory, but in practice the jobs are much better drawn on the lines between the work levels. Most UGMs, for example, contribute to District decisions."

Our Standard Reply

In theory it is possible to draw circles on lines, but....real life jobs are not circles. And in practice it is just not possible to design successful roles which blur level boundaries.

As indicated in Ch. 2, staff do, of course, contribute at many levels. But the issue is where their primary responsibility for results is to be located. *Fudging this necessarily precise specification is disastrous.* This is the commonest serious error found in District structures.

Box 3.4

In mini-Districts, where the DGM must handle the L-4 work, the L-5 work will be done partially, implicitly or not at all. A major factor will be the calibre of the DGM. However, L-5 DGMs would not usually be attracted to L-4 Districts. Regional officers sometimes step in and attempt to perform L-5 work, but the quality of this work will not be high because Region is insufficiently close to the local situation and cannot pursue implementation in an ongoing and detailed way.

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In maxi-Districts, the DGM may need to work at L-6. In this case, the UGM's would require to work at L-5, and they would need to set up their own subordinate general managers working at L-4.

The precise nature of the various responsibilities, exactly how the necessary arrangements operate, how each tier depends on higher levels, how the tiers need to be staffed, and how they can work together coherently, make up the substance of the remaining Chapters.

Typical Mistakes in A Teaching Hospital District

In this hypothetical case based on NHS reality, the District would be chronically overspending, and relations between unit general managers and district headquarters strained. Management costs would tend to be low because UGMs lack adequate support staff. Analysis of situations would be difficult, so management by crisis would generally prevail.

UNIT SITUATION

Name	Contents	Budget	Problems in Definition
1†	Large teaching hospital site	£39M	Unwieldy and unmanageable Could not possibly be run at L-4
2	A few other acute hospitals	£10M	Not sufficiently self-contained for development purposes
3	A specialist & a general hospital	£14M	Conceptually confused
4	Mental illness services	£15M	—
5	Community services	£5M	Too small in comparison to the rest Could possibly be run at L-3

†Note that numbers are unsuitable as a Unit name. A UGM cannot develop a Unit identity if the Unit is not designed to have one. The avoidance of names reflects the incoherence of the entire structure.

A BETTER ARRANGEMENT FOR UNITS

Name	Budget	Nature
Milson Wing	£13M	Services for children and women; minor specialties; Dental Hospital.
Medical Services	£15M	Most medical services
Surgical Services	£15M	Most surgical services
Regional Specialties	£14M	Regional specialties

[These four Units together make up the *Teaching Hospital Institution* which includes one main site and several outlying sites which could be contracted in number. (An alternative arrangement with three Units would also be possible.) The Institution would need to run at L-5, probably with the DGM as the Institutional Head. It would require its own L-4 Works Officer, and input from an L-4 or (if possible) L-5 DMO. The various site/hotel management responsibilities at L-4 could be divided amongst the UGMs or other institution-based L-4 managers.]

Name	Budget	Nature
Mental Health Services	£15M	No change
Community Services	£14M	Usual community services plus 250 bed community hospital, a small geriatric hospital, and mental handicap services (following transfer from neighbouring Districts).

UGMs have similar, but not identical, needs for an L-4 DNS, L-4 medical input and L-3 support staff in planning, administration, finance, personnel, and information services. The end result might be an increase in management costs, but these would still be low in comparison to those in small Districts.

Box 3.5

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The Significance of Budgets

An extended discussion of budgetting, financial management and information services for general managers must await another occasion. However, the basic relation of budgets to levels of work and general management can be simply stated and must be thoroughly understood if the District structures proposed are to operate properly.

Managers are intuitively aware that the ways in which finance is managed and budgets devised have a powerful effect for better or worse on coordination and cooperation within an organisation. Hence there is intense sensitivity about who holds budgets, or uses savings, or can exercise virement, and related issues. *Many supposedly progressive initiatives in this area are seriously misconceived.* The work-levels approach is a great help in sorting matters out.

The logic of levels of work, confirmed in the field, indicates that *detailed budgets are a primary tool precisely at L-4.* At L-4, where services are being reduced or closed down and new ones developed, it is absolutely essential that there is costing and monitoring otherwise planning will become unrealistic and implementation will get out of hand. The amount of unexpected variation in service demand over a year must also be managed at L-4, and this requires defined powers of virement between budgets. Such powers are not required at L-3, even though monitoring of the financial position and control of certain budgets (i.e. those directly relating to the flow of work that the L-3 manager must handle) may be delegated. Budgets are not appropriate at L-2, even though such managers often sanction expenditure.

The DGM at L-5 does not need to hold specific budgets or control all virement. What he does need to control are *reserves* and the *limits to virement.* In times of emergency or in particular cases certain savings developed in Units during a year will have to be clawed back. But, if virement within or between Units is routinely exercised by the DGM, the UGMs cannot deliver on their annual plans and will lose credibility within the Unit. The DGM must alter the finance available to Units annually using the planning process, and must provide a scenario for Units looking several years into the future. Financial management at L-5 on an ad hoc or continual crisis basis is unsatisfactory.

UGMs at L-4 can be expected to control costs more tightly than DGMs because they are just above the managers who deliver services. UGMs must place firm limits on workload, manning and item expenditures by L-3 line-managers, and must aid them by setting policies and priorities. However, if the UGM delegates all budgets (including establishment) to L-3 managers or lower, control of developments will be lost and unexpected but inevitable overspends in particular parts of the Unit cannot be managed. Once expenditure control is lost, the situation progressively worsens in the Unit and the whole District.

Box 3.6

Chapter 4

GENERAL MANAGEMENT AT REGION

Problems

Over the years, Regions have struggled. Griffiths recommended the appointment of a Regional General Manager, but made little comment on the functioning of the Regional tier. Further reorganisation was required and this was generally introduced by the new RGMs, often with the aid of management consultants. However, long-standing difficulties persist.

The quality of Regional functioning is often questioned by Districts [20]. District staff do at times receive conflicting views from different Directorates at Region. They complain that Regional policies misunderstand local realities, minimize the practicalities of operating, or ignore resource issues. Inappropriate exercise of powers—sometimes too heavy and sometimes too light—by Regional staff in the various functions has led to friction.

Districts have been particularly disrupted by the tendency of Regions to dump political initiatives on them without transforming them in the light of NHS realities. Too often dialogue between Region and Districts is inadequate or absent, and Regional monitoring is exercised in a confused and ineffective way. As a result, Regional officers feel at times powerless to affect Districts, and in a few cases have persistently failed to control District over-spending or to generate agreed developments.

Perhaps not surprisingly, the idea of abolishing RHAs is regularly raised in Parliament. So the very necessity of Regions must be established before we proceed to examine some of the problems and issues noted above.

Are Regional Structures Necessary?

There are actually three questions. Is some sort of *Regional executive* structure necessary? Is some sort of *Regional governance* structure necessary as well? And, if the answer to both these questions is in the affirmative, is the present set-up (which provides both) an optimal one?

Any doubt about whether a Regional executive is necessary can be quickly laid to rest. The answer is a simple unequivocal yes. From the levels-of-work framework, it is clear that there is a need for L-6 work to be performed, and there is little doubt that it needs doing in relation to separate clusters of Districts.

Frequently, the need to control or monitor the large number of Districts (200+) is cited as the obvious justification for a Regional executive. However, this argument is too facile and does not reveal the deep realities involved in management at L-6.

The specific work to be done at the level immediately above the District involves:

(a) *comprehensive planning in relation to health-care needs in the Region, and handling operational clashes between Districts that flow from this;*

(b) *introduction of new specialist functions (such as a medical specialism, or a management specialism), and overview of all existing functions within Districts;*

(c) *coordinating planning and provision of many services whose catchment or scope is naturally far larger than is possible or sensible for a single District to handle;*

(d) *definitive allocation of available finance and overall control of all other main resources.*

Such executive work demands a detailed managerial appreciation of local needs and aspirations and can only be done satisfactorily through direct awareness of the

relevant socio-geographic and health service realities. This requires regular proximity to the Districts, and cannot be effectively performed from Whitehall. The above executive work, in addition, absolutely demands to be set within a framework of authoritative, that is to say *politically legitimate*, value judgements. So *governance* work is also needed, and again it must be done in close touch with local realities.

A scenario could be envisaged in which the present RHAs were dispensed with. A Regional executive could be set up within the civil service using decentralized offices, with political oversight and legitimation provided by London-based Ministers. But this option has severe drawbacks. A dynamic managerial ethos has never prevailed in the civil service, and using the civil service like this goes against the spirit of a recent Government Report [17]. Also, although it is true that RHAs in England are only weakly representative of social communities, they are nevertheless far better placed than London-based Ministers and their political advisers to assess local needs and preferences.

It looks as though the present set-up of RHAs in England may be the best that can be contrived under our present national constitution. (In Scotland, Wales and Northern Ireland, the situation is different. Each of these has Ministers who, with civil service support, must perform, amongst other things, the needed NHS executive and governance work.)

KEEP REGIONS–ABOLISH THE RHA?

It should be noted that Regional management within the NHS absolutely requires a complementary governing structure [16]. At present, this is provided by Ministers for Scotland, Wales and Northern Ireland, and by members of RHAs in England.

The IHSM recommends that Regions might function better without the RHA and its members [21]. However, final value judgements on social needs must always be taken by elected representatives (or their appointees) rather than by employees.

The abolition proposal ducks the real issue of how such value-based decision-making can be improved, and the proper relation between governors and executives [7,22].

Box 4.1

Managing as the RGM

The work of the RGM stems from the requirements of managing at L-6. All activities are epitomized in the overall responsibility *to provide frameworks that ensure that operational provisions in the various Districts are satisfactory, mesh sensibly, and embody National conceptions of the NHS.* In pursuing this responsibility and in framing operations within his Region, an RGM is faced with a variety of management tasks including:*

1: Determining responsibilities

Internally this involves clarifying the roles, responsibilities and authority of senior Regional HQ staff, and of all necessary Regional top working parties and advisory committees; and externally it concerns helping DGMs do the same, ensuring that responsibilities for regional and sub-regional specialities are definitively assigned, and that provision of services for smaller Districts by larger Districts is organised.

2: Getting action

This involves developing dialogues with National level management, Regional Directors, the RHA, and DGMs, so that, wherever required, Regional priorities, policies and strategies may be developed and acted upon. Looking upwards the focus is on the implications of new concepts, and looking downwards the focus is on frameworks for operation.

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* Each aspect of managing listed in Ch. 2 (p. 16-17), as well as the basic activity of *determining responsibilities*, will be used here, and also in Ch.s 5 and 6 in relation to DGMs and UGMs.

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3: Dealing with change
This involves ensuring National directives for remodelling operations are elaborated into programmes suitable for implementation in Districts, and initiating necessary Region-wide reforms to be interpreted and implemented by Regional Directors and DGMs themselves. Some direct contact with UGMs is implicit in this latter brief.

4: Providing functions
This involves systematizing the general management function in the Region; and ensuring specialist system functions like information are systematically developed in the Region, specialist assessment functions like personnel and medicine comprehensively developed in the Region, and specialist action functions like nursing and catering comprehensively developed within each District.

5: Pursuing achievement
This involves comprehensively planning to meet the range of health-care needs as given by the National level, organising the definitive provision of all necessary resources (financial, human, material, informational) for DGMs to realize these, and monitoring actual District performance in these two dimensions.

6: Establishing leadership
This involves providing definitive leadership for Regional HQ staff and for DGMs while maintaining the distinctive qualities of the particular Region in dealing with the National level on behalf of the RHA.

7: Participating in the mission
This involves developing a distinctive climate which promotes continued and active participation by all staff, both at Regional HQ and in the Districts.

The National-Regional-District Axis

The effective operation of Region is fundamentally predicated on the capability of the RGM to transform Ministerial and DoH directives at L-7 and L-6, and provide an L-6 output consisting of guidelines and frameworks which assist and channel practical implementation by the DGMs. The DGMs then need to work on these guidelines and frameworks to use them in a way that suits their own actual operating situation.

For this axis to transform ideas into actions effectively, the RGM must engage in two sets of dialogue. On the one hand the RGM must be in dialogue with the Director-General (or his equivalent) at National level. Only in this way, can the RGM appreciate exactly what is required. On the other hand, the dialogue between RGM and DGMs themselves must be strong, direct and vigorous. (It is recognized, of course, that each of these GMs has a separate employing authority.)

In these discussions, National, Regional and District Directors—who are staff officers at L-6, L-5 and L-4 respectively—play a major but secondary part. (See Ch. 8, p.61-63, for further discussion.)

These discussions must not be a dialogue of exhortation and complaint or a picking over of administrative minutiae, but a working process essential for appropriate decisions and actions within the axis. Looking upwards, the RGM must expect a clear articulation of the new concepts of health care needs and services which are to guide him together with the national priorities, criteria, resource assumptions and time-scales, and must in turn raise issues related to local feasibility. Looking downwards, the RGM must articulate the general principles, orienting priorities, reasons, and criteria for action in the Districts, including resource assumptions, times scales, and other relevant factors, while the DGMs must indicate the practical realities and how they will be handled.

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The proper working of the National-Regional-District axis cannot be over-emphasized. In the absence of dialogue, DGMs are dumped with insufficiently modified National initiatives. Too often the dumping continues down the line so demoralizing both front-line managers and health professionals. As noted earlier, dialogue will be difficult to manage if the National level has a confused focus of responsibility. A serious problem comes from the fact that DGMs are not all working at L-5. L-4 DGMs will find the demands made on them excessive. They will regard L-7 concepts and L-6 frameworks as too vague, and will desire more detailed specification of exactly what is required of them. Understandable attempts by the RGM to adapt to them may lead to invasion of the responsibilities of L-5 DGMs and a stifling of development in the most progressive Districts.

Levels of Work of Staff Posts at Region

A source of friction in many Regions has been the tendency for Regional staff to see themselves as automatically more senior than all District staff. Region is a higher tier, but that does not mean that all Regional posts are pitched at a higher level than all District posts. Most top posts are, but some are not; and subordinates within Directorates are never more senior.

Both *kind* and *level* of work expected of the various Directorates and posts at Region need to be carefully established by the RGM when designing and staffing a Regional organisation. Region-District relationships cannot be effective if the design is unsatisfactory, or if the Regional functions are undeveloped.

In the selected list below (based on analyses and limited observation), an RGM working at L-6 is assumed. In each case, the work to be done is stated in level terms and compared to the corresponding post in typical Districts.

Regional Treasurer: probably L-6, typically senior to District counterparts.
Regional Personnel: L-5, typically senior to District counterparts.
Regional Planning: L-5, typically senior to District counterparts.
Regional Estates: L-5, typically but not invariably senior to District counterparts.
Regional Medical Officer: L-5, typically but not invariably senior to District counterparts.
Regional Nursing Officer: L-4, equivalent to District counterparts; or L-5 to shape nurse education.
Regional Pharmacist: L-4, equivalent or senior to the District counterpart.

Since the introduction of general management, a variety of new posts have been introduced into RHAs to cope with new management initiatives and to grip the Districts more firmly. Jobs such as 'Director of Information', 'Director of Health Policy', 'Operations Director', 'Director of Quality Assurance', 'Director of Support Services' and 'Assistant General Manager' have emerged, and may all be justifiable. However the total system will only function effectively if the kind of work is precisely defined and if the level of work in each case, usually L-5 or L-4, is definitively established. Staff at L-4 need to be assigned to an L-5 Director. (And, of course, all those in post must be capable of performing satisfactorily at the required level.)

Sub-dividing Regions geographically to assist and monitor the implementation of policy is also common, but *is positively undesirable at L-5.* (It may be acceptable at L-4). Top staff posts which are not forced to take an overall view tend to drift into acting as an additional level of management, in this case between the RGM and DGM.

Staff expected to assist authoritatively in the shaping and structuring of District activities, for example by defining and creating multi-functional project groups or task forces, have to work at L-5. L-4 Regional staff may contribute to Regional policy-making, develop actual programmes within Districts, and monitor Districts generally. L-3 Regional staff will work within Regional HQ providing back-up and support in

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policy and planning. On occasion, their specialized talents will be used for defined monitoring or to supply agreed training or some other specific service within Districts.

It is natural that all staff at Region working at L-6 or L-5, together with professional representatives such as the RNO, should be brought together by the RGM in a Regional Top Management Team. This is not a consensus or voting body, and the RGM working unambiguously at L-6 should be able to give a distinctive lead.*

All L-5 directorates will require L-4 subordinates, and these will typically require staff at L-3 and lower. Regional functioning at these lower levels has suffered greatly from poor morale. The single most important action to improve morale is to ensure that staff are in real jobs at a specified level of work which is commensurate with their capabilities, and that accountability relationships make sense. The detailed internal structure of Region at these lower levels will not be examined. However the principles of organisation and management relevant to Districts and Units (Ch.s 5 and 6) will apply here. Indeed, we might argue that, for morale purposes, adherence to the principles are even more necessary. Staff at the lower levels at Region, unlike similar staff in the Districts, are not gratified by the ability to provide or immediately influence a direct output to patients. Common errors—pitching posts between levels, setting up line-management within a level, permitting subordinates with similar gradings to perform at different levels of work—all need to be rooted out.

In Conclusion

Above all else, RGMs must ensure that they and their top Directors develop close and realistic dialogues both upward with the National tier and downward with their Districts. To do this it is essential to be clear about both the scope and the limitation of contributions expected from Regional posts at various work levels. Sharpening the focus on the distinctive work of Region, strengthening the functions, and restructuring Regional HQ organisation may all be needed.

IMPROVING REGIONAL PAPERWORK

In the nature of things, top regional staff have left the world of actual health services delivery completely behind them. Work reality consists of navigating a sea of paper. Paper is partly passed down to Region, partly produced by Region, and partly requested by Region.

District staff see Region, like the DoH, largely through the paperwork. Because action by District staff, depends not only on *what* is actually written in Regional documents, but also on *how* it is written, the quality of the drafting becomes of great significance.

