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DECISION-MAKING AND PLANNING IN A DISTRICT HEALTH AUTHORITY: A REVIEW AND A CASE STUDY

P G L FORTE

School of Geography
University of Leeds
Leeds LS2 9JT

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1: Introduction

In recent years few days have gone by without the financial difficulties of the NHS being brought to the public's attention. These have focussed, often emotively, on the likely consequences for services of not increasing funding for the NHS at a rate regarded as necessary to maintain existing standards let alone extend them. The additional effects of a positive discrimination in funding to poorer areas of the country has only exacerbated the problems of some authorities, especially in the south east. The Government, however, regards the problem not so much as one of the actual level of funding but as one of poor management structures and practices and has concentrated its efforts on improving those areas. Is that a valid argument or does improving the efficiency of health service decision-making (which tends to be defined in terms of the speed of reaching decisions and "value for money") lie in other areas?

In this paper we consider this question through a detailed analysis of the decision-making process as observed over a 2 year period in a small district health authority (DHA) in industrial northern England. The district level was chosen as it represents the point in the NHS where policies and plans are finally transformed into "actual" health services for consumption. We related this analysis to theoretical concepts of uncertainty, decision-making and organisational structure. The conclusions drawn suggest that administrative changes can indeed improve the flow of information and decision-making efficiency but are not in themselves enough.

We begin, in section 2, with the background to decision-making in the NHS with particular reference to the district level. The NHS,one of the

largest and most complex organisations in Britain, has undergone two major administrative changes in the past 12 years alone. An essential feature of the decision-making process is how to reconcile the freedom of the clinicians, who are the main consumers of resources, to treat their patients with the aims of the non-clinical administrators, the providers of the reources, who are responsible for overall levels of service provision.

In section 3 we report the detailed analysis of decision-making in a DHA as recorded in the minuted meetings of the Authority members and the district management team (DMT), supplemented by informal interviews. This indicates the types of issues being faced at that time, how they were tackled, and by whom.

Sections 4 and 5 trace the course of actual decision areas, with a focus on the planning system in section 5.

The models of uncertainty postulated by Friend and Jessop (1969) form the framework on which we analyse the minutes in section 6. The form uncertainty takes is closely linked to the structure of the organisation and the location and ability of the people taking decisions within it.

Finally, in section 7, we draw some conclusions and suggest ways in which the system might be improved.

2: Health Service Organisation and Decision-making

We begin with a brief overview of the organisational development of the NHS and the role of the DHA within it. We then outline the responsibilities of some of the more important district committees, setting the scene for the analysis in section 3. We conclude with some comments on how we can actually define what we mean by a "decision" and decision-makers.

2.1 The development of the administrative system

From 1948 until 1974 the NHS was characterised by the fragmented structure of its organisation. Comprehensive service planning was non-existent, a situation which was exacerbated by the myopic perspective on funding the service (which is still a problem today) and by the attitude that it was not really necessary as enough money could always be found to meet its requirements. By the end of the 1960s, however, it had become clear that the administrative structure could not cope with the strains imposed by the size and scope that the NHS had reached. The solution was believed to lie in "technological" changes to the administrative and management structure. This was very much in keeping with ethos of the time and obvious parallels can be drawn with the reorganisation of both local and central government which was being considered at the same time.

For the NHS the outcome was a major reorganisation in 1974 which set up a 3-tier administrative structure. The old Regional Hospital Boards remained the basis for the new Regional Health Authorities (RHAs). Beneath these were Area Health Authorities (AHAs) and these, in turn,

were divided into health districts each serving between 160,000 and 250,000 people. Important aims of the reorganisation were to allow more effective central guidance of national health strategies and to improve the management and effectiveness of service provision throughout the system by involving both administrators and practitioners in its running. This style of concensus management, which brought together the resource spenders and allocators for the first time, was regarded as the best way in which to tackle the complex questions of resource allocation.

