KINGS FUND FELLOWSHIP

Preparing for Reorganisation in the Medway Health District

- An Organisational Analysis

Report of a Study on:

(a) Methods of describing existing patterns of decision making within the District;

(b) An assessment of the advantages and disadvantages of alternatives to the present arrangements for Unit management.

BY

Ann Denholm
District Nursing Officer
Medway Health District

and

Peter Griffiths
District Administrator
Medway Health District,
and
Acting Area Administrator
Kent Area Health Authority,
during part of the period
of this Study.

C O N T E N T S

A C K N O W L E D G E M E N T S

We would like to acknowledge the help we have received from a number of people during the production of this paper.

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We also owe an enormous debt of gratitude to the various members of our secretarial staff, who assisted us throughout, and in particular to Mrs. Maudie Van Den Berghe, who typed innumerable drafts.

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Finally, our very sincere thanks are due to Professor Maureen Dixon, the academic collaborator for this project. Her judicious use of a red pencil, combined with constructive criticism and encouragement in appropriate proportions at the right time, has been quite invaluable.

"Specific individual behaviour at work is as likely to arise from the nature of the role which the individual occupies, its relation with other roles, and with the entire structure of the social system within which that role is positioned, as from the personality of the individual".

"... in order to create an environment at work that will stimulate social as opposed to anti-social behaviour, we must be able to describe that environment in objective terms, and we must establish a clear language in which all of us can communicate with each other, so that we share the same mental models of the many social institutions within which we take up different roles."

Wilfred Brown. Organisation. Heinemann Educational Books Ltd. 1981. Chapter 1. Pages 3 and 6.

THE PROJECT

Purpose of Project

In November 1980, as part of a chief officer development programme, the authors of this paper were offered King's Fund College Fellowships, in order to explore a number of organisational issues related to reorganisation of the National Health Service.

During that year, like all other senior officers in the NHS, we were beginning to think very seriously about the changes in the organisation that "Patients First"[1] had identified as likely to be required. Both of us were concerned that individual disciplines appeared to be formulating ideas on these changes on their own, particularly those relating to the criteria for new units. While we both accepted that some alterations were needed to improve organisational effectiveness, we wanted to be certain that any such alterations were based on real service needs determined locally, and that we were not pressured into jettisoning any good features of our present organisation.

Both of us received information about the Kings' Fund Fellowship at about the same time. In discussing whether either of us should pursue the matter further we concluded that a joint project would give us a number of benefits. Firstly, there would be the personal advantage of working together in preparation for an event that was going to affect many of the staff for whom we were responsible. Those groups of staff would know that the District Nursing Officer and District Administrator were working together and listening to each other's views and that any conclusions reached were joint views. Secondly, the discipline of a Fellowship would ensure commitment to reaching conclusions that would hopefully be helpful, not only to our staff, but also to the Chairman and Members of the new District Health Authority. Thirdly, we would have the benefit of an academic collaborator to guide and assist us in our work. Fourthly, it would help us to think more logically and objectively about future changes.

We would have preferred to undertake the project as a full District Management Team as we were aware that inevitably our perceptions of the present organisation are only those of Administrator and Nurse. However, a team project would not have been practical in terms of the conditions of the Fellowships and we are grateful to the King's Fund for agreeing to the joint venture, which we feel has been of greater value than an individual approach. We are confident that any misconceptions that have arisen can be easily corrected during future discussion with our colleagues.

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[1] Patients First: A consultative paper on the structure and management of the NHS - DHSS, 1979.

The next step was to discuss the project with our DMT colleagues and immediate subordinates. There was a need for them to be aware and in agreement with the fact that some time and energy was being devoted to the Fellowship. More importantly, we wanted to ensure they were aware of the field of study (ie an analysis of the relative strengths and weaknesses of the present organisation) so that anxieties were not generated that we were preparing new structures behind closed doors.

It is probably fair to say that, initially, these discussions produced a reaction of amused, slightly sceptical tolerance. At this stage there was no great interest expressed, but equally no antagonism, although when we started to collect information our managers demonstrated more interest in what we were doing.

Background Information about the Medway Health District

Before describing the method of approach chosen for this project, some background information about the characteristics of the Health District is needed.

General Characteristics

The present Health District forms a natural unit consisting of the local government Districts of Medway, Gillingham and part of Swale. The western end comprises a densely populated area of the old Medway Towns of Rochester, Chatham and Gillingham. The majority of the people living in and around these towns also work in them. The growing town of Sittingbourne, which is the centre of the Swale District Council, lies towards the east. However, the outlying areas, the Isle of Sheppey to the far east and the Hoo Peninsular and the Isle of Grain to the far west, present service provision problems because of their geographical isolation. Within the District as a whole, approximately 50% of the workforce is employed in the service industries. Next in importance is manufacturing, employing 44% in the Medway Towns and 15% in Sheppey. In the rural areas 15% are employed in agriculture. Social Class III predominates in most of the District, the exception being Sheppey where 42% were classified in Social Class IV in the 1971 Kent Development Plan Sample Survey of Households. This classification gives an indication of possible health and social deprivation, and is a significant factor for health service planning purposes.

Population

The population has increased by 30% in each of the last two decades and is expected to increase by a further 15% by 1986. In 1980 the population was 327,400 (OPCS estimate) with a projected increase to 343,000 (KCC projection) by 1986.

The population structure is significantly different from the rest of Kent, as an exceptionally high proportion is in the 0-14 and 15-44 age groups. Although the number of elderly will rise in future years, this trend is in line with the national pattern. The population in the District is likely to retain this socio-economic and demographic structure with the continuation of building schedules already programmed.

Health Service Characteristics

Health services for the District are scattered with no focus for all services in any one place. Clinical services are provided from ten hospital units. The initial phase of a major District General Hospital at Medway was completed in 1969, and since then there has been no development of hospital services, though the next phase is now being planned in tandem with improvements to the Special Care Baby Unit and Obstetric Unit at All Saints' Hospital, Chatham. Acute services in the Medway Towns are, therefore, continuing in inadequate and old buildings at St. Bartholomew's Hospital and All Saints' Hospital. Long stay beds for the elderly are provided in the east of the District, geographically isolated from the main population centre. The District continues to rely on hospitals outside the Health District for long stay services for the mentally ill and mentally handicapped, though community services for both groups are being developed as fast as resources permit.

The geographically isolated population of Sheppey is served by a small general hospital which provides all specialties, but is at a disadvantage in attempting to provide the full range of modern health care because of its isolation and small catchment population. Using Regional bed norms, the District has a total deficiency of 950 beds in all specialties, of which 339 are in the acute specialties including geriatrics. As mentioned above, the population growth of the last 20 years shows no signs of decreasing or changing in structure, so the relative deficiencies will increase before any significant capital developments can improve the situation.

Staff

Some 3,719 staff are employed in the Health District, delivering care from hospitals, clinics, day hospitals and centres, health centres and patients' homes.

Financial Resources

For historical reasons, Medway is considerably under-funded: not only is it the most deprived District within the Kent Area Health Authority, but the Kent AHA is the most deprived Area within an over-provided Region in RAWP[1] terms. Though this position is well recognised by both Region and Area, and a higher proportion of growth funds has come to Medway since 1976 than any other District, its 1980/81 budget of £18.2 million is only 68% of its 1988 RAWP target. Expressed in financial terms, this means that £5 million would be needed to bring the health services in the District to the national average levels of funding now, and £9.4 million by 1988.

It is against this background that the management structures of all services were set up in 1974. At that time, and since, great care has been taken to ensure that no resources have been unnecessarily expended on managerial posts or support for them. In comparison with many other Districts management structures are slight, particularly in support posts for senior officers. This factor probably has some bearing on the way decision making and planning takes place in the District at present.

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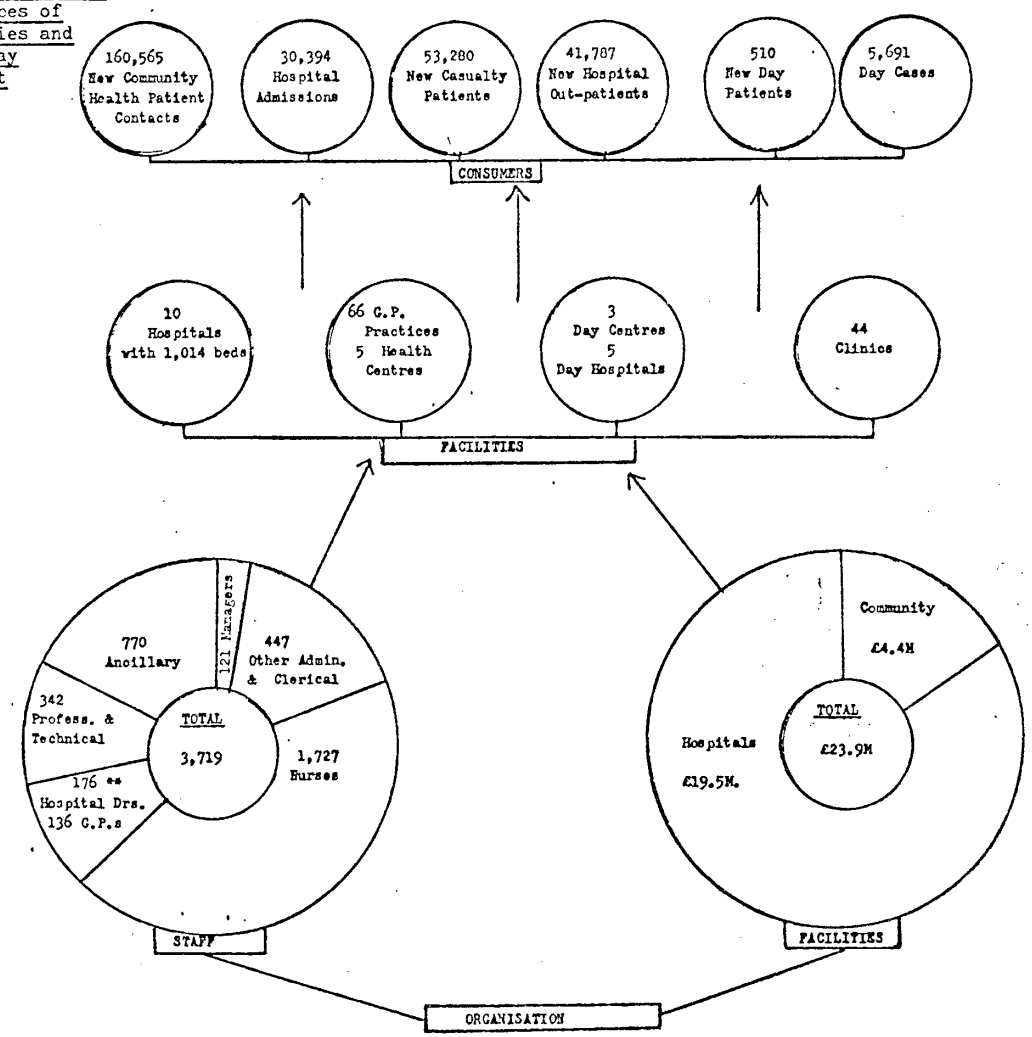
1 Sharing Resources for health in England: Report of the Resource Allocation Working Party. DHSS, 1976.

The Relationship between numbers and types of staff, facilities and budgets - Medway Health District



** Includes C.P. Support

The financial information is expenditure for 1980/81.

Method of Approach to Project

Programming our Work

Whilst accepting the advantages of the joint approach, it was apparent from the outset that considerable self-discipline was needed in arriving at a programme to which both participants could work. A definite programme was agreed with the academic collaborator. Initially this included thirteen working days at the King's Fund College. In addition, an objective was set to devote at least two hours per week jointly on the project, as well as the individual work needed in reviewing literature and later in writing up the project. In fact, because our working bases separated after a few weeks we were not able to maintain the joint two hours per week on the project and as a result increased our working days at the Kings' Fund to seventeen, which included one full week. With hindsight we wish we had arranged two consecutive weeks away from the day to day working situation as the continuity of application to the subject would have been of great value.

Choosing the Model of Analysis

One of the personal development aims of the Fellowship was to increase the authors' skills in organisational analysis by obtaining more information about the various techniques that can be used and gaining some practical experience in applying them. During the first five weeks our reading was thus directed, and in broad summary we endeavoured to absorb information concerning the various models:

(a) theories concerned with organisational structures in terms of accountability and authority relationships;

(b) theories concerned with organisations as decision making systems;

(c) theories involving analyses of personal and group characteristics and consequent behaviour in organisations;

(d) political theories expressed as the use of power and conflict in organisations.

We also aimed to broaden and deepen our knowledge of organisational theory in general. The bibliography produced as Appendix 1 gives a list of those books and papers we found useful.

Whilst we found most of the theories relevant in part, the concepts outlined in the book "Health Services"[1] a series of essays edited by Elliott Jaques of the Brunel Institute of Organisation and Social Studies (BIOSS) seemed to us to have the most practical relevance in analysing the problems we wished to consider.

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[1] Health Services - A Series of Essays, Editor Elliott Jaques, BIOSS.

Page 10, paragraph 2 and Appendix 2 :-
There was an omission to specifically acknowledge that the Glossary of Terms in Appendix 2 were from "Health Services - A Series of Essays", Editor Elliott Jaques, BIOSS.

Although an external analyst was not involved, we did have the help and interest of an academic collaborator with specific experience in this field. Also we felt that exploring issues jointly enabled us to check each other's perceptions and observations, and in this way reach reasonably unbiased conclusions.

