THE ROLE OF REGION IN THE POST WHITE-PAPER NHS

RHAs, the eternal favourite for abolition, have suffered only some thinning out of their activities and powers in "Working for Patients". Or is this a misleading image? Warren Kinston sees the white paper ushering in an era of stronger and more controlling RHAs and argues for some long overdue management changes

In order to examine implications of the white paper[1] for regional health authority management and to appreciate the changes needed, it is necessary to overview, selectively and briefly, the developments proposed by the Government for the NHS.

At the national level, the ill-fated NHS Management Board, with its unsatisfactory mix of political and executive figures, and the non-functioning NHS Supervisory Board are being replaced by a lookalike NHS Management Executive and NHS Policy Board. In his national address to managers, the Secretary of State indicated that this arrangement would operate just like any health authority and its top executive team — a frightening thought, but most unlikely to be the case anyway.

Below the RHA, there are now going to be (at least initially) an extraordinary mix of NHS institutions rather than just one. There will be district health authorities (DHAs) responsible for using funds to set up contracts which ensure that their population receives comprehensive health services. The DHAs may also (at least in the short term) be providing services themselves. There will also be family practitioner committees (FPCs) who are responsible for controlling provision of primary health care via general medical practitioners, dentists and pharmacists. (FPCs in the past were accountable directly to the DHSS.) RHAs will also have a direct budgetary link to a number of large GP practices, apparently by-passing the FPC. Finally, there will be the new "self-governing" hospital trusts (SGTs) which will be providing a variable mix of in-patient, out-patient and community services.

The governance arrangements for NHS institutions will alter. The white paper nervously refers to the new governing bodies as "management bodies". This may be a mistake if it confuses authority members as to their precise role. Indeed, the phrase "self-governance" in relation to SGTs is misleading. It could equally be said that DHAs and RHAs are self-governing. The issue for the RHA is whether the trusts are to be seen as independent or not. The answer is straightforward — they are not. *SGTs are not commercial or voluntary ventures — they fit solidly within the NHS and are fully accountable to the Secretary of State*. Despite wishes by some for direct lines to the DoH (as in the good old days pre-1974), this accountability will almost certainly operate via RHAs. Change there will be, but, as the white paper emphasises, the SGTs will be "public corporations" not commercial or private concerns.

The new feature of SGTs promised in regard to their accountability is *the use of regulation rather than planning as a form of control*. However, it should be recognised that regulatory control can easily become more heavy-handed and constricting than planning control. Hospitals in the USA and Netherlands, for example, have been far more burdened, restricted and monitored by their governments in the name of an independent but regulated health service, than those in the NHS have ever been. The likely outcome here is that some relaxation of control in peripheral or local matters will be associated with tight control in national core concerns (such as control of borrowing) or politically sensitive matters (such as access to services). The Secretary of State is expected to retain wide reserve powers and is likely to use them for political reasons or at the behest of the Treasury to block competitive ploys or operating tactics or pricing techniques of the type routinely employed by businesses to attract custom and gain a business advantage. The RHA (who else?) will surely be expected to monitor and exercise control on his behalf.

▶ Is a Regional Tier Still Required?

Now that the RHA's existence has been confirmed (Para. 2.7), it might be thought that the question of whether or not a regional tier is required is merely academic. However, neither the white paper nor its associated Working Papers clearly explains the reason for retaining RHAs, and the details of the nature of the regional control of DHAs, FPCs and SGTs are fragmentary, scattered

and insufficient. The main emphasis is on setting performance criteria, monitoring performance, and evaluating effectiveness (Para. 2.7). However, the centre already does this, and DHAs are expected to do likewise, and so are units. Is there to be duplication? If not, how is the regional role different?

Much is made of the removal or devolution of RHA services in order to increase focus on essential tasks (Paras. 2.8–2.9). In deciding on retention or removal, cost-effectiveness is to be the arbiter (Para. 2.9). But cost is never the sole criterion for major decision-making, so what other criteria should be used? RHAs are to have "a key role to play in managing the wider programme of changes that are set out in [the] White Paper" (Para. 2.7) — but many other bodies are crucially involved, so what is distinctive about the RHA?