Common errors which must be avoided include:

*poor titling and lack of focus
*poorly constructed sentences
*verbosity or excessive length
*lack of a logical ordering within the document
*lack of awareness of other related documents
*omission of key elements of relevance to Districts

When such errors compound, Regional documents will be simply left to gather dust, or will be responded to mechanically.

One of the striking features of good civil servants is their capacity to draft circulars well. This ability is fundamental in the political arena where justiciable statutes, public edicts, and value decisions must be promulgated. It is also called for in the upper reaches of management. Perhaps DoH staff could arrange some tutorials!

Box 4.2

* Comments about District Boards in Box 5.1 in the next Chapter also apply to the Regional variety.

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Chapter 5

GENERAL MANAGEMENT AT DISTRICT

Problems

Devolution of responsibilities to Units and decentralization of functions occurred rapidly in many places following the introduction of general management. However this left exposed many important issues about District management itself. For example: What support does the DGM now require? What are the new District Management Boards supposed to do? How is the DGM to ensure that Units develop as expected? How should the DGM interact with UGMs, and other Unit staff and health professionals? How can the DGM ensure that DHA policies command general support? What new arrangements for representation of medicine and nursing are required? How can a notion of the District as HQ be combined with the sense of the District as the whole?

In pursuing these matters, what managing means for a DGM will be indicated; then the multiplicity of posts, teams and meetings needed for the work to get done are considered, the main issues in inter-Unit interaction examined, and finally a note on the Health Authority provided.

Managing as the DGM

The work of the DGM stems from the requirements of managing at L-5. All activities are epitomized in the overall responsibility *to provide complete coverage of operational provision in line with higher level conceptions and frameworks*. In pursuing this responsibility and in shaping operations within his District, a DGM is faced with a variety of management tasks including:

1: Determining responsibilities
This involves clarifying the function of each Unit, and the roles, responsibilities and authority of all senior District HQ staff, top Unit staff, and necessary District teams and meetings.

2: Getting action
This involves producing all necessary policies and strategies to ensure the shaping, maintenance and development of District services on the basis of dialogues with the RGM and Regional top officers, UGMs, and the DHA. Looking upwards the focus is on implications of the frameworks for operation to be used, and looking downward the focus is on the ranges of services to be provided.

3: Dealing with change
This involves implementing given National and Regional change directives, and at the same time initiating District-wide directives to be programmed costed and implemented by District Directors and UGMs. Some direct contact with L-3 managers and medical consultants is implicit in this brief.

4: Providing functions
This involves ensuring that each particular speciality and service is assigned to someone at L-4, with general management provided where needed. It therefore involves ensuring the systematic development of specialist system functions like information services, and the comprehensive development of specialist assessment and specialist action functions like personnel and nursing respectively.

5: Pursuing achievement
This involves systematically planning for given health-care needs in the light of the community served, covering all aspects of operational implementation implied by these needs, and developing the total available resource (financial, human and material) so that each service may be given an appropriate allocation. Results in each of these dimensions should be monitored.

6: Establishing leadership
This involves exerting leadership comprehensively across the District, while accepting the lead given by both the RGM and the DHA.

7: Participating in the mission
This involves developing a definitive culture which encourages the continued and active participation of all District staff in the NHS.

Posts Supporting District General Management

The DGM needs a variety of senior staff posts whose holders will all be working more or less closely with him. It is essential to be clear for each post, the level of work expected and how the post-holder needs to relate to the DGM. It is helpful to divide the people involved into four main groupings.

Direct assistants or staff officers

Such people need to work at L-4. Hence they may appropriately be titled 'Director'. They include at least a Director of Planning and a Director of Personnel. In larger Districts, other posts such as a Director of Administration may be required. There also is a growing need for a separate Director of Information Services.

These assistants are the DGM's 'own' staff, his 'right hand men', who are directly and unequivocally accountable to the DGM and need therefore to work in close physical proximity with the opportunity of regular daily contact. Note that these posts reflect specialist management disciplines (or functions). 'All-purpose' assistants or deputies are not usually appropriate, and combined roles with professional heads (below) are not wholly desirable.

Within each of these L-4 staff divisions, there is need for one or more posts for specialized staff at L-3. For example, planning might include a specialist statistician or performance review officer; and personnel a specialist training officer, public relations officer or head of management development. The DGM might occasionally deal with such staff, but he would generally require the simultaneous presence of the relevant L-4 officer. Without an L-4 officer in charge, issues will not be fully understood, and work may not get effectively progressed without the DGM himself being dragged down into it.

District Professional Heads

The expected level of work of posts in this group may vary somewhat depending on the particular function and on local needs and expectations. For example: District Treasurer—typically L-5, Director of Public Health (or DMO)—typically L-4, District Nursing Officer—L-4, Director of Estates—typically L-4, District Physiotherapist—L-4 or L-3, District Dietitian—typically L-2. (More will be said about some of these roles in later Chapters.)

While DGMs might like to feel that these staff are really just another group of assistants, this is only partially true. (Maintaining a misleading fiction ultimately weakens an organisation.) Even if these people are accountable for most purposes directly to the DGM (or even a UGM), the DHA may on occasion require a direct

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report from them as 'leaders of their profession'. On occasion, the DGM, too, needs them to act in a professional leadership role on his behalf (cf. Box 7.5, p.56).

Some Heads, such as the District Treasurer and Estates Director, will need regular contact with the DGM. Others do not need to work in such close proximity, and might be primarily accountable lower down in the organisation. However, each still needs to have right of access on high-level professional matters.

Unit General Managers

The UGMs are the prime operational subordinates of the DGM and should be working one level below the DGM—at L-4 in the typical District. They are directly accountable to the DGM, but cannot be considered as the DGM's 'own' staff. The DGM and his UGMs have sharply different concerns and pressures, and so an inherent tension exists between them, as indeed between any line-manager and his operational subordinate. UGMs need to be physically located according to the needs of their own Unit. Easy access to the DGM is essential, and contact should be frequent, though not daily.

Elected Medical Representatives

There should be at least one medical consultant and a general practitioner who have easy access to the DGM. Such representatives are accountable primarily to those who elect them, not the DGM. They will be based in their normal place of work. Posts to be filled by election cannot have a level of work assigned, but it can be hoped that the individuals elected are capable of working at least at L-4.

Teams and Meetings at District Level

No single meeting or team can possibly accommodate all the necessary interactions amongst the DGM and the four groups of top staff just described, upon whom he depends. So-called District Management Boards (DMBs) have been popular but often function poorly (see Box 5.1). In practice diverse bodies, teams and meetings are necessary.

These include:

- Informal Meetings
- A Policy Advisory Group
- General Manager Meetings
- Nursing Management Meetings
- District Professional Committees
- District Health-Care Planning Teams
- Other Arrangements

[The labels used for the various groups vary greatly around the country and no special significance need be attached to these labels.]

DISTRICT MANAGEMENT BOARDS

Formerly the DMT was the top executive body in a District. This body has now been replaced by the DGM. However, most DGMs immediately set up new but very similar bodies with L-5 & L-4 officers and several medical consultants, and called them 'management boards' (DMBs).

DMBs were not to be DMTs, but little thought was given to what such Boards should or could do. It was imagined (incorrectly) by many that this board was in some way equivalent to a Board of Directors in a business. The true equivalent of the company board is the governing body, the DHA (or Health Board in Scotland). In these, consensus is sought and decisions can rest on majority voting. Such an arrangement would not be compatible with the DGM's responsibilities.

DMBs were often said to be for policy-making, but they are far too cumbersome for this. Sometimes they have become all-purpose and have generated unwieldy agendas. Large bodies or meetings like DMBs are mainly useful for general discussion: e.g. to receive communications from the DGM, to act as a brain-storming forum, or to explore emerging issues informally.

Box 5.1

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Informal Meetings

The DGM needs to meet daily throughout the week on an informal basis with each or all of his direct assistants, and also with various District professional heads, particularly those operating at L-4 or L-5, in many and varied combinations. Paperwork should flow naturally from the purpose and achievements of the meeting. No single body or team is appropriate, and excessive protocol or procedural rigidity should be avoided. 'Action sheets' might be usefully drafted during some meetings.

Policy Advisory Group

The DGM also needs a formally constituted group which reflects the political influences in the District, and can comment and advise upon major policy issues at important stages in their development, and certainly before their final presentation to the DHA. *Such a group is primarily procedural, and not the forum for negotiations or detailed exploration of possible plans.* (This might even be how some DMBs work!) The membership would include one or more representative consultants, a representative GP, the District Nursing Officer or Adviser or other representative top nurse, the Director of Public Health or equivalent, the District Treasurer, and possibly the Director of Estates and UGMs. Staff assistants whose support the DGM can take for granted (e.g. Directors of Personnel, Planning, Administration, Information) would only be present in attendance, and not as full members because the DGM determines or deals with their views directly.

General Manager Meetings

The DGM requires meetings with his UGMs to explore, progress and review District issues and initiatives with formality, again, kept to a minimum. In this regard, the DGM needs to meet both regularly and ad hoc with each UGM individually, with UGMs in groups set up for particular initiatives involving more than one Unit, and with all UGMs as a group. In these settings, some or all of the DGM's direct assistants will usually need to be present. District professional heads or elected representatives might sometimes need to attend according to the business in hand.

Nursing Management Meetings

The District Nursing Officer or Adviser (DNO or DNA) is no longer main line-manager of all nurses in the District. The devolution of top operational nursing responsibilities to individual DNSs in the Units is a development which should ultimately greatly benefit nurses and patients. DNSs, including any UGMs who are *de facto* DNSs, need to meet regularly together to cooperate on District-wide nursing issues. One of them or the DNA may act as chairman. *However, significant changes in nursing throughout a District are unlikely to take place without the DGM's drive and determination,* whether or not he attends and chairs the meetings. In other words, it would appear that any authority for a DNA to pursue executive changes in nursing throughout a District derives from the DGM.

District Professional Committees

We are referring here to bodies which are radically different from any of the executive groups just discussed. These committees would be normally constituted by representatives accountable to their colleagues who elect them, and not to the DGM. The District Medical Committee is a significant and well-established body which is still required in the general management era. A District Nursing Advisory Committee, Paramedical Advisory Committee and other participative structures are generally lacking in most Districts, but perhaps deserve developing. The main difficulty in the successful operation of all these bodies is ensuring, first, that they effectively represent their constituency, and second, that they target their concerns unambiguously on L-5 decisions and District-wide issues, leaving other bodies to handle lower level matters. Much of the work to be done will either be procedural (e.g. ensuring that all professional matters are correctly handled) or consultative (e.g. on the DGM's policies). They should brief their Chairmen or whoever else represents them on the Policy Advisory Group.

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District Health-Care Planning Teams

As noted earlier, the DGM is responsible for seeing that strategies for health care delivery are developed which are focused on patient-needs, and which systematically cover the range of these needs as given by higher levels. Note that a team is not the only way of getting such work done. Such planning will typically cross disciplines, specialties, and Units (see: below, Fig. 5.1, Fig. 6.2, and p.70-72); and needs to be carried out in association with organisations in the voluntary, local government and private sectors, and sometimes with neighbouring DHAs. The DGM needs to set the context required for such work to be carried out, and ensure that the results enter the District policy and planning process.

Other Arrangements

DGMs might require regular meetings of other kinds focusing on defined areas of business (e.g. progressing work for the Authority and its members), or on high profile projects (e.g. dealing with income generation).

The Basic Matrix at District Level

One of the principal concerns of DMTs in 1982 was the need to prevent excessive autonomy in the Units, which, it was feared, would entail loss of flexibility at HQ for managing the District as a whole. The effect of this was to prevent proper development of L-4 Unit management. For example, at that time most District staff wanted to retain the ability to vire any and all spare money regularly between Units. As indicated at the end of Ch. 3, nothing could be more demoralizing for a L-4 manager. Units must have the degree of autonomy appropriate to L-4, and be allowed and expected to function within a given revenue allocation, otherwise inefficient Units will constantly be bailed out by more efficient ones.

However, *the issue of cross-Unit interdependence and interaction does not disappear with proper devolution of L-4 powers: it becomes sharper because health-care needs are typically not defined by Units.* For example, within a typical District, it will be possible, and perhaps tempting, for a General Hospital Unit to move recuperating or chronically ill patients rapidly back to their homes. This may well reduce hospital costs or enable a higher throughput, but these same patients, if they are not to be neglected, may need to be cared for in the community and will require *resources* and facilities to be available there. District costs may not alter or may even increase as a result of meeting patients' *needs* by such *activities.*

Needs, resources, activities: achievement in a District depends on successful work and organisation in each of these three dimensions which taken together generate a matrix as in Figure 5.1 opposite.

Units led by UGMs align with the *operational activity* dimension and provide definitive accountability for all implementation. (This is why they need to be designed pragmatically—in order to manage and control all staff, all facilities and all expenditure as firmly as possible—not to suit patients primarily.)

However, a *health-care needs* dimension must be recognized to complement operations. Here is where the main control of health-care objectives and priorities in terms of patient's conditions and needs should be located. At District-level, it is necessary to take a systematic view of the NHS's mission, and division into programme areas is therefore required.

A third dimension, *resources*, must also be recognized, and here the focus is on providing support for both health-care needs planning and operations. Resources, such as money, people, information, and buildings, impose their own logic on a District, and require their own organisation. Resources must be provided comprehensively throughout the District.

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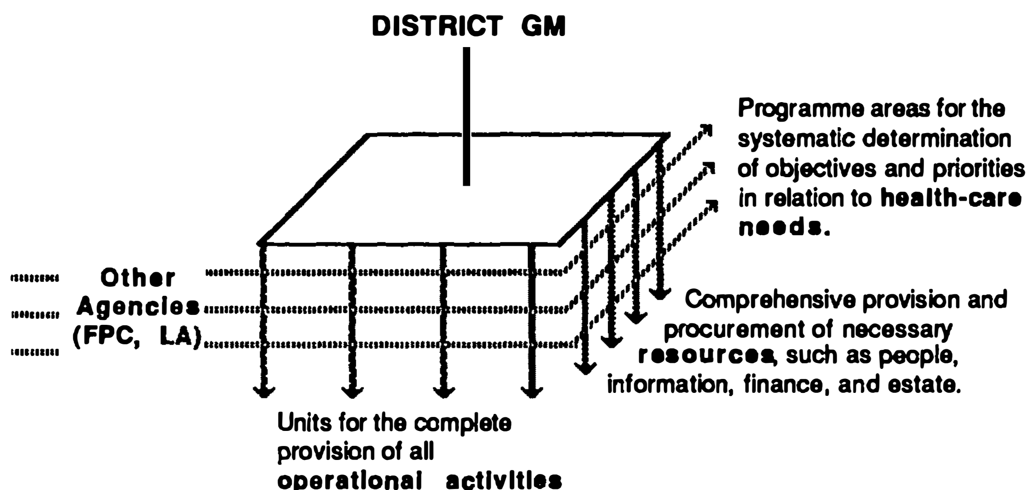
Figure 5.1: The Basic Matrix at District-level

Pursuit of achievement by the DGM demands a distinct focus on each of the three dimensions in the matrix. Note that all GMs and top officers and functions have responsibilities in each of the dimensions.



If the mission of the NHS is to be fulfilled, each dimension in the matrix requires to be treated separately, and embodied in its own organisation and policies. A common error is to assume that the dimensions are divided amongst the functions: that the planners own the health-care needs and related objectives/priorities, that estates staff own the buildings, that health professionals need only focus on the services they have been trained to provide. This is a serious misunderstanding. Some alignment between function and dimension does occur. But it must never be forgotten that *all* managers and professionals have a responsibility to make contributions in each of the dimensions. For example, the development of a hospital building depends partly on technical criteria (specified by the works specialists), partly on the activities to be performed within it (specified by health professionals), and partly on which health-care needs and patient problems are most significant (developed in a complex process involving staff in various functions, planners, the patients themselves, Health Authority members, and people in other agencies).

The idea of focusing on patient-needs is not new in the NHS. But previous attempts have not been successful for a variety of reasons, and programme area planning appears to have got an undeserved bad name. Currently, programme areas are weakly developed even where overtly promoted e.g. child health, dementia, maternity care, heart disease, cancer care, diabetes, AIDS.

Past failures have been due to

- *over-elaborate structures*—
  a major initiative in Districts was probably not appropriate in the absence of a comprehensive National and Regional lead;
- *over-sized teams*—
  one individual who knows the area may do better than a team who endlessly talk and compete with each other;
- *level-of-work confusion*—
  it was often not clear whether an L-3, L-4 or an L-5 output was being sought, and staff were not selected by level;
- *absence of support*—
  often no guidelines, no information, and no administrative support were made available;

- *competition with Units over execution*—
  teams thought they had to deal with detailed implementation, whereas this was precisely the job for Units;
- *lack of consensus on needs*—
  professionals, especially in different disciplines, disagree violently about what needs count and which of these deserve priority.

As indicated earlier, inappropriate attempts to set up Units according to care-groups have been common. Sometimes Units can be designed to align with specific District programme areas, e.g. services for the mentally ill or mentally handicapped. However, this is normally not so across the board. The commonest Units, those providing general hospital or community services, cover a variety of programme areas. *Even when alignment apparently occurs, different work, organisation and approaches are required in these two dimensions of the matrix.* The vertical dimensions in Fig. 5.1 are internal to the NHS, while the horizontal dimension involves other Agencies where patients receive different forms of assistance for their needs.

To achieve progress in the three dimensions simultaneously is no easy task. Work at National and Regional levels is essential to aid the DGM develop the necessary financial and planning guidelines in each dimension.

The DGM is reliant on work in District programme areas to produce concrete proposals which are oriented to basic health-care needs, rather than to administrative or professional convenience, or Unit ambitions. He is equally dependent on the UGMs to work out the practical details and costs (not measured only in finance!) of any proposals, and manage implementation once these are agreed. He is also concerned to ensure that resources are being systematically provided and used to the best effect by UGMs, and for this depends on District HQ functional staff (finance, personnel, information services, estates). The DGM leans heavily on the Directors in planning and finance to ensure that efforts in the three dimensions are coordinated, realistic and meet higher-level requirements.