The second factor which the BIOSS reading helped clarify for us was the need to be absolutely clear about the definition of terms and words that are used. Initially we had both agreed to avoid the use of anything that could possibly be construed as 'jargon'. However, we are now convinced that the use of precise terminology in describing organisational relationships is essential. The absence of a common understanding of everyday terms such as manager, coordinator, staff officer, contributes to role confusion and this may ultimately reduce organisational effectiveness. Throughout this paper we have used the definitions of these and other terms describing organisational relationships reproduced in Appendix 2. The appendix also includes some terms not used in this paper which may be helpful in defining management structures.

Our approach in designing the method of information collection and its interpretation was therefore influenced by the BIOSS concepts and also takes account of our other reading and some involvement in team development training.

Specific Areas for Attention

In deciding on which areas to focus our attention, we have concentrated on Health Circular (80)8[1], the main aims of which can be summarised as simplification of the NHS structure through the abolition of multi-District Area Health Authorities and the establishment of local District Health Authorities and greater emphasis on the delegation of responsibility to officers at unit level, with a reduction in management costs.

The implications of these national proposals have been widely discussed at local and regional levels, and it seems that some interesting views and assumptions are emerging. For example:

(a) that medical, nursing and administrative structures must be compatible.

(b) that "units" mean a reinstatement of tripartite hospital administration, ie a matron, an administrator and Chairman of Medical Staff Committee in each hospital.

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[1]Health Circular (80)8 Structure and Management - DHSS 1980.

(c) that the unit "team" will be accountable corporately to the District Management Team and therefore will work on a concensus basis.

(d) that the Unit Administrator, in exercising his coordinating role will emerge as the dictator of policy.

(e) that the virement of budgets at unit level may mean underspent nursing money being diverted for other purposes or alternatively overspending of the unit nursing budget being financed within the overall unit budget.

It is these perceptions of how the aims of HC(80)8 should be implemented that led us to conclude that the three areas on which we should concentrate were:

(a) the centralisation versus decentralisation issue, involving questions of delegation, devolution of authority, accountability, loss of consistency of practice etc.

(b) the need for compatability between nursing, medical and administrative structures.

(c) the question of team accountability and the inter-relationship of teams with management hierarchies.

The framework of organisational analysis we used is described fully in Appendix 3.

Information Collection

First of all we examined all the organisational charts so that we were clear about the manifest, that is the formally described, situation.

Then we held group discussions with a selection of middle and senior nursing and administrative managers in our most complex sector, the features of which included clinical specialties provided in a hospital and community setting, non-alignment of nursing and administrative structures, a high degree of multidisciplinary team work and separate functional nursing and midwifery managers of the same grade with accountability to officers working off site.

We followed the group discussions by sending a questionnaire (Appendix 4) to a selection of first, middle, senior and top managers which was designed to determine the levels of decision-making relating to:

- control over financial resources
- control over personnel
- involvement with planning
- working relationships with medical staff

We also referred to written descriptions obtained from a General Divisional Nursing Officer and two of her Senior Nursing Officers who had been asked to describe their roles in the reality of the day to day situation.

At this stage we felt we had a fairly clear picture of the position, as it is <u>assumed</u> to be by individuals in the organisation.

CENTRALISATION VERSUS DECENTRALISATION

Introduction

The major emphasis on devolution in HC(80)8 reflects the current Government philosophy that decentralisation in itself will somehow improve organisational effectiveness; this being based on the view that greater delegation of decision-making will achieve such objectives as greater sensitivity and awareness of local needs, improved coordination and integration of services, eg health, voluntary and local authority; and greater efficiency and improved financial control.[1]

This philosophy is already producing a number of paradoxical situations within the service. Although Ministers are making genuine efforts to reduce the involvement of the DHSS in detailed management of the health service, a number of questions arise about whether these efforts will result in decentralisation, let alone greater efficiency and effectiveness.

- Is the establishment of a National Supply Council and the transfer of DHSS supplies work to it really a move towards decentralisation within the National Health Service?

- Do Regional Health Authorities, who, after 1 April will be relating to 15 or more District Health Authorities rather than three or four Area Health Authorities, see this as an opportunity for decentralisation or as a recipe for a greater degree of involvement in the work of District Health Authorities?

- Will the advent of more local District Health Authorities and part-time Chairmen lead to greater delegation of work to District Management Teams or greater centralisation of decision-making?

- Is this new thrust for decentralisation facilitated by that other major Government policy, reduction of management costs; for example is the emergence of 15 different ways of tackling the same problem in a Region, or several 'Unit' ways of duplicating effort within a District Health Authority, consistent with achieving maximum economies of scale and use of scarce skills and expertise?

There are two general points arising from the above kind of questions that we considered would be worth pursuing further by looking at our own organisation in more detail. The first relates to establishing a better understanding of the relationship between the different levels of work and the processes of decision making. The second concerns what appears to us to be a predominant reaction within the Health Service to the idea of greater delegation, namely that it is something that other people should do to us not what we should do to them.

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[1]The Ontario Experience - Regionalisation and Decentralisation - An unpublished paper by Maureen Dixon, 1979.

Findings

As mentioned previously our main source of information within the District was the use of a questionnaire sent to some 28 managers. We tried to ensure that there was an adequate representation in the management group who received the questionnaires of first-line managers, middle managers, senior managers and chief officers. The questionnaire was aimed at establishing the degree of decision-making discretion that managers considered they had. The four general areas covered were related to control over financial resoources, influence and involvement on personnel matters, contribution to planning in its wider sense and the nature of the managers' relationship with senior medical staff. In addition to the questionnaire we discussed with a smaller group of managers working in one particular sector some of the general issues.

Our findings can best be summarised under the headings of the questionnaire.

Control over financial resources

One of the key managerial discretion areas is concerned with virement, ie the authority to make changes within and/or between an agreed budget(s). As far as the nursing budget is concerned, manoeuverability relates almost entirely to the staff component and any decisions to change the budget in any way are almost exclusively restricted to the Senior Nursing Officer grade and above. In the main, any changes within a division would be sanctioned by the Divisional Nursing Officer and between divisions only by the District Nursing Officer.

A similar situation exists for general administration where virement is almost entirely limited to sector administrators but with any significant changes within a sector budget and/or between sectors being sanctioned by the Operational Services Manager.

Non-staffing items are controlled in three ways. The overall budget for the routine or consumable items is technically controlled by the sector administrator but all of these items are subject to direct requisitioning on stores by users and the degree of budget control is limited. Still within the overall budget, individual non-routine items are controlled through expenditure authorisation limits. For example, sector administrators can authorise the replacement of a piece of medical and surgical equipment up to £300 and above that figure decisions will be taken by the Operational Services Manager. The third area of control relates to agreed programmes for new and/or more major projects. The major programmes in this category relate to capital projects, maintenance and improvements, and equipment and vehicle replacements and renewals.

Decisions relating to such programmes are taken exclusively at senior or top management level, although there is considerable discussion about what should or should not be included with a wide range of managers.

The District Nursing Officer and Operational Services Manager liaise with the District Finance Officer and agree any substantial variations within and/or between their agreed budget headings.

The District Management Team are only involved in issues of virement if policy decisions have to be made with regard to any major under or overspendings on the overall District budget. In summary, top and senior management can exercise a relatively high degree of discretion in their use of financial resources but middle management levels are fairly restricted and first line managers have no authority to vary their budget components.

Personnel

We were anxious to establish what degree of discretion our managers had over the staff for whom they were accountable and through the questionnaire we looked specifically at issues such as authority to appoint staff, regrade staff and conduct the various stages of the disciplinary procedures. Taking appointment arrangements first; in the nursing organisation, all managers were clear about appointment procedures and the managers answering the questionnaires identified the manager once removed as being responsible for appointments, eg Divisional Nursing Officers responsible for Nursing Officer appointments, Senior Nursing Officers responsible for sister/charge nurse appointments etc. In administration, all managers were also clear about appointment arrangements ie managers appointed their immediate subordinates, eg Operational Services Manager appointed Sector Administrators , appointed Deputy Sector Administrators and certain heads of departments.

What we were unable to determine from the questionnaire was when a manager's manager was involved in the appointment process, did he or she allow their subordinate the power to veto the appointment of any unsuitable candidate. This is a question that is helpful in determining where full managerial roles exist. However, it appears possible to us that there may be some doubt, particularly at the first line management level in our organisation, ie ward sisters, heads of departments, that such veto rights exist.

With regard to disciplinary procedures, again all managers who answered the questionnaire understood the limit of their authority in giving informal or formal warnings and/or authorising suspension or dismissal. This is not surprising given the very explicit Area Health Authority policies and procedures that have been implemented over the last five years. What is clear from looking at the procedures closely is that the degree of discretion provided for first line and middle management is extremely limited and in fact, according to the policies, authority to suspend and/or dismiss an employee can only be authorised by a chief officer.

The D.M.T. is only involved in appointment arrangements inasfar as one or other of the chief officers making an appointment for a senior member of staff may seek their colleagues' views on candidates. The team is not involved in individual disciplinary matters which are the province of the chief officer concerned and/or if necessary the employing authority.

In summary, discretion over matters concerning staff discipline is limited to senior and top management. It was not possible to determine if the decisions concerning the appointment of staff were taken at the appropriate level, although in our view it is likely that the distinction between supervisory and full managerial roles is somewhat unclear.

Involvement with Planning

Of the 28 managers responding to the questionnaire, some 19 indicated that they were involved with preparations for the annual District Plan, although significantly the 9 managers who said they were not involved included all of the first line managers. Managers described their contribution to service planning in terms of participation in multidisciplinary planning teams. In relation to capital projects, decision-making with regard to the selection of projects was seen to be a senior or top management function, although most middle and senior managers confirmed their involvement in the processes of advising on which schemes should be undertaken and/or in their implementation.

Service and capital planning ar major parts of the D.M.T's work. It is the D.M.T that agrees all the capital projects having looked at a wide range of bids included in the District Plan. As far as service planning is concerned, the D.M.T have a wide range of health care planning teams and working parties providing it with advice and recommendations. Whilst such recommendations provide an important point of influence, it remains the D.M.T. who make decisions on any proposals that have resource implications.

In summary, the District's approach to planning generates a considerable opportunity for the involvement of managers and other professions in the process, but decision making is firmly anchored with the D.M.T.

Working Relationships with Medical Staff

We included this subject heading in the questionnaire because we wanted to establish what opportunities managers at different levels of the organisation had for working with and influencing medical staff. We identified that only 6 of the managers were regularly involved in attending meetings of the medical advisory machinery via cogwheel divisions. The main point of decision-making in terms of the control over those resources in which medical staff have a particular interest, such as medical and surgical equipment and approval for additional medical and/or nursing staff, rests with senior and top managers.

Sector Administrators are responsible for organising the appointment processes for junior medical staff (house officers and senior house officers), and are also responsible for managing staff residential accommodation. These responsibilities provide opportunities for regular contact with both senior and junior doctors.

In carrying out their work, the D.M.T. have always recognised the vital importance of involving and influencing senior medical staff. Apart from consultants' involvement in the more formalised multi-disciplinary groups and teams, which are referred to in a later section, one or more members of the D.M.T. (in addition to the Consultant and/or General Practitioner member) are involved directly with the three main medical advisory committees, ie the District Medical Committee, the Medical Executive Committee and the combined Hospital Consultants' Committee. This involvement provides an important opportunity for influencing views. The team exercises fairly direct control over the processing of, and setting priorities for, additional medical staff appointments in all grades. A high priority has been given to the development of information services that can help the team in that sensitive area of monitoring clinical service performance. As mentioned previously, the purchase of all new and replacement medical equipment (above £300) and the investigation of any serious complaints or untoward incidents involving medical staff are also undertaken from District Headquarters.

In summary, each level of management in the administrative hierarchy has regular and distinctive points of contact with medical staff, although the degree of discretion to respond to medical staff initiatives is vested in senior and top managers - ie above sector level. In the nursing organisation, there are relatively few natural opportunities for nurse managers(other than ward sisters and the District Nursing Officer) to relate with medical staff, other than through the more formalised multidisciplinary teams.

In reflecting upon this picture of a relatively centralist approach to decision making and trying to determine why our organisation works in this way a number of points emerged.

The financial climate over the last 15 to 20 years has partly determined how and where decisions are made. Until 1974 and because of the shortage of money, virtually all service improvement proposals were vetted and approved by senior or top management. After 1974 the District gained significant development funds under Regional and Area resource reallocation policies and there was pressure on the D.M.T. to demonstrate firm control over all new investment programmes.

As referred to previously the Area Health Authority Employment and Termination Policies and Procedures that were agreed in 1975/1976 in response to employment legislation have made a major impact on the relationship between managers and their staff and resulted in a highly proceduralised and centralised approach to personnel decisions.

The third point relates to some of the underlying characteristics of the District's organisation and the influence that these may have on levels of decision making. One of the hallmarks of the present management environment is the value placed on achievement of common standards and consistency of practice through the promulgation of agreed policies and procedures. Managers are encouraged to consult their managers before embarking upon any unnecessarily uncertain course of action. One of the influences on the degree of delegation practiced is often expressed as being related to judgements about the present capacity or experience of subordinates to cope with certain additional work. Senior or top management prides itself on the level of knowledge of what is happening in the organisation and therefore encourages formal and informal communication of information up through the system. The distinction between passing information to your manager and/or seeking his advice and in reality him making the decisions can sometimes be difficult to detect.

