TALKING POINT

District general managers: who will they be?

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Twelve of the 14 English regions have now appointed a general manager: a nurse, two treasurers, a medical administrator, and eight administrators. The next step in the process is to appoint district general managers. Many districts jumped the gun—they probably did not realise that there was going to be a formal start—and have interviewed and designated (some privately) their general manager. The permanent secretary at the Department of Health and Social Security, Sir Kenneth Stowe, seems to have thrown the process into some confusion with a “letter of guidance” to regional chairmen outlining a recommended process for appointing district managers.

Members of the department of social administration have been meeting district chairmen and authority members to help them “prepare for general management” as recommended by the Griffiths inquiry¹ and adopted by the government.² Several issues have been discussed including the role of a general manager and how he should be selected, his relationship with other staff, and how he should be assessed.

What should the general manager do?

General management differs from the consensus management now in use in the National Health Service: this shared managerial responsibility will be replaced by one person, a general manager, who will be responsible for the health authority's performance. This general manager will be responsible for other managers who will, in turn, supervise groups of professionals. He cannot possibly have an intimate knowledge of all the professional procedures of his subordinates and will have to rely on his professional managers. So the capacity to work with and persuade other professional groups will be vital, and ideally the new general manager will be treading a careful path between consensus and autocracy. Experience of how general managers operate in other countries' health services suggests that he needs to take note of professional opinion but need not be bound by it. If consensus is unobtainable the general manager decides, for consensus management by a group of equals is one thing, whereas consensus management where there is a general manager—for example, the prime minister in the British cabinet—is another. In calm waters it matters little who sails the ship; in a gale the vessel needs a captain, and with the NHS being buffeted around the general manager will be expected to captain and steer the service.

Inside or outside appointment?

The NHS has around 250 district authorities—or their equivalent—so where will that number of general managers be

found? Will they come from the health authority, from the NHS, or from outside? Is there sufficient talent in the NHS to meet the ambitious expectations of the DHSS? Is there sufficient talent outside, and if so can the NHS afford it? These are crucial questions, and there are doubts whether they have been thought through before the management changes were launched.

A common practice seems to be for chairmen to ask each health authority officer if he is interested in being the general manager and who he could work with. Even before the permanent secretary's letter was issued some district authorities were intending to advertise externally. Some were dissatisfied with their existing chief officers, while others were not convinced that they would make good general managers and so wanted to test the market.

Generally, the odds seem stacked against appointments from outside the NHS and against applicants from outside the health authority. The argument ran that internal appointees would be quicker to get in post and would reduce the managerial hiatus that many authorities are experiencing. It would also facilitate the next round of designing the management structure and appointing the unit managers. There were reservations about appointees from outside the NHS because the newcomer would have to overcome the problem of different “cultures” and assuage any hostility from his subordinates, even though he would presumably bring in to the service particular qualities and experience.

NHS health authorities are complex organisations, and appointees from outside might find it hard to adapt to and to understand the NHS's peculiar style of management—in particular, the role and influence of clinicians. Furthermore, the hire and fire ethos of business has been alien to the health service. On more practical grounds some authorities are worried that an outside appointee would mean that an additional salary would have to be found, at least for some time, whereas an internal appointment would not have to be replaced, at least, not necessarily at the same salary scale.

What incentive for outsiders?

On the other side of the coin what incentive is there for an outsider with ability to apply for a general manager post at the salaries being offered? Appointees from outside the NHS would have to give up their jobs and be appointed on a limited three or five year contract. In any case, at the time of writing few outside appointments have been made, though I have no information on how many outsiders have applied. Ironically, at the time of writing the top management post in the NHS, which the government wants to fill from outside, remains vacant, an embarrassing hiatus for a government that has been urging health authorities to press ahead with the Griffiths changes.

One benefit that may accrue from this reorganisation is that managerial talent could be more evenly spread across the country—a sort of managerial RAWP—as officers

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from managerially strong districts who have not been appointed general managers in their own districts apply elsewhere.

Relations with other staff

Other chief officers, such as the treasurer and nursing manager, will be directly accountable to the general manager for their managerial functions, but where opinions are divided on professional matters the officers will have the right of access to the health authority. As in many instances the division between managerial and professional responsibilities will be unclear this "court of appeal" function will strengthen the power of chairmen and their authorities. Even so, it will be important for authorities to define where the division lies if the position of the general manager is not to be undermined.

Inevitably, a major question is the relationship between the general manager and the clinicians, but hard and fast rules may be hard to agree and the matter will no doubt be solved locally by the general manager and clinicians. If not trouble seems inevitable. The manager will certainly not be a latter day medical superintendent, trying to interfere in clinical practice, but where a clinician abuses his position, say by being persistently late for his clinics, then the manager will be justified in acting, though whether through the regional medical officer (in the case of a consultant) or directly will no doubt be a matter for discussion. In authorities where the general manager plans to downgrade the district management team—a change strongly opposed by the BMA—this sort of managerial decision affecting doctors may prove controversial. Where general managers and clinicians will have the greatest conflict, however, will be in allocating resources: as I see it that will be the general manager's responsibility, albeit after hearing the opinions of interested parties. Once again different local practices may evolve that reflect local circumstances.