(The DoH will of course eventually produce a longer list of functions for the RHA but the present ambiguity will almost certainly be perpetuated — evidence of good drafting, Sir Humphrey might say.)

The point being made here is that regional general managers and top regional staff will not be able to organise (or reorganise) themselves to function satisfactorily if explicit clarity about the *raison d'etre* of their existence is lacking.

In a recent Guide for NHS managers based on extensive consultations and seminar work, the logic of a regional tier was spelled out in detail[2]. This work was based on research which revealed that the situation in giant organisations like the NHS is as follows.

There is a maximum size or complexity to which any operating organisation can grow. Many DHAs are at or near that size. Indeed given recent demands for stronger management of medical services, many general hospitals are too, which is why so often they do not fit well inside DHAs. The responsibility of a manager at the top of an operating organisation at or near the maximum size is to shape that organisation in the light of detailed local realities, and to handle all exigencies of operation by controlling all lower levels of management directly.

When, as in the NHS, it is desirable to draw many such operating agencies together into a unified organisation, two higher levels of management are required. Both are concerned with orienting the operational agencies.

The work at the very top level of management involves defining basic parameters: what needs are to be met, what services are to be provided, what general customs and practices are to be altered, how the institution as a whole is to be constituted. (The white paper was clearly an example of such work.) Existing reality must be changed to fit these basic conceptions, and hence the top manager needs both a vision and the capability to see it through. Of course, there are limits to what is possible (socially and technically) and the potential for disruption is just as enormous as that for benefit.

Below this highest level of management, Level 7 in our terms*, there is further supra-operational work to be done — at Level 6. This work involves translating basic parameters into something which is feasible in principle in the actual situation. In other words, frameworks must be devised that are detailed enough to be used by those heading up operational agencies. L–6 work therefore mediates between the general vision and political requirements at L–7 and the wide range of actualities and operational needs in the many delivery agencies (which optimally operate at Level 5).

Top (L–7) managerial work must be carried out at the centre — but the situation here remains confused despite the white paper. L–6 work needs to be carried out by managers who fall into two categories: (a) those in L–6 specialist staff posts at the centre who support the L–7 work; and (b) those in L–6 general management line-subordinate posts who are accountable for clusters of operating agencies.

Specialists in L–6 *staff* posts (each with a subordinate hierarchy) mediate the L–7 requirements in relation to particular issues of finance, organisation, information, manpower &c as applied to the NHS nationally. They need to be centrally located. General managers in L–6 *line* posts mediate the central output (L–7/L–6 combined) in relation to the practicalities of a set of operating agencies clustered conveniently. The number of agencies in a cluster needs of necessity to be limited. (Hence in England the NHS would need to be carved up into regions even if all L–6 staff were located centrally in Whitehall.) Physical decentralisation makes sense, because those in L–6 line-roles must interact personally with the L–5 chiefs of their operating agencies (currently DGMs) and have some understanding of local communities and service realities. This will be particularly necessary when, in addition to DHAs, RHAs will have to cover SGTs and FPCs, and possibly have dealings with the private sector and local authorities.

What all this adds up to is the fact that the rationale for regional management is in essence unchanged. An L–6 output is still necessary to ensure that *there are usable frameworks for operational provision, and that the various operating agencies mesh sensibly and embody or adhere to national conceptions of the NHS*. In the past such a role has been honoured as much in the breach as in the observance. Of course, the scope of regional control and the kind of control would be different under the white paper proposals because new types of operational agencies are being instituted. For example, in respect of SGTs, there will probably be a new responsibility for monitoring and adjudicating given regulations.

▶ The Work at Region

The white paper has made a great palaver about RHAs divesting themselves of their service-provision functions, and concentrating on their planning and monitoring role. However, this worthy recommendation may not be as easy to implement as it seems. RHAs have tended to have trouble with planning and monitoring — perhaps because the phrase is so vague and not level-specific. Commonly they have got themselves involved in work that analysis indicates to be peripheral to their L–6 role and which the white paper correctly identifies for devolution. Typically such work (often manageable at L–4) could be handled by each DHA on its own, or by a consortium of DHAs, or by one DHA serving the remainder. Ambulance services, work-study, blood transfusion services, and computing services are good examples.