The following are some of the advantages of the present pattern of work. The present management structure is economical and this is borne out by the District's present below-average management costs. The relatively high concentration of decision-making at the centre has not been achieved through a central concentration of staff resources. The D.M.T. is able to respond speedily to changes arising from either the external environment eg Community Health Council, Regional Health Authority, Area Health Authority pressure and/or from internal demands, eg medical staff, managers and/or staff representations. The information we obtained from the questionnaire and from our discussions with a cross-section of managers indicated a relatively high degree of satisfaction with the management environment. As has been referred to earlier in the report, there appears to be a high degree of understanding of roles and relationships throughout the organisation and very little feeling expressed of over-management or unnecessary duplication of work.

COMPATABILITY BETWEEN NURSING, MEDICAL AND ADMINISTRATIVE STRUCTURES

As mentioned in Section I, some of the views and assumptions which emerged following the publication of HC(80)8 as a result of early discussion, often unidisciplinary, were that medical, nursing and administrative structures must be compatible and that the concept of unit management meant a reinstatement of the tripartite hospital administration model involving a 'matron', an administrator and a representative of the medical staff. Conversely, anxieties also arose, particularly from midwives and psychiatric nurses, where it seemed that successful integration of institutional and community services had been achieved under an appropriately trained nurse manager, that these arrangements would be sacrificed in order that some uniform type of unit structure could be applied within a health authority.

The strength of feeling over this was such that the four main nursing unions, the Health Visitors' Association, the Royal College of Nursing, the Royal College of Midwives and the Association of Nurse Administrators joined together to produce a document giving guidelines on management structures which was endorsed by the Secretary of State and sent to each of the newly appointed Chairmen of District Health Authorities [1].

In general, the present management structures in Medway are not in alignment. The nursing services are managed through four divisions, one of which is the nurse education division*. Of the three service divisions one, namely midwifery, is client group based; the second comprises hospital services encompassing some functional subdivisions eg psychiatry, geriatrics, theatres; and the third consists of the community services, together with three small hospital units within a compact geographical area. The administrative services are institutionally based for the sectors with the community services managed as a single entity.

The medical services are brought together on a specialty basis through cogwheel divisions, of which there are seven, including the Medical Executive Committee. Some of these divisions, including the Medical Executive Committee, have nurses and administrators in attendance; others, including the medical and surgical divisions, function on a unidisciplinary basis.

In examining some of the practical problems that may have arisen from our present situation, we looked at three different types of the District's substructure.

(a) A multispecialty sector with many different organisation strands. This includes both hospital and community components of the maternity and psychiatric services.

(b) The major acute hospital services in the Medway Towns part of the District, which included the functional, institutional and specialty basis of organisation for each of the professions.

(c) The community services, which provided for close alignment between administration and nursing structures but not medical.

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[1] Guidelines on Management Arrangements in the restructured N.H.S. R.C.N. - H.V.A. - R.C.M. - A.N.A. - 1981.

*We have not examined the working of the education division for the purpose of this project, in view of the clear guidance in HC(80)8 that, pending the implementation of the Nurses, Midwives and Health Visitors' Act, existing arrangements for nurse training should containue undisturbed. In any event, the education division would not have the same characteristics as a proposed unit, though it will be necessary to determine how its administrative support is provided in the future.

Findings

The Multispecialty Sector

Though there was a lack of compatability of nursing and administrative structures and no definitely defined medical voice for this sector, we found that, rather contrary to our expectations, there was clear understanding of how each discipline was organised and who was responsible for what task. The notable exception to this is the perception of some medical staff of the roles of the Senior Nursing Officer and the Divisional Nursing Officer in the general division, where some role ambiguity seems to exist.

The lack of compatability of structures made coordinating mechanisms between the disciplines more complex and tenuous and placed more practical responsibility on the Sector Administrator for "whole hospital" issues. This raises the "bring back the matron" lobby, to which further attention is paid in Section III. In this sector at present, there is a nominal institutional nursing head, namely the Midwifery Divisional Nursing Officer, who is based off site. This role was originally identified as necessary because there were three Senior Nursing Officers and one Senior Tutor, with responsibilities on site, and there were practical difficulties of identifying one as institutional head for whole hospital issues, particularly for the Sector Administrator, who sometimes needed a single point of reference. In practice, it would appear that the need for this post was much less important for staff than originally perceived. Clearly on a personal basis, working relationships in this sector were very good. However, the differences in the nursing and administrative structures did appear to engender a strong unidisciplinary work pattern in relation to the operational services work for the hospital and this suggests that perhaps more attention needs to be paid to the service giving/service seeking relationships defined in Appendix 2, page 11. We return to this point in Section III.

Paradoxically, the managers in this sector were involved in a large number of multidisciplinary groups and teams. The Sector Administrator provided administrative support to some of these and there did not appear to be any major difficulty in combining the administrator's contribution to this multidisciplinary work with the hospital institutional services role. The contribution by medical staff to whole hospital decision-making was negligible, though there is a hospital medical staff committee chairman. However, the medical input to multidisciplinary work in the 'discrete' care groups in this sector was very considerable and was regarded as fundamental to achieving satisfactory policies for the delivery of care.

Acute Hospital Services in the Medway Towns

The Medway Towns acute service facilities consist of the Medway and St. Bartholomew's hospitals and a convalescent ward at St. Williams' Radiotherapy Centre.

The incompatability of nursing,administrative and medical structures seemed to cause more problems in this area, which forms the major part of one nursing division, and includes the only accident/emergency department in the District. One Senior Nursing Officer is responsible for all three hospitals, while each of the two general hospitals has its own Sector Administrator responsible to the Operational Services Manager. The consultant medical staff work at both general hospitals and there is a constant inter-hospital use of in-patient facilities. The only realistic point of medical staff coordination is at chairman of Medical Executive Committee level.

Whilst nurses and administrators work closely together in each hospital, much of the inter-hospital coordination over subjects such as bed management problems, rests with nursing management. The unavoidable problems and tensions that will arise between staff working in situation of constant pressure as in this part of the organisation, appear to be compounded by the organisational arrangements that do not provide for natural multidisciplinary working links above ward level.

As mentioned above, the medical and surgical cogwheel divisions meet without a nurse manager or administrator in attendance. Nurse managers, especially at Senior and Divisional Nursing Officer level, feel the need to "keep in touch" with consultants, who communicate on a day-to-day basis with ward staff. Understandably, the consultants feel that their relationships with the ward sisters are the critical ones in delivering care to their patients, and tend to the view that they should not need to talk to nurse managers.

In the Medway Towns acute sector, nurse managers felt that their only contact with consultants was when there were problems to solve and their need to be seen by medical colleagues in a more positive role was very explicitly stated. With reference to this, it is worth noting that in the section on Centralisation versus Decentralisation, we had actually identified that Sector Administrators had regular opportunities for contact with medical staff at all levels where nurse managers at the same level did not.

Community Services

Administratively, community services are organised as a sector, the administrator being accountable to the Assistant District Administrator (Planning). The community nursing and health visiting services are managed by a Divisional Nursing Officer, who also manages two small hospitals and a mental handicap family support unit in the eastern part of the District.

The community midwives are managed by the Midwifery Divisional Nursing Officer. In spite of these differences in the structures there was clear understanding of the different roles, and communication lines seem clear and straightforward.

The Community Health Administrator's coordinating role was well accepted by medical and nursing staff, and this aspect of his job is more obviously emphasised than the line management responsibilities which in the main are delegated to a subordinate. There is another significant difference between the management of the community and the hospital services. There is no Senior Nursing Officer (Community) in the nursing structure, with the nursing officers being accountable to the Divisional Nursing Officer. Therefore the Community Health Administrator communicates directly with the Divisional Nursing Officer on a regular basis whereas in other sectors and divisions the Sector Administrators relate on a day-to-day basis with Senior Nursing Officers and with Divisional Nursing Officers only occasionally.

There is no one fixed point of medical contact for the Administrator and Divisional Nursing Officer. Both work closely with the appropriate Principal or Senior Medical Officers and where necessary directly with the District Community Physician. There is a General Practitioner subcommittee of the Local Medical Committee, to which the Community Divisional Nursing Officer is invited if there are nursing matters for discussion. The General Practitioner member of the D.M.T. acts as a reference or communication centre for all General Practitioners if needed.

This pattern of working relationships between the Administrator and the Community Divisional Nursing Officer, and the liaison arrangements between them and medical staff seemed to operate well.

In summary, a number of points have arisen that appear to be related to the grading structures and levels of work within and between the nursing and administrative disciplines. The first point that was more particularly related to the nursing structure in our review was the situation where managers and subordinates regarded the same work as appropriate to their post, and where grade differentials are fairly tight. This was in contrast to the situation in administration, where the grade differential between, for example the Operational Services Manager and Sector Administrators (this being a manager and subordinate relationship) is considerable.

At second-in-line officer level, there are differences between the nursing and administrative disciplines. The three second-in-line administrative officers, ie Personnel Officer, Planning Administrator, and Operational Services Manager, often work directly with the District Nursing Officer and the two latter often attend D.M.T. meetings. Whilst the Divisional Nursing Officers also have specialist areas of responsibility and act up for the District Nursing Officer on occasions, they have less direct contact with the District Administrator as head of administration, and do not normally attend D.M.T. meetings.

Another distinguishing feature between the disciplines is in the perceived different number of managerial levels: the nursing organisation having five management levels, ie Ward Sister, Nursing Officer, District Nursing Officer, and the administrative hierarchy four management levels, ie Head of Department, Sector Administrator, Assistant District Administrator, District Administrator.

Some of the senior nurse managers expressed strong views in support of a clearly defined nursing head in hospital units to symbolise the unity of the nursing staff within that unit, and to coordinate "whole hospital" issues on behalf of all the nurses working there eg major accident procedures, fire prevention etc. It was interesting to note, however, that in the multispecialty sector we examined in some detail where an institutional nursing head had been artificially created some years ago, most of the managers we discussed this issue with found the post unnecessary now and confirmed that the post was only used on "social occasions".

As far as compatability with the medical structure is concerned, though some useful working relationships have emerged from multi-disciplinary group working, there appear to be few natural opportunities for medical staff to communicate with middle level nurse managers, while Sector Administrators are in regular contact with them.

THE DEVELOPMENT OF MULTIDISCIPLINARY TEAMS

In recent years multidisciplinary teams have become an increasingly prominent feature of the health care scene. Their development has occurred both in management and clinical settings. (A project paper[1] produced by the King's Fund in September 1980 shows that, over the last 10 years, at least 16 major reports have been produced nationally that recommend greater multi-disciplinary team working in one form or another). The forthcoming reorganisation has directed further attention at some important team development issues.

The advice and guidance in HC(80)8 has resulted in discussion within the service about the possibly reduced role of D.M.T's in the future, given the greater emphasis in the circular on individual accountability of chief officers to their Authorities. Additionally, some staff within the service have assumed that the references to 'units' and greater delegation in the future must result in the establishment of Unit Management Teams with some form of 'corporate' accountability.

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[1] Kings Fund Project Paper - Sept. 1980.

See also An Annotated Bibliography of Health Care, Teamwork & Health Centre Development Ed: M.M.Warner: University of British Columbia.

Senior Nursing Officer, Divisional Nursing Officer and

The form of multidisciplinary team or group working arrangements within any District and the question of accountability are therefore important elements in the consideration of new management arrangements, and we considered that a review of the present Medway position might highlight points that could be taken into account in any future proposals for change.

In collecting data about the District's present 'group' working arrangements and in addition to the forms of information collection outlined in Section 1, we analysed the terms of reference, membership and meeting frequency of some 33 groups. We did not have the time as part of this project to attend meetings of any of the groups in order to explore directly with the participants the issues we reflect upon later, and we have therefore relied heavily on our own perceptions of the internal dynamics of some of the groups' work and on the views expressed from time to time by our own staff and other D.M.T. colleagues.

In terms of information analysis, one of our first practical problems was trying to define the different types of groups at work and the main characteristics of each. This was important because the titles used - eg team, group, working party, committee - are often interchangeable. The results of this attempt to produce a classification system are outlined in Appendix 6.

In the course of the review, we also found it helpful to produce our own checklist of the main features we regarded as essential to multidisciplinary teamwork and we develop a number of points arising from this further in Section III.

Findings

Clinical teams

The development of multidisciplinary clinical teams providing services to certain client groups in the District raises a number of important issues. At present, such teams are restricted to community-orientated care groups, and perhaps the most well-developed model is that of the mental handicap team, although similar teams already exist for child and family psychiatry, the young disabled, the elderly infirm and the terminally ill. These teams provide the most structured means to date for coordinating the work of different agencies at the point of service delivery, eg health staff, such as doctors, nurses, psychologists - local authority staff, such as social workers, teachers and voluntary bodies and special interest groups.

In looking at the work of our Mental Handicap Team so far a number of points arise. Firstly, the members of the team are enthusiastic to share ideas and work together. Of particular importance is the attitude of the Consultant member, who, although making a major contribution, clearly does so in the style of an equal rather than automatic team leader.

The team has a remit for focusing on the needs of individual clients and families in order to ensure that the best possible advice and/or care programmes can be devised and to ensure that the potentially many different services being provided to the individual are adequately coordinated. However, the team has so far concentrated more on those issues that would be the concern of all mentally handicapped people in the District, eg establishment of a register of mentally handicapped people, developing information leaflets for families, identifying deficiencies in certain parts of the service, improving staff training etc. A number of the members of this team are also members of the Health Care Planning Team and this is seen as a useful means through which the staff concerned in the delivery of service can also influence future plans and policies for the service. A senior administrator is a full member of the Mental Handicap Team and appears to provide an important role in helping to coordinate the team's work.