GENERAL MANAGERS & FINANCE

Prior to general management, the only person who could authorize expenditure in many Districts was the District Treasurer! The benefits of such an arrangement, given the absence of proper controls and information, should not be forgotten.

However the disadvantages are serious. The old arrangement reflected a serious abdication of management by administrators and health professionals alike.

Key Points to Remember

- The finance department is primarily there to support, rather than to implement.
- Finance staff can advise authoritatively on the use of *money* but not on the use of *resources* in general.
- All *expenditure* decisions should be made by staff responsible for the *resource* with finance staff acting in a monitoring role.

Box 5.2

In Conclusion

In considering how to get effective general management at District level, three main points may be emphasized:

➡ In order to maintain the proper L-5 perspective, the DGM must delegate all the detailed work of specific programme construction and implementation to UGMs and District Heads working at L-4.

➡ Direct contact by the DGM with a considerable variety of specialist staff is essential; and distinct types of District HQ and cross-District teams and meetings must be set up.

➡ Achievement depends on integrated progress in relation to health-care needs, resource provision, and operational activities, and demands appropriate organisation of each dimension of this matrix.

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THE DGM AND THE HEALTH AUTHORITY

Management work and governance are different things, and the duties of the District General Manager and those of the District Health Authority should be recognized as complementary. All structures and processes should reflect this; and the way the Table below is constructed seeks to bring out this relationship. For more details, see references [7,16,22].

The DHA should	The DGM should
•identify and proclaim common values and ideals, and ensure basic standards are not violated;	•identify with the given values and develop a culture corresponding to them in the District;
•pursue the mission of the NHS by appointing and appraising the GM, and blocking overspending;	•mobilize resources and develop all necessary organisation to pursue the mission comprehensively;
•set and check main priorities, and adhere to higher level governance, taking into account community and staff views;	•help members explore priorities and value preferences, and see that these are embodied in plans and adopted in practice;
•help in the development of feasible directions for services, sanction service strategies and review progress;	•develop options for members to consider, and submit service strategies in detail in the light of their preferences;
•support (formally or in informal settings) specific action by executives.	•see that all necessary action is taken, and keep in touch with achievement and cost.

The DHA should NOT	*The DGM should NOT*
•avoid making judgements about when conditions are scandalous, and refuse to act or accept responsibility;	*•fail to recognize the centrality of values in society, and refuse to regard the values of the DHA as relevant;*
•attempt line-managerial review of GMs, or deliberately permit overspending;	*•ignore aspects of the mission expediently, or passively await resources;*
•ignore Ministerial decisions on political matters;	*•regard policies and priorities as something that emerges from 'sensible' action;*
•either try to develop detailed strategies, or abdicate thinking on all strategic issues entirely to the DGM;	*•generate only one 'best' option on a take-it-or-leave-it basis, or swamp members in paperwork with very many or no options;*
•set any detailed operational priorities or tasks for the DGM or his subordinates.	*•withhold information on any aspect of operations if requested by a member.*

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Chapter 6

GENERAL MANAGEMENT IN THE UNIT

Problems

The whole thrust of general management reaches its apogee in the Units because this is where all actual health services have to be delivered in an integrated way. All major initiatives—improved quality of care, cost-improvements, more effective outcomes, better use of information—depend in the end on Unit management (but see Box 6.1).

TO BE ASSUMED
Unit problems are often due to an unsatisfactory Unit definition (as noted in Ch. 3). However, in this Chapter it is assumed that Units have been set up as viable entities, typically at L-4.

Box 6.1

Here is where unrelenting demand combines with scarcity of resources to produce a potentially explosive mixture. When there is significant inability by Unit management to manage workload or control demand, persistent overspending develops and drastic cuts in services are likely. Pressures on middle managers intensify. Tensions escalate amongst health professional staff, between Units, and between Region and District.

At a certain point, irrespective of the performance figures and the fact that patients are being treated, the disorganisation, disruption and demoralization in the Unit marks breakdown in the management process.

From our workshops and field contacts, it appears that organisation, if not completely broken down, is confused and ineffective in many Units (cf. Fig. 6.1). Managers complain about lack of access to the UGM, uncertainty persists about the new sub-unit roles, disputes about budgetary and other responsibilities are rife, the medical consultants are either uninvolved or feel bulldozed into inappropriate arrangements, functional management (especially in nursing) is seriously inadequate, service development takes second place to endless discussions about resources, and the focus on the needs of patients is weak.

Analysing these problems reveals a number of key questions for all Units. Is a Top Management Team required? If so, should its composition parallel that of the

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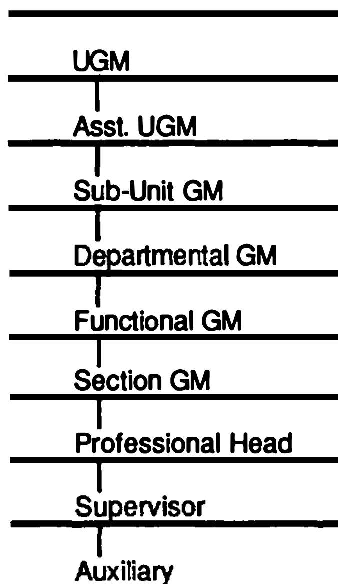

Figure 6.1: Schema of an over-loaded hierarchy of general management.

In some Units, a new hierarchy that boggles the imagination has emerged.

This hierarchy may accord with pay and gradings, but it does not reflect management. Only by clarifying the expected levels of work and assigned authority can staff operate effectively.

Remember: there is only room for *three levels of line-management* in a typical Unit (including the UGM).

In the figure, all managers are called general managers–GMs–in accord with the fashion. Although the title 'general manager' is misleading below L-4, this is insignificant compared to the overall muddle.

District 'Board'? How are medical consultants to be formally involved? Is a Director of Nursing Services required? What kind and calibre of support staff are required by UGMs? How are the various functions to be managed? And how is functional management to be subordinated to general management? How is the Unit to be subdivided? How is a focus on patients to be maintained?

The problems and questions above will be addressed in this Chapter. However, first, what managing means in general for the UGM will be summarized using the same framework as for the RGM and DGM.

Managing as the UGM

The work of the UGM stems from the requirements of managing at L-4. These tasks are epitomized in the overall responsibility *to provide a given range of services comprehensively within a given social territory*. In pursuing this responsibility and in balancing the many services within his Unit, a UGM is faced with a variety of management tasks including:

1: Determining responsibilities
This involves identifying the full range of tasks and duties to be performed within the Unit, and developing an appropriate Unit infrastructure in which roles, responsibilities and authority are precisely specified.

2: Getting action
This involves regular dialogue with the DGM and his staff officers so that the UGM fully appreciates his ranges of services and terms of reference, and can test out innovative proposals; together with regular dialogue with the L-3 managers, both so that they know what is broadly expected of them, and so the UGM can develop an appropriate policy response to any creeping developments or imbalances in operation.

3: Dealing with change
In addition to introducing change of his own and maintaining stability in general, this involves thoroughly reforming operational activity as prescribed by higher levels whatever the UGM's own view of its priority may be; developing a programmed response to DGM initiatives; and ensuring any changes introduced are maintained. Some contact with L-2 professional staff and first line-managers is implicit here.

4: Providing functions
This involves providing general management as prescribed; and managing and liaising with functional heads appointed or assigned to the Unit to ensure that, within it, situations calling for the provision of specialized systems (e.g. information) are being dealt with, that specialist assessment functions (e.g. medicine) are being systematically delivered, and that specialist action functions (e.g. physiotherapy) are being comprehensively developed.

5: Pursuing achievement
This involves simultaneously developing plans oriented to patient-needs as the situation demands, systematically procuring actual resources of all sorts for all within the Unit, comprehensively providing operational activities, and reviewing results.

6: Establishing leadership
This involves systematically providing Unit leadership in relation to any issue, while accepting and extending the DGM's leadership and organisational culture.

7: Participating in the mission
This involves developing an ethos of service and commitment which promotes the continued and active participation of all Unit staff.

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Top Management of the Unit

The appointment of UGMs with L-4 responsibilities as described above is a crucial step in providing firm management control within Districts. In comparable commercial undertakings, only one L-4 post would be necessary and desirable. However, our findings suggest that the complexity of health services demands the existence of a small Top Management Team headed by the UGM, but containing other L-4 members as well. Unlike other organisations, health services have a range of highly specialized professional to manage, including large numbers of quasi-autonomous individuals (i.e. medical consultants) working at L-3 or sometimes higher. The larger and more complex the Unit, the more will such an L-4 team be needed. (The team will be supplemented by L-3 staff as well, but their presence is not so problematic.)

The presence of other L-4 staff in the Unit does not appear to inhibit the UGM acting as a clear leader.* The UGM is authorized to decide on the form of the top management arrangements, to control agendas and chair meetings, to decide detailed roles and responsibilities of other L-4 staff, to decide the main priorities and procedures, and to make the definitive judgements on matters carrying high uncertainty or risk. Although the UGM should still aim to gain consensus on most major decisions, unilateral decision may be called for occasionally.

> **WHO IS MAIN LINE-MANAGER OF L-4 TEAM MEMBERS?**
>
> Having more than one L-4 manager in the Unit, unthinkable in most commercial firms, seems essential and workable within the NHS. But it brings an issue about main line-management to the fore. Following the principles presented in Ch. 2, it seems that the UGM cannot be the full line-manager of other staff operating at the same work level.
>
> In consequence, it is likely that for certain matters—mainly to do with career progression, appraisal or discipline—the DGM might become involved. This is an area of uncertainty and we are watching NHS developments with interest.
>
> *Box 6.2*

Team Composition: In considering which appointed officers might be needed for an L-4 Unit Management Team,** the disciplinary background of the UGM appears relevant (more so than at District-level). Note that, as at District, all-purpose assistants or deputies are generally inadvisable.

Nursing: Given that most Units employ many hundreds of nursing staff, there will usually be a strong case for an L-4 DNS [8]. However this may be less necessary if the UGM is a former nurse, or if nursing required in the Unit is less specialized.

Medicine: Some additional medical input with an L-4 perspective is essential, or at least an advantage, if the UGM is not a former consultant. (However involving consultants in Unit policy-making appears to have become more difficult...see below.)

Planning: If the UGM is not a former administrator, then, depending on local factors, an L-4 administrator to plan and handle other administrative functions may be appropriate. In the absence of such a post, an L-3 planner is invariably required.

Finance: Many Units now have a finance officer operating at L-3, and this seems essential. It is possible that in certain of the Jumbo Units (see below), an L-4 Unit Finance Director with L-3 management accountant subordinates might be appropriate.

Personnel: Many Units will need their own personnel manager at L-3, but rarely higher unless the role includes other functions.

Information: As computerization extends, the need for an L-3 specialist increases.

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* It may be that in the most effective Unit Teams, especially those within general hospital Units, such leadership reflects the L-5 potential of the UGM. Many, after all, will move on to become DGMs. In this regard, see the comments on General Hospital Units on p. 43.

** In line with the comments in Box 5.1 (p.34), the label 'board' is also inappropriate at Unit level.

Works: Most Units require an L-3 works officer, but certain Units might require or benefit from an L-4 post.

Once the L-4 management posts in the Unit have been identified, responsibility for the main Unit development and control tasks can be divided up. The medical consultants should be directly managed by the UGM (but not main line-managed: see Ch.7). Other L-3 staff must either be line-managed by the UGM or assigned to other officers ***unequivocally in L-4 posts.*** For example, as well as the nursing services, a DNS might manage staff in hotel services or paramedical services, liaising as needed with any existing District Head or Coordinator. (Such arrangements must involve active work, and not remain a paper exercise as was common in the pre-Griffiths era.) Responsibility for progressing the various L-4 development projects and programmes within the Unit can also be divided up amongst the available L-4 officers.

MEDICAL CONSULTANTS AND THE UNIT MANAGEMENT TEAM

Prior to Griffiths, the Unit Medical Representative role was a powerful and practicable method for ensuring the involvement of medical consultants. In so far as medical consultants have distanced themselves from general management, which appears to be the situation in many Units, such a role now functions with difficulty. For example, as resource scarcity increases, competitiveness amongst consultants makes representation more problematic.

Including an ineffective person in the management team weakens its executive drive. If the reality is a power battle amongst consultants or between consultants and the UGM (or if pressure grows for several consultant representatives on the UMT), then it may be preferable for the UGM to dispense with the idea of a single medical representative. Instead, the UGM could meet with a small 'cabinet' of consultants elected from the Unit medical committee to consult on policies and developments without the pressure of responsibility for executive decision.

In some Units, medical consultants have been appointed as part-time Assistant General Managers, and this less ambiguous arrangement can work well.

Box 6.3

General Hospital Units: Now that the National focus is shifting to hospital services for acute physical illnesses, to consultant involvement in resource management, and to greater control of medical services in terms of waiting time, effectiveness and so on, it may become more difficult to assume that such Units, even those with relatively small budgets of £20M, can be run as L-4 entities. With over 50 consultants, such hospitals comprise 10-20 specialties each of which may be thought of as a 'business area' containing a number of 'businesses' (i.e. individual consultants). Each business now needs to be managed systematically (L-3) in a way not previously expected, and each business area requires proper development (L-4). Given that developments are many and increasing, if the whole is to have shape and coherence, then ongoing L-5 input is essential. In some cases, this will be provided by the UGM. However, in many, it might depend on some greater ongoing input from the DGM than currently imagined necessary. It may even be necessary to split the Unit into two or more parts headed by UGMs or their equivalent, as suggested below for L-5 Jumbo Units.

Jumbo Units (L-4): Top management in Units which have budgets of £30M or more, but are still to be run at L-4, may be structured along different principles. The UGM may be able to head up several internal L-4 divisions each with a different Top Management Team. For example, a Unit which consists of Community, Mental Handicap and Mental Illness Services might operate with an L-4 Specialist in Community Medicine (SCM) in the Community part, an L-4 psychologist in the Mental Handicap part, and an L-4 DNS in the Mental Illness part. The UGM would have the same team of staff officers (finance, personnel &c) for each part, but would otherwise run a separate top management team in each division. If, however, finance or posts

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were regularly moved during the year between the divisions, then the arrangement would break down, because the L-4 work in each division would be undermined. The various L-4 staff members would then insist on being on a single Unit Team (however unwieldy such a Team might be), in order to look comprehensively at the situation and participate in the big decisions. Pressures might then develop for ongoing L-5 input.

Jumbo Units (L-5): Top management in Units with budgets of £40M or more must operate at L-5. The first necessity is to subdivide the Unit into effective L-4 parts. The GM at the top might either be the DGM or a UGM. Top management can follow certain of the principles indicated for District management in Ch. 5. In a large general hospital, the internal L-4 divisions might be set up in relation to different medical services. This would allow for the possibility of a few medical consultants holding comprehensive budgets as 'Clinical Directors' and acting as L-4 general managers (see Box 7.2, p.54), and a top L-5 medical role would also be possible as well. Other ways of dividing the Unit would also exist. Each divisional general manager would require support staff at L-3, and possibly also at L-4, as in conventional Units (see Box 3.5, p.25).*

Stronger Staff Support: To help the Unit (or any L-4 division of a Jumbo Unit) function as a cohesive integrated entity, *sufficient effective staff officer assistance at L-3 is absolutely necessary*. Some of these roles have already been mentioned. Examples include:

planning manager, personnel manager, information services manager, finance officer, management development officer, performance review officer, assistant general manager (but note comments on p.42).

Units simply will not operate effectively without a proper complement of these L-3 staff roles—even the smallest Unit needs at least one or two. In line with the definition in Ch. 2, these officers assist in the production of Unit policies and plans, and assist with or coordinate their implementation when they are agreed. They participate in the dialogue with consultants and with L-3 managers, and also mediate and help implement demands on the UGM from District-level. In most cases they are main line-managers of staff in their own service, but usually with only a few subordinates. Occasionally a staff officer may be used to line-manage a small ancillary service such as portering. However severe tensions emerge if such staff are expected to handle a major operational responsibility e.g. for a hospital, or for nursing.

> **Capability is precious!** The UGM should identify any staff of L-4 ability in the Unit and invite or encourage them to tackle major development tasks on his behalf. For example some paramedical managers or SCMs or staff officers will have (or develop) this capability. Special appointments or role changes are not usually needed.
>
> *Box 6.4*

The Basic Matrix at Unit Level

Achievement in the Unit depends on organising according to each dimension of the basic matrix that we identified at District level (Fig 5.1, p.37). It is our experience that UGMs are largely unaware that they need to organise in this way, and, in particular, have only a hazy conception of organising with a direct concern for patients. For example, most Unit strategies (as prepared for Region) are resource-oriented—indicating which facilities will open or close and which functions or posts are to be enhanced—but saying little or nothing about precisely what health-care needs will be met and precisely what activities will actually be carried out.

At Unit level it must be realized that, as at District, there are these three different dimensions of *operational activities*, *resource provision* and *planning for health-care*

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* The Guy's Hospital model appears to accord broadly with the ideas in this paragraph.

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needs to be considered when pursuing and assessing achievement. In Fig. 6.2, the first two dimensions are displayed vertically, and the third horizontally.