However, there are a range of regional activities which it is rather dangerous to describe simply as service provision because they cannot be properly provided by DHAs. These constitute the core management role. Such non-devolvable activities require specification with greater precision than is afforded by reference to planning and monitoring. An analysis is available in the Brunel Guide[2], and it is outlined here with slight modifications in the light of the white paper.

First, RHAs will continue to have a prominent role in *introducing a continuing stream of new centrally-inspired conceptions, policies and regulations into NHS operations*. Typically

*In the framework of levels of management responsibility used in the Guide[2], the top is Level 7, the mediating level is Level 6, and the top of an operating entity is Level 5. Level 4 corresponds to the work of developing multiple services as required, for example, of the UGM. Level 3 involves dealing with concrete socio-technical systems and corresponds roughly to middle management. Level 2 is first-line management or professional work which requires handling of one-off complex concrete situations: and Level 1 is technical work or tasks whose output can be fully prescribed. More specific definitions and fuller descriptions with examples are available[3–5]. Extensive research indicates that it is impossible to talk unambiguously and sensibly about management without using this framework of levels. For simplicity, the level notation (L–5, L–6 etc) will be avoided and only used for posts or work where necessary and where the sense of the passage is clarified.

there will be an associated responsibility to monitor once changes have bedded in, and of course to react when matters are judged to be unsatisfactory. This responsibility of RHAs is not to be minimised because its scope is so all-embracing.

For example, it is notable that RHAs are not only expected to organise the setting up of SGTs, but are also assigned an ongoing responsibility to ensure that SGTs which are not thriving are identified. RHAs will have powers to improve the management of SGTs or return them to the care of a DHA. Given the confidence in regional management amongst DGMs, such powers might make the hardiest nervous about the supposed independence gained by moving to an SGT.

Second, RHAs must make the *definitive allocation of available finance and control overall all main resources*. RHAs will have the responsibility to allocate finance to DHAs and FPCs and will probably control the NHS capital borrowing allowance for SGTs. However their responsibility for the control of other main resources is not clear. This gap in the white paper must be filled and it is examined more fully in the next section. (Setting budgets for GP practices is inappropriate in level-of-work terms — it is a service for the FPC of the sort that the white paper expect to be devolved. Presumably this is a transitional arrangement.)

Third, RHAs must *plan comprehensively for health care needs, including monitoring and handling operational clashes between agencies that flow from this*. The white paper implies that such planning and monitoring is still required, but is not clear about the distinction between needs (such as heart disease) and services (such as health education and heart transplants). The main problems have been over-involvement in operational details and a predominant focus on resources and services rather than on needs. (Indeed, needs-oriented planning could be strengthened and systematised at the centre too: for example the centre has taken AIDS on board but not heart disease.) As regards the handling of operational clashes (such as inter-district disagreements about closures of large mental hospitals), this will be needed as much in the future as now. Disputes between HAs (or FPCs) and SGTs are likely and will, presumably, be arbitrated by the RHA, because the alternative is litigation.

Fourth, RHAs must *coordinate planning and provision of many services whose catchment or scope is naturally far larger than is possible or sensible for a single operational agency to handle*. RHAs have certainly concentrated on this work in the past. The stress in the white paper on the rights of SGTs to chart their own course might appear to lessen this role. However, it can be confidently predicted that the already restricted scope for SGTs to function will be further circumscribed. For example, RHAs will probably be empowered to ensure that over-provision or removal of supra-district services does not occur irrespective of cost-advantages or management preference within the SGT.

Finally, RHAs must *introduce new specialist functions and overview all existing functions within their operational agencies*. RHAs have always been involved in such things as the introduction of new management specialisms (like management accounting), the provision of nursing education, major medical developments and the staffing of new medical specialties. However, they have never seen it as a comprehensive responsibility or realised that well-developed functions lie at the core of all recruitment training and, indeed, morale and quality within the NHS[2]. The white paper offers little guidance in this respect.