"Management" Teams

The other form of multidisciplinary team that is currently attracting the most interest with reorganisation is the so-called multidisciplinary management team. The experience locally of such teams is restricted to the fields of geriatrics and psychiatry. The geriatric multi-disciplinary management team that was established arising from a Hospital Advisory Service recommendation some four years ago, has now not met for about 18 months. The demise of this team can probably be attributed to two main factors; firstly, its area of work cut across the management boundaries of two administrative sectors which included long-stay hospital facilities in two hospitals in one geographical part of the District, and the acute geriatric in-patient and day hospital facilities in a general hospital in another part of the District. The terms of reference for the team limited its horizons to operational (as opposed to health care planning) problems and this has resulted in a situation where the product of the team's work became very difficult to identify. Secondly, the consultant medical staff involved were not wholeheartedly committed to this form of multidisciplinary work.

In contrast, the psychiatric management team with much more restricted terms of reference, ie concerned only with the acute psychiatric facilities provided in one general hospital, two days hospitals and a developing community nursing service, is proving to be a much greater success, at least if measured by the enthusiasm of its members. The team's area of work is also consistent with nursing and administrative management structures.

Health Care Planning Teams

Since the District is relatively deprived, the D.M.T. have regarded it as important to concentrate on producing well developed short term plans and proposals in order to demonstrate the case for the redeployment of resources from other Districts and to show that any additional resources received can be spent effectively.

The development of health care planning teams since 1974 has provided a potent force for focusing attention on the District's objectives for the future, at the same time involving a wide range of District staff in considering questions of priority within their own fields of work.

The teams also made an important contribution in their early days to facilitating the integration of Health, Local Authority, CHC and voluntary services.

About 18 months ago, the membership of the teams was reviewed as it had been found that some of them were too large and were becoming more committee-like in character and a number of members made little, if any, contribution. Over the last 18 months, it has become apparent that the 'planning for the future' role of the team is rapidly being exhausted and that the centre of interest is moving more towards the work of the other multidisciplinary teams described previously.

Managers throughout the District are spending an increasing amount of time in group work situations, and the managers' discussion group we met with as part of this project confirmed that between 20% and 30% of their time was being spent in such group working situations. There is relatively little training given to our managers in team membership skills, and virtually none at all for medical staff.

The differences between the acute services sector of the District and the other care groups in terms of multidisciplinary work and team development is very apparent. Clearly the approach towards the planning, management and delivery of services is much more doctor dominated for the acute services. This is certainly not surprising and is probably the situation in most other Districts. There are a number of reasons why the pressure for more formal multidisciplinary arrangements have been stronger in the community-orientated care groups than in the primarily hospital-based acute services, eg the greater need for inter-agency coordination referred to earlier, and the emergence of professions seeking independent practitioner status, such as psychology and social work etc.

However, whatever the reasons for this difference in the management style for acute services and the other care groups, the implications of this within the District are quite considerable. Groups of staff and managers are likely to feel increasingly that the opportunities to participate and influence decision making in one part of the organisation are significantly limited in comparison with another.

In summary, the District's present arrangements are a mixture of, on the one hand, the somewhat random development of 'teams' finding their own way, setting their own priorities, with relatively little D.M.T. interest in their work and, on the other hand, a far more structured approach as represented by the health care planning arrangements.

POINTERS FOR THE FUTURE

INTRODUCTION

Prior to exploring further some of the issues identified in Section II some consideration needs to be given to the alternative basis for units as identified in HC(80)8 and which are:

Community services

Geographical subdivision consisting of hospital and community services within a defined territory

Client care services

Hospitals or groups of hospitals

There are certain inherent tendencies in each of these approaches. Units based on either institutions or community services are unlikely to be immediately effective for introducing a change in management practices such as the philosophy of decentralisation suggests. The status quo is more likely to be maintained with the perpetuation of traditional practices and attitudes. On the other hand, the involvement of relevant medical staff in management arrangements and the needs of professional training, especially nursing, will be easier to achieve.

Development of community services remains a national priority, and since approximately 90% of illness is treated in the community and almost all preventive medicine and health education takes place there, this is as it should be. The analysis of the community sector working in Medway, confirms our view that a Community Unit (excluding Midwifery) should be formed. Medical input to the unit team could be provided by a specialist in community medicine, as suggested in 'The Tasks and Responsibilities of Community Medicine',[1] the report of the Community Medicine Specialty Sub-Committee, S.E.T.R.H.A., though our own experience suggests the unit could function without this.

A geographically based unit is the one which lends itself most readily to principles of delegation. The intrinsic difference between this concept and most of the sectors and divisions of today would make it easier for the right 'distance' to be achieved between unit managers and the D.M.T. members who will be their bosses. The very nature of the sub-division would beg for decentralisation and in greater initiatives from unit managers. Hand in hand with this would go a loosening of central control and the loss of some consistency in the application of policies and procedures throughout the District which are features of devolution of responsibility. However, the practical difficulties of providing the different specialties to each unit with its supporting community care would make it a daunting task, particularly as various functional groups in the nursing and midwifery and health visiting professions are insisting on self management at unit or director of nursing services level.

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[1] Report of the Community Medicine Specialty Sub-Committee S.E.T.R.H.A. 1981.

There will be some places where geographical units can be established, but it is difficult to envisage a District where all units can or should be geographically determined.

Units based on client care groups would facilitate the harnessing of professional skills on services needing particular attention. However, a problem with this approach is that the general characteristics of different care groups vary, and indeed it is difficult to classify all care in this way. It would appear that there are very few discrete care groups. By this we mean 'separate' groups requiring care from staff with specialised training whose services is confined to one 'separate' group of patients. The client care groups which meet these criteria are the mentally handicapped, those who have a psychiatric disorder, and expectant and newly-delivered mothers with their babies. We find difficulty in applying these criteria to other groups of patients including the elderly and children because their care, particularly that given in the community is provided by staff who give a service to patients with all types of illness.

An elderly patient - whatever that means - may have an acute illness needing hospital treatment in a medical, surgical, orthopaedic or gynaecological ward; can require psychiatric treatment at a day hospital, or as an in-patient; may need nursing at home, or support from a geriatric day hospital or centre; or may be admitted to a geriatric assessment ward, prior to a stay in a rehabilitation or long stay ward. Local facilities will indicate whether the location and number of hospitals suggest that a geriatric unit can be formed, and this may be advantageous. If this is inappropriate, then the special needs of this important and ever-increasing group of patients can be given the emphasis they need through the media of multidisciplinary management and/or clinical teams, whilst the day to day care and support of hotel and domiciliary services could be provided from within general acute and community units.

Most of the care given to children, whether preventative or curative, takes place in the community. The hospital in-patient and out-patient components of care might be linked within the community unit, if local conditions make that appropriate. Alternative models would be to include it in the midwifery unit, where the alignment with special care baby units is a sensible concept, or if geographical features so dictate, within a hospital unit. In the case of the two latter, it will be very important to ensure adequate cross unit liaison, so that continuity of care is maintained, particularly for cases of non-accidental injury, potential or proven.

In practical terms there are problems in trying to 'fit' medical and surgical patients and those who have been the subject of trauma into the client care group classification, since they do not have homogeneous needs. The formation of 'hospital' or 'group of hospitals' units are the realistic method of harnessing professional skills and time most efficiently to achieve organisational goals, where medical care is provided by surgeons and physicians.

The conclusion that we have reached for unit construction is that it would be neither practical nor desirable for all units to be formed on the same basis. However, there are a number of common concepts that do need to be uniformly applied and these are outlined in the following paragraphs.

CENTRALISATION VERSUS DECENTRALISATION

In Section II we describe the situation in the District where decision making is relatively centralised and how this has arisen. We now need to relate what we have learned to any possible changes in the future. Irrespective of the strengths and weaknesses of our present arrangements a general observation would be that our patterns of decision making are influenced substantially by individual chief officers' own management styles, the way in which the D.M.T. operates and the policies and procedures that cover how finance and staffing matters are managed rather than any deliberate attempt to determine corporately what kind of work should be undertaken at what level. This question of being able to distinguish between different work levels is of particular importance given the establishment of more local District Health Authorities and pressure for greater delegation to units. The advent of management cost limits will add a new dimension to the preparation of management structures and, as referred to in the introduction to Section II, may paradoxically add greater pressure for centralisation of work.

In examining some of these issues we have found the Brunel literature on work strata particularly helpful. The concepts involved have been developed from the time-span of discretion work originally promulgated by Jaques and developed as a descriptive model by Rowbottom & Billis.

The work strata model postulates that every post in an organisation is established to meet a perceived need and that at least five separate levels of response to need can be identified. Work at each of these levels is characteristically different. At each level or stratum the tasks to be done are identified together with the amount of discretion and responsibility required to accomplish them. A move from a lower to a higher stratum is accompanied by an increase in discretion and responsibility. An effective manager of a subordinate must be in the next higher work stratum. As well as providing a means of specifying individual accountability and authority, the work stratum system can be used to identify the type of decisions and therefore work to be undertaken at different levels, (see Appendix 2).

Work at the lower levels is concerned with individual situations or problems. At level 1 the tasks are specifically identified eg typing a letter. At level 2 judgement has to be exercised, eg locating the fault in an electrical circuit. Moving up to level 3 requires response to a continuing flow of needs and the ability to introduce systems and procedures, eg developing a new method of dealing with complaints.

At the next two levels, conceptual skills are required. Level 4 work is that of comprehensive service provision within given territorial or organisational boundaries, eg the planning and management of a District's obstetric services. In comprehensive field coverage which describes level 5 work the brief is extended to meeting needs of any kind within some broad field, where the specific range of services to be provided cannot be laid down beforehand, though the kinds of service have to be defined and agreed with any governing body and parallel organisations.

This description of level 5 work appears to match fairly accurately the work of a District Health Authority, which is to be charged with developing and providing a comprehensive range of health services within a given territory, subject to the overall strategic planning and resource guidelines laid down by the Regional Health Authority and in consultation with other organisations, eg the Local Authority and Community Health Council. If this is accepted, then it follows that officers of the D.M.T. must be capable of level 5 work. It would then follow that the unit officers would be undertaking level 4 work, because it is intrinsic in the guidance so far given that they are to be directly accountable to District Officers. If this approach is accepted then important parameters are set for the new units, whose officers would expect to be involved in producing comprehensive plans and budget proposals for their spheres of authority as well as managing them on a day to day basis.

The reality of the situation is that some D.M.T. officers will not be capable of functioning at level 5, and that some unit officers will not be capable of level 4 work. We are not suggesting that the system will cease to function if this happens, but to draw attention to some possible consequences, which may include irritation and lack of cohesion within a team. More significantly, if a D.M.T. cannot produce stratum 5 work, the greater the chance of more Regional involvement. Likewise, if unit officers are not capable of undertaking stratum 4 work, then District will become more involved.

In addition to work strata one other step that may be helpful in determining what work is appropriate at what level is the one where a distinction is drawn between operational and non-operational work. Broadly speaking operational work can be defined as that which is directly related to the main goals of the organisation or, in other words, those activities for which the organisation was established. The provision of nursing and medical services is directly related to the care and treatment of patients for which the N.H.S. was established; whereas the provisions of financial information is a non-operational activity. Arguably, the organisation of operational work needs to provide for the maximum degree of decision making discretion at the point of service delivery and this calls for a devolved model of organisation. However, the reverse may be true for non-operational work where uniformity of policy and practice and economy of scale may outweigh the arguments for a highly decentralised model. It may therefore be appropriate for each unit in future to be able to exercise more direct control over a whole range of staff and services that are directly related to patient care/treatment. However, it may be quite inappropriate to establish each unit as a separate entity in terms of its own personnel, financial and other systems.

A factor that needs to be taken into account when considering operational and non-operational work, is the difference between those services or activities that need to be organised or provided on a District-wide basis but not necessarily District-controlled. For example, very few people would argue that new units should each have the whole range of their own supporting services eg laundry or central sterile supply department. Therefore there is no reason why officers in one unit should not be accountable for providing services to other units. (see page 34 relating to service giving/service seeking relationships).

In our own District it would seem that some of the main options for the future do revolve around either the establishment of level 4 'units' (ie those capable of comprehensive service provision) or acceptance that units will remain at level 3 and that level 4 and 5 work will continue to be undertaken at District.

Two of the characteristics of level 4 work that have already been referred to are the degree of management discretion that can be exercised and the comprehensive approach to planning and development for the future. It is likely that such work on the administrative side would be at Scale 23-29 level and for nursing the present equivalent of the Divisional Nursing Officer posts. Given management costs, staff availability and the size of the District, it is unlikely that more than two or at the most three such level 4 units could be established. This approach on the face of it comes the closest to mirroring the philosophies outlined in HC(80)8 whereby broadly the units are concerned with the management of the organisation whereas the D.M.T and D.H.A. are concerned with setting the policies within which the management is conducted and monitoring the effectiveness of the enterprise generally. An alternative is one that aligns more closely with present arrangements, that is level 3 units but with a clearer recognition that level 4 and 5 work will be undertaken from District Headquarters. This approach would almost certainly involve the creation of senior staff officer roles to support the District Administrator and District Nursing Officer and involve the D.M.T. in a more direct way with the planning and management of individual parts of the service.

COMPATABILITY BETWEEN NURSING, MEDICAL AND ADMINISTRATIVE STRUCTURES

A number of points emerge from the Section II work under this heading which provide some pointers for the future in Medway.

The first relates to a difficulty we had in visualising how the 'appropriate senior member of the medical staff' would be identified for each unit. The guidance contained in DA(81)1[1] Medical Advisory Machinery indicates that "the medical representatives on a unit group should be elected by all the medical staff working in the unit or by an appropriate sub-set". eg in a mental illness or mental handicap client group the medical representatives would be elected by colleagues in these specialties and a district general hospital unit medical representative would be elected by the District Hospital Medical Committee, or by the Medical Executive Committee if there is one.

