TALKING POINT

Management training of clinicians in the NHS

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I recently attended two separate management courses for clinicians in one month. Two in one month might sound excessive to the surgical senior registrar who was unable to attend because of "clinical commitments." It was a pity that he or she missed the section on the structure and working of advisory appointments committees for consultants.

The first course, "unit general management for clinicians," was organised by the BMA and the National Health Service Training Authority. Set up in October 1983, the authority's ideals are based on "a firm view that manpower is the most valuable and most costly resource in the NHS" and "that the service will be better able to achieve its objective of providing the best health care service that the nation can afford if it can depend on an efficient well trained work force."¹ To this end it organises research, education, and training programmes affecting most categories of NHS staff. The second course—"senior registrars—preparing for management responsibilities within the consultant post"—was arranged and funded by the Yorkshire Regional Health Authority. I would like to outline some of the ideas and theories presented in both courses.

Knowledge was disseminated to "eager to learn trainees," who were no doubt a self selecting group. Lectures, discussion groups, problem solving exercises, self awareness techniques, videos, and open forums were employed to provide variety; participation was the order of the day. The social aspects are important during intensive residential courses, and we reflected and reviewed what we had learnt over a beer or two.

The NHS after Griffiths—from democracy to autocracy?

We examined the NHS in detail in terms of its social, political, and financial constraints. We were introduced to the NHS Management Board. Key members include Mr Michael Fairey, chairman of the Health Service Information Advisory Group; Mr Stephen Miller, director of financial management; and Mr Len Peach, director of personnel, on loan from IBM and now acting chairman. We next encountered the regional general manager, who regardless of discipline is "charged with the general management function and overall responsibility for management performance in achieving the objectives set by the authority."² The managers at district and unit are on fixed term contracts of three or five years—perhaps a good incentive to produce results quickly. At the bottom of the management line is the clinician at the "shop floor" with a lifelong contract. We are seen as the ones who spend the money and in the future will receive our clinical budgets. The Griffiths report concluded that the devolution of responsibility was too slow because of a lack of "direction and dynamic." It recommended a small strong general management body at the centre of the NHS to ensure that responsibility moved as far down the line as possible to where action could be taken effectively. This is "top down" management, but the shop floor worker (the consultant in this case) spends the money—"responsibility accounting" upwards.

How is the money divided?

The health service suffers from two major difficulties—infinite demands and finite resources. NHS management trainers rightly see this as one of the fundamental premises to instill into clinicians. Choices have to be made. One patient's community nurse is another patient's day hospital place. There is an increasing scale of disadvantage as the level of decision making is ascended. The doctor sees his patients, the hospital its catchment area, the region its communities, the Department of Health the health needs of the population, and finally the government the overall needs of the community. At the highest level, therefore, money spent on defence is money not spent on the NHS. We were told of the "glorious" days starting in the 1950s when NHS spending seemed limitless, especially in the Thames regions, which received the lion's share of the financial cake. Then in 1975 the government set up the Resource Allocation Working Party (RAWP).³ Its remit was "to review the arrangements for distributing NHS capital and revenue . . . securing as soon as practicable a pattern of distribution responsive objectively, equitably, and efficiently to relative need." Based on demographic data and degree of social deprivation a RAWP formula was developed to enable equal distribution of money between the capital and the provinces. Unfortunately, as the fountain of money has dried up, one region's community nurse has become another region's day hospital place.

"If you can't measure it you can't manage it"

Dear to the heart of all managers is the belief that "if you can't measure something you can't manage it." Accordingly, we were given a résumé of the techniques that have been or are being used to measure "efficiency" in the NHS. The Rayner scrutinies are based on the idea that if you send an outside expert into a department for 90 days he will be able to locate deficiencies and problems which can then be rectified and, therefore, "efficiency savings" made.

The Körner Steering Group on Health Services Information was set up by the Secretary of State in 1980. It was to agree and implement the principles and procedures appropriate to guiding the development of information gathering in the NHS. A core body of data was obtained and transmitted as a minimum data set. Performance indicator packages consist of masses of data stored on floppy discs that at the touch of a microcomputer will display how services seem to be working at a local level. "What's your bed occupancy rate?" "How many new outpatients does your colleague see?" They also allow the comparison of data from other hospitals in the same district, a different district, the region, and the country. "Why do Mr Smith's postoperative patients remain in hospital longer than anyone else's?"

Finally, we were told of the QALY—the quality adjusted life year. Based on the aggregated value judgments of a sample population, each illness is given a QALY score—1 is normal health, 0 is dead, and most illnesses have a score between the two figures. Minus scores are awarded for illnesses thought to be "worse than dead"—for example, coma. Once this has been done the objectives of the NHS can be redefined in terms of QALYs obtained per given amount of expenditure, renal dialysis costing £14 000 per QALY, renal transplantation £6000 per QALY, cardiac transplantation £11 000 per QALY, and total hip replacement £750 per QALY. Is this the way ahead for dividing up the limited resources of the NHS?

Will we spend money on the most cost effective—that is, the cheapest—QALY producer?

A clinical budget is simple, we were told. The basic theory is that the clinician will be allocated on paper a sum of money—the amount spent last year, say, plus a few per cent extra for inflation. Together with the unit general manager he will establish a plan or target for the year—for example, to perform 75 hip replacements. Throughout the year a record of the actual “performance”—how much money has been spent on each item of service—will be given to the budget holder, who can then compare resources currently being used with the amount originally planned. Any marked differences can then be acted on to remedy the position and prevent overspending at the end of the year. It takes only an hour or so a month, we were told. It is a way of controlling costs and establishing responsibility so that the most effective use can be made of finances.