Given these five main areas of responsibility of the RHA, it becomes possible to examine the structures and policies that might flow from them. However, such a task is beyond the scope of this article. In the space available, just two things, but both of prime importance to RHAs in the post-white paper era, can be identified for comment from consultancy work: management specialisms and policy dialogues.

▶ A Major Structural Gap

Management of resource is a perennial concern and needs a proper focus at the RHA. As well as money, the main resources in the health service include people, expertise, building and land, information, organisational systems, plans, and community good will. If these resources are well-developed and used, then the NHS will prosper, if poorly developed then the reverse will be the case. Management of resource relates particularly to the second, fourth and fifth of the RHA's responsibilities listed in the previous section.

The specialised understanding of the main type of resource is embodied in *specialist management disciplines*. Specialist staff assist general managers by producing and monitoring policies for the development and best use of the resource. The personnel function concerns itself with people, the training function with expertise, the finance function with money, the estates function with building and land, the information services function with information and computing equipment, and so on.

The development of almost all these disciplines in the NHS is still generally poor. The present lamentable state was identified by research carried out for the Royal Commission over ten years ago[6]. In recent years, the estates and finance functions seem to have progressed. However other functions have been handled cavalierly. For example, it is often imagined that managers developed in other disciplines can, without proper training, take on specialist personnel work or provision of computing services. More dangerously, it has been hoped that specialist staff at middle management grade can successfully perform the work of the complexity required. A further problem has been an isolation of such functions from general management. The end result is that, in many DHAs, people are treated badly, departmental procedures are poor or absent, planning is haphazard, building maintenance is inappropriately deferred, information systems persecute front-line staff, and organisational roles are confused. The specialists in post are typically under stress, their skills either ignored or misused by general managers.

Where does the responsibility for developing these functions lie? Our analyses point the finger directly at national and regional tiers. Ideally work at both tiers is required. However, if the national tier fails to carry its responsibility, then the regional tier can just about rescue the situation. If the RHA fails, then DHAs, FPCs and SGTs are simply too small to compensate.

Why is the tier important here? The answer is that the tier relates to the level of work that makes any specialist management discipline viable. Our research indicates that in almost all the key disciplines, it is *essential* to have someone working at L–5, and *desirable* to have their superior working at L–6[2]. Optimum-sized DHAs or SGTs with a top executive at L–5 will want specialist support at L–4 and will not find it appropriate or economic for anyone (other than the treasurer) to work at L–5. (Where the top executive works at L–4, most specialist staff will be only affordable and workable if the post is pitched at L–3). At the RHA it is natural that posts like the director of personnel, director of information services, director of planning and director of estates should be pitched at L–5, one level below the RGM.

What needs to be recognised is that however much of the regional operation is privatised or devolved à la *Working for Patients*, some small group of high-level staff is still needed. These regional specialist directors must set policies or at least monitor subordinate agencies in respect of the best use

of that resource, must handle any RHA contracts for privatised jobs within the function, and should develop policies (e.g. in respect of training, staffing, funding) to ensure that their functions are developed systematically by directors within subordinate agencies.

In the absence of such work, RHA executives will again try to meet central demands in respect of resources by providing services rather than by orienting DHA managers. This will distract from regional core work, and NHS resources will continue to be poorly-managed.

▶ Relations Upwards and Downwards

The emphasis in the Brunel Guide and reiterated here is that output from the RHA must be kept firmly to providing frameworks for operations. These will, first, promote central conceptions of the NHS and pursue definitions of health-care needs (the RGM at L–6), and, second, shape the use of resources of all types (the functional directors at L–5). But — and this is the second point deserving comment — how well these roles are realised in practice will depend crucially on the *quality of the dialogue* which can be generated by the RHA's top management both upward and downward.