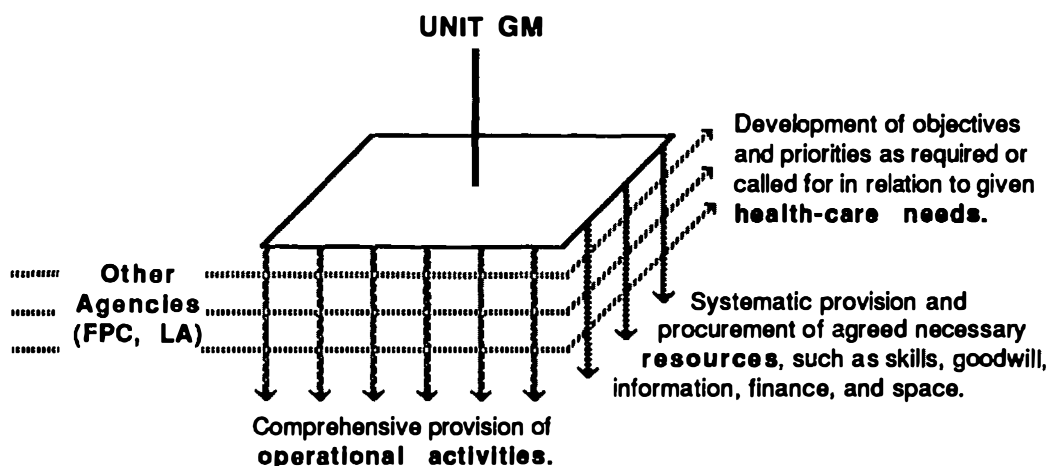
As at District, the *operational activity* dimension includes the various methods whereby health care needs are actually met. Accountability relations here allow a closely specified allocation and monitoring of work and people, and hence the tightest possible grip on costs.

The *resource procurement and provision* dimension is also means-oriented, being about support for both operations and planning for needs. Even more than at District, resource must be viewed concretely, and not solely identified with finance: it includes personalities, organisation, experience, skills, space, equipment, materials, information, staff goodwill, community support, and so on. As was noted earlier, resources impose their own logic on what can be done. In the Unit, resources must be systematically dealt with so that planning in the needs dimension is possible, and so that service activities can be developed and delivered in an orderly way.

The *health-care needs* dimension focuses on *ends*. The programme areas and their objectives within this dimension derive from the mission of the NHS, and therefore have the most direct relationship to patients (actual or potential). As at District-level, this dimension not only cuts across the Unit's operating and support structures, but also across other Units and agencies like FPCs and LA housing and social services. In other words, some specific care-group organisation is essential in Units, because no group of patients or set of actual patient needs is ever the sole responsibility of just one profession, or is handled in only one site, or even usually by only one agency.

Figure 6.2: The Basic Matrix at Unit-level

Pursuit of achievement by the UGM demands a distinct focus on each of the three dimensions in the matrix. Note that no function is completely aligned with just one dimension; senior staff in the Unit are inevitably drawn into each of the dimensions. Note that each dimension of the matrix is itself a matrix.



These three dimensions overlay the same reality, so all L-4 and L-3 staff potentially contribute to each. Each dimension demands its own full organisation: its own roles and responsibilities, its own policies and procedures, its own information and budgets.

Each dimension of the matrix itself has matrices within it. For example, patients may be classified according to their expressed needs or problems, and according to their diagnostic condition. Analysing need in just one of these (sub-)dimensions will

lead to an inadequate appreciation of need, and hence gaps in provision. Similarly, when resources are reduced to the single dimension of finance, things invariably go wrong, and the only imaginable remedy for problems is to throw money at them.

However, the most important matrix within the matrix, for the present purposes, is to be found within the operational dimension. Here, the Unit must be systematically subdivided in two ways as follows:

➤Subdivision must ensure that activities in all *specialisms* are controlled. Here *functional line-managers* are called for.
e.g. divisional nursing manager, works officer, principal pharmacist, catering manager, support services manager, head occupational therapist, superintendent physiotherapist, medical consultant.

➤Subdivision must also ensure that multi-disciplinary operations in *all sites, sectors and departments* are controlled. Here *operations coordinators* are necessary.
e.g. hospital manager, sub-unit manager, clinical services manager, out-patient department manager, sector manager, some assistant general managers.

These operational subdivisions will now be examined in turn, before once again the focus returns to the needs of patients.

Stronger Functional Management

The extreme reaction against the rigid disciplinary compartmentalization that used to characterize the NHS, combined with over-enthusiastic advocacy of so-called 'strong' management, has led to the notion of pushing general management the whole way down the organisation to areas where it simply does not belong. *Work from L-1 to L-3 is inherently 'specialist' and not 'general'.* In order to ensure that such work is performed effectively and efficiently, *strong L-3 functional management is absolutely essential.* This means *main line-management* as defined in Ch. 2.

Responsibilities: From research in a number of disciplines over the years, it has been possible to develop a general list of L-3 line-management responsibilities:

•staffing and workload management of a given service or service division (including setting standards and policies, reshaping roles, assigning tasks, altering systems, maintaining services in the face of disruption)

•systematic development of professional or technical expertise, updating methods, and introducing 'good practices' at lower levels within the existing service

•planning and managing overall expenditure on supplies, equipment, and other workload-related items against a given budget (and aiding in the management of the establishment budget)

•regular monitoring of actual activity, output and quality, including organising the collection and analysis of necessary information to run the service

•selection (in part), induction, ongoing appraisal, development, and de-selection of L-2 subordinate staff, and overview of all L-1 staff (including maintenance of morale within the whole service division)

•introduction and consolidation of all changes required by higher levels, whilst maintaining ongoing operation

•negotiation on interface issues with other L-3 staff of the same or other disciplines, including medical consultants, both within and without the Unit.

In the case of managers who are health professionals, some direct clinical work may also be desired and desirable. However opportunities for clinical work will be more or less limited depending on the professional group and the circumstances. For example, a medical consultant may do a great deal, while a nurse manager coordinating the running of a hospital as well will do virtually none.

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Size: Just as a Unit had to be sufficiently large to merit L-4 operation, and not too large to be unmanageable, so an adequate size of the L-3 service (or service division) is crucial in ensuring that L-3 management can be effective.

> **If an L-3 service division is too large,** then the system will spiral out of control with recurrent breakdowns, crises, work-overload, and staff demoralization. The manager may be inclined or encouraged to perform L-4 work, and conflict with higher management will be likely.
>
> **If an L-3 service division is too small,** then the grading and available salary may not attract a manager of sufficient calibre, and resources for the needed L-2 support staff and secretarial assistance will not be made available. Also small divisions will not be self-contained, and meetings will start proliferating, leading to delays in decision and action.

The appropriate size of an L-3 division will vary from function to function and from District to District. An appropriate number of (non-medical) divisions, and hence L-3 main line-managers, is probably not less than 12-15 in the typical Unit. (A more detailed analysis of factors to consider when dividing for this purpose has been provided in relation to nursing [8].) The following sample list indicates the extent of necessary variation at L-3 in a typical Unit:

Many L-3 line-managers in one function	eg. medicine
A few L-3 line-managers for one function	eg. nursing
One L-3 line-manager for one function	eg. pharmacy, patient administration
A few functions sharing one L-3 line-manager	eg. portering + security + transport
One L-3 line-manager shared with other Units	eg. speech therapy, catering

Stronger Operational Coordination

Prior to Griffiths it was common for departments or sectors to lack leadership, or at best to be run by a team coordinated by an administrator of varying and often insufficient seniority. The move to 'sub-unit managers' who manage part of a Unit such as a defined sector, department(s), or small hospital is therefore a positive development.

However, it is seriously misleading for these individuals to be labelled as general managers or to be considered as the 'boss' (i.e. main line-manager) of all staff working within the sub-Unit division. For a start, such sub-unit managers never act as strong managers of consultants. Second, they will fail in attempts to introduce changes which are objected to by L-3 line-managers in particular functions because they do not understand the implications of specialized working practices well enough. Finally, sub-unit managers cannot zoom into the details of workload, staff deployment and professional or technical procedures in most disciplines to alter the professional system, reshape roles, set new policies, specify different quality standards, or train staff. *If no-one else is providing this sort of management, then the sub-Unit is, in actuality, out of control.*

WHERE SUB-UNIT MANAGEMENT GOES WRONG

- Sub-Units too large (or rarely: too small)
- Sub-Units conceptually incoherent
- Manager not linked with line-managers
- Level of responsibility not clear
- Manager not given necessary dialogue and contact with UGM or other L-4 manager
- Manager not given any support facilities

In many situations, most staff in the sub-Unit are nurses, and the sub-unit manager appointed—though applicants from any discipline were invited—turned out (as if by pure chance) to be a nurse!

Such arrangements are phoney. Nursing always needs its own L-3 main line-manager(s); and so do other disciplines. From these managers and amongst the medical consultants, someone should be suitable and willing to carry the additional responsibilities of a sub-Unit manager. (Of course, this will often be a nurse.)

Box 6.5

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When sub-unit managers are forced into an ambiguous line-managerial role and given the title 'general manager', they may find themselves unsure as to whether they are expected to provide an L-3 output which, as noted above, is always in part beyond their specialist knowledge; or an L-4 output which, like many UMTs pre-Griffiths, they are not adequately legitimated or staffed up to provide. When finance is short, such sub-unit managers have only a crude approach to saving money: gross reduction in services or service quality. This is locally demoralizing, and on the larger scale damages the reputation of the NHS.

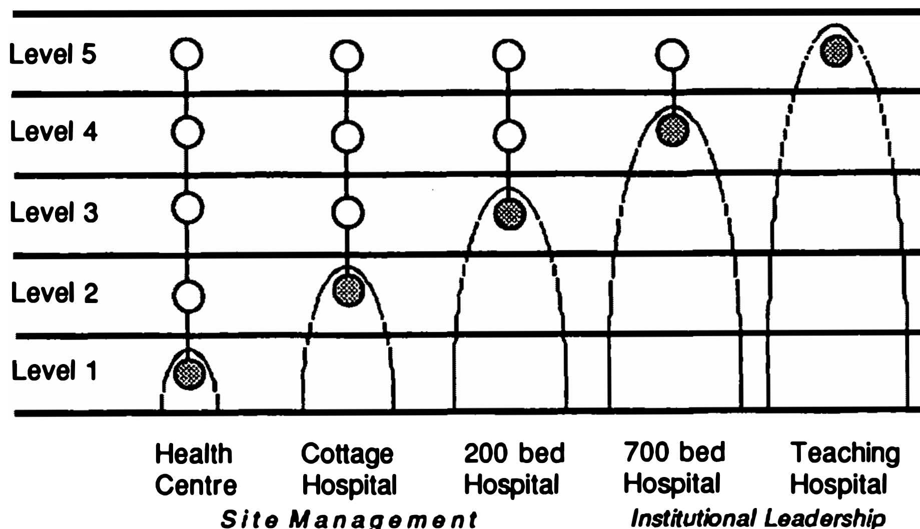
The requisite responsibility and authority (and often the unspoken reality) of these posts is that of L-3 *operations coordinators*. Typically, the coordinator of a facility is a line-manager of certain staff within the facility. (It would not be desirable for one of the UGM's staff assistants to have the job.) The individual assigned the role is one who is prepared to take on responsibility for:

- •managing cross-disciplinary change processes,
- •communicating across professional groups,
- •liaising with other parts of the Unit or District,
- •resolving internal problems and difficulties
- •mediating conflicts between disciplines
- •representing views to higher management,
- •helping implement Unit priorities,
- •collecting and coordinating information,
- •coordinating bids for more resources,
- •working out costs and plans for given developments with those involved
- •monitoring and evaluating progress on plans.

These are important tasks indeed, but they are not general management and they do not require full line-managerial authority over all staff. Nor are they a substitute for fulfilment of line-management tasks noted earlier. (The above duties are more briefly summarized in Box 6.6.)

Operations coordinators are commonly seen in four forms: site, departmental, sector and ward-group managers. However such labels by themselves may be extremely misleading. Site management will be considered first (Figure 6.3).

Figure 6.3:
Site Management & Institutional Leadership: The Alternatives
[In the larger institutions, one or more L-3 site services managers will be needed—see text.]



Every site at all times should have someone appointed as its recognizable leader. Figure 6.3 shows typical levels of work called for according to the size or type of site involved. No less than five radically different jobs can be identified. In each case, except the last, the leader should be linked to an external manager at the next higher work level so that appropriate higher level responses to the needs of the site can be made. In relation to operations coordination, it may seem more appropriate to regard leaders on L-4 and L-5 sites as 'institutional heads' rather than as 'site managers' because they keep away from managing the daily crises in routine operation and other matters typically designated 'site problems'.

OPERATIONS COORDINATORS: PRINCIPAL RESPONSIBILITIES

- Coordinating L-3 and L-2 staff across disciplines
- Ensuring that persistent and urgent problems are dealt with
- Checking that L-3 systems are developed and mesh satisfactorily
- Monitoring finances and overall throughput
- Handling boundary issues of the sub-Unit

Box 6.6

Turning now to department and sector managers, analysis reveals that the level of work of managers of multi-disciplinary departments or sectors will usually turn out to be either L-2 or L-3, and occasionally L-4. Sometimes operational coordination will be needed at two distinct levels. For example in a community Unit, a few L-3 sectors are usually required with each divided into L-2 localities. As previously reported [8], the role for community nursing managers set out in the Cumberlege Report [23] confused these levels of responsibility. Out-patient departments call for designated supervisors at L-2, as well as a departmental manager at L-3. Large departments, like radiology and pathology in a teaching hospital, require L-3 and L-4 management.

Wards typically form natural operational groupings which demand coordination of staff in various disciplines (medicine, nursing, paramedical, catering &c) so that the patient workload and associated costs can be effectively controlled and quality of care can be maintained. Here, the natural coordinator is usually either an L-3 nurse manager or one of the medical consultant working on the wards.

In all cases, coordinators need to set up regular team meetings comprising the relevant L-3 managers, at times supported by the Unit accountant or planner, so that work can be properly monitored, costs controlled, developments planned for in detail and issues handled decisively.

Examples of L-3 Operational Subdivisions

In a *Mental Illness Unit*, six community sectors existed. In examining the work to be done, it was clear that each was too small to be run at L-3; but putting the six sectors together formed an entity too large to be run at L-3. A new arrangement to reconstitute three sectors, each viable at L-3, was introduced. This led to a more satisfactory involvement of consultants and functional heads, and subsequently the various L-2 professionals could be effectively reorganised.

In a *General Hospital Unit*, the L-3 multidisciplinary operational subdivisions needed to be designed from scratch. The pattern adopted on a trial basis was: radiology, pathology, general outpatients, accident and emergency, medical ward services, general surgical ward services, special surgical ward services, orthopaedic ward services, maternity and paediatric ward and outpatient services, and theatres.

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Sharper Focus on the Patient

Better coordination of operations and stronger functional line-management alone are insufficient without some specific organisational focus on the patient.

Some care-group organisation is essential because, as noted earlier, no patient or set of patient problems or health-care need is ever the sole responsibility of just one profession, or is handled in only one site, or even by only one agency. For example, out-patient department care of a patient following discharge is a common, but not the sole approach to patient follow-up. Clearly the out-patient department manager cannot be expected to plan for the full variety of ways in which patients may need to be followed up. Similarly, however important medical consultant input may be, nursing care, chiropody care, administrative handling, and efforts by other disciplines may all be essential if a patient with foot ulcers is to be properly treated.

What is required within a Unit is multi-disciplinary coordinators or sometimes small teams operating in selected areas. An integrated response to a given range of patient-needs should ideally be provided, but no L-4 Unit is ever sufficiently comprehensive to enable the permanent authoritative handling of this. The needs to be considered require to be given or pre-defined by District or (more usually) higher levels, and Unit arrangements should link with District and Regional arrangements. The resulting programme structure in the Unit needs to work both at L-3 (system development and work-load control) and at L-4 (programme development and budgetary control).

Care-group coordinators working on programme issues or areas at one of these two levels would be expected to obtain information, develop proposals, help implement plans, and monitor and evaluate results. In doing this work, they must be assigned the authority to get cooperation from line-managers within the Unit and others outside it in neighbouring Units or Agencies.

To give an idea of the distinction of programme from operational and support structures, an example from a Mental Illness Unit might be helpful. Here the normal range of health professions were employed, and the service was divided for operational coordination into two general community divisions, a community psychogeriatric division, and two hospital site divisions. Most consultants worked in more than one division while nursing arrangements closely paralleled these divisions. The main programme areas crossing all divisions were dementias, functional psychoses, substance abuse and alcoholism, neuroses and family disorders, child and adolescent psychiatry, and metabolic and other disorders. As noted above, in this Unit it proved impossible to develop these areas comprehensively—instead problems, opportunities and issues had to be handled as they arose or as demanded by higher levels.

OBJECTIONS

UGMs have objected to our description of sub-unit managers and coordination on a number of grounds:

#1: *'There are too many L-3 functional managers for me to line-manage myself.'* If this is so, then a DNS or L-4 UA may be required. Inserting a tier of supposed line-management is disastrous; while leaving the functional managers floating weakens quality, standards, workload management and cost-control.

#2: *'Coordination is weak, old-fashioned, and not part of the new dynamism expected of managers.'* Coordination is as strong as the UGM wishes to make it, and can be as strong and dynamic as needed. Sub-unit managers do not need line-managerial powers because they are incapable of performing the work implied by these.

#3: *'Coordination is just too complicated.'* Coordination is not complicated: it is a natural, universally applied approach, easily understood and implemented by NHS staff. The matrix principle, which underlies it, is a way of simplifying the complexity inherent in all achievement.

Box 6.7

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A Structural Check List for Unit General Managers

In conclusion, the main themes of this Chapter may be summarized in terms of the following check-list for UGMs which assumes an L-4 Unit:

- ➡ Is it clear that the Unit is to be run at L-4, and not L-3 or L-5?
- ➡ Has the level of work in every single post been explicitly determined?
- ➡ Is everybody clear who their main line-manager is?
- ➡ Are all main line-managerial relations set up between posts precisely one level apart?
- ➡ Are specialist L-3 managers designated for each function?
- ➡ Are the resultant L-3 divisions viable—not too large or too small?
- ➡ Do all L-3 managers, including medical consultants, understand their precise responsibilities?
- ➡ Are any other L-4 posts on the UMT required?
- ➡ Is there adequate dialogue between L-4 managers and each L-3 line-manager and medical consultant?
- ➡ Are the necessary Unit staff officer posts (planning, personnel &c) set up at L-3?
- ➡ Have L-3 line-managers been given appropriate secretarial and staff assistance?
- ➡ Have sub-unit managers in the form of strong operational coordinating roles been set up for control of all sites, departments and sectors?
- ➡ Are there specific realistic arrangements to ensure a direct organisational focus on selected patient-needs?
- ➡ Is the responsibility for actively developing resources of all types accepted and organised for?