Assessing general managers

Unlike most other NHS staff general managers are being appointed for three to five years with the possibility of re-appointment. Some health authorities, partly to help the general manager know what is expected of him, are already planning how he should be judged. The evaluation process will culminate, of course, in the decision whether to reappoint the manager or not. This may be quite soon in those authorities where managers are being appointed on three year contracts, as a reasonable length of notice has to be given and time will be needed for a new appointment. Most authorities will probably have a regular process of discussion and evaluation, something that has not always happened in the past, but the new short contracts will make such a procedure essential.

General managers will take time to settle in and cannot be expected to achieve practical results in under a year. But I envisage three levels of evaluation. Firstly, the general manager would be evaluated on how well he was developing working relations with other staff and members of the authority. Secondly, after, say, three years he could be evaluated on his success in achieving specific tasks, like meeting a budget, changing the level of service of a hospital, implementing the annual plan, etc. Thirdly, there would also be other less precise objectives that the general manager would be expected to have achieved—ones for which subjective judgments would have to be made by the health authority when it came to reappointment. Examples might be the extent to which power had been delegated to units or what progress had been made in developing clinical budgets. Inevitably, the boundary between objective criteria of meeting the budget, say, and the subjective criteria of the amount of progress in some areas is not precise. What happens, for instance, if the authority fails to meet its budget through no fault of the general manager? But these are

factors that the authority's review group would consider when considering reappointment.

What rewards for success?

Other questions will arise. How do you reward the general manager—or anyone else in the NHS for that matter—for innovation and success? What happens to the functions of the officers who are not appointed general manager and who are no longer chief officers reporting directly to the authority? While the ability and personality of the general manager is important, the management structure that authorities develop is undoubtedly of major consequence. Looking ahead, how do you identify future general managers and what type of training do they need? Who are to be the unit general managers? It is said that to be a good film director you do not need to have been an actor, but it helps: to be a good manager you need managerial ability and technical knowledge. The closer you are to the coal face the more important it is to have knowledge, and as the Griffiths report emphasised clinicians (and general practitioners in the community units) should pay their full part in this.¹ But what administrative and financial support will doctors require to help them function as general managers—and how will clinicians in unit management marry their clinical responsibilities with their management activities?

These questions have yet to be answered. Perhaps this is not surprising, for despite claiming that this is not another re-organisation the government expects a quantum leap in the standards of management of the health service. Whether the appointment of general managers will achieve such an aim we will see. General managers, rather like the DHSS, will have power to direct resources, but they will be able only to influence what is done with the resources. The success of a general manager will depend largely on his ability to influence the health professions with whom he will have to work: that will be his greatest challenge and will probably make or break his managerial term of office.

References

- 1 NHS Management Inquiry. *Report*. London: DHSS, 1983. (Griffiths report.)
- 2 Department of Health and Social Security. *Health service management. Implementation of the NHS management inquiry*. London: HMSO, 1984. (HC(84)13.)

THIRTY YEARS AGO

Hospital authorities throughout England and Wales have been asked by the Minister of Health, Mr. Iain Macleod, to make sure that the most effective use is made of hospital beds. He points out (Circular H.M.(54)89) that although the annual number of in-patients has increased by one-sixth since the early days of the National Health Service the total waiting-list is still about half a million and that the reduction of waiting-lists is of immediate urgency. A large increase in the number of beds would be very costly, and if all facilities could be provided it is doubtful if the additional manpower to staff them could be found, the Minister points out.

Experience, the Minister says, has shown that much can be done to increase the number of patients who can be treated each year per bed. A number of hospitals have shown that over 90% of beds occupied is practicable. He suggests that hospitals should reconsider their arrangements for reserve beds to meet emergencies, and for the allocation of beds both to individual consultants and between male and female patients in the same specialty. Waiting-lists should be regularly overhauled, and patients nearing the top of the list might be warned to hold themselves in readiness against an immediate summons. Steps in connexion with diagnosis might be started in out-patients before admission to minimize the time spent in hospital by the patient. Beds in an acute hospital can often be freed by full use of convalescent accommodation, out-patient departments and resettlement clinics, and consideration of the patient's home circumstances. (*British Medical Journal* 1954;ii:183).

Rural Dispensing Committee: first year's work

The Rural Dispensing Committee, which was set up in April 1983 to decide how significant changes proposed for dispensing in rural areas can best be regulated in the interests of patients, has issued its first annual report.

The arrangements for supplying drugs and appliances to patients under the National Health Service are based on the principle that the dispensing of drugs should normally be carried out by pharmacists. Doctors may supply drugs and appliances, however, if the patient has difficulty in obtaining them from a pharmacist because of distance or the patient lives in an area that is rural in character more than one mile from a pharmacy.