Looking at dialogue upwards, there is a question of how far the work of NHS management currently handled by civil servants will be transferred to the Audit Commission (if about monitoring) and to the Management Executive (if executive). In any event, arrangements whereby RGMs must interact primarily with civil servants such as principals and assistant secretaries working below L–5 are ultimately unsatisfactory. The main regular contacts of the RGMs should be with the chief executive, central L–6 specialists, and higher level civil servants. The main contacts of directors at the RHA should be with L–6 specialist staff and their L–5 subordinates.

Downwards, the previous excuse for the absence of proper dialogue and participation was often the number of districts per region. In the post-white paper world, the number of subordinate agencies will probably increase. But numbers are not and never really were the issue. The problem in the past has been on the one hand the RHA failing to stick to its own responsibilities (and, one presumes, not being centrally instructed or supported in this regard) and on the other hand many DHAs not being set up to operate at L–5. (A key element in the formation of SGTs and subsequent consolidation of HAs and FPCs will be the need to ensure that L–5 entities are set up whenever possible. This need has been intuitively appreciated in the idea of fusing HAs, or HAs and FPCs, but systematically implementing it is another matter.)

Regular dialogue is required with all operating agencies, and this must be masterminded by the RGM and the regional directors. Some of it may be on a one-to-one basis, some in groups, but none will work satisfactorily if levels-of-work and specialist capabilities are ignored. For example, assistant regional directors cannot expect to get very far in confronting DGMs effectively about lack of progress in some specialist area because the DGM typically sees the world in a more complex way and cannot in any case respond adequately on technical matters.

Whether or not the national level produces policies on any given matter, the RHA must do so if its operating agencies are in difficulty. A prime example of failure in this regard may be found in the drive over recent years for better information. The unending requirements for more and more information centrally, combined with the specific need to implement Körner and the general need to introduce information technology, have generated severe staffing problems and hostility in many DHAs. There have been too few staff expected to do too much work, staff without the necessary training expected to handle specialist work, and general wastage and irritation from the blunders consequent on this situation. Realistic and comprehensive policies are therefore needed to cover organisation, manpower and funding which are the contextual elements within which any information developments can be pursued, and it is up to the RHA to produce these. Failure follows from the absence of a dedicated top director, lack of effective dialogue, or insufficient backing by the RGM.

Wherever needed policies are absent or unsatisfactory, continuous stress within DHAs results and tensions between the RHA and its DHAs grow. Furthermore, as noted earlier, regional top officers constantly pressed by central demands for results often find it easier to employ staff themselves to do the necessary work than to get DHAs into the right shape to do it for themselves. Hence the unplanned development of the RHA as a servicing organisation for DHAs which district officers are then compelled to accept.

It can be predicted that this situation, which the white paper correctly wishes to remedy, will recur unless regional policy-making responsibilities are taken far more seriously than they have been in the past. This, in turn, depends on a systematic approach to action by the RGM supported by appropriate regional directorates staffed by people of the necessary calibre, and the development of effective dialogue.

▶ Conclusion

The message of the present analysis of *Working for Patients* in respect of the RHA is simple. The general urge for devolution of responsibilities to let DHAs (and in future FPCs and SGTs) get on with their operations is correct in tone, but the failure to specify and explain the core work to be done and how best to do it will hamper efforts. Simplistic references to setting targets and monitoring by figures are just not enough[7].

The white paper could well usher in an era of real progress if it leads to RHAs focussing on their core responsibilities as described here. These are essentially about orienting operating agencies rather than doing their work for them. The RHA will be experienced by operational managers as a constructive force if it can mediate central demands by devising frameworks that are really useful, and also, if it can engage in an effective dialogue upwards so as to modify national policies in a way which recognises operational realities. *Most RHAs will have to restructure themselves to achieve these objectives.*

What will the future feel like? The RHA will have the power that comes from applying regulations. The RHA will be assigned the power to drive through national changes whether these arise from need or politics. Finally, the RHA will have the power that comes from controlling the scarcest commodity for which all will compete — money. Whether RHAs function well or poorly, it can be confidently predicted that they will be an important and controlling force within the NHS.

References

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