Although in theory it seemed the ideal solution, success was more elusive in practice. Two main reasons can be identified for this; one was the complexity and upheaval caused by the reorganisation itself which was simply underestimated, the other was not to implement an integral part of the reorganisation - the comprehensive planning system - until two years later. The effects of these were to preoccupy people with the establishment of the new administrative structure let alone concentrate on issues of service provision. The changes were also taking place in a steadily worsening financial environment for the NHS just when a comprehensive planning system was most needed. Morale in the service declined sharply and it was evident that further changes were required. A Royal Commission was set up and the recommendations it made on reporting in 1979, were adopted. For the second time in less than ten years, the health service was reorganised. This took place in 1982 when the middle tier of administration (the AHAs) were abolished and their former subdivisions, the health districts, became full authorities in their own right. The RHAs were left unchanged.

Also in the early 1980s the idea of concensus management was being re-evaluated. This was partly due to the philosophical approach of the

then Government keen to see a stronger and more clearly defined management structure which, it believed, would lead to a greater efficiency in service provision. An NHS inquiry (1983) chaired by Griffiths recommended that an executive decision-making structure should be introduced at all levels in the NHS and answerable to a central NHS Management Board. This replaced the responsibilities of the DMT, which had had executive responsibility from 1974, and which now remained only in an advisory role. The full ramifications of these changes have yet to be fully assessed, but do not directly concern us here as they took effect after the period we are considering.

2.2 The planning system

A comprehensive operational and strategic planning system was only introduced in the NHS in 1976 and underwent major revision in 1982 immediately prior to the study period. In essence it is a formal system which allows government policies to be filtered down to the regions and district, modified to meet particular local circumstances and priorities. The regional strategic plan, drawn up by the RHA with the approval of the DHSS, sets out the regional priorities for care groups, the allocation among districts of supra-district specialties, capital, revenue and manpower assumptions and a timetable for the completion of plans. It is regarded as the focus and benchmark for operational plans and districts have the opportunity to comment upon it before it is finally adopted.

Districts are required to produce an annual operational plan showing firm proposals which expected to be implemented in the ensuing year. This includes service developments, capital works, a revenue budget and joint finance expenditure plans with local authorities. It is also

expected to indicate provisional proposals for the following year. Although the bulk of the planning preparation is done by the district's planning teams, the DMT also had (at that time) a crucial role to play in plan preparation through its co-ordinating role between groups in the district. Decision-making with specific reference to this process is discussed in more detail in section 4.

To summarise:

1. During the period for which we carried out the analysis (1982/1983 inclusive), the NHS had just undergone its second administrative reorganisation and the district had become an authority in its own right.

2. Concensus management through the DMT was still in force. Team members were answerable to the District Health Authority which, in turn, was accountable to the RHA and DHSS.

3. Financial cutbacks and the general slowing down in the growth of funding were key issues underlying many of the decisions taken at DHA and DMT level.

4. The planning system had been reorganised and was only just becoming fully operational.

2.3 Administration at the district level

Our analysis of decision-making process is at the district health authority level over a 2 year period (1983/84), chiefly through its main policy making body - the Authority members - and their executive arm, the DMT. A district has a good deal of autonomy in how it provides its services although it is obviously subject to negotiation and restrictions from the RHA and DHSS. In this section we outline the principal roles, responsibilities and constitution of some of the many committees and individuals involved to varying degrees in the management process.

i. The District Health Authority (DHA)

In this DHA this consisted of 15 members, appointed by the Secretary of State for Health and legally responsible to him for the operation of health services in the district. They were part-time and most of them had no formal background in health care although some had been serving members of the former AHA. The memebers comprised local council representatives, academics, local figures and a representative of the Community Health Council (CHC) which is the statutory "consumer watchdog" of the district's health services. Also usually in attendance at the meetings are the senior officials of the district such as the Treasurer, District Administrator and a consultant representative. Meetings were held once a month - in public and with the press in attendance - at one of the hospitals. Occasionally this was combined with a visit to a particular part of the district.