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Chapter 7

GENERAL MANAGEMENT & THE HEALTH PROFESSIONS

The Challenge

The most significant challenge posed to general managers concerns working with health professionals and managing their contribution effectively. Health professionals are the staff identified by the public with the NHS. They are the people whom patients feel they need, who control the resources in practice, who are not primarily socialized into the managerial ethic, and whose systematic involvement in management has always been problematic.

Much of what has been said in earlier Chapters is applicable to managing the health professions. Although it is beyond the scope of this Guide to provide a detailed analysis of the organisation of each of them, certain features which relate directly to the introduction of general management must be highlighted.

Doctors, nurses and paramedical professionals will be considered in turn.

General Management and Doctors

General management poses a question unique to medical consultants: Are we to be involved in management or not?

For decades, consultants have seen administrators working alongside, helping them, even being answerable to them. General management is changing this. The new GMs are unequivocally 'above' or 'senior' in some way, a position which is intensely disturbing to many doctors. However GMs themselves are disturbed, because the *macho* approach to management generated, or even demanded, for the first flush of recruitment interviews is unworkable.

The involvement of medical consultants had been developing positively in many places after the 1982 reorganization, but the implementation of general management seems to have brought this to a halt. Consultants are now generally uncertain of their position. In many places disconnexion or open conflict is marked. Some recent NHS management initiatives have attempted to deny the seriousness of this problem. But, once initial enthusiasm has been burnt off, such management drives tend to run into trouble, and the end result may be a situation worsened by failure and discouragement.

How do attitudes differ? The underlying difference between the approach of GMs and consultants is simple: Whatever their personal concerns about the NHS and the way it is funded and managed, GMs feel that in the end they have no option but to buckle under, shut up (or at least leave the Institute of Health Services Management, their professional body, to do the talking), and commit themselves to working within the system as best they can.

AN IMPRESSION

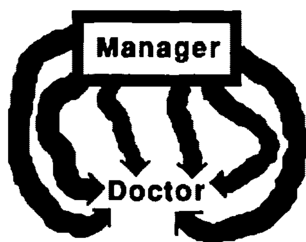
Our impression is that the present NHS changes are irreversible, and that management in the NHS will become tighter and more systematic. This means that if medical consultants do not participate actively, they are liable to be marginalized, or their status will be altered dramatically (e.g. by the introduction of short-term contracts).

Box 7.1

Consultants appear to have an option. Will they accept the changes and identify with the stronger ethos of systematic management? Or will they fight the changes by disinterest, passive opposition or disruption? Whatever the ultimate result, progress depends on both consultants and GMs gaining a better sense of the level of work at which doctors operate, and of how medical work might be appropriately controlled.

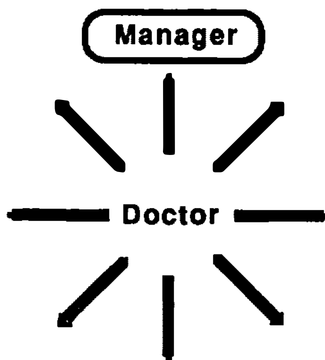
What is the level of work expected of doctors? Junior medical staff are expected to assess and manage cases, but not to develop their own systems of practice i.e. their posts are at L-2. Medical consultant staff are expected to provide a service and to develop their practice systematically i.e. their posts are at L-3 (and so their responsibilities follow the list on p.46). Consultants, individually, are not assigned the right or duty to develop a range of services comprehensively or to introduce new services (as would be appropriate at L-4 or L-5 respectively). Although most consultants work at L-3, their capability varies. A few function, unsatisfactorily, at L-2, and others (especially in teaching hospitals) are capable of work at L-4 or higher. (University teaching and research frequently demand higher capacities.) Higher level work capabilities are also desirable for medical representatives at Unit or District level

What control should the GM have? There are four main images of control. Two of these are pure fantasy. The two remaining are possible, but only one of these seems realistic.



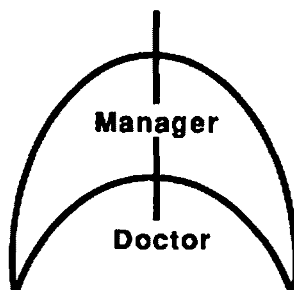
The Totally Managed Doctor
In this fantasy, which ran wild shortly after Griffiths became official, the manager can decide what where when how and why the doctor does anything at all, down to instructing him to blow his nose and with which grade of tissue.

This image was a reaction to the opposite fantasy, which in the pre-Griffiths NHS was perilously close to the reality in many places:



The Totally Autonomous Doctor
The manager here is unable to affect or influence the doctor in any way at all. His only recourse is to throw up his hands in despair, proclaim that doctors are a law unto themselves, and then try to develop plans which can somehow ignore or circumvent doctors completely.

By contrast, the reality, many outsiders to the NHS claim, should be one of strong management. By that they mean:



The Line-Managed Doctor
The manager can set the general policies and standards within which the doctor must work, can assign general responsibilities and specific tasks in line with his judgement of the doctor's abilities and performance, and can zoom into any detail of work being done to check, query, or alter it as he sees fit.

However, medicine simply does not work that way because of clinical autonomy. Clinical autonomy protects the patient and is rooted in the patient's need to trust his doctor. Hence, the remaining possibility is:

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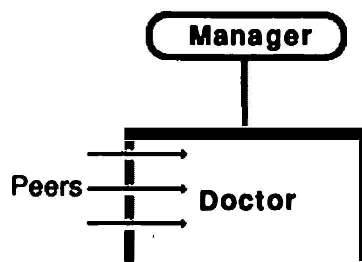

The Partially-Autonomous Doctor
The manager can decide resource constraints (facilities, supporting staff &c), pursue service policies, coordinate agreed developments, and monitor (check, query, discuss, report) out-of-bounds behaviour (e.g.in relation to contract of service, legal or ethical matters, agreed policies). Details of clinical policies and reviews of clinical decisions within the doctor's sphere of discretion are left to the peer group.

This seems the most realistic image.

What does clinical autonomy mean for GMs? Clinical autonomy must, in our view, be distinguished from *practice autonomy*. Clinical autonomy applies to L-2 work: it means, in brief, that the consultant has the final right to decide on the care of the individual whom he is treating, always within given policies, priorities, resource constraints etc. Practice autonomy is the equivalent at L-3. Consultants have a significant degree of practice autonomy, that is to say they can organise their practice in the way they prefer. The exact limits to discretion here are not clear, but are of great importance to GMs and other functional managers. One way in which GMs have attempted to grasp this nettle has been by appointing 'clinical directors' (see Box 7.2), however many problematic issues remain.

CONSULTANTS AS CLINICAL DIRECTORS

One the many new roles to emerge with general managers has been that of 'clinical director'. However, what this role implies is not always clear!

General hospitals can naturally be divided up into clinical sections corresponding to consultant specialities (singly or grouped). It is appropriate, indeed essential, that these sectors or subdivisions of the hospital are strongly managed in the sense of 'operational coordination' (see p.47-49). A doctor might well be the manager of a section, working regularly with other staff at L-3 (e.g. nurse manager, works officer, Unit accountant).

The term 'clinical director' might be better reserved for consultants explicitly assigned L-4 duties (see Box 2.3 and pp. 43-44). Such consultants could be expected to engage in financial analysis and management, and be given support for this. [Note that where there are more than a few clinical directors, L-4 roles for each will probably not be workable.]

Box 7.2

Do GMs have greater control than managers in the past? Not in principle! Ultimate control of resources and the exercise of monitoring and coordinating authority have always been available, but the use of these powers in relation to consultants was lax or even positively discouraged. The issue of whether doctors' contracts should be held by the DHA or RHA is insignificant in comparison to the convention of life-time security, which no GM in the Regions or below can unilaterally alter. Despite the absence of some of the conventional tools of control, DGMs and UGMs should be expected to take the initiative and develop the necessary arrangements for the appropriate control of medical work (to be carried out in large part by consultants themselves). The political situation prevents any National lead, but an enlightened consultant body working closely with an enterprising DGM (and supported by their DHA and the RGM) could achieve a great deal. Because GMs have a greater control over the context of medical work than previously, they can both assist consultants far more than previously and exert greater leverage on less cooperative consultants. As noted on p.43, if more control of medical work is officially expected, then this will have far-reaching implications. In particular, the emergence of L-5 medical roles oriented primarily to clinical work becomes likely.

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Is budgetting the key to controlling doctors? No. Many GMs have taken Griffith's view that doctors are 'natural managers [because] their decisions largely dictate the use of all resources' [1] as a reason to impose responsibilities for extensive budgetary control and financial management on to consultants. The Griffith's view is basically correct, but once again, enthusiasts have taken it too far. Appropriate budgetary management at L-3, where medical consultants work, is limited to operating and workload-related costs which they directly and immediately control. Such work should not to be confused with 'financial management'.

Both our analyses and practical experience show that consultants typically do not want to handle budgets or financial analyses of any complexity. Attempts to turn all consultants into financial managers (in effect at L-4) have failed and will continue to do so. Such misguided efforts feed the alienation of doctors referred to above.

THE AUTHORS' SYMPATHIES

Consultants are victims of the system, and are at the moment its natural scapegoats.

Our fieldwork reveals consultants to be generally neglected, misunderstood, and exploited. Many are bewildered, and feel ignorant and helpless. We note that GMs ignore or refuse to deal with obstacles which block their useful participation.

Two quotes from consultants say it all: 'Reorganisations come and go but nothing changes for us' & 'Tell me, when will the 1974 reorganisation come into effect?'

Box 7.3

What special management arrangements are required? A variety of special arrangements are required for involvement of medical staff at the Centre, Region, District and Unit: medical officers, medical committees, medical representatives on management and planning teams and so on But the main points to emphasize are:

- ➡much more dialogue is needed between UGMs and individual consultants;
- ➡better defined L-5 frameworks are required for general hospitals;
- ➡more multidisciplinary team work at L-3, involving and at times led by medical consultants, is essential.

Does size of District or Unit matter? The involvement of consultants and the requisite arrangements for them will be heavily dependent on the size of District and Unit. In the **typical District** there will be about 50 medical consultants with at most a few capable of working at L-4. In the **mini-Districts**, there will be fewer consultants, and possibly none capable of L-4 work. In the **maxi-Districts** or in Teaching Hospital Units, there may be over 150 consultants with many capable of working at L-4, L-5 and higher. Here is where the role of clinical director is most possible (see Box 7.2). Properly adapting arrangements to the numbers and calibre of consultants is essential and the advocacy of a single model nationwide is likely to be counterproductive.

Concluding Message: *If, on the one hand, GMs respect clinical autonomy and sensitively appreciate the realities of the local situation, and on the other hand, medical consultants recognize the need for systematic management and do not hide the difficulties of their own position, then a mutually satisfactory outcome is definitely possible. But difficult!*

General Management and Nurses

General managers might like to treat the nurses as just another occupational group. But, this would be unrealistic. Nurses make up by far the largest workforce within the NHS, are key health professionals, and make the greatest impact on the patient's sense of being well looked after while ill. In any case, issues that involve nurses do arise in the work of general managers at all levels and must be catered for.

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In this section the need for line-management within nursing will be emphasized. and the need for a nursing officer/adviser to aid the general manager at each tier will be examined. Fuller details are available in [8].

Who should manage nurses? Many GM enthusiasts have all but denied the reality of any specific management in nursing at all. The ward sister (L-2) is then claimed to be another general manager, who just (by chance) happens to be a nurse. Nothing could be more erroneous. Only a nurse can manage a ward, because the essence of running a ward (or a team in the community) is an appreciation of the nursing needs of all patients so that nursing priorities amongst them can be handled and appropriate nursing care ensured. Even where ward leadership is recognized as belonging to nursing, L-3 nurse management above the ward has too often gone unrecognized or been poorly formulated. The work here concerns, among other things the development of nursing systems and procedures, the induction training and appraisal of nurses, and the promotion of proficiency and good practice amongst nurses and ward/team leaders. How someone who is not a nurse can do this defies imagination.* Indeed, the nurse manager probably needs to have specialized further in the relevant sphere of nursing. The use of L-3 nurse managers as sub-Unit managers is not inappropriate—as long as the sub-Units are properly designed, and an arrangement which deprives other disciplines of an L-3 professional input is avoided.

> **WE AGREE, BUT....**
> It is true that nursing organisation in many Districts has been unsatisfactory for many years. However, this is *reason for improving nurse management, not for removing it.*
>
> *Box 7.4*

What do UGMs require for coverage of nursing in the Unit? Nursing management at L-3 is absolutely essential. Here, however, effectiveness depends on appropriately dividing the Unit so that the management task is neither too small nor too large. In the **typical District**, Units are almost invariably too large for nursing within them to be managed as a single L-3 division. Several L-3 divisions are required, and the case for a separate L-4 DNS in most Units is strong.

By definition, neither an L-3 nurse line-manager, nor an L-3 nurse staff officer, can take the load of L-4 work generated in a Unit off the UGM. In the absence of an L-4 DNS, the UGM must himself regularly do all such work in relation to nursing. The duties include:

- detailed overall control of the nursing budget and establishment
- planning, negotiating, costing, implementing and evaluating developments in nursing services
- restructuring nursing services and roles
- managerial control and development of L-3 nursing staff
- appraisal of the work potential of L-2 nursing staff.

> **RALLYING THE TROOPS**
> Management work at L-4, as at all levels, is not mechanical or just a matter of issuing orders. In nursing, its essence involves talking with nurses at L-3 and L-2 *and convincing them by explanation and persuasion* that they can indeed manage within the resources provided.
>
> General managers do not always have the experience and ability to deal directly with nurses in this way.
>
> *Box 7.5*

Altogether, this makes up a substantial job—and to this must be added leadership responsibilities (see Box 7.5). We therefore conclude (as in Ch. 6) that a professional nurse manager at L-4 would be highly beneficial for the large majority of Units.

There are two provisos: first, that all DNSs are indeed capable of working at L-4; and second, that DNSs are willing and able to identify with the ethos of general

* In certain areas where nursing blends with behaviour management, education, and relating helpfully and sensitively (e.g. mental handicap, parts of mental illness services), nursing loses its functional distinctiveness and someone like a psychologist, knowledgeable in the relevant skills and patient needs, can realistically serve as the L-3 line-manager.

management, and accept UGM and DGM leadership. Tolerating underperforming nurse managers (because they had to be there for political reasons) was common in the past, but should no longer be acceptable. Similarly the past tendency to allow nurses to fight endlessly and exclusively for more nurses is also unacceptable.

So much for the typical District. In **mini-Districts**, the whole District is equivalent to a Unit; so a District Nursing Officer at L-4 would be essential, and L-4 DNSs will not be appropriate in the Units. In **maxi-Districts** and **Jumbo Units**, there will be an absolute need for DNSs in each Unit, and indeed probably more than one per Unit.

What do DGMs require for coverage of nursing in the District? Our analysis of functions suggests that nursing, as a specific function, exists up to but not above L-4 (see Ch. 8).* This was why the pre-Griffiths Chief Nursing Officer role stuck at L-4 and depressed the contribution of all subordinate Directors of Nursing. That particular role has now passed away without much mourning or protest. The current position where the DGM is ultimate main line-manager of DNSs (and hence all nurses) is therefore wholly appropriate. However, District policies will frequently have a nursing dimension for which the DGM needs advice; and in larger Districts the DGM may require assistance from a nurse in pursuing or monitoring nursing developments. In addition, there is a flow of material from National and Regional levels that involves nursing directly or indirectly and which must be processed from a District perspective rather than being simply left to each Unit. The DHA, too, will wish to have its own nursing adviser. In smaller Districts, some arrangement with DNSs, and possibly with a representative committee, may suffice as described in Ch. 5. However, in most Districts, there will be a case for appointing a DNO or DNA, full-time or part-time (see Box 7.6). Because the nursing function ceases after L-4, it is positively inappropriate for a DNO/DNA post (invariably at L-4) to be set up as the line-manager of the DNSs.

THE DNA ROLE

In most Districts, there is a case for the appointment of a *District Nursing Adviser* (DNA). The DNA role in such Districts may be combined with that of the DNS or be left free-standing according to the needs of the DGM. It must be recognized that severe tensions in the DNA role are inevitable. If the DNA is also a DNS, then there is the difficulty of combining the role of specialist staff assistant to the DGM with accountability to a UGM and main line-managerial responsibility within a Unit. Even where the DNA is free-standing, there is the difficulty in combining a representative role and accountability to the nursing profession and to the DHA on the one hand, with an officer role and accountability to the DGM on the other.

Box 7.6

What do RGMs require for coverage of nursing in the Region? The RGM does not manage any practicing nurses at all. However, in so far as many national initiatives involve nurses, it is essential for political reasons that there be a nursing voice at Region. The level of work of such an RNO post need not be above L-4 in regard to the provision of nursing advice. If, however, the operation of nursing education must be substantially shaped and structured within the Region (as seems desirable), then an L-5 post is required. The work specifically associated with nursing is typically not full-time and hence it is usually appropriate for the postholder to be given additional responsibilities or multi-disciplinary service development projects.

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* The nursing profession itself needs to operate at higher levels, but this is largely handled outside the NHS, for example in academic or political settings. Nursing is no different in this regard from other functions including medicine. Specialist functions originate in broad social needs outside organisations. They are used by organisations to achieve an integrated end beyond the sphere of the function. So no function wholly controls its destiny within an organisation. Similarly no organisation wholly controls the development of a function. (Note however that nursing education runs from L-2 to L-5).

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In respect of nursing, two further points are relevant. First, the danger exists of the RNO sucking up many matters (like standards and procedures) to Regional level, which are best dealt with by nursing managers within Units, or by specialist nursing associations. This tendency must be resisted. Second, the link between RNOs and DNOs (or DNAs) has become highly problematic since the introduction of general management, because of the great variety of DNO/DNA roles and their loss of direct management control over nurses. In the light of this, DNSs might appropriately be expected to contribute significantly to the Region-District dialogue from a nursing perspective. If the RNO is to be responsible for the overall shaping of nurse education operations, then a strong functional line to DNE's is essential.