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[1] DA(81)1 - Medical Advisory Machinery.

Medical representation on multispecialty units and units involved with both hospital and community work should, it is recommended, have consideration given to the involvement of more than one doctor. This may create practical day to day working problems as well as altering the balance of the unit management arrangements. This point leads naturally into another factor which may well affect the way that units are established within the new authorities and that is the power base of the clinicians. In their book 'Crisis in the Health Service'[1] Andy Alaszewski and Stuart Haywood argue the case for a local perspective on health services. They refer to the lack of success in getting central policy implemented, however good this is because it is the clinicians who exert control over much N.H.S. expenditure by virtue of their independent contractual status. An example of this is the inability of most authorities to reallocate resources to any significant extent to the 'cinderella' services as outlined in 'Priorities for Care'[2]. The relevance of this is that clinicians working mainly in hospitals are going to want some units to be hospital based. Their interest and involvement is essential to the satisfactory planning and delivery of services so it would be pointless to ignore a method of harnessing that interest and involvement.

We found in our analysis that in the multispecialty sector where obstetrics, psychiatry and geriatrics were the major components of the hospital, contributions by medical staff to 'whole' hospital decision making was negligible, but the medical input to multidisciplinary teamwork especially in psychiatry and obstetrics was very significant.

In the three hospitals involved in providing the main focus of the acute service in the Medway towns medical staff involvement in multidisciplinary team or group working was limited, but medical staff involvement in day to day management issues was frequently required and one authoritative voice was needed.

With regard to future working arrangements, there is a need to both recognise and accept that consultants work at all levels. A useful analogy is in an organisational 'lift' in which Medical staff can travel and only get off at a particular level if there is a reason to do so. At the level of the ward sister there is a clear, frequent and direct need for communication about patient care. In the recently published research report on "The Role of the Nursing Officer"[3] by Jones, Crossley - Holland and Matus, this point is emphasised in a quote from a paper by J.H.Robb published in Social Science and Medicine. He says "the different shapes of the (nursing and medical) structures become obvious when one notes that the consultant is at the top of the medical structure ... while the ward sister with whom he has direct clinical communication is about the middle of the nursing structure. Many consultants take the view that this fact is a demonstration that most of the positions above the level of ward sister are strictly unnecessary, that insofar as these nurses are doing any real or essential work it is work which could be done equally well by administrators, thus making available more nurses for work on the wards or other direct patient care situations".

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[1] Crisis in the Health Service, Chapter 6 - Andy Alaszewski & Stuart Haywood.

[2] Priorities for Health and Personal Social Services in England - H.M.S.O. 1976.

[3] "The Role of the Nursing Officer" - Jones, Crossley - Holland & Matus 1981.

If the role of the nurse manager is more clearly defined and understood by the medical staff and there is a flattening of the hierarchy, then medical staff may relate more readily to intermediate level managers who will be regarded as making a distinctive management contribution.

The next point relates to the differences in the type of work done in the different disciplines and in particular between the nursing and administrative managers. Nurse managers feel that their work is directly concerned with ensuring that patients and/or clients are cared for as well and as speedily as possible. Administrators readily accept that their role is to facilitate this and in broad terms the way they do this is through the service giving relationship. Such a relationship arises when someone needs to be able to request from others whom he does not manage resources and/or materials to carry out his job. A surgeon requires a portering service to transport patients to and from the operating theatre. A ward sister requires her ward to be cleaned and sufficient clean laundry delivered to her ward each day to ensure that her patients can be cared for in a safe, comfortable environment. Both request these services from an administrator, who as the service-giver is expected to provide the service to a previously mutually agreed standard; if he cannot do this he should notify the service-seeker and discuss alternatives. However, there are also responsibilities vested in the service receiver which are:

- to draw deficiencies to the attention of the service-giver in a positive way, not just grumble that the floor is dirty or the sheets are short;

- to negotiate improvements if possible;

- or, if not, to report sustained deficiencies to the attention of superior authorities.

It appears to us that perhaps insufficient attention is being paid to the significance of the mutual responsibilities of the service-giving/service-receiving relationship. There are, we think, two possible reasons for this. The first relates to the emphasis over the past two decades on relieving nurses from non-nursing tasks to free them to devote more time to direct patient care activities. This is a laudable objective in itself, but has fostered the attitude in some nurses that such services as catering, cleaning, provisions of laundry and CSSD are totally outside their sphere of influence and responsibility. Secondly, the economic situation over the last few years has resulted in all managers being acutely conscious of the need to make the best possible use of all the resources for which they are individually accountable. Thus, saving some money on catering might mean more to spend on furnishings or an improvement in the level of maintenance. We feel this may have engendered the rather inward looking unidisciplinary pattern of working we identified. We are not suggesting this was the result of poor working relationships - indeed the reverse was found to be the case, but we consider that joint examination of all the facets of the service-giving/service receiving relationship should be a positive feature of the unit administrator, director of nursing service medical representative responsibilities in the future.

The third point is a further reflection of the work strata theory described under the previous heading. Whether the model chosen for the 'unit' of the future embodies level 3 or level 4 work, it does seem important that managers of different disciplines who work together regularly need to be capable of working at the same level and have similar discretion parameters to their posts. Should a director of nursing services have wider discretion of virement or personnel matters than the administrator(s) with whom he/she works, confusion and tension are likely to result.

Another issue that will require careful thought in future structures is the role of "specialist" or staff posts. By this we mean officers who assist their managers in managing the activities of their subordinates in a specific dimension of their work, eg personnel, planning research, control of infection. Our perception of the role of a staff officer is that he is expected:

(a) to help to formulate policies or schemes in the field of work concerned, taking into account the experience and views of the managers' other subordinates;

(b) to see that agreed policies or schemes in the field concerned are implemented by the managers' other subordinates; issuing detailed procedures and programmes; ensuring adherence to these programmes, and interpreting agreed policy;

(c) to deal with the daily flow of communications and problems coming to the manager in the field concerned: sorting, filtering, exploring and initiating and coordinating appropriate response wherever possible.

To carry out these tasks, a staff officer requires authority to issue instructions. However, if the managers' subordinate does not agree with instructions given, he cannot disregard them, but he must take them up with the manager direct. A staff officer has no authority to make official appraisal of the performance and ability of the subordinate. (Ref. Appendix II for diagrammatic interpretation of this role).

Staff Officer roles within the N.H.S. are often denigrated. The main reasons for this seem to be:

- the perception that line management experience is all important from a career development point of view, and lack of evidence of an operational services job at senior level is seen as a handicap towards promotion. In this connection it should be remembered that it is perfectly possible for an officer in a staff post to manage quite a large labour force, eg some Personnel Officers.

- the view that the people occupying staff roles cannot provide the specialised advice and information any better than the Operational Services Managers.

- confusion between the roles of the specialist staff officer with specific knowledge and expertise to help a manager in a particular field of work, as opposed to the provision of general assistance to a manager which can be satisfactorily provided by someone in a lower rank than the operational managers.

Brown argues that one of the reasons why the resolution of the relationship between specialist and operational managers has not emerged is because of the widely-held belief that one employee cannot give instructions to another without being his manager. He goes on to point out that, unless staff officers and operational managers in the same immediate command are of the same rank, then the staff concept will not work. If staff officers are clearly of lower rank (and lower capacity) they cannot give staff instructions to the operational managers. If they are of clearly higher rank the operational managers will feel they have several bosses, which is just as bad.

In the past, there has been a tendency for staff posts to be either in a level below or above the operational managers to whom they relate closely in the working situation. For example, the Senior Nursing Officer, Personnel, if often providing information for or requesting information from Divisional Nursing Officers and assistant District Administrators (Planning) are in the same position vis-a-vis Sector Administrators.

If Brown's argument is accepted it provides both an explanation of past tensions and some lessons for future management structures. The 'flattening' of hierarchies arising from the direct accountability of unit officers to D.M.T. officers may result in a wider span of control for them. This may give rise to the need for additional help. It will be very important to determine the type of help required and whether it can be provided by a more junior officer, eg a senior or principal administrative assistant servicing District Health Authority meetings, or a specialist officer with a district-wide function, eg a personnel or planning officer. In some cases both may be needed but if it is in the latter category the rank of the personnel and planning officers will need to be the same as the unit officers; in other words, they need to be capable of working at the same level. If the unit work is at level 4 then the staff officers should be at level 4. If the unit officers work at level 3 and the staff officers at level 4, a quasi-managerial role will develop between the staff posts and the operational managers, thus defeating the object of the direct accountability of unit officers to District officers and giving rise to the 'several bosses' syndrome mentioned earlier.

In future structures care needs to be taken that this does not happen and that where staff posts are identified as necessary, their roles are clearly defined. It will be equally important, in the interests of career development of officers with potential, that experience in a staff post is seen as valuable to both the service and the job holder.

In Section II we mentioned the strong views held by some nurse managers in support of a clearly defined nursing head or 'matron' in hospital units and went on to note with interest that in the multispecialty hospital where such a post had been artificially created in response to a perceived need, most managers confirmed that this post was now only used on "social occasions". Because of the persistent and fairly strong national lobby for the return of the 'matron' as reflected in both the Royal Commission on the N.H.S.[1] and "Patients First"[2], we spent some time considering this, particularly as medical colleagues are partly responsible for the size and strength of the lobby and we were concerned about developing natural opportunities for consultants and nurse managers to work together effectively.

Since 1966 much of the criticism levelled at the nurse managers' role stems from the rapid implementation of the Salmon and Mayston's Committee's recommendations without any proper evaluation and the subsequent upheaval of the 1974 reorganisation of the N.H.S. Both Salmon and Mayston commented on "the incoherence of nursing administration" and proposed fairly radical reforms in the nursing management structure, and in the training of nurses for managerial posts. Some of the proposed changes, notably the disappearance of the traditional hospital 'matron', and also the identified need to select managers by proven ability rather than length of service aroused great antipathy, both within the profession itself and from medical staff. The critics of the changes seem to have misunderstood their aims which were to create the environment for a properly managed work force to deliver the best nursing care possible, and for direct representation of the nursing voice in decisions affecting both the planning and delivery of patient care. It is ironical that the changes in the nursing management structure came to be associated in many people's minds with the divorce of management from clinical practice. The nursing profession itself is partly to blame for this as the reforms were introduced before most nurses, and indeed other health service professions, understood the need for them. For the last fourteen years or so, nurse managers have been under considerable pressure to learn the new skills needed to ensure that they can take their place alongside others in the multidisciplinary team situation, and much greater emphasis has been placed on management training rather than on professional role development.

The traditional matron who could be clearly identified as a nurse, symbolised not only the "boss" but also someone totally conversant with and understanding clinical needs and considerations. Perhaps the desire for her reinstatement has more to do with the need for greater recognition of clinical skills than for other reasons.

A literature search via Med-line on the perceived status of the matron undertaken for this project yielded little of value to the debate.

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[1] Report of the Royal Commission on the N.H.S. - D.H.S.S. 1979

[2] "Patients First" Consultative paper on the Structure and Management of the N.H.S. - D.H.S.S. 1979.

The Community Health Council was approached for an opinion on whether the absence of 'matron' was causing problems either for them or for the public. Their reply suggested that it was not doing so and that, once the location and individual responsibilities of nurse managers was understood, it was useful to be able to contact a functional manager on a specific issue - eg maternity, psychiatry, care of the elderly.

In considering future structures, we suggest that there are certain "whole hospital" issues that need to be identified as the responsibility of one nurse manager. The Director of Nursing Services will often be the appropriate post holder, but if the situation arises where there are two or more managers of the same grade working in the same hospital and in practical terms this is likely to happen in the nursing hierarchy, it will be necessary to define which role carries coordinative authority over the others. In identifying such coordinative roles it is important that the coordinator is in the same or a higher grade than those being coordinated, but not on a higher management level or the coordinator will become seen as the manager.

It may also be worthwhile considering in a small hospital whether the general coordinative role, normally assigned to an administrator, may occasionally be more suitably vested in a nurse manager who can be based on site. There are two or three institutional units in the Medway Health District where this might apply.

DEVELOPMENT OF MULTIDISCIPLINARY TEAMS

Having described the situation in our District of the development of three types of multidisciplinary team, we now wish to concentrate more specifically on the question of accountability within and/or between teams and then to focus on identifying those general characteristics that may need to be present if a team is to work effectively.

There are a number of reasons why more formalised and structured team or group working situations have increased over the years and will undoubtedly continue to do so in the future. Some of the main reasons for such development are:

- The increasingly high technology nature of medicine creating a very much greater degree of interdependence between professions

- The complexity of health care delivery and the greater emphasis on collaboration between different agencies, eg Local Government, voluntary sector etc, creates demands for more sophisticated coordinative arrangements.

- The emergence of a wide range of staff groups seeking either self management and/or parity with the medical professions as independent practitioners. In these situations a minimum requirement is seen as equal contribution to decision making through group or team working arrangements in both the clinical and management situation.

The above reasons in themselves raise an interesting point about whether teams working is not more concerned with satisfying the needs of the staff and the system rather than necessarily being the most effective way of organising work or delivering service. However, given the likely increase in collective work practices the issue of accountability in the process of providing care to an individual and/or taking management decisions is not just of academic interest.