The Authority members were supposed to be primarily concerned with strategic policy issues, shaping the future pattern of services under

their control and interpreting national and regional guidelines on services in the context of local priorities, and leaving the day-to-day management of the district's services to the DMT. As well as meeting as a full committee several smaller standing and ad hoc sub-committees were set up to supervise particular areas of policy or communication. Over the years these became indespensible as a means of carrying out the Authority's tasks of review and deliberation. The two most important of these on finance and on personnel, were established shortly after the DHA was created. When, after two years a review of their functions was undertaken, their remit was endorsed and strengthened to give them wider responsibilities of reporting and recommending action to the DHA and a new standing committee on patient services was also set up.

ii. The District Management Team (DMT)

In this district there was a team of six consisting of four full-time officials; the District Administrator (DA), District Treasurer (DT), Chief Nursing Officer (CNO), District Medical Officer (DMO) and, from a management point of view, two part-time officials; a representative of the district's hospital consultants and one from its general practitioners (GPs). Between them they represented the most important allocators and consumers of the district's resources. The DMT acted as the reticulist "hub" of the district, receiving information on district services via other committees and individuals and channelling it back to the Authority. This channel also worked in reverse as the DMT put into operation DHA policies and instructions. It was the main point of contact between the administrators and the clinicians, often the scene of most of the important conflicts between these two groups, and where the concept of consensus management was most under trial. In this district relations were, for the most part good and this even extended

to rotating the chairmanship of the team for a period.

It met twice, sometimes three times a month, to consider the actions needing to be taken on both short and long term management issues. There were no sub-committees; all actions were delegated to individuals or, occasionally, a small group. Despite difficulties in resolving opinions at times, the atmosphere in the team was generally constructive. This was probably helped by the small size of the district where it was easy to maintain wide ranging informal contacts and so most DMT members were well briefed of current events in the district.

In addition to these two main committees there were many others representing more specialised sectors of interest and with varying degrees of importance. Some of these were standing, others are ad hoc, and the responsibilities of some the more important ones are summarised below:

iii. Medical Executive Committee (MEC)

This important and influential committee met every month or so and represented the interests of the hospital-based consultants and their staffs. It was itself made up of smaller "divisions" which focussed on the activities of particular clinical areas, such as pathology, anaesthetics, surgery, etc. One result of this was that it did not always put forward a unified front in discussions on clinical resource allocations with the DMT or DHA.

iv. Joint Consultative Committee (JCC)

This committee was supposed to co-ordinate the joint provision of services between the health authority and the local authority for those groups, particularly the elderly, mentally ill and mentally handicapped, where responsibilities for service provision was split. It is a very difficult service area to administer and plan for and matters were made more complex in the study district because the local authority had to deal separately with two health authorities. Prior to the 1982 reorganisation both health authorities were districts in the same Area health authority and enjoyed co-terminous boundaries with the local authority. In the period we are considering the new health authorities actually moved away from co-ordinating their joint service provision together, each dealing with the local authority independently.

v. Unit Management Groups (UMGH, UMGC)

These were being established during the study period and the DMT was engaged in actively devolving responsibility to them for daily management matters. Two groups were set up in this district; one for community services, the other covering the hospital sector.

vi. District Support Planning Team (DSPT)

This was the main planning team for the district's services and it co-ordinated the activities of a number of smaller groups with expertise in specific service areas such as the District Planning Team, Mental Handicap (DPTMH).

vii. District Medical Advisory Committee (DMAC)

A joint DHA/medical committee which considered longer term policy issues for medical services. A similar district advisory committee was later set up to cover dental services (DDAC).

viii. Family Practitioner Committee (FPC)

Due to the separate administrative and funding arrangements within the DHS for FPC services (GPs, dentists and opticians) there was little active co-operation between the DHA and the FPC covering the area. A GP representative was on the DMT but there was perhaps surprisingly little activity when it is considered that about 90% of the hospital patients are referred there by GPs.

ix. Community Health Council (CHC)

This is a statutorily appointed council at the district level, charged with representing the consumer's interests in local health provision. There was an annual meeting held with the Authority members, apart from that its role in this district was confined to one of a pressure group on various health matters.

x. Joint Staffs Consultative Committee (JSCC)

The joint trades union negotiating committee. This usually met with the DMT.

A wide variety of other committees reported and liaised from time to time with the DMT and Authority, some only annually but others depending

on whether they represent the interests of groups affected by particular decisions. Some, such as the Ambulance Liaison Committee, involved other health authorities as well. They will be described wherever they are referred to in the text; for a fuller list see the appendix.