The subordinates required to support RNOs in regard to nursing or any other function for which they are responsible will be determined by the level at which an RNO is *actually* working. It would be a waste of talent for an RNO to be automatically assumed to be working at L-4 if capable of more. Similarly, it is seriously unsatisfactory for the RNO to be automatically regarded as working at L-5 if this is not the case. If this happens, initiatives will not progress as expected and provision of L-4 supporting staff, say in quality assurance, will be inappropriate.

What does the NHS Management Board require for coverage of nursing in the whole NHS? Some nursing input is again called for, and it is at present coordinated and provided by the DoH Chief Nursing Officer (CNO). It would seem that this post needs to be pitched at least at L-5 if appropriate contributions to issues of nursing care, nursing education and nursing management are to be made with due appreciation of the political dimension.

***Concluding Message:** Nursing management needs improving, not removing.*

General Management and the Paramedical Professions

If nursing management has too often been downgraded, management of the paramedical professions has been too often cursorily dismissed. The principal professions included here are pharmacy, physiotherapy, occupational therapy, psychology, chiropody, speech therapy, dietetics, and radiography.* Each profession may be small, but their combined staff numbers and budgets are substantial. More importantly, the cumulative significance of these professions for patient care is great. In addition, many within these groups are eager to participate in management and to improve their management skills. Leading professionals are generally aware that their group will only thrive if their management practice is sound. GMs are foolish to ignore any health professional or group who can spread the gospel of systematic management, and might demonstrate to others what can be achieved.

Like all professions, those in the paramedical group continually develop as new methods emerge and old ones become discredited. GMs therefore need strong L-3 specialist line-managers for each group. The problems in organising such roles are similar to those in nursing.

Furthermore, almost all hospital and community developments and rationalizations of services involve paramedical professionals. Unless some L-4 input from the specialist profession is provided, such plans are repeatedly found to be unrealistic. A typical consequence of this is the current shortfall of occupational therapists.

It is particularly important that GMs do not assume that their Principal Pharmacist in the DGH or Occupational Therapy Head in the Mental Illness Unit can automatically

* We are putting to one side organisational issues associated with the important contribution of dentists, medical scientists such as medical physicists and medical biochemists, and medical technicians such as audiologists and laboratory scientific officers.

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perform the necessary L-4 work for the District simply because they have been given a new title. Combined Unit and District Head roles, though popular, are not ideal because they usually embody assumptions that violate level-of-work realities. It is important to recognize that L-4 specialist input need not be provided full-time within each District—certainly not in the smaller Districts. Arrangements can be developed on a part-time or consultative basis using staff with contracts in other Districts.

The main problems which the paramedical professions themselves face have not been dramatically altered by the introduction of general management. Analyses of the main issues have already been published [5,24] or are examined elsewhere in the Guide, especially in Chapter 8. We conclude by reminding the reader that each specialist profession must be considered separately by general managers, and clear answers given to the following questions:

✳What level of work is expected of the District Head?

✳To whom is the District Head accountable?

✳What authority does the District Head have over their staff?

✳How is responsibility divided between District Heads and General Mangers?

✳How is budgetary responsibility assigned?

✳Must the District Head be full-time, or is a part-time post possible?

✳Who is the professional line-manager for each therapist?

✳Are the L-3 divisions (if needed) set up and staffed appropriately?

'PROFESSIONAL' VERSUS 'MANAGERIAL' RESPONSIBILITY
Part of the Solution or Part of the Problem?

As a political device for defusing controversy, the distinction between professional and managerial accountability is first-class. The civil servant who created it deserves promotion.

As an executive tool, the distinction is meaningless or positively pernicious.

All professionals are actively engaged in managerial activities—from L-2 upwards. And all managerial activities performed within a function like nursing or medicine are imbued with professional concerns.

The idea of separating professional and managerial concerns acts as a block to the involvement of clinicians who develop a fantasy that it is possible to perform only professional work, and leave all management work to others. The opposite is the case. Clinicians working in private practice would automatically manage their practice—and they should in the NHS too.

Box 7.7

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Chapter 8

OPERATING THE WHOLE SYSTEM

Central Control and Local Freedom

Emphasis has already been placed on the way in which general management responsibilities, and the structures which inevitably follow, differ so sharply at the various tiers of the NHS. It is necessary now to turn to the ways in which those differences must be bridged.

> **DISTRICT CONTROL... or... UNIT FREEDOM?**
>
> For many DGMs, the problem of delegation to Units lies in the fear (or observation) that UGMs and Unit staff may go their own way and resist or subvert guidance and limitation by District headquarters.
>
> Unit staff, in turn, tend to see District HQ staff as intruding on their sphere of operation, backtracking on promises of delegation, and interfering with their legitimate powers of decision.
>
> The reverse situation also exists in which District staff delegate excessive powers to UGMs, or manifest undue trepidation about working in Units or with Unit staff.
>
> *Box 8.1*

Here consideration will be given to how the whole system may operate in a coherent and integrated way. In this Chapter, the focus will be on the dynamic processes in the National-Region-District-Unit axis. *Conflicts and tensions between tiers of organisation are never wholly resolvable. However, many can be avoided or dramatically reduced: first by understanding precisely which tensions are unavoidable and which can and must be dealt with; and second, by implementing sensible arrangements so as to accommodate these latter legitimate management needs.*

In discussing what is needed for the coherent operation of the NHS, we will work successively through the elements of managing noted in Ch. 2 (pp.16-17). Nothing further will be said about *distinguishing responsibilities* precisely, as this has been the theme throughout. The other elements of managing will be considered in turn: *getting action, dealing with change, providing functions, pursuing achievement, establishing leadership,* and *participating in the mission.* In doing so, we will demonstrate the way that the successful performance of these management processes depends on the integrity and clarity of the structure of responsibilities. In each case, existing misconceptions or errors in current NHS management practice and inherent tensions to be faced by GMs will be noted.

Getting Action

"Whose decision is it anyway?"
Many general managers and others believe that decision-making is a simple one-step process which follows from the responsibility assigned. This is mistaken. Decision and action always involve two levels—explicitly or implicitly.

Getting appropriate action demands setting specific objectives adapted both to *current realities* and to *wider requirements.* So objective-setting always requires *dialogue* and *zooming* between adjacent levels of work. In this process, the focus alternates between proposed context (i.e. criteria or policies) at the higher level, and possible content (i.e. programmes or actions) at the lower level. Dialogue may often occur mentally or implicitly, but it must be buttressed by periodic face-to-face dialogue. *If dialogue is inadequate in quantity or quality, then tensions will escalate and action will be inappropriate or lacking.*

In the NHS, with its seven levels of management, there are *six foci of action* and hence *six sets of dialogues* with GMs involved in the upper four of these as follows:

Below GMs:
Between L-2 and L-1:
the focus should be on **concrete actions**
Between L-3 and L-2:
the focus should be on **concrete assessments**

Involving GMs:
Between L-4 and L-3:
the focus should be on **concrete services***
Between L-5 and L-4:
the focus should be on **ranges of services***
Between L-6 and L-5:
the focus should be on **frameworks for operation**
Between L-7 and L-6:
the focus should be on **basic concepts of health-care and its delivery.**

The need for genuine dialogue** in relation to decision cannot be overemphasized in developing a workable relation between managers in adjacent tiers. Dialogue must occur directly and in person. GMs who conduct their dialogue through biannual meetings and letters written by junior staff cannot expect to see dramatic results.

In the dialogue, the GM at the lower level will be seeking to influence the formation of policy by clarifying the practical realities, needs and desires of his outfit. The GM at the higher level will be seeking to assure himself that he has identified and resolved the key policy issues satisfactorily and that the way forward is understood and achievable. Action depends on the GM in the lower level having sufficient scope for his own objective-setting on the one hand and, on the other hand, genuinely accepting the policy framework set by the superior GM. Furthermore, the latter must accept that implementation will regularly throw up issues which indicate that exceptions or modifications have to be made to existing policies, or that a new policy has to be developed. As well as regular contact, periodic zooming into particular issues to maintain a realistic picture of management at lower levels will be required.

In order to ensure vertical coordination and interlocking of action through the hierarchy, two mechanisms which enhance dialogue and zooming are required: *staff officers* as earlier defined, and *management team meetings* to include two levels of line-management. Each of these will now be examined.

Staff Officers: Around the central dialogue, supplementing it but in no way attempting to substitute for it, are a variety of additional dialogues in which staff officers to the general managers play an important role. It must be appreciated that staff officers appropriately operate one work-level down from the GM being assisted, like the GM's operational subordinates. However, staff officers have a somewhat different orientation to these. Staff officers must accept and identify with the pervasive policies which their bosses are setting, and take cognizance of the even broader frameworks within which their bosses must work. By contrast, line-subordinates must look downward towards the specific actions which their own subordinates must take, and ways of tackling feasibility and acceptability further down the line.

Figure 8.1 shows the overall picture of interlocking dialogue involving GMs and the main staff officers. If all the lines are used to proper purpose, the resulting effect can be very powerful. But it is easy to slip into distorted patters of operation. For example, it is usually far less strenuous for GMs to talk with their HQ assistants than

* The term 'service' here is not restricted to a defined health-care or other service, but refers to any actual concrete socio-technical system e.g. a project involving many people and complex situations, an information system in operation.

** We are not suggesting any specific pattern or contents of actual dialogue or zooming here, nor are we suggesting that nothing should ever happen before talking about it. We assume that managerial styles vary greatly, and that action and communication between all relevant parties are ongoing.

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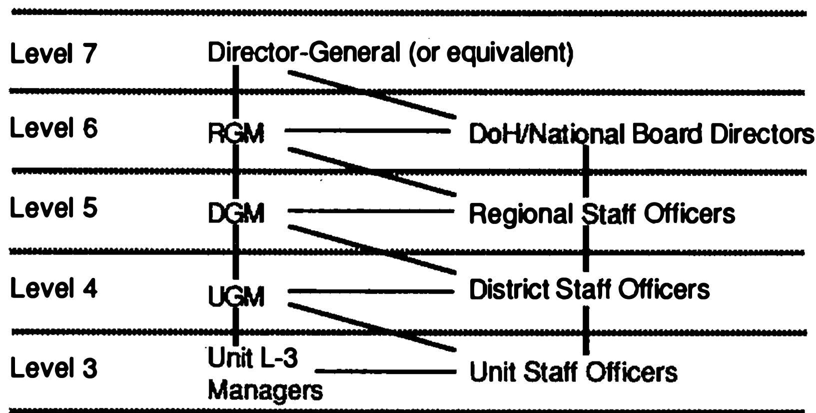
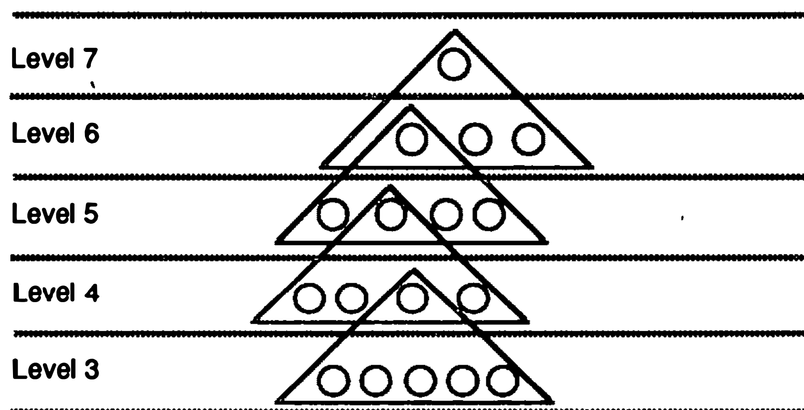
to deal with their operational subordinates. (Because they never see things their bosses way, do they?) This may encourage the GM to withdraw from line-subordinates into a cosy staff world, and allow too much traffic down the staff-officer channel. This situation may be worsened if these HQ assistants avoid the GMs, because they feel more powerful talking to their own staff subordinates, and try to effect action through them. By contrast, occasionally, the valuable staff channels may be underused.

Figure 8.1: Staff officers and dialogues which are the prerequisite for appropriate action. Staff officers also have their own small hierarchies which are not shown. L-3 managers may also need staff officers.



Management Team Meetings: Any one line-manager will always need to dialogue with several or many subordinates simultaneously in a 'management team meeting'. These meetings are necessary for subordinates to develop a shared appreciation of the policy context and constraints, and to minimize the likelihood of spillover effects of action by one subordinate division on to another. Staff officers are often present and use the decisions, agreements and understandings developed in these meetings to legitimate their subsequent instructions to the operational subordinates. Figure 8.2 shows the appropriate interlocking of management team meetings.

Figure 8.2: Management team meetings.
These are sometimes referred to as Executive Teams or Groups. They are essential to ensure that context is understood, that action or programmes result, and that subordinate actions mesh or do not needlessly conflict.



[Note that the above diagram is schematic; the numbers in each team are not meant to be representative; each subordinate may have a team; teams continue down to L-2/L-1.]

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DIALOGUE

When we use the term dialogue, we are not referring to a mechanical or formal procedure of communication, but to a fundamental aspect of human interaction which is characterized by:

✱clarity of role or position *✱explanation* *✱mutuality*

Dialogue therefore allows the possibility of persuasion, and results in a genuine and workable joint understanding. Things start to go wrong:

- when there is no dialogue or contact is too infrequent,
- when there is contact or communication without dialogue
- when one-to-one dialogue is not bolstered by staff officer support and management team meetings.

Box 8.2

Successive General Management Dialogues. Bearing in mind the important mechanisms just described, the overall pattern of dialogues between GMs at the different levels can be overviewed. (Discussion of the National-Regional interface will be left, however, until National arrangements are clearer and political and executive roles within the DoH are more specifically distinguished.)

In the dialogue between the RGM and the DGMs (supported by discussion between Regional staff officers and the DGMs, and between Regional staff officers and District staff officers), the prime aim of the RGM should be to prescribe the context for the Districts in terms of a desired framework for operation, (including boundaries, priorities, time-scales and resourcing assumptions). The DGMs should contribute details of the practical issues in applying this framework and indicate the ranges or varieties of services or programmes that will be required to implement the framework, and how the resourcing implications will be dealt with. The RGM cannot zoom into the lower levels of work within the District, but Region does have monitoring powers, and the RGM, himself, and other top officers (at L-5) should be available for consultation and appeal.

GIVING UP 'GUIDANCE'

The first casualty of this new approach to action should be the term *guidance*. Policies at the higher level are not just *guidance*, but *prescriptions* within which discretion needs to be exercised. The term guidance is favoured by the civil service, and is appropriate where no direct management control exists (e.g. in central government's handling of local government or industry). It is completely inappropriate in the context of general management in the NHS.

Box 8.3

In the dialogue between the DGM and the UGMs (supported by discussion between District staff officers and UGMs, and District staff officers and Unit staff officers), the prime aim of the DGM should be to prescribe the context for the Unit in terms of a desired range of services (including boundaries, priorities, time scales and resourcing). The UGMs should contribute details of the practicalities of developing the specific constituents of the range, including confirming that detailed programmes are feasible within the specified criteria. The DGM must be prepared to zoom into these details if necessary and should provide the opportunity for additional consultation with UGMs as matters progress.

In the dialogue between the UGM and an L-3 manager or medical consultant within the Unit (again supported by staff officers), the prime aim should be to prescribe a context for the particular service (again with its boundaries, priorities, time-scales and resourcing). The service manager should contribute details of the systematic developments that are needed and possible, explaining the specific effects of particular criteria or policies. The UGM must be prepared to zoom into details if necessary and should provide opportunity for additional dialogue, individually and via management team meetings, as matters progress.

Dialogues and team meetings at lower levels (L-3/L-2; L-2/L-1) are similarly required and GMs must ensure that they take place.

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Dealing with Change

DGMs and UGMs are usually able to identify with all of the following sentiments:
"By gosh those people down there are difficult to budge!"
"My boss is insisting, so I have to work out something to get my people moving!"
"Higher levels simply don't understand how difficult it is just trying to stand still!"

Change in the NHS, in the sense of systematic development, must be organised so that it does not become needless disruption. Our researches indicate that this requires penetration of managers up and down *two* levels in the hierarchy. It also involves general managers in *actively promoting both change and stability.*

The tensions inherent in this demand are evident. Indeed many general managers say they feel like jugglers who are constantly being tossed more balls, or footballers whose goal posts are always moving. They dream of a golden age in which they will be allowed to bring about changes they feel are desirable in their Region, District or Unit—in their own way. This is a dream indeed. Coping with the flow of demands for change from all directions while keeping an even keel is perhaps the most puzzling, challenging and potentially dispiriting problem for DGMs and UGMs.

Major change in the NHS, as elsewhere, always demands management across *three* consecutive levels. This is because the upper level typically devises the idea, provides the impetus and systematically organises for its realisation, while the middle level develops detailed specifications and the programme for change in the light of the actual situation, and the lower level puts the change into being as specified.

Managers two levels higher can never fully appreciate the realities on the ground. Effective top level managers are aware that failed initiatives for change are often worse than none at all, because of the cynicism, demoralization and loss of confidence in management that results. They therefore require the managers one level below to put to them the difficulties and practical issues (including intangibles like attitudinal change and training needs, as well as tangible matters of resources, arrangements or facilities) which must be dealt with if the affected subordinates are to deliver what is required.

Nevertheless, any new drive for change, however well-grounded in current realities, inevitably creates a new priority and so *change initiatives must alter the balance of existing priorities.* This fact needs to be appreciated at all three levels involved in the change. Failure to do so leads to frustration and resentment.