It is in the area of the so called clinical multidisciplinary teams that some of the questions of accountability are best illustrated. How are client referral patterns to such teams to be defined and what are the boundaries of collective decision-making? These will obviously be regarded as issues of some importance to those people being encouraged to make referrals to teams, and particularly general practitioners. Indeed, the question will arise as to whether any referral should be made to such a nebulous entity as a team.

In our view it is necessary to be clear that such a team cannot be held accountable for individual client care or treatment but may be charged with coordinating the views of different professions or disciplines in order that the appropriate and personally accountable member of the team can provide the best possible advice to the individual client or patient.

Although it is essential in team work that the participants be prepared to share information, knowledge and experience and be influenced by other points of view, this should not be confused, particularly in the clinical setting, with ideas of concensus management or shared accountability. One of the best descriptions of the ingredients required to achieve the right balance between the need for team working and individual accountability is the ILEA definition of a Child and Family Psychiatric team, ie "The members of the team collaborate as equals and are dependent on one and other in providing a comprehensive service to their client; they accept that this inevitably entails a restriction on their freedom to act individually; they are aware of and accept the limits of their professional competence and are prepared to consult with their colleagues in other disciplines whenever necessary".

The only point we would draw attention to in the use of the word 'equals' in the above definition is that there is a need to recognise the different degrees of independent action that can be exercised by team members. Consultant medical staff are to a large extent free standing 'decision' takers and are not accountable to anyone else for their actions. That is certainly not the situation for some other members of clinical teams such as nurses and social workers who may have to account to their immediate superiors for the decisions they are making. Therefore the extent to which individual members of clinical teams can commit themselves to collective views will vary.

The kind of accountability issues raised in clinical teams also arise in the management setting. There is no doubt that one of the main aims of this reorganisation is to strengthen the unit level of management and increase the status and calibre of administrators and nurse managers at that level. This in turn may lead to greater pressure for collective and/or team type working arrangements that are seen to mirror the D.M.T.

This pressure for increasing local decision making may also depend upon the level at which units are established (see pages 30 - 32)

What we would challenge is the idea that some form of corporate team will emerge at the unit and that such a team will be collectively accountable to the D.M.T. This idea is often expressed as being essential in terms of achieving responsibility for the unit budget and therefore the authority for the team to switch resources between the different parts of the budget. Whilst we would encourage the need for increased multidisciplinary consideration of resource allocation and/or reallocation policies within a planning framework at unit, we regard the control of resources within such policy boundaries as essential management functions that must remain with individual managers who in turn will account to their managers. The reallocation of resources within and/or between different budget headings can be easily facilitated when determining the degree of discretion to be devolved to individual unit officers and need not be used as an excuse for the establishment of a corporate team.

We referred in the paragraphs on clinical teams to the fact that not all team members are equal in terms of decision making freedom and that this must always be a constraint to implementing a philosophy of collective responsibility. In our view the same situation would also be true for so-called Unit Management Teams. Directors of Nursing Services and Unit Administrators are to be accountable to the D.N.O. and D.A. respectively, according to HC(80)8 and those chief officers in turn are to be accountable to the District Health Authority for the services that they control.

Although it may be expected that chief officers will delegate considerable authority to their unit officers and expect them to undertake a range of management tasks within a multidisciplinary framework, this is not the same as assuming that abdication of line management responsibilities could in any way be the order of the day.

In terms of team effectiveness, it is clear from our study that there can be drawbacks, particularly where any participants, and in particular medical staff, are not fully committed to this form of work. Not only will diffusion of accountability and responsibility result, but the lack of positive results from the team can also be damaging to staff morale and be counterproductive to achieving service improvements. On the other hand team organisation can be successful and produce service improvements. The likelihood of this happening will be greatly increased where:

- there is no conflict between the individual accountability of members of the team and their managers outside it;

- the area of concern is discrete;

- the members of the team work at the same level;

- the team embodies and does not ignore existing organisational structures, hierarchies and peer groups; and

- members are not encouraged to think of themselves as autonomous or corporately accountable, but rather as individuals with individual responsibility, who work together in a team to make decisions which no one could make individually.

SUMMARY

This study, undertaken in preparation for the coming reorganisation, has attempted to describe the manifest, assumed and extant patterns of decision-making in the Medway Health District. Finally, we considered the requisite situation for the formulation of new units.

We have been unable to sustain a case for units to be formed on a common basis and would therefore endorse the flexible approach outlined in HC(80)8.

Although it may be fashionable to consider the work that will be undertaken at unit level as a starting point, our work leads us to conclude that the reverse is true. The D.M.T. must form a view about what work and decisions it is appropriate for the District Health Authority and the D.M.T. to undertake and this should be the point from which unit work is then determined.

Whilst compatability in management structures between the different disciplines is desirable, our study has shown that, given the establishment of appropriate coordinative roles, any differences can be overcome. However, what is required is that managers in the different disciplines who work together regularly and who share common work interests should be of similar capacity and have similar decision making parameters.

We are convinced that one team cannot be accountable to another. The new units will undoubtedly require doctors, nurses and administrators to work closely together over a wide range of management tasks. This need for improved collaboration should not be confused with any form of corporate accountability.

APPENDIX 1.

KINGS' FUND FELLOWSHIP PROJECT

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GLOSSARY OF TERMS USED TO DESCRIBE ORGANISATIONAL RELATIONSHIPS

Attachment:

1. Attachment arises where it is wished:

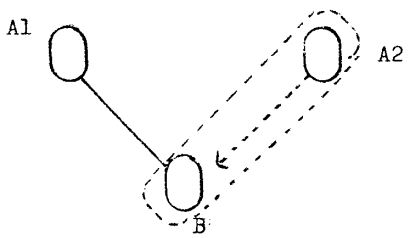
   (a) to supplement the work of A2 by allocating B. from another occupation or specialism to work closely with him; whilst

   (b) maintaining managerial support and control from a superior A1, in the same occupation or discipline.

2. In all cases B must be personally acceptable to A2 at the time of attachment and continue to be so.

3. Thereafter, two distinct situations may arise.

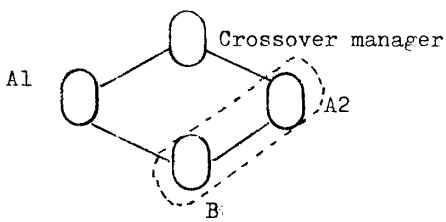
   (i) Attachment-with-Monitoring and Co-ordination



4. A2 may be given authority to co-ordinate B's work with his own and that of others, and to monitor such things as adherence to employment contract, minimal competence and basic standards of behaviour. (In addition, in some situations A2 might carry prescribing authority).

5. A1 will continue to carry a full managerial relationship to B.

   (ii) Attachment-with-Co-management



6. If, and only if, A1 and A2 themselves share a common manager it may be possible to establish a co-management situation, in which the exact division of managerial functions is as follows.

7. A1 is expected:

(a) to induct B in technical matters, and to help him deal with technical problems;

(b) to co-ordinate his work with that of similar participants in the field;

(c) to appraise B's performance and abilities, to keep B informed of his assessments, to arrange or provide training, to arrange transfers or re-attachments (or dismissal);

(d) to attempt to provide continuity of service where B is absent, or where a transfer or re-attachment is in hand.

8. A2 is expected:

(a) to induct B into the local work situation, and to help him with operational problems;

(b) to assign appropriate work to him;

(c) to help A1 appraise his performance and abilities.

9. A1 should be able to give direct instructions to B provided they are within policies established by the 'crossover' manager, and provided they do not conflict with A2's policies or instructions. A1 must be able to see that B's special competence is being used in an appropriate way.

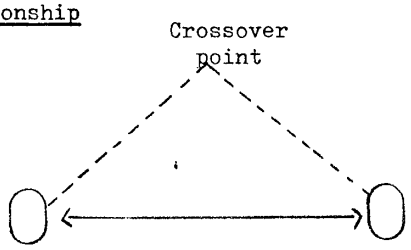
10. A2 needs to have authority of veto in the attachment of B, authority to join in official appraisals of B's performance and ability and authority to initiate his transfer elsewhere. (Note the distinction of attachment from either outposting, or secondment, or functional monitoring and co-ordinating.

Binding Professional Standards

1. Binding professional standards are the necessary standards and norms of behaviour by which members of a professionally developing occupational group must abide. Beyond a certain degree of professional development, such standards become absolute and binding, and it is imperative that they should not be abandoned out of deference to the judgement of a more highly qualified or experienced superior.

2. Binding professional standards thus stretch beyond the general limits set by law and social norms that constrain every member of society. However, although they curb the possible direction by superior officers and bodies, they do not in themselves make such managerial relationships impossible.

Collateral Relationship



1. A collateral relationship may arise where the work of two people ultimately subject to the authority of a common manager or superior body, interacts in such a way that mutual accommodation is needed in certain matters, and where it is not appropriate that either has authority over the other. (Their tasks may be complementary, or they may be supplementary, or they may be unrelated, apart from use of common resources).

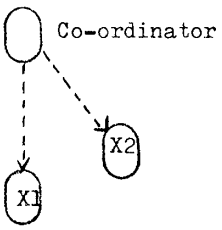
2. Each person in the collateral relationship is expected:

   (a) to accommodate to the other's needs as far as is reasonable;

   (b) to refer to the next higher level of authority any significant problem of mutual work which he has been unable to resolve.

3. Where collateral colleagues fail to reach agreement, ultimate resolution can only be found at the crossover point represented by the common manager or superior body.

Co-ordinating Role



1. A co-ordinating role may arise where it is felt recessary to establish one person, with the function of co-ordinating the work of a number of others in some particular respects and where a managerial, supervisory or staff relationship is inappropriate.

The activity to be co-ordinated might, for example, be:

- the production of reports, estimates, plans or proposals:
- the implementation of agreed schemes or projects:
- the overcoming of unforeseen problems affecting normal work.

2. The co-ordinator is expected:

(a) to propose specific actions and programmes;

(b) to keep himself and others informed of actual progress;

(c) to help overcome setbacks and problems encountered in carrying out agreed programmes.

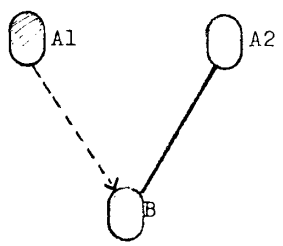
3. In carrying out these activities the co-ordinator needs authority to make firm proposals for action, to arrange meetings, to obtain first-hand knowledge of progress etc., and to decide what shall be done in situations of uncertainty, but he should have no authority in case of sustained disagreements to issue overriding instructions. X1, X2, etc., have always the right to direct access to the higher authorities who are setting or sanctioning the work concerned.

Encompassing Profession

1. An encompassing profession is one whose knowledge is deeper and more embracing than that of other professions dealing within the same field of work. Two professions may have different areas of competence in such a situation, but the one has prescribing authority over the other on the grounds that it has a broader theoretical base.

2. The case for prescribing authority is more obvious when a comparison is made between a 'craft' whose technicians have a special competence in the execution of certain tasks, and a 'profession' where there is a greater depth of understanding and penetration of complex problems.

Functional Monitoring and Co-ordinating.



1. Functional monitoring and coordinating may arise where it is desired to monitor the work of B in occupational or technical respects, and to coordinate it with the work of other practitioners in the same function or field, whilst leaving intact in all its essential elements the managerial or directive relationship between A2 and B.

2. Specifically, A1 is expected:

   (a) to help to select B (either in an advisory role or with the right to veto);

   (b) to provide advice to him in the specialist field concerned where such is needed;

   (c) to coordinate his work with that of other similar participants in the field;

   (d) to monitor the adherence of B to any established policies or practices in the specialist field concerned;

   (e) to provide for B's technical training.

3. A1 should not have authority to provide official appraisals of B's work, or to initiate his transfer or dismissal. Such authority rests with A2.

4. A2 may be an individual manager of B, or a composite body to whom B is directly accountable.

   Note the distinction of functional monitoring and coordinating from either attachment, secondment or outposting.

Independent Practice

1. Independent practice is a situation where though the professional practitioner may be employed he has freedom to pursue his professional practice as he thinks best (within available resources) provided he stays within certain broad limits of professional ethics, contract, and accepted norms of behaviour. There is independent practice where it is deemed that there is a pre-eminent need to establish a voluntarily maintained relationship of trust and co-operation between a specifically identified professional practitioner and a specifically identified 'patient' or 'client'.

2. Through this relationship the patient/client is provided with a personalised service, through his personal practitioner who indicates the necessary treatment and makes N.H.S. resources and services available to him.

The degree of freedom required by the professional practitioner to facilitate such treatment implies tenure of employment and the exclusion of managerial control even from within the same profession; it also requires a capacity on the part of the practitioner to cope with work at both the 'systematic provision' (Stratum-3) and 'situational response' (Stratum-2) levels.

Managerial Role

1. A managerial role may arise where it is wished to make a person A fully accountable for the work of another, or others, B.

2. Specifically, A is expected:

   (a) to help to select B;

   (b) to induct him into his role;

   (c) to assign work to him and allocate resources;

   (d) to keep himself informed about B's work, and to help him deal with work problems.

   (e) to appraise B's general performance and ability, and in consequence keep B informed of his assessments, arrange or provide training, modify role, or arrange transfer or dismissal.

3. A needs the authority:

   (a) to veto the selection of B for the role;

   (b) to make an official appraisal of B's performance and ability;

   (c) to initiate transfer or dismissal.

Monitoring Role

1. A monitoring role may arise where it is felt necessary to ensure that the activities of X conform to satisfactory standards in some particular respect and where a managerial, supervisory, or staff relationship is impossible or needs supplementing. The aspect of activity being monitored might, for example, be:

   - adherence to contract of employment (attendance, hours of work, for example);
   - safety;
   - financial propriety and security;
   - level of expenditure;
   - technical standard of work;
   - adherence to personnel policies.