2.4 Decisions and decision-makers

Before the analysis proper it is worth pausing to consider what we mean by a "decision" and a "decision-maker". The concepts are, in fact, difficult to define accurately. Here we outline some of the reasons why that is so and offer our own working definitions.

The actual point at which a particular decision can be said to have been reached - the "when" - becomes more difficult to pin down as the complexity and scope of the issue involved increases. No hard and fast rules can be applied to judge when it occurs. For our purposes we use those decisions recorded in minuted meetings, even though they may have been taken outside of this forum. Complicated issues are often only resolved gradually over a period of time with meetings acting as a focus for recording that a particular line of action has been taken. One decision area - the laundry - still had not been resolved after 2 years.

The more involved the issue, the less the degree of certainty with which the decision-makers can judge beforehand the likely outcome of their actions. This degree of certainty is, in turn, largely determined by the amount of information available in the decision area. The health service both abounds in these types of areas and is at the same time noted for its lack of relevant information. As a result a short-term perspective in decision-making is commonly adopted, even when it is

appreciated that there are important long term implications. There is little alternative but to do this if the health service is not to seize up entirely. It can, however, lead to later decisions in the same subject area being taken by default with little room left for manoeuvre. It is a trend which only emerges in the longer term, hence the value of a retrospective study.

The importance of personality, politics and power must also be recognised but their influence cannot be quantified. Informal interviewing, however, can be usefully employed here to "flesh out" the bones of debate as reported in minutes. The question of power in particular is an interesting one. The authority to take decisions is fairly well defined, although still not measurable in any objective sense, through the lines of delegation and accountability. This is linked to the idea of "where" a decision is taken and we conclude this section by considering this in relation to organisational structure.

2.5 The locus of decision-making

The classic model of a bureaucratic organisation has a well defined hierarchical structure with clear lines of accountability and responsibility emanating from the top. This is an adequate description for most real world cases and, with reservations, for the NHS too. The essential differences with the NHS, however, are that its administrative structure has a large degree of autonomy at lower levels and it has complicated lines of accountability. The first point allows us here to regard the DHA as a relatively self-contained unit with "external" links to other parts of the NHS as well as outside the health system itself. (These aspects are cosidered in more detail in another paper, Forte (1986) forthcoming). The accountability problems are more difficult to

reconcile. They stem from the concept of clinical freedom, which is the right of clinicians to treat patients as they see fit. As the primary consumers of resources this means that they are not, in effect, directly accountable to the administrators who are the resource providers.

A useful analogy in terms of decision-making in the organisation has been drawn by Beer (1972) who compared the flow and handling of information and the levels where particular types of decisions are taken in a typical organisation with the human nervous system which handles essentially similar problems of control and information handling but on a vastly greater scale. The essential point is that although the brain is ultimately responsible for overseeing the functioning of the nervous system it could not do so without some sort of filtering of the information available or without various parts of the system operating in a semi-autonomous way, leaving the brain "free" to concentrate on more specialised tasks and keep the whole system operating with some sort of policy perspective.

Applying this model to the NHS at the district level we can draw a parallel between Beer's concepts of organisation structure and the functions of the DMT and the Authority members. The DMT should, in effect, filter information to the DHA and ensure that it is not being preoccupied with mundane management decisions. However, this process is complicated by the independence of the clinical lines of accountability. In effect this is saying that the district has two heads instead of one, but that only one of them controls the amount of resources available. Unless the information network for both current management and forward planning is very good, situations will arise where "low" administrative levels in the district find themselves becoming involved in resource allocation decisions which they do not have the competence or

perspective to handle properly. Hence the referral up the administrative structure of otherwise day-to-day mangement problems and a source of annoyance and additional strain on the administrative system. This is a source of uncertainty in decision-making which we return to in more detail in section 5.