The techniques of management

Having been given the basic facts behind NHS management we were then introduced to the various management techniques employed. Plan the day, the week, the future. Get a good diary and a good secretary. Reactive management means responding only from crisis to crisis. Planned time management is the key—build into the day a set time for the reactive problems that may arise. Define the boundaries of your own role at work and give yourself enough time to deal with what you are meant to be doing. Delegation comes next. Avoid doing someone else's job; pass down items of work to the appropriate person in the same way as items are passed down to you. Offer support, teaching, and advice, and take the responsibility for what happens.

We were told of the seven Cs for management of meetings. Communicate throughout the meeting, control the agenda, coordinate areas of common agreement, coax the quiet members, compare contributions impartially, clarify to ensure understanding, and concentrate on using time effectively.

The courses allowed practical techniques in the management of stress: we had a half day off during the week for relaxation.

During each course we completed personality questionnaires. We received a computer printout of our “personality” and were

compared with a unit general manager. Did you know that before being interviewed for a unit general manager's job the candidates are asked to complete similar personality questionnaires, which are then used in the final selection procedure? I am passive, expedient, experimenting, and tender minded—unit general managers are not.

Organisation laboratory

The highlight of each course was the organisation laboratory. A mystery figure is introduced as the managing director of a new company in which all the members of the course are given positions in either a management or worker capacity. Combining role play, individual personality traits, and above all assumptions, the day is spent running the organisation. This sounds childlike; it is not. Anger, frustration, support, and cooperation are all uncovered as the participants experience the feelings of working in various jobs in the organisation. Could that be the NHS organisation?

The Griffith report said that “involvement of doctors is critical to effective management at local level,” and the implementation circular strongly endorsed the view “that clinicians should be encouraged and enabled to play a more active role in management, especially unit management.”⁴ Clinicians in the health service are already managing people and resources. With the introduction of formal clinical budget holding and the increasing awareness of efficiency and improving standards of care a knowledge of the rules of management game becomes increasingly important.

I should like to thank Miss Felicity Matthews, Dr Helena Waters, and their NHS management training colleagues.

References

- 1 NHS Training Authority. *Annual report 1984/5*. Bristol: NHS Training Authority, 1985.
- 2 NHS Management Inquiry. *Report*. London: DHSS, 1983. (Griffiths report.)
- 3 Department of Health and Social Security. *Sharing resources for health in England. Report of the resource allocation working party*. London: HMSO, 1976.
- 4 Department of Health and Social Security. *Health service management. Implementation of the NHS management inquiry report*. London: DHSS, 1984. (HC (84) 13.)

(Accepted 11 July 1986)

THIRTY YEARS AGO

A Pathologist's Pay

SIR,—I have discontinued my membership of the B.M.A., as I have come to the conclusion that it fails to act in the best interests of the profession. My reasons for relinquishing my membership were not entirely due to the fact that I am no longer engaged in the medical profession, and I am willing to rejoin if I can be convinced that the Association is making some effort to help my many friends who are living in straitened circumstances.

I wished to become a pathologist when I qualified in 1952, but found that at no time in the ensuing seven or eight years was I likely to earn £1,000 per annum. I therefore entered the family business, where I pay a good representative over £1,000 per annum, plus car, plus expenses. Our travellers have no technical training and their only qualification is that they can sell our goods. It seems altogether wrong that if I were to offer them the salary of a doctor with higher qualifications working as a registrar they would leave forthwith.

Most young men qualifying in medicine desire to get married, have a home, a family, security, and freedom from debt. Can you say that the work of your Association has brought them that? What hope have they got of obtaining luxuries like a car, a television set, or public school education for the children? I would have preferred to earn my living in my profession, but I wished to marry and felt that I owed my family a minimum standard of living not obtainable as a registrar and certainly beyond the scope of a house officer. Worse still, there was precious little hope for the future, for even if I had higher qualifications what chance had I of obtaining a consultant's post?

Do not think that I am grumbling, for I am happy with my lot. I feel strongly that those in the profession whose position is secure and remunerative are continuing to be favoured at the expense of those who have little in

the way of remuneration or security. The purpose of this letter is to judge whether the B.M.A. is worth supporting, and my conclusions are that it has been weighed in the balance and found wanting.—I am, etc.,

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(*British Medical Journal* 1956;ii:95.)

Increased Prescription Charge

SIR,—This latest *bêtise* penalizes the needy and the indigent—the old folk who are too proud to get their shillings back from the National Assistance Board, the widow with small children, the colostomy patient and his multiple needs of gauze and wool and cellulose. Mr. Macmillan, who probably has never had occasion to take an N.H.S. prescription to the chemist, cannot know what harm he has done to the Conservative Party by his crass stupidity. Or is this madness the calculated policy of the Cabinet?

If the doctors had been consulted—instead of being suddenly informed of a *fait accompli*—they might have suggested an extra prescription charge might be allowable on particularly expensive drugs, such as oxytetracycline or chlortetracycline, costing over £1 per prescription, the charge to be *ad valorem*. But to make a *Diktat*, sudden, final, without discussion or explanation, leaves all of us doctors speechless.—I am, etc.,

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Leeds.

(*British Medical Journal* 1956;ii:198.)