During its first year the committee received 74 applications to provide pharmaceutical services in rural areas. The committee also received 37 notifications of decisions made by family practitioner committees on whether or not a particular area was rural in character. In its role as the final appellate authority in such cases it dealt with nine appeals. In three others the family practitioner committee's decision was not challenged but the committee was asked to consider whether any conditions should be imposed to reduce the impact on existing doctors or pharmacists.

The report highlights the importance that the Rural Dispensing Committee attaches to the views of bodies which represent the public and it has consulted, for example, community health councils and parish councils.

Mileage allowances for hospital doctors

Agreement has been reached by the joint negotiating committee for hospital staff on revised rates of car mileage allowances, taking effect from 1 July. The profession has been negotiating a system of allowances that provided adequate compensation for the loss sustained by consultants after the Inland Revenue decided to tax home to headquarters mileage. Advance letter (MD)2/84 gives details of the revised rates. Revisions will be made from 1 July each year and will be prospective only. Revisions reflecting petrol price changes of more than 5p will be prospective and implemented from the beginning of the month after agreement. An allowance for higher depreciation between 9000 and 15 000 miles has been included. Public transport, motor cycle, and passenger allowances have not been changed. Car loans and use of Crown cars are negotiated by the General Whitley Council.

"In house" practice booklets for patients

The General Medical Services Committee has agreed to recommend to local medical committees that "in house" booklets could be issued

to existing patients in a practice. These should be low key and could include the following information:

(a) The names of the doctors in the practice, the practice address(es) and telephone number. It would be appropriate for the telephone number to be in bold type and for it to be repeated as appropriate throughout the booklet.

(b) A clear statement of the consulting arrangements of the practice, together with the procedure for making an appointment.

(c) The procedure for accidents and emergencies and requests for home visits.

(d) Information about the times and arrangements for special clinics.

(e) Information with regard to ancillary services and other facilities available if applicable.

(f) A reminder to patients with regard to medical cards could also be included.

(g) Information that a trainee may from time to time form part of the practice may also be appropriate.

(h) Indication of the area covered by the practice.

Medical Research Council

The annual expenditure of the Medical Research Council for the past five years was given in a recent parliamentary written answer.

MRC expenditure

	England* (£m)	Wales (£m)	Scotland (£m)	Northern Ireland (£m)	Total (£m)
1979-80	61.5	1.8	7.2		70.6
1980-1	78.9	1.8	9.7	0.1	90.5
1981-2	89.1	2.1	12.3	0.1	103.6
1982-3	94.7	1.9	11.1	0.2	108.9
1983-4	100.8	2.2	11.5	0.2	114.7

*Includes Medical Research Council's central administration costs.

Grading of medical secretaries

The Joint Consultants Committee has long supported the regrading of medical secretaries and in 1978 produced a report jointly with the Department of Health and Social Security, *Secretarial Services for Hospital Medical and Dental Staff*.¹

At its last meeting on 23 October the JCC was told that the DHSS had recently written to regional personnel officers reminding them of the 1978 report and pointing out the flexibility in the present Whitley Council grading structure. The management side of the Whitley Council believes that the existing structure provides an adequate range of grades for secretaries which "could be used to reflect the wide differences which existed in the weight of responsibility of individual posts." The DHSS has pointed out that medical secretaries are not distinguished from other secretaries for grading purposes and it is the actual duties performed that determines their grading. Medical secretaries may be graded shorthand typist, personal secretary,

higher clerical officer, and general administrative assistant.

The chairman, Mr A H Grabham, said that he was doubtful whether the letter to personnel officers would achieve much; he hoped that another letter could be sent out at district level. The Chief Medical Officer has invited the committee to study the problem and to report urgently.

Reference

- 1 Joint Consultants Committee/Department of Health and Social Security. *Secretarial services for hospital medical and dental staff*. London: JCC/DHSS, 1978.

Cutting waiting lists

Health authorities have been asked to make greater use of facilities available in private sector hospitals to help cut waiting lists. Speaking at the annual general meeting of the Association of Independent Hospitals, the Parliamentary Under Secretary of State for Health, Mr John Patten, said that the private sector already made beds available to the National Health Service, for an agreed reward, and these arrangements had existed for many years. The NHS would help to meet demands and the private hospitals would act as a valuable source of regular and dependable income.

BMA Mersey regional office

The BMA's Mersey regional office has moved to the following address:

BMA Mersey Regional Office
22 Oxford Street
Liverpool L7 7BL
(tel: 051-709 5660).

BMA membership at 31 October 1984

General practitioners	22 031
Senior hospital doctors	10 531
Junior hospital doctors	20 382
Community medicine and community health doctors	2 093
Civil Service doctors	332
Armed forces doctors	626
Occupational health	598
Medical academic staff	1 918
Members in practice but not identifiable by group	1 759
Total in practice	60 270
Retired members	8 275
Total UK membership	68 545
Total overseas membership	6 862
Associate members	5 508