Responsibilities for change and stability alter according to which grouping of three levels is focused upon. The higher the level or the grouping, the more radical the brief for change, and the lower the level or the grouping the more concern for stability, as indicated below:

Operations are *remodelled* by:	L-7—L-6—L-5.
Operations are *reformed* by:	L-6—L-5—L-4.
Operations are *improved* by:	L-5—L-4—L-3.
Agreed change is *maintained* by:	L-4—L-3—L-2.
Operations are *stabilized* by:	L-3—L-2—L-1.

Note that change does not need to emerge from those managers at the top of the triad. A manager at the middle or lowest level within the triad can bring about change of the type of the triad within the authority and responsibility assigned.

From the above listing, it is clear that L-7 and L-1 staff are each primarily concerned with just one aspect of management change—the former ever wanting to bring it about, and the latter eternally at the receiving end and tending to resist it. Those at L-6 and L-2 relate to two modes of change. However, as expressed in the typical sentiments quoted at the top of this section, managers at L-5, L-4 and L-3 are invariably faced with no less than three experiences in relation to changes of various sorts. *(These experiences are simultaneous in relation to any particular centrally-driven change initiative.)* This is because each such manager works at the top, middle and bottom levels of consecutive triads with successively more radical briefs for change.

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To handle the impact and process of change, the previous two aspects of management—clear responsibilities and effective dialogues about objectives—must be in good working order. In addition, extended management meetings and individual contacts which penetrate down two work-levels are periodically required. At present, these requirements are not widely appreciated.

Below, this framework is used to explore the multiple responsibilities for organising, mediating and grounding mandatory* change in a typical District. The table reveals some of the intrinsic tensions and indicates how difficulties may be unnecessarily increased:

Mandatory Responsibilities	*Where Things Often Go Wrong*
The DGM (L-5) must simultaneously:	
➡put National directives for reorganisation or remodelling of operations into practice as specified;	➡National directives are often not clear, or passed down untransformed by Regions;
➡develop District programmes to implement Regional reforms;	➡Regional frameworks are often too specific, or without resource guidelines, or too vague and woolly;
➡drive the introduction of specific changes throughout the District.	➡DGMs often inappropriately expect initiatives to be sustained by staff officers or UGMs, and avoid any personal contact with L-3 managers (including medical consultants).
The UGM (L-4) must simultaneously:	
➡implement Regional directives as detailed in District programmes;	➡Regional policies often ignore basic realities, or DGMs avoid mediating change for the UGM;
➡develop Unit programmes to meet District initiatives for change;	➡Unit structure may not permit these programmes to be devised or delivered;
➡ensure that all new and agreed changes in the Unit stick.	➡UGMs feel unable to develop their own initiatives; inappropriately expect their staff officers to handle L-3 line-managers; and avoid personal contact with L-2 managers and professionals.
The L-3 manager must simultaneously:	
➡implement District initiatives as detailed in Unit programmes;	➡DGMs are often not aware of the realities of the situation, and out of direct contact with L-3 line managers;
➡develop programmes to ensure that Unit initiatives and agreed changes stick;	➡L-3 functional management is often absent or weak, or confused with operational coordination; and dialogue with UGMs is lacking;
➡ensure that stability is preserved.	➡L-3 managers feel unable to develop their own initiatives; have insufficient support staff; lack L-4 policies on workload; and do not work closely enough with medical staff.

*The reader is reminded that optional change is also important in organizations as noted in the paragraph opposite the listing of the triads on p.64.

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SOURCE OF WEAKNESS IN CHANGE AND ITS EFFECTS

Weakness at National level (L-7) means:
lack of fundamental conceptions necessary to change the NHS to meet new social and technological realities and outlooks
i.e. *the NHS cannot properly transform itself, especially in relation to medical developments.*

Weakness at Regional level (L-6) means:
lack of clear and feasible frameworks which can help Districts reform operations in the light of new given concepts or changed circumstances
i.e. *operational change is incoherent, or completely absent in many places.*

Weakness at District level (L-5) means:
comprehensive long-term change occurs patchily or slowly, if at all.

Weakness at Unit level (L-4) means:
comprehensive change never really bites or soon crumbles when the pressure lets off i.e. *new developments will not stick.*

Weakness at L-3 means:
irrespective of any changes, there are *recurrent breakdowns and endless crises.*

Box 8.4

Providing Functions

The cry can be still be heard in places: "We're all general managers now!" No! Not at all! General management did not do away with functional management. Indeed, Griffiths (correctly) referred to general management itself as a function.

What functions introduce into an organisation is specialization, and standardization of special knowledge and skills. One consequence is the need for a multiplicity of functions. Another is the need for *dual influence relations* i.e. specialists with two 'bosses', a higher specialist and a (higher) generalist. Not recognizing the need for strong functions and not providing for the dual influence situations which inevitably follow are prevalent and serious mistakes.

In Chapter 2, we identified the need for three types of functional management, in addition to general management, and suggested that each of these crosses four consecutive levels of work. This idea can now be elaborated and applied.

What is a function? *Functions are primarily about the provision of standardized and specialized procedures, methods, and techniques, and therefore about training, recruitment, standard-setting, and regular development of skills and methods.* Within any organisation, functions require to be comprehensively organised over four successive levels, but no more. The boundaries of a function do need redefining periodically. This occurs both within the organisation but outside the function, and outside the organisation within the relevant academic or political arenas (cf footnote on p. 57).

What distinguishes the types of function? Functions are primarily distinguished by the lowest level which specifies *the kind of work that is basic and requires to be standardized* within that function.* As noted above, there are four types of function as follows:

* Note that many apparently mono-functional departments (e.g. personnel, estates) are a composite or grouping of related functions whose type may vary. The analysis of included functions is therefore essential to designing departmental organisation, and this is a current area of research.

The first type, L-1—L-4, is concerned with the management of *specialist action*, and includes both relatively simple functions such as domestic work, and professionalized functions such as nursing.

The second type, L-2—L-5, is concerned with the management of *specialist assessment*, and includes functions like personnel and clinical medicine. Here there is no meaning within the discipline in L-1 work.

The third type, L-3—L-6, is concerned with the management of *specialist systems*, such as planning and finance where at a minimum whole socio-technical systems must be handled. (See Box 8.5).

The fourth type, L-4—L-7, is *general management* which overviews and encompasses all other functions.

How are the four types similar? In each case, the lowest level provides the function *as standardized or specified in training*, the next level provides the function *as needed in the situation and so controls its delivery*, the third level ensures the function is *systematically provided*, and the top level ensures the function is *comprehensively developed*.

TYPE 3 FUNCTIONS

Where the basic level of work in a specialized field is L-3, the minimum requirement is handling a fully developed socio-technical system. This applies particularly to specialist management disciplines like *financial management, management development, planning,* and *information services.*

The recent demands for effective management budgetting and expenditure control in Units led correctly to the widespread appointment of L-3 management accountants. Something similar should have occurred in the other key disciplines noted above. In general it has not.

For example, in *information services*, GMs have not realized that the present DoH initiative means introducing a completely new function into the NHS. Typically, a sole specialist information officer at L-3 has been appointed at District level, and Units make do with L-2 information officers who are virtually irrelevant to what is needed. The need for an L-4 specialist as District Director to make the necessary assessments in relation to information and IT has generally gone unrecognized. Instead the top work has been inappropriately tacked on to a top finance or planning specialist. Information systems and the use of information and IT need to be promoted, developed and serviced by specialist staff, rather than be given as an additional task for a busy manager in another function. Regional support or external consultancy firms can complement but not fully substitute for in-house expertise.

Box 8.5

Coordinating the functions. The analysis above reveals that specialist management (of all three types) is required at L-3 and below, but that general management does not start till L-4. However, this does not mean that the requirement to overview and integrate specialist functions is not needed at levels below L-4. Far from it. What must be realized is that this need cannot typically be met by a single person who is the line-manager-cum-integrator. What is mostly needed at L-3 and below is *strong functional management plus effective cross-functional coordination.* (Such coordination unavoidably generates dual influence situations—see below.)

Functional *management*..or..functional *managers?* Strong functional *management* is essential in all NHS disciplines within the District (especially at L-3 and L-4). However, whether *specialized managers* are required in each function and at every level of the function is another matter.

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It is evident that simple disciplines like portering, linen, central sterile supplies, domestic work, or catering can be grouped with others if there are not enough staff to generate separate L-3 line-manager roles. However, most of the major functions, such as pharmacy or personnel, absolutely require a specialized L-3 manager. And for some disciplines, like estates and nursing, one or more specialized L-4 managers are also needed. *It must be emphasized that L-3 and L-4 management of each particular function has to be done somewhere, even if not by a separate L-3 or L-4 specialist head.* Sometimes L-4 responsibilities in one function may be combined with those of related functions under a L-4 operations manager or L-4 DNS or L-4 paramedical manager. Otherwise, if the District is not to stagnate, the L-4 work must be performed by one of the UGMs or the DGM.

ESTABLISHING DISTRICT HEADS
Step 1: Determine the level of work required for the District Head. This will depend partly on what is wanted by the DGM or DHA, and partly on what is needed by the services currently existing in the District.
Step 2: Then establish executive accountability by finding a line-manager or GM working one level of work higher. Tucking the Head in where convenient may be possible, but avoid phoney accountability or pseudo-contractual arrangements.
Step 3: Then clarify the division of authority in the dual influence situation. Whenever the Head is at L-4, joint control over budgets and establishment will be essential. Authority on other issues will vary (see text).

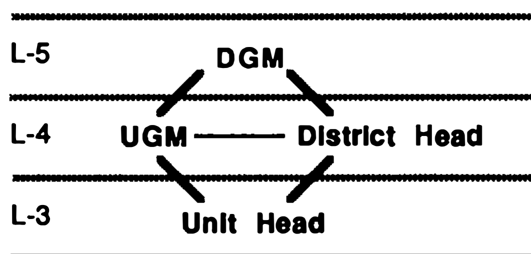
Box 8.6

Because the same functions are usually carried out in more than one Unit, it is often desirable to appoint somebody as a cross-District coordinator, the so-called District Head, *notwithstanding the complexities that this brings.* In such cases, functional heads within Units inevitably find themselves in a *dual-influence* situation, and this seems to be a potent source of tension and confusion for all concerned.

Despite claims to the contrary, such situations cannot be avoided or denied. Indeed they are everywhere in the NHS. Wherever one person must accept instructions from two or more others, careful definition of where authority rests is required. Such explicit definition is particularly needed for things like appointments, work programmes, priorities, and budgets. There are two broad categories of dual influence arrangement: cross-level and within-level

Cross-level dual influence relations. These typically exist when the District Head is expected to work at L-4 and the Unit Head at L-3. This occurs in works, planning, personnel and sometimes in paramedical professions such as pharmacy or physiotherapy. The appropriate main line-manager of the District Head is the DGM. This arrangement is illustrated in Fig. 8.3.

Figure 8.3: Cross-level dual influence relations. The District Head is at L-4 and needs an L-5 main line-manager.



Here, the Unit Head inevitably feels that he has two bosses: the UGM and the District Head. These District Heads typically require near-full control of L-4 decisions in regard to such things as technical matters, minimum standards, professional organisation, and further education. They need to monitor functional activity in the Unit, and set specific tasks in relation to District needs. They are (or should be) involved in discussions with the UGM on planning and budgetary decisions in relation to their function, and matters like appointment or discipline of their L-3 staff. The District Head should not be setting policies unilaterally, making strategic plans unilaterally, or allocating or reallocating resources unilaterally. The UGM often requires near-full control over specific task setting within the Unit, quality of service over the minimum, and immediate priorities. Although District Heads of this sort are sometimes said to be

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accountable to a UGM, this is a convenient fiction, because relations and potential disputes with other UGMs mean that the DGM will be drawn into decision-making, and must make the definitive appraisal of the Head's performance.

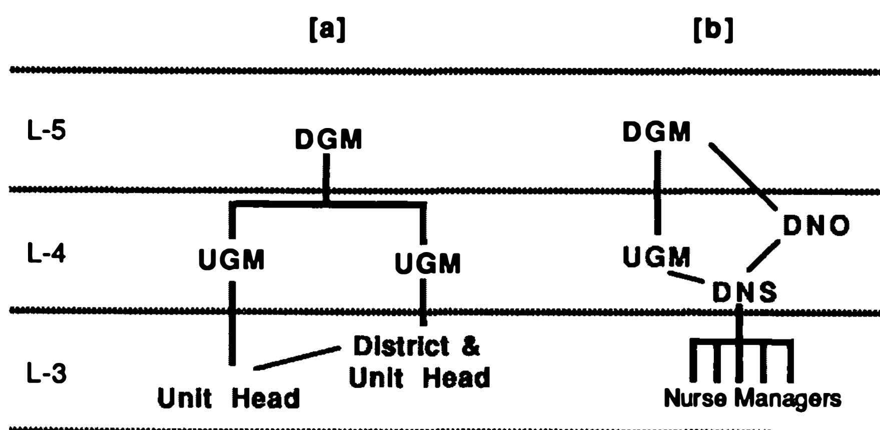
> **CENTRALIZATION AND DECENTRALIZATION OF SERVICES**
>
> Some time ago we predicted that the proliferating empires in planning, personnel and works at District HQ would diminish with the clear establishment of L-5 and L-4 responsibilities at District and Unit respectively [5]. This has indeed eventuated. Indeed in some places it appears to have gone too far. Leaving L-4 District Directors of Personnel without L-3 staff of their own and bereft of powers to use the personnel managers appointed by the UGM is clearly unsatisfactory.
>
> If it is decided to set up a District-level function at L-4, it is essential that a bare minimum of support is provided. This minimum often, but not invariably, includes at least one or two members of staff at L-3 and L-2 and a secretary. Furthermore, given that District policies are delivered in the Units, dual influence arrangements must specify how Unit staff in the function are to be a resource for the L-4 Head.

Box 8.7

Within-level dual influence relations. These are of two sorts depending on whether the District and Unit Heads are both expected to work at L-3 or at L-4. In paramedical areas, it is not uncommon for both District and Unit Heads to work at L-3 (see Fig. 8.4a), or for the District Head to be the only L-3 specialist manager in the whole District. In this case, the District Head can also be a Unit Head and made formally subordinate to one of the UGMs. Such a District Head can purvey professional advice on request to both the DGM and DHA, and is expected to contribute to L-4 decisions, but not to work in detail on them or negotiate them. There is typically a responsibility for recruitment, coordination of staff transfers, rotation, and training.

The sole example of the second case appears to be nursing (Fig. 8.4b), where both DNSs and the DNO/DNA are typically expected to work at L-4. Again, the DNO can carry no more than monitoring and coordinating authority.

Figure 8.4: Within-level dual influence relations at L-3 (a) and L-4 (b).



Functions at Regional and National Tiers. In terms of the three types of specialist function described at the start of this section, the major ones staffed at Region are Type 2 (such as personnel, medical services, estates) and Type 3 (such as information, finance, planning). Most Regional Heads need to operate at L-5, but the *exact responsibilities for the function differ according to the Type*. The numerous issues of organising and managing these functions within Region and in relation to District functional officers are a current focus of research and beyond the scope of the Guide. The National tier requires functional heads at L-6 (with L-5 subordinate hierarchies) in regard to Type 3 functions, and is involved in shaping all functions.

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Pursuing Achievement

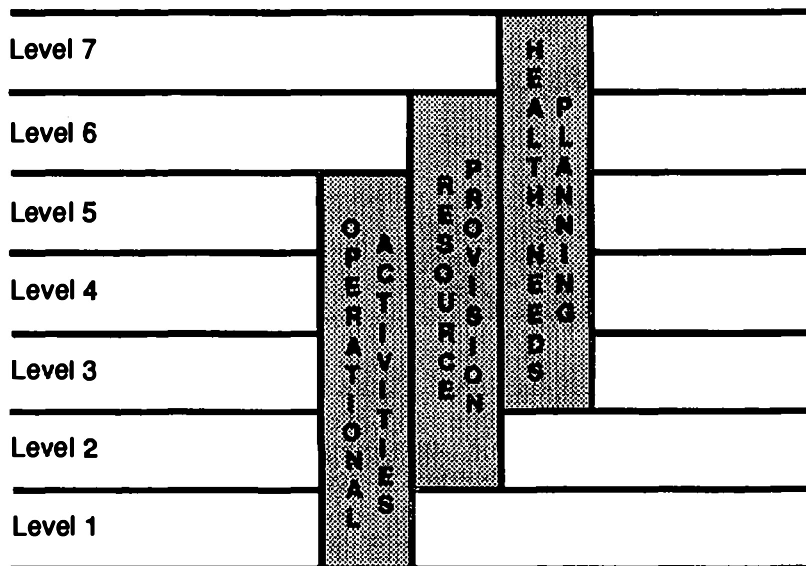
What counts as real achievement:
Providing another new hospital?
Seeing more patients per day?
Improving the patient's condition?

Assigning responsibilities, getting appropriate action, dealing with change, and providing functions are necessary in themselves, but not in the end what it is all about. GMs must focus on achievement, on realizing the mission of the NHS, that is to say, on pursuing the *comprehensive provision of health care for the total population.* Any results need to be assessed in these terms.

The approach to managing from this perspective is based on the idea that pursuit of the mission depends on provision of resources and facilities to handle the exigencies of operation. There are therefore three complementary dimensions within which what counts as achievement must be defined and then thoroughly and exhaustively pursued. As noted earlier, these are *planning oriented to health-care needs*, *provision of resources and supporting facilities*, and *operational activities*. These three dimensions were the bases for the matrix structures presented in Chapters 5 (Fig. 5.1) and 6 (Fig. 6.2), and were referred to in discussing the work of the GMs. Each dimension operates over five levels and requires its own organisation and procedures, its own roles and relationships, its own information and budgetary structure, its own policies and plans.

Once again it must be emphasized that no dimension is owned by a single function: people are not the sole responsibility of the personnel department but of all functions, the planners are not the only staff who plan or consider patient needs, and so on. Indeed the functions (occupations, disciplines) are essentially extrinsic to the NHS, while achievement expresses its raison d'etre. When functions become too powerful, the NHS is in danger of becoming distorted and patients will suffer.