3: Analysis of DHA and DMT Minutes

3.1. Review of previous research into NHS decision-making

Inspection of current health administration journals and literature quickly reveals extensive discussion, opinion and comment on many aspects of planning and decision-making at all levels in the NHS. Much of the comment is anecdotal and, while it forms a useful and frequently illuminating contribution to the debate and brings a wide range of issues to public attention, it does not really provide a sufficient basis on which to develop any theory about the processes involved. Fox (1978) looked at planning in relation to the AHA tier of administration which was a topical subject in the late 1970s. At about the same time Dearden (1978) questioned in more general terms the rigidity of planning on the administrative system while Irving and her colleagues (1981) queried whether planning was actually achieving anything at all. Brown and Prince (1982) focused on accountability in planning, and Beveridge (1983) examined some of the wider implications for the relationships between local and central health authorities stemming from the 1982 reorganisation. The list is as extensive as it is topical.

However, a number of researchers have attempted to construct more generalised theories about the decision-making process and administrative relationships. This ranges from work undertaken on a national scale eg. Kogan and others (1978) for the Royal Commission on the NHS, to smaller, more detailed studies such as those of Weller and Webber (1980), who focused their attention on decision-making at the AHA level and Barnard and others (1980) who did the same for the (then) health districts. Their work forms a useful starting point for our own.

3.2 Methods of research

A combination of interviews and the analysis of the content of minuted meetings are the principal means of this type of research. The survey for the Royal Commission was a large undertaking which was preceded by a pilot survey used to establish the main issues involved, and individual case studies were also be used to illustrate particular processes in action (Kogan et al. 1978).

Weller and Williams (1980), as part of a wider DHSS project, examined the implementation of the planning system in one regional health authority over a three year period. They used a researcher as a non-participating observer who attended all meetings along with the usual analysis methods contents analysis and interviews.

A similar approach was adopted by Barnard, Lee and Reynolds (1980) who analysed decision-making in a health district over a six month period using what they described as the "retrospective tracer" method. This involved following the course of the topics through the minutes of meetings supplemented, where relevant, by other documents and interviews. They concluded that no single source of information was complete or free from problems of bias and that diversification of sources was the best insurance against those problems.

Bearing this in mind we have built on this previous experience for our own research, adapting where necessary to take account of its retrospective nature. Most of the work is drawn from minutes and related documents, supplemented by informal interviewing. We look at the same information in differnet ways in order to draw out some of the

rich inter-relationships, not otherwise be immediately obvious, and use planning and financial issues as a backcloth to an examination of the type and areas of decision making occurring at the levels of both the Authority members (who we will refer to as the DHA), and the District Management Team (DMT). In this section we illustrate this with examples of three management issues; in the following section we look at decision-making with reference to the planning system.

3.3 Background issues

During the period we are considering (1983/84) the health service was still coming to terms with the effects of its second major administrative reorganisation and the overall financial climate was a constant cause for concern. The DHA had only come into existence as an authority in its own right a matter of months beforehand and was still "finding its feet" in administrative terms. This state was exacerbated by restrictions on administrative and clinical manpower levels which were then being imposed by the DHSS and which, in turn, meant that several important posts could not be filled from the outset. The problems of finance were further complicated by the need to consider the effects on services of a new district general hospital facility, begun in 1983 and due for completion in the late 1980s. Even in day-to-day issues financial concerns underpinned most of the items for discussion on the agenda.

Starting at the DHA level and then moving down to the DMT, we examine the nature of deliberations and preoccupations in the district with particular reference to:

1. The basic committee structures and composition in the district and how they operated during the study period.

2. An analysis of the decision-making processes by examination of the types of subjects discussed including their sources, frequencies and outcomes.

3. The extent and nature of work which is delegated and the effect of imposing deadlines for action.

4. The courses taken to reach a decision for particular topics.

3.4 Decision-making at the DHA level.

All of the meetings of the DHA followed standard committee procedures. Certain items regularly appeared on the agenda such as the minutes of the previous DHA meeting and the reports of other health committees in the district (the family practitioner committee; medical committees and other planning and administrative committees). Some topics, such as those concerning personnel or other sensitive policies, were discussed in the regular session of the meeting closed to the press and public, although on at least one occasion some of the local authority members of the DHA wanted discussion of a "closed" issue, concerning policy, to take place in the open session of a meeting for political reasons. The CHC on at least two occasions came into conflict with the DHA by leaking sensitive issues to the local press.