2. Specifically, the monitor is expected:

   (a) to ensure that he is adequately informed of the effects of X's activities;

   (b) to discuss possible improvements with X or with X's superiors;

   (c) to report to the manager or superior body to whom he is accountable sustained or significant deficiencies;

   (d) to recommend new policies or standards where required.

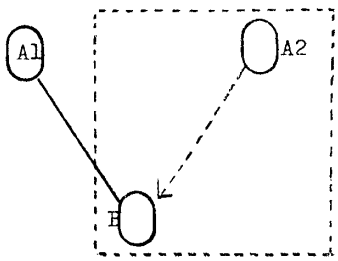
3. The monitor needs authority:

   (a) to obtain first-hand knowledge of X's activities and problems;

   (b) to persuade X to modify his performance, but not to instruct him.

   He should not have authority to make or recommend official appraisals of X's work. He should not have authority himself to set new policies or new standards.

Outposting



1. Outposting may arise where it is wished:

   (a) for B to work within a site for which A2 already carries some general responsibility; but

   (b) without B's manager A1 actually attaching him or seconding him to A2.

2. In this situation the role of A2 must be limited to:

   (a) inducting B into the local setting;

   (b) monitoring the adherence of B to local regulation and practice;

   (c) co-ordinating the activities of B so far as local problems or developments are concerned.

Prescribing Relationship

1. A prescribing relationship may arise where:

   (a) a person of one occupation needs the direct help of a person of another in achieving the goals of his own work; and

   (b) the knowledge base of the first occupation is accepted as encompassing that of the second.

2. The prescriber needs authority to determine particular tasks to be carried out, at an appropriate level of specificity.

3. He is expected:

   (a) to check that the person receiving the prescription performs the task adequately and, if not, to withdraw the task;

   (b) to monitor the general standard of work produced.

4. The person receiving the prescription is expected to refer back to the prescriber if he feels that either the objective of the task or the context in which it is to be carried out is unsuitable.

Prime Responsibility

1. In a situation where many members of a variety of professions are involved in the consideration of a particular case, the practitioner who has prime responsibility is ultimately in charge of the case. He coordinates the actions and decisions of all those practitioners brought into the case and ensures that all underlying needs are met. More specifically he has coordinating but not managerial authority to:

(a) make a personal assessment of the general needs of the case at the time of assumption of prime responsibility;

(b) undertake personally any action needed, or to initiate such action, through subordinate or ancillary staff;

(c) refer, when and as necessary, to colleagues and other independent agencies for collaboration in further assessment or action, or for action in parallel;

(d) keep continuous awareness of the progress of the case, and take further initiative as necessary.

2. Further, although it may not be true for agency services, where the practitioner with prime responsibility is in independent practice, he has the right and the duty to decide when to relinquish extended collaboration with colleagues, or when to terminate all further action on the case.

Profession

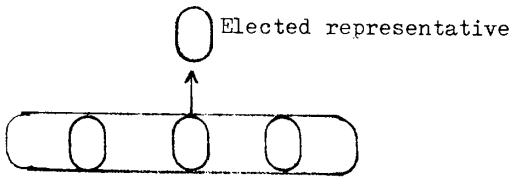
1. A profession is an organisational group which has a developed body of theoretical knowledge, the application of which must be within the bounds of an ethic or impartiality and objectivity; it implies the exercise of insightful judgement to assess real needs and appropriate responses in a variety of situations rather than the simple carrying out of prescribed tasks. Professional associations are usually formed to further the development of this specialised knowledge and practice (as well as to protect collective interests).

2. At a certain stage of development the possibility of managerial control of professional members by non-members must be excluded. This happens when the latter can no longer judge the competence of such professionals nor assess the technical problems encountered. Only monitoring and co-ordinating role relationships are possible in this context.

3. Parallel with the development of theoretical knowledge and practice is the evolution of specific professional standards and norms of behaviour. When such prescriptive and prohibitive/prescriptive limits are absolute and binding, the individual member must model his behaviour accordingly, irrespective of contrary direction by a superior. Maintenance of these standards is encouraged by the support of professional associations and the necessity of public registration, where such exists.
(See Binding Professional Standards and Independent Practice (P.2 and 3))

Representative Role

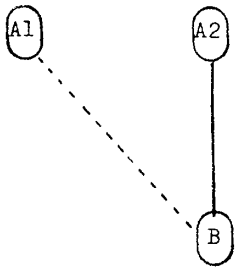
1. Where any group wish to express the consensus of their views and feelings, or to negotiate with another body, they may choose to do so through the medium of an elected representative.



2. The elected representative needs to carry some degree of discretion in presenting views or negotiating, even if he is specifically mandated. (A delegate is a representative who works only to a specific mandate). He is accountable to the group for what he says and does, and if he is judged inadequate by them they must be able to replace him.

3. Elected representatives must be distinguished from individuals who are appointed by some external agency to advisory or executive bodies because they are typical of the group from which they come.

Secondment



1. Secondment may arise where it is desired to transfer B from his original manager A1 to some other manager A2 for some limited period, such as the time to complete a particular project or the time for B to gain some desired training or experience.

2. In this situation the new manager A2 will be expected:

   (a) to induct B into his new position, and assign work and allocate resources to him;

   (b) to review B's work, and to provide A1 with appraisals of his performance.

(c) to help B's personal development in his work during the time of his secondment.

3. A2 needs to have authority to veto B's secondment in the first instance, and to initiate his return should his performance prove unsatisfactory.

4. The original manager A1 will be expected:

(a) to provide a continuing official appraisal of B's work;

(b) to provide for B's formal training, and to make appropriate plans for his career development.

(note the distinction of secondment from both attachment and outposting)

Service-giving Relationship

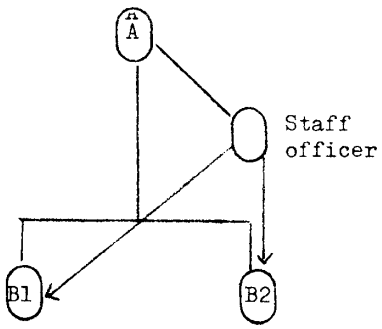
1. A service-giving relationship may arise where a person needs to be able to request from others, whom he does not manage, the provision of resources or facilities to be used in his own work.

2. The service-giver is expected to provide an appropriate service to meet each request, or to notify the service-seeker if this is impossible, and to discuss alternatives.

3. The service-receiver is expected to draw any deficiencies in services to the attention of the service-giver, to negotiate improvements if possible, and, if not, to report sustained or significant deficiencies to the attention of superior authorities.

Staff Officer Role

1. A staff-officer role may arise where a manager A needs assistance in managing the activities of his subordinates B1, B2, in some particular dimension of work such as personnel and organisational matters, or the detailed programming of activities and services.



2. Specifically, the staff officer is expected:

   (a) to help to formulate policies or schemes in the field concerned, taking into account the experience and views of A's other subordinates;

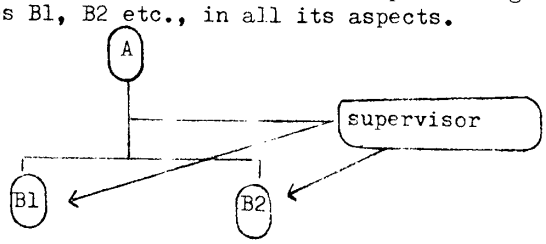
   (b) to see that agreed policies or schemes in the field concerned are implemented by A's other subordinates: issuing detailed procedures and programmes; ensuring adherence to these programmes; and interpreting agreed policy.

   (c) to deal with the daily flow of communications and problems coming to A in the field concerned; sorting, filtering, exploring, and initiating, and coordinating appropriate response wherever possible.

3. In carrying out these activities the staff officer needs to have authority to issue instructions. If B1 does not agree with the staff officer's instructions he cannot disregard them, but must take the matter up with A. The staff officer should have no authority to make official appraisals of the performance and ability of B1.

Supervisory Role

1. A supervisory role may arise where a manager A needs help in managing the work of his subordinates B1, B2 etc., in all its aspects.



2. The supervisor is expected to help A in inducting new staff, assigning specific work, and dealing with specific work problems.

3. The supervisor needs the authority to give instructions to B1. If B1 does not agree with the supervisor's instructions, he cannot disregard them, but must take the matter up with A, his manager.

Work-strata and Grades

1. The five-level system of work-strata is a classifactory scheme for deploying staff in the most effective way for the attainment of organisational goals. Each stratum specifies the tasks to be done and the amount of discretion and responsibility required to accomplish them effectively. As one moves from a lower to a higher stratum, responsibility and discretion increase.

2. Within each work-stratum there is a grading system which creates subdivisions according to special experience and competence, and for career planning and progression. Being in a higher grade in the same stratum allows for monitoring and coordination but not for managerial responsibility and authority. An effective manager of a subordinate must be in the next higher work-stratum. In this way the work-strata provide a clarification of a person's accountability and authority and can be applied to all types of organisations.

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

The Brunel Framework of Organisation Analysis

Manifest Situation -

the situation as formally described, codified or displayed.

Assumed Situation -

the situation as it is variously assumed to be by individuals in the organisation.

Extant Situation -

the situation as revealed by systematic exploration and analysis.

Requisite Situation -

the situation as it would have to be to meet a given context of needs most appropriately.

APPENDIX 4.

NAME _____

TITLE/GRADE _____

WORKING BASE _____

1. Control Over Financial Resources

a) Who decides on the distribution of funds between different budget headings in the Medway Health District?

b) Once your budget(s) is set, what degree of change can take place and with whose authority?

c) Within your staffing budget(s), what changes can be made by you, eg. decreasing full-timers, increasing part-timers, etc?

d) Are there any expenditure limits placed on you, eg. anything above £500 on non-staffing items which have to be referred to District?

e) What are the present limits on the scale of maintenance and improvement works that you can authorise?

f) Generally, what range of new non-staffing items can you authorise, if any?

g) What level of "Capital expenditure" is delegated to you, if any?

2. Control Over Personnel

a) What authority do you have to appoint staff and up to what grade?

b) What authority do you have to conduct the different stages of disciplinary action:-

Dismissal

Final Warning

Recorded Warning

Informal Warning

c) Do you have authority for regrading staff? If not, who authorises this?

Control over Personnel contd.../

d) Over what range of issues do you negotiate with staff representatives?

3. Involvement with Planning

a) Do you contribute in any way to the Annual District Plan?

b) What service planning work do you do?

c) In what way are you involved in major maintenance or Capital Projects?

4. Working Relationships with Medical Staff

a) Do you attend Medical Advisory Committees, and if so, in what capacity.

b) What are the limits on the scale of medical and surgical equipment replacements and renewals that you can authorise?

c) What control/responsibility for medical staffing matters exists at Sector/Unit level?

d) Do you attend any Health Care Planning Teams, and if so, which?

5. Any Other Comments on the above or related questions?

/THANK YOU FOR YOUR HELP

APPENDIX 5.

SUMMARY OF REPLIES FROM QUESTIONNAIRES

Question 1: Control Over Financial Resources

(a) Who decides on the distribution of funds between different budget headings in the Medway Health District?

Single Level

Most managers put decision making directly into the hands of the D.M.T. Those specifying the D.M.T. alone numbered 17.

Some managers thought decisions about distribution of funds were made either by the D.F.O. or the District Finance Office alone. These numbered 2. One manager did not know of an answer to put to this question.

Inter-relationships

The remaining set of 8 managers viewed the distribution of funds between budget headings as a process between the D.M.T. and the D.F.O. (5 of these managers noting further advice/consultation sought at a lower level, i.e. the A.D.A. (O.S)/middle managers and heads of department).

Definitions

Distinctions were made between staffing and non-staffing growth funds (on which the A.D.A.(O.S) would advise the D.M.T) and existing funds (which could be discussed between administrators and the D.F.O) and or another occasion between recurring (D.F.O) and non-recurring and growth (D.M.T).

(b) Once your budget(s) is set, what degree of change can take place and with whose authority?

A difference between theory and practice was noted by the D.F.O. Mention was made of A.H.A. virement limits and distinctions made between non-staffing growth funds and normal recurring funds.

Flexibility

Total flexibility within a budget (without reference to others) only appeared to exist either at very high levels of the organisation or across reasonably small budgets, at lower levels. Virtually all managers, however, reported some limitation or obligation to negotiate/consult with other managers who were either their superiors or representative of a different discipline. One manager reported no flexibility.

Authority

The D.M.T. were mentioned, and only then indirectly, five times.

Team Officers, acting on behalf of the D.M.T. such as the D.N.O., D.F.O. and D.A. were mentioned 16 times; the A.D.A.(O.S) in relation to Sector Administration 3 times.

Types of change

Little or no consultation (normally above scale 14)	total flexibility within overall sum allocated to non-staffing growth funds.
	Apparent flexibility within pay or non-pay items: furniture, fittings and office equipment.
Consultation necessary (Div. N.O's: scale 14 and below)	increases in wages or food
	grades of staff and other services
	between areas (within a Nursing Division)
	transfer of monies (virement)
	increases in student midwives/tutor
	book allowances/visual aids

(c) Within your staffing budget(s) what changes can be made by you e.g. decreasing full-timers, increasing part-timers, etc?

With the proviso of staying inside budget limits or referring decisions on virement of staffing budgets the answers reflected in the main an ability to alter the staffing ratios at will for most managers - 15 in fact.

4 managers qualified their answers to the extent that changes could be made but that normally consultation with professional heads of service, departmental heads would be required.