Figure 8.5. The three dimensions of achievement.
Note the triple responsibilities for general managers at Levels 3, 4, & 5.



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The matrix in Figure 8.5 implies that:

➡the Director-General (or equivalent) must
definitively *plan for health needs* within the NHS;

➡the RGM must
comprehensively *plan for health needs ....* and
definitively *provide all resources* within the Region;

➡the DGM must
systematically *plan for health needs ....* and
comprehensively *provide resources.....* and
definitively *implement all necessary activities* within the District

➡the UGM must
plan for health needs ***as the situation demands***...and
systematically *provide resources....* and
comprehensively *implement all necessary activities* within the Unit;

➡the L-3 line-manager must
plan for health needs ***precisely as specified****....* and
provide resources ***as the situation demands****....* and
systematically *implement all necessary activities* within the Unit.

From Figure 8.5, it should be noted that National and Regional levels are distant from concrete activity and cannot be over-much concerned with the exigencies of on-going health care delivery that press so hard on DGMs and UGMs. Also note that the actual deliverers of much of the service at L-2 and L-1, so affected by decisions about which needs are to be met, are not themselves responsible for planning the future of health services.

The most complex part of the matrix is at L-3, L-4 and L-5 within the Districts. GMs at District and Unit, and L-3 line managers too, find themselves with responsibilities in all three dimensions. They are the managers who must integrate planning for patient-needs with the development of necessary resources and facilities, as well as ensuring all operational activities are performed and exigencies dealt with. Unfortunately the commonest response in the NHS to this complexity is to attempt to collapse the matrix incoherently into a single dimension mixing elements of all three, or to consign what are general issues to the sole care of individual functions.

COMMON FALLACIES

'We all know that patient-needs really come down to more nurses or more theatres or new diagnostic facilities!'
NO—because needs must not be defined in terms of resources or activities, but in terms of symptoms (such as pain or lack of mobility), care-group or disease-type.

'As a UGM, I don't need to know what professional activities are being carried out in my Unit!'
NO—it is not enough to employ more CPNs or build community health care centres: UGMs should pay attention to what CPNs will actually do, and what will actually go on in the centres.

'We need more resources, and that means waiting for higher levels to allot more money or more staff!'
NO—because usable resource, like experience, goodwill, information, space, systems &c is more subtle. Such real resource must be actively and diligently developed and maintained. This work is not to be disparaged as 'administration', but should be seen as an essential part of management.

Box 8.8

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Confusion shows up most clearly in relation to planning. In reality, most planning in the NHS is not mission-driven. Instead it is responsive to pressures of health professionals for more staff and facilities, or drives by politicians and the public for glamourous developments—like new buildings or the latest technology. Steps to meet new or altered health problems are currently driven in an ad hoc way by crises and cause celebre, such as AIDS and cervical cancer. Of course, there are many local plans to meet particular operational problems like the introduction of a new method, or readjusting activities to deal with an ill staff-member.

PLANNING IN THE THREE DIMENSIONS
In *mission-based planning*, the concern is with the basic health care needs and their relative priorities. Planning is typically idealized with the emphasis more on ends rather than means. Plans typically cross lines of accountability and costs are estimated in an approximate fashion.
In *resource provision*, the concern is with providing developing and maintaining resources required by the mission and used in operations. Plans focus on types and amounts of resource required and on their best use. These include finance, personnel, buildings, land, equipment, materials &c, as well as intangibles.
In the *operating* mode, the concern is with running actual operations, Here the actualities, personalities and environmental factors must be handled. In so doing, there is an emphasis on how plans feel and fit rather than on what is rationally desirable.

Box 8.9

Establishing Leadership

Any integrated achievement within the NHS is dependent on decisions and arrangements provided by leaders—and accepted by followers.

In discussions about general management there has been much discussion of the need for managers, especially GMs, to *exert* leadership, but surprisingly little about the need for them to *accord* leadership to others.*'Followership'*, as it might be termed, is important—yet how much is heard about the responsibilities, attitudes and behaviours required? Or the difficulties and challenges?

Except at L-7 and L-1, every manager is both leader and follower. The result is an inevitable tension throughout the NHS. Recognizing and managing this tension is particularly necessary for the UGM who is at the very bottom of the general management function. Below we spell out the conflict experienced by UGMs, but a similar list could be produced for other managers.

*As **leader** of an array of subordinates, a UGM must:*

➡identify and proclaim the basic *values* relevant to the Unit, so as to develop a strong Unit ethos;

➡clarify and pursue the specific *mission* of the Unit, so that effort within it is coherent;

➡set clear *priorities* within the Unit, because this is essential for handling resource scarcity;

➡set coherent *strategic objectives* for the Unit, so as to get orderly sustained progress in a desired direction;

➡set or oversee the main *tasks* for the Unit so as to ensure effective control.

*As **follower** of the DGM's leadership, a UGM must:*

➡identify with basic *values* promoted by the DGM so as to help in developing a particular District culture;

➡observe and uphold the general *mission* assigned to the Unit, and avoid capture by idiosyncratic initiatives;

➡observe and uphold all given *priorities* so that DHA and DGM policies may be implemented;

➡clarify and pursue given *strategic objectives* in order to assist the DGM progress agreed District strategies;

➡pursue any specific *tasks* as may be assigned to enable the DGM to deliver.

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Clearly for each form of purpose [15,25], the UGM is pulled in two different directions. In examining each form below in turn, leadership deficiencies found in fieldwork are noted.

Values: The importance of culture building does not seem to be fully appreciated by DGMs. Cultures, often unsatisfactory, simply evolve in relation to circumstances. Sometimes the hysteria that swamps the NHS periodically becomes a substitute for culture. A DGM does have the power to build a culture if he wishes. But UGMs do not, and may find themselves uncomfortable in their DGM's culture.

Mission: The DGM typically defines the mission for a Unit broadly, so further clarification must be pursued by the UGM. We have noted lack of clarity in both General Hospital and Community Units about 'what business they are in'. The end result of such confusion is disputes between District and Unit staff or between Units, and fragmentation of effort within the Unit.

Priorities: Establishing and setting priorities is still handled in a disorganised, haphazard, or unrealistic way by most GMs. Full systematization is undesirable, but some improvement would aid staff at all levels. Clashes over priorities, and whether they are or are not being implemented, frequently sour District-Unit relations.

Strategy: Too often a District strategy is regarded as the sum of Unit strategies; or the Unit strategy is determined by picking through the District strategy for relevant items. If DGM and UGM are to work together effectively, *both require their own distinct strategic objectives*. By Unit strategies, we refer to the broad direction and means whereby the Unit is to be reshaped. Such live strategies may have only a weak resemblance to strategic plans which go to Region, which are principally resource-based and oriented to National requirements. UGMs must produce unofficial strategic plans specifically designed to orient their subordinates and medical consultants.

Tasks: UGMs must not only perform their own work and see that others assist in its progression, they must often perform work purely because the DGM desires it. This may be experienced as a distraction.

Leadership as a general topic is too extensive to be explored here. Its essence lies in matching and harnessing people to the work to be done. It therefore relates closely to the elements of managing listed in Ch. 2 and used to head up the main sections in this Chapter. We have elsewhere explored the links between the elements of managing and psychological qualities of staff [14] (and also between work-style and leadership [13]). It may be usefully noted that the form of leadership (and followership) varies according to work-level. As the tiers are ascended, flexibility in following broadens and responsibility for leading increases.

GM PERSONALITY FEATURES

The psychological literature on successful leaders suggests that they manifest:
- a need for mastery
- a readiness to persist
- active and assertive behaviour
- needs for recognition
- desires for self-development
- goal-oriented relationships

These features do not however take into account the way leadership is modified by work level [14] or by work style [13].

Box 8.10

The tension between leading and following must be handled through a continuing cycle of work assignment, appraisal, and reassignment (or other action). We trust that it is appreciated that sensitive and realistic staff appraisal is fundamental to organisational integrity and the first step in reducing tensions between managers. The history of the NHS (and other public sector services) reveals a marked and inappropriate tolerance for underperforming managers. Such tolerance is misplaced: it benefits neither the boss, nor other staff, nor patients, nor the tax-payer—nor even the person who is underperforming.

Certain misconceptions exist in regard to appraisal, and so some further comments are provided in Appendix II.

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Participating in the Mission

In the end, the NHS only functions because people choose to work in it, and go on choosing to work in it.

The word 'participation' does not have a high profile in current NHS discussion, and yet the idea behind it is one of the most fundamental in all managing. If people did not choose to participate, there would be no NHS. Leadership itself can only operate after people have willingly entered the organisation, and have shown they are prepared, personally, to join in a common effort to share the values, pursue the ideals and realize the mission of the NHS. Participation in the mission is something which applies at each of the seven basic levels of responsibility.

In the NHS, it has not been too difficult to recruit a range of professionals and others prepared to dedicate themselves to it. However, keeping that dedication alive, well-nurtured, and appropriately contributing, is not so easy. Genuine commitment is not an endlessly replenished substance. Idealism can readily turn to cynicism and enthusiasm to demoralization—then burn-out results.

The provision of attractive rewards and working conditions is of course essential. However, participative mechanisms must go further than this to include involvement in the processes of work and policies of the organisation. Mechanisms such as staff surveys and referenda, consultative committees and representative councils, and social and sporting events too, are all required.

A New Model of Managing

Readers who have followed the main argument of this Guide, and particularly this Chapter, may now be aware of a new model of managing that is emerging [14]. All the essential features of organisation and management appear to find a place within this model.

As indicated in Ch2 and the sub-headings of this Chapter, grouping the seven basic work-levels successively in ones, twos, threes &c focuses light in turn on what now appear to be seven universal aspects of any process of managing. The seven groupings are as follows: distinguishing responsibility (G-1), getting action (G-2), dealing with change (G-3), providing functions (G-4), pursuing achievement (G-5), establishing leadership (G-6), and participating in the mission (G-7).

Only some of the new insights generated by this research have been presented here. We are currently gaining further experience with the new model by applying and testing it in our consultancy projects. We expect to be using it in future publications and workshops for NHS staff.

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Chapter 9

IN CONCLUSION

As stated at the start, we believe that general management is here to stay, and that its operation will be a permanent theme in attempts to improve the NHS. In this Guide, based on years of fieldwork, we have presented a comprehensive framework for general management which is coherent, practical, and adaptable.

Although the account presented is certainly not complete or perfect, it does enable the problems and challenges for general managers posed in Chapter 1 to be sensibly and systematically addressed.

In describing the present state of the NHS, we have not hesitated to be blunt. We have identified many existent misconceptions and defects. Although such failings are profoundly damaging to achievement and morale, it must be emphasized that they are rooted in complex problems and do not reflect on the quality of NHS managerial staff. Without doubt the NHS has many good managers. What we address is not any lack of basic managerial talent, but the current weakness in basic management thinking and education.

Readers may make use of this Guide in various ways. Some may find that it simply helps them get a better understanding of the general situation. Others may go further and put a particular insight, or even one whole stream of thought, to direct practical use. Others again may follow a few pioneering colleagues who have already recognized that, taken together, the ideas here provide the basis for a complete revolution in management practice and outlook.

Appendices

&

References

Appendix I

LEVELS OF WORK

Level 7 - **Total Coverage (Defining Basic Parameters)**
defining the basic nature of needs and services and the institutions to deal with them,
e.g. Executive responsibility for the whole NHS (e.g. a possible Director-General, Chairman of the National Management Board); DoH Permanent Secretary.

Level 6 - **Multi-Field Coverage (Framing Operational Fields)**
producing frameworks to bridge the divide between basic definitions and all fields and/or territories of actual operations,
e.g. DoH Deputy Permanent Secretaries; Regional responsibility for Districts.

Level 5 - **Field Coverage (Shaping Overall Operations)**
shaping the totality of operations in a particular field and territory,
e.g. providing health services in a District; shaping medical services throughout a Region.

Level 4 - **Comprehensive Provision (Balancing Multiple Services)**
dealing comprehensively with a range of services for a whole territory,
e.g. developing a range of community nursing services, or a general hospital; or a comprehensive personnel service for a District.

Level 3 - **Systematic Provision (Handling Concrete Systems)**
dealing with socio-technical systems to handle a flow of concrete tasks (open-ended or prescribed),
e.g. developing and introducing a new admissions procedure, or an information system; running a medical practice; coordinating work in the operating theatres.

Level 2 - **Situational Response (Assessing Concrete Needs)**
dealing with concrete open-ended situations,
e.g. making a diagnosis, handling a busy ward, dealing with a complex personnel problem.

Level 1 - **Prescribed Output (Responding to Concrete Demands)**
carrying out concrete tasks whose objectives (i.e. aspects of the end product) are completely specifiable beforehand so far as is significant,
e.g. carrying out some routine nursing, or cleaning, or clerical, procedure or task.

Note:
The first label for each level includes responsibility for all lower levels as well; the second label in brackets refers to the essential responsibility at that level.

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Appendix II

APPRAISING PERSONAL PERFORMANCE

Because a management system as a whole depends on effective performance by individuals, organisations must be designed using accountability relationships which include appraisal of personal performance (see Box App.1). This is now occurring in the NHS in the form of the system of individual performance review (IPR).

We trust that it is appreciated that sensitive and realistic staff appraisal is fundamental to organisational integrity and the first step in reducing tensions between managers. The history of the NHS (and other public sector services) reveals on the one hand an extraordinary tolerance for underperforming managers. On the other hand, scandals lead to scapegoating while politicians, authority members and top managers responsible for inappropriate appointments escape censure. Tolerance, scapegoating, and denial of poor performance are all equally misplaced.

In Chapter 2 (Box 2.2), a variety of unsatisfactory situations which come to light in appraisals were described. This included people of both too low and too high calibre for their job.

The main line-manager relation is the key to effective appraisal, because the line-manager is the one whose own performance suffers from unsatisfactory performance by subordinates. Appraisal is most straight-forward for the UGM, because the DGM is the line-manager. However, the DGM and RGM have no line-manager. The DGM needs to be appraised by both the DHA and RGM. The Director-General and the RHA ought to appraise the RGM; and the Secretary of State ought to appraise the Director-General. (Note that appraisals of GMs by governing bodies are different from managerial performance review because feasibility cannot be authoritatively assessed by governors [7,16].)

APPRAISAL & MAIN LINE-MANAGEMENT

For those within a straightforward management structure, the main line-manager at the next work-level is by far the most appropriate person to appraise personal performance on a given task or in a given job because it is part of his own job to:

- assign tasks and responsibilities in the light of expected feasibility
- assess quality of discretion and adherence to limits during work

and he is in a good position to judge the feasibility of the task or job after the event.

Main line-managers at higher levels may appropriately *check* and *approve* such appraisals to ensure no breaches of procedure and adherence to fairplay. However, they are not in a good position to assess discretion or to make judgements on feasibility.

Main line-managers two work-levels up can also be expected to judge what work-level individuals will be capable of in the coming years. (Here, the views of immediate main line-managers may be affected by the limits of their own capabilities and potential.)

Box App.1

Misconceptions: Performance appraisal in practice is a sensitive and difficult matter. It is not helped by a number of prevalent misunderstandings. Certain principles of performance appraisal need to be kept in mind:

➡ **Personal performance and results are not the same thing.** Relatively poor results in highly adverse circumstances may indicate good performance and vice versa. In other words *feasibility* is always an issue in setting and achieving targets. A target may be susceptible to quantitative measurement, but feasibility can only be assessed. Hence *performance cannot be measured but only assessed.*

➡ **Unacceptable performance is not equal to incompetence.** Disciplinary action is often based on evidence of breaking the limits of the authorized or tolerable, but people can stay within these limits and still perform at an unacceptable level or in an unacceptable way. *Keeping to acceptable limits and performing well within limits must be seen as utterly different issues.*

➡ **Formal review alone is insufficient for genuine appraisal.** The current IPR approach is highly procedural as befits a mighty bureaucracy. However, formalized procedures can only supplement and never replace the continual process of task-setting and appraisal that occurs in any leader-follower relationship. Typically, managers undertake many more tasks than those listed on an IPR schedule and task-objectives are being continually reviewed. In any case, one year is not an appropriate review period for general managers. So: *formal review must be seen as no more than an aid to full and definitive appraisal.*

As implied above, an individual may be capable (and may even perform well) at the expected level of work, but still be judged unsatisfactory for a variety of reasons such as carelessness, managerial style, or personality clashes. However, *if the individual is not capable of performing at the expected level of work, then the required work will simply not get done at all.* GMs and their key appointees at each level must perform for the system to operate properly, because staff at one level cannot fully substitute for failure of staff at an adjacent level. So failure of performance by any GM will lead to severe disruption.

By examining the tasks a manager is actively undertaking, it is possible to clarify whether work at the desired level is being addressed at all. The various level-of-work descriptions are a prime tool here. Consideration of *time-spans* in the various tasks being undertaken may also help. The DGM at L-5 should be giving much attention to tasks which will come to fruition in 5-10 years time. Some tasks of the UGM at L-4 should lead to a payoff in 2-5 years time. L-3 managers should be pursuing some tasks whose success can only be reviewed in 1-2 years time.

A Portrait of Failure: If a GM is not capable of handling the complexity of his post, then he will become stressed, perhaps to the point of falling ill. In addition, the Region, District or Unit becomes distorted and demoralized as those about the general manager attempt to maintain an image of his legitimacy, work to compensate, or fail themselves. The under-performing general manager will repeatedly complain that the tasks being set are unrealistic, unsuitable, not feasible, or not specific enough. He may recruit others to support this contention, or argue that the long-term perspective is impossible in the climate of cuts, short-term targets, new initiatives and political pressures. Tasks that should be handled personally will be inappropriately delegated, while the GM becomes over-involved in lower level work so interfering with or duplicating the efforts of others. Subordinates may be appointed who also cannot perform as required. Tensions will grow between managers at various levels and between organisations, because the underperformer takes up time and energy of managers at the level above and disrupts or avoids those at the level below. The end result, as failures accumulate, is an organisation which is severely under-managed, where expenditure is out of control, and whose development is fitful or negligible.

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