The DMT was the most important source of information for the DHA both via its monthly report and through individual team members. Most of the reports from other committees were merely noted and not discussed at length. Issues raised by some of these reports, however, often appeared at later meetings as subjects for discussion.

TABLE 1. PERIODICITY OF REPORTS RECEIVED BY THE DHA

Committee	No. per annum			
	12	6-12	2-6	1
DMT	*			
FPC		*		
DMAC		*		
IC				*
JCC			*	
CHC				*
NMAC			*	
RC				*
DDAC				*

Most of the items on the DHA agenda were generated from within the district but there was also input from the RHA and the DHSS. Although covering fewer subjects they usually had important long term implications. Thus it was the DHSS which prompted action and discussion on manpower, management changes and financial aspects such as competitive tendering, audits and patient charging. The DHSS also became involved in what otherwise might have been thought to be a wholly local or regional matter; the provision of the laundry service to the district. This stemmed from ultimately political considerations connected withgovernment initiatives in promoting competitive tendering in the public services. The DHSS was also behind other directives and requests made by the region to the district, for example the establishment of voluntary organisation representatives on JCCs, and overall manpower levels.

Important RHA inputs to the district concerned the implementation of the planning cycle in the region and financial allocations to the district. Policies on service provision also figured in communications, including services for the mentally ill, the co-ordination of regional specialties, training and the regional computing strategy.

Other contacts outside the district included the local water authority and adjacent health authorities.

3.5 Outcomes at the DHA level

At the district level the DHSS and RHA inputs were translated into local policies and action and taken account of in the development of district-initiated policies. These included local financial savings initiatives and service plans such as care for the terminally ill and for geriatrics. It was also here that operational problems appeared on the agenda with the DHA sometimes having to act as final arbiter between the administrators and clinicians.

We can examine the type and source of topics which came up for discussion and the frequency and relative importance of their appearance on the agenda, taking financial, planning, operational and manpower matters as broad headings for consideration.

TABLE 2. PRINCIPAL TOPICS; FREQUENCY OF DISCUSSION

Subject	No. of times
Financial information/strategy	51
Manpower	27
Planning	18
Specific operational problems	18
Laundry	9
Womens' clinics	8
Geriatric policy	7
Mentally ill policy	6
Acute services review	2
Transport services	2

The DHA often deferred taking decisions until they had been given further consideration by its own sub-committees or the DMT. Replies to specific enquiries addressed to the DHA were often delegated to the DMT

to carry out on its behalf with the request that the DMT report back on the outcome. This involved 1-4 items per month on average. The type of action requested varied but most frequently it was to give "further consideration" to a subject. Of 21 items referred in this way during the study period 14 of had time limits attached.

The region was the main destination of direct replies from the DHA which were not routed via the DMT. Most of these (on average one a month but sometimes as many as five in one month) were direct responses to information requested by the region. There were only two such contacts directly with the DHSS during the study period.

3.6 Timetables at the DHA level

These are defined here as the recording in the minutes of dates and deadlines for action or reporting back to the DHA. As it met only once a month, most of these target dates were between one and three months ahead although occasionally some were set for issues requiring more urgent attention. Most of the deadlines were either self-imposed or placed on the DMT. Only one or two were applied to other district committees. Table (3) displays them according to their main subject nature and time scale.

TABLE 3. PRINCIPAL TOPICS; TIMETABLES FOR ACTION

Subject	Urgent	1 mth	2 mths	3 mths	>3 mths
Planning	2	5	3	2	1
Finance	2	6	3	2	-
Manpower	-	3	2	-	-
Operational	2	1	1	-	1

Major operational problems, if they were brought to the attention of the DHA usually required, by their very nature, to have urgent action

taken. They were often followed by a request for the investigation of longer term solutions by the DMT and were essentially problems internal to the district.

Other timetables imposed on planning, finance and manpower issues, on the other hand, came from outside the district from the region (in finance and planning), and the DHSS (manpower). These were sometimes declared "urgent", particularly planning matters, but usually gave at least 1-2 months' notice.

Self-imposed deadlines were more generous in that they could be allowed to slip to accommodate current workload pressures. They were usually concerned with longer term issues rather than short term problems.

There is little point in setting deadlines if they are not actually adhered to. We examined matters with timetables for action referred by the DHA to the DMT to see if they were carried out in time. As the executive arm of the DHA effective implementation and management of policy depends on their efficient administration. The majority of deadlines were met but some reports on non-urgent affairs were delayed for a variety of reasons:

TABLE 4. REASONS FOR DELAY

Reason for delay	Number
Sent back to DMT for more consideration	9
Awaiting reply/information from outside the district	7
Awaiting outcome of discussion within district	4
No reason given	4
Shortage of time	2

A shortage of manpower in the district headquarters was cited on at least one occasion as a reason for delay, but the necessity to undertake widespread consultations with interested parties, both inside and outside the district (especially where clinicians were directly involved) emerged as one of the main reasons for delay. Another was a tendency to defer taking a decision until "further discussion" or "more reports" had taken place. This is symptomatic of a type of uncertainty in the decision-making environment that we will pick up in the next section.

3.7 The DHA: A reflection on its decision-making role

The DHA showed elements of both active and reactive thinking and decision making during the study period. It initiated some important proposals for the district in service policies for the terminally ill, elderly and mentally ill and set up its own financial strategy which looked to the longer term development of services. Some of these were in response to the national and regional financial and planning climate, but the DHA was putting forward constructive proposals of its own allowing reasonable time for discussion and formulation of its ideas.

More frequently, however, the DHA was forced into a reactive position, having to make decisions and respond to proposals with little time for detailed consideration. This mainly occurred in connection with the DHSS and RHA. Manpower targets and the case of the new laundry were prime examples of the former's involvement whereas matters connected with the planning cycle were typical of forced decision-making with the RHA. Neither the district nor the region had a highly developed planning strategy and a consequence of this was often impossibly short timescales for responses and submissions by the district to regional

proposals with important long term service implications for the district. At the same time the district's own planning system was not sophisticated enough to be able to cope with rapid responses of this kind.

It was also placed in a reactive position at the district level, usually as a result of action by the clinicians. The need to come up with funds unexpectedly to support the long term financial implications of equipment donated by a local charity appeal is a good example of this. Organisers of the appeal had sought clinical advice in the district as to a suitable piece of equipment to target the appeal for but had not consulted the treasurer's department. This led to revised consultative arrangements with the clinicians to prevent that situation arising in the future.

3.8 Decision-making at the DMT level

The DMT operated an informal committee structure in its meetings. There were no sub-committees; individual members, or occasionally groups, undertook particular actions. Most members were on other district committees concerned with specific topics anyway; eg. planning or clinical matters. The small scale of the district's operations meant that the potential for communication between groups in this respect was very high given that key officers were on several committees at once.

As might be expected the sources of information for the DMT are more varied than those of the DHA. Over the two year period some 70-80 different bodies were in contact with the DMT on some subject. Virtually every health service committee in the district reported to the

DMT ranging from the School of Chiropody to the Computer Contingency Working Group but the majority of them reported only once or twice a year. More important committees, on the other hand, reported once or sometimes twice each month. Table 5 shows the frequency of reporting of the major committees.

TABLE 5. DMT SOURCES OF INFORMATION

Committee	Monthly	6-12pa	2-6pa	Annually
MEC	*			
JSCC		*		
DMAC			*	
DPTMH		*		
DMT/UMG(C)	*			
DMT/UMG(H)	*			
CHC			*	
Fire Precautions				*
Occ. Health			*	
Hlth & Safety			*	
DSPT		*		

Routine reports from other committees acted as summaries of information and raised topics for further discussion. Other important sources contributing to the DMT workload were individual officers and the regional health authority (Table 6).

TABLE 6. FREQUENCY OF INFORMATION FROM PRINCIPAL SOURCES

Source	Frequency	DMT Member?
RHA	63	
MEC	28	
DHA	?	
DMO	40	Yes
CNO	12	Yes
DMT	20	
Other HAs	16	
DHSS	12	
Consultants	27	Yes
DT	20	Yes
UMGs	42	
DA	16	Yes

The FPC was as conspicuous by its absence here as it was for the DHA.

The high level of contacts disguise the fact that some issues took place over a long period of time and that the DMT had more than twice the number of DHA meetings. Some