9 managers implied or stated that they had no discretion regarding changes although 4 of these felt they would be able to advise and/or prepare a case to their superiors for changes according to the needs of the service.

(d) Are there any expenditure limits placed on you - e.g. anything above £500 on non-staffing items which have to be referred to District?

Administration

A.D.A. (O.S)	Up to £7,500 on medical and surgical
	Up to £1,000 on other items.
Sector Administrators (inc. C.H.A)	Usually no limits on furniture and fittings (within cash limit)
	Up to £300 on medical and surgical.

The Assistant Sector Administrator at Milton Regis must refer to the Sector Administrator for any expenditure above £25.

Nursing

Most nurses did not possess an expenditure budget. Exceptions are the budget for staff uniforms, travelling/interview expenses and the midwifery training school. Major items of expenditure for post basic education are discussed with the D.N.O. and the limit for equipment or expenditure by the wards was £500 in each case mentioned (N.O. level)

(e) What are the present limits on the scale of maintenance and improvement works that you can authorise?

Only one figure was mentioned by the C.H.S., that being a limitation of up to £300, above which priorities were determined between the A.D.A(O.S), who in turn along with the District Works Officer coordinated the works programme, ensuring a balance throughout the District. Other Sector Administrators pointed out, however, that the limitations were not clearly defined.

Of the remaining managers 8 felt they could authorise routine maintenance work but not any significant improvement works. A further 8 felt they could initiate and advise on the need for attention but that the power to authorise was not in their hands.

4 managers considered the question did not relate to them and 2 concluded they had no authority at all in this area.

(f) Generally, what range of new non-staffing items can you authorise, if any?

The financial ceiling for the Sectors and for the Senior Chief MLSO was £300 in relation to medical and surgical equipment. Most District Heads below the A.D.A(O.S) and the Sector Administrators were all able to buy items of furniture and office equipment.

Nurse managers practices varied from no authority (8) to being able to order necessary items such as small items of medical and surgical equipment, dressings or appliances for particular patients and office equipment, (6) Again, 4 nurse managers whilst having no authority directly were able to initiate or advise on a need.

(g) What level of capital expenditure is delegated to you if any?

Most managers (23) stated that they had no involvement with capital expenditure. Of those that did, one participated under the auspices of the Psychiatric Management Team (£50,000) and another in the coordination of the new Psycho-Geriatric Unit and Nicholas Day Ward (£18,000).

Both the A.D.A's had an advisory role to the D.M.T. in this area, the A.D.A.(O.S) obviously being responsible for allocated expenditure on medical and surgical items, vehicles, replacement laundry, CSSD plant and the A.D.A(P) for any D.M.T. allocated block capital schemes or A.H.A. allocated joint funding projects. Two managers went on to define the level of their involvement in capital expenditure as the setting of priorities from within the given budget.

Question 2: Control over Personnel

(a) What authority do you have to appoint staff and up to what grade?

Most managers have authority to appoint - only 4 stated they had no authority, although 2 of these were involved in interviews up to a specific level. Whilst almost all administrative grades were involved in multi-disciplinary interviews and appointments, only 1 nurse manager reported similar participation across the nursing boundary; the appointment of Ward Clerks.

The limitations on direct authority to appoint appeared to be:

None:	for D.F.O.
Up to Scale 14:	for A.D.A. (O.S)) present arrangements for staff
Up to Scale 4:	for A.D.A.(P)) "directly accountable"
Ancillary grades:	for C.S.S.D. Manager
Up to Scale 4:	for C.H.A.
Certain heads of Dept. (except District) and all those directly accountable to S.A.:	for S.A's
Up to Scale 4:	for D.P.O.
M.L.S.O's	for Senior Chief M.L.S.O's
Up to N.O's	for Div. N.O's
Up to Tutor grade:	for D.N.E.
Up to Sister/C.Nurse:	for S.N.O's
Student Midwives only:	for Senior Midwifery Tutor
Below Midwifery Sister:	for N.O.Midwifery
Up to Staff Nurse:	for N.O's.

(b) What authority do you have to conduct the different stages of disciplinary action?

As might be expected, most managers' authority was progressively limited in this area. Two nurse managers felt they had no authority to give an informal warning. 4 managers felt they had no authority to issue a recorded warning, and this rose by 6 by the formal warning stage and 7 by the dismissal stage.

Most managers were quite clear that authorisation from a Team Officer was a pre-requisite for dismissal.

(c) Do you have authority for re-grading staff - if not who authorises this?

Only 3 managers regarded themselves as having intrinsic authority to re-grade:

the A.D.A.(O.S)

the C.S.S.D. Manager

the Catering Manager (St. Barts)

Final authority was seen to rest with the D.A. or D.N.O. with a positive role for Personnel at Area and District level and possibly the Regional Assessment Group or Quadrant depending on grade.

(d) Over what range of issues do you negotiate with staff representatives?

Discipline	(6)
Grievance	(9)
Health & Safety	(6)

Other matters included bonus schemes (at District level), gradings, demarcation issues, contingency plans, national agreements at Sector level, conditions of work, shift hours, 37½ hour week at Div. N.O. level, and more individual personnel problems below this level.

Question 3: Involvement with Planning

(a) Do you contribute in any way to the Annual District Plan?

Most managers (19) had some involvement with the District Plan preparations, although 9 had no involvement at all.

Directly:		Indirectly:	
D.F.O.			
A.D.A. (O.S)	.....	S.A's	Senior Chief M.L.S.O.
A.D.A. (P)	.....	C.H.A.	
D.P.O.		C.S.S.D. Manager	
D.N.O.	.....	Div. N.O's	S.N.O's/Sen. Midwifery Tutor
		Health Care Planning Team	
		Special Care Baby Unit	

(b) What service planning work do you do?

7 managers had no involvement with service planning and a further 3 described their role as very limited. 10 managers were involved through multidisciplinary planning teams. Those S.N.O's not providing some input to planning teams fed information and advice up through the Div. N.O.

The District administrative role involved the determination of priorities and the coordination of the service planning process in conjunction with any information received from the Sectors. The D.F.O. and the D.P.O. were not directly involved in participating in any District service planning.

(c) In what ways are you involved in major maintenance or capital projects?

Some managers were upset in their answers by the typing error contained in the original questionnaire and did not distinguish between maintenance and capital projects.

District officers (A.D.A(O.S) and A.D.A.(P))again had a coordinative role and either set the parameters of the scheme for other administrators or were in liaison with Area or Region and D.M.T. All S.A's appeared to be involved in on site projects, if not in terms of preparation of statements of need, bids for funding, then it was a corordinative contingency planning (decanting) exercise.

Most of the nurses 9 were not involved at all in this field and those who were, were either caught up on planning/project teams/joint funding 3, or in an advisory capacity 4.

Question 4: Working relationships with medical staff

(a) Do you attend Medical Advisory Committees and if so, in what capacity?

18 of the managers sampled had no cause to attend Medical Advisory Committees. A further 2 only attended whenever they were in an acting up capacity. The A.D.A.(O.S) attends meetings of the M.E.C. where there are items of interest or when acting up for the D.A.

Consequently only 6 managers had a regular involvement with Medical Advisory Committees. For the administrators (S.A's) this was as the Administrative representative, usually also acting as Secretary for the particular Division concerned and for the nurse administrator, likewise a representative role, usually of the discipline of nursing but also sometimes for the specialty, (e.g. Psychiatry).

(b) What are the limits on the scale of medical and surgical equipment replacements and renewals that you can authorise?

The main limit for the Sectors appeared to be £300 on any one particular item although where Trust Funds were available, the limit seemed to be indefinite. Any items from the Sector budgets above £300 are referred to the A.D.A.(O.S).

The limit on the Unit Administrator at Milton is £25, whereas for a District Head such as Mr. Moore in the C.S.S.D., there is no limit on medical and surgical equipment necessary to ensure continuity of service.

There was only one nurse who appeared to have a budget in this area since her scale of expenditure stopped at £100. All the remaining nurse managers made requests via nursing and medical staff for the Sector Administrator to authorise. Div. N.O's saw their role as being one of influence rather than authority.

(c) What control/responsibility for medical staffing matters exists at Sector/Unit level?

6 managers did not consider this question.

5 managers considered that there was no control at Sector level over medical staffing.

Most of the remaining managers put the responsibility for junior medical staffing matters at Sector unit level, that is, the appointment of House Officers and Senior House Officers (and locum Registrars at All Saints). The Sector Administrators and the C.H.A. developed this further by including day to day establishment control, issue of contracts, negotiation over overtime, accommodation, agency staff and curtailment of services.

Some nurses, whilst seeing professional responsibility resting with the Consultant and the S.A., being responsible for all the administrative details, saw their role at the unit as being that of liaison with senior medical staff should any problems with junior staff arise.

(d) Do you attend any Health Care Planning Teams and if so, what?

19 managers had no involvement (other than 1 who acted as a replacement member)

A.D.A. (P)	...	Mentally Ill Elderly Maternity Young Chronic Sick
C.H.A.	...	Child Health Primary Care Mentally Handicapped Young Chronic Sick Maternity/Family Planning
Div. N.O. (Gen. I)	...	Primary Care
Div. N.O.(Midwifery)	...	Maternity Primary Paediatric (ad hoc basis)
S.N.O. (All Saints)	...	Elderly Mentally Ill
N.O. (Community)	...	Elderly Young disabled

CLASSIFICATION OF COMMITTEES, WORKING GROUPS, TEAMS & PROFESSIONAL MEETINGS

Purpose	Examples	Membership	Main Characteristics
Exchanging and passing on of expertise and information in order to facilitate the management process.	Briefing groups Special project groups Nursing Procedure Committee Single discipline Policy information Manager/Subordinate Groups	Single discipline or single discipline + invited specialist officer to advise	Meetings of a manager and an individual or group of subordinates where the work is primarily controlled or directed by the manager.
Corporate Planning and Management Service Planning	D.M.T. H.C.P.T's Psychiatric Management Team.	Multi-disciplinary with all disciplines having an "equal" role.	Members of two or more disciplines meeting on a regular and continuing basis and making decisions on a 'consensus' basis. Formally recognised within the organisation A non-specific remit within a general subject area.
Teams concerned with the programming of specific projects such as capital developments.	Regional & District Project Teams. Major maintenance co-ordination.	Multi-disciplinary with specialist officers playing an important role.	Members of two or more disciplines meeting on a regular but defined period basis and making decisions and recommendations on a 'consensus' basis. Primarily concerned with programming and controlling and implementation of a specific task.
Provision of specialist service.	Control of Infection Committee Radiological Protection Committee.	Multi-disciplinary but with a common specialised interest.	Members of two or more disciplines meeting on a regular and continuing basis and making decisions and recommendations on a 'consensus' basis. Formally recognised within the organisation. A specific remit within a specific subject area.
Obtaining user views of service.	Supplies Group Laundry & Linen Services Commissioning groups	Provider of service + representatives of users.	The manager/provider of a service meeting with representatives of the 'users' receiving that service to obtain 'user' views. Decision making remains within the control of the manager.

Purpose	Examples	Membership	Main Characteristics
Management Process Groups	Information group Planning Group Personnel development group	Multi-disciplinary	Members of two or more disciplines meeting on a regular and continuing basis and making decision or recommendations on a 'consensus' basis. Primarily concerned with processing work or providing information support for managers.
Diagnosis and treatment of a particular client/ patient.	Joint outpatient clinics Shared inpatient care	Single discipline but different specialties.	Members of one discipline but different specialties working regularly together in order to agree on a diagnosis and/or treatment or care regime for a particular patient/client.
Diagnosis and treatment of a particular client/ patient.	Case conferences Assessment Centre groups	Multi-disciplinary	Members of two or more disciplines working together on a regular and continuing basis. Normally the leadership and ultimate decision making role discharged by a Consultant. The precise purpose is to pool information on the most appropriate treatment and/or care regime for a particular client/patient.
Caseload Patient/Client focussed groups:	Mental Handicap Teams Symptom Control Team Child & Family Psychiatry Team.	Multi-disciplinary	Members of two or more disciplines working together on a regular and continuing basis and arriving at 'consensus' decisions. Whilst individual client/patient needs considered, there is a concern with a defined 'caseload' of patients/clients. Such teams often act as the interface between the provision of direct care and the management system and work to develop 'Management Team' characteristics eg, information systems involved with resolved issues and contributing to planning and policy matters.

Purpose	Examples	Membership	Main Characteristics
Provision of professional advice to statutory authorities, colleagues and/or other bodies.	Medical, Nursing, Pharmaceutical, Dental — Advisory Committees	Single discipline but several different grades	Members of one discipline meeting together under a defined constitution or terms of reference and, where formal committee procedure applies, ie Chairman, decision making by voting. The prime purpose is to provide uni-disciplinary advice to colleagues with the profession and/or other agencies outside the profession.
Staff Interest consultation and negotiation.	Joint Mangement/Staff Health & Safety.	Multi-disciplinary representatives of staff and management.	Representatives of staff and management meeting together on a regular and continuing basis and normally subject to 'committee' forms of working but where, within the committee, decision making is by'consensus'.
Consumer Groups and Voluntary Organisations.	Community Health Councils League of Friends.		Members (normally unpaid) meeting together with statutory and/or charitable status and concerned with improving the service available to either particular or general groups of the population.
Statutory Authorities	Regional, District — Health Authority; Local Government Councils	Elected or appointed members with varied backgrounds and interests.	Members (normally unpaid) meeting together as an 'Authority' established by statute to be ultimately responsible for the planning and provision of services and the employment of the staff required for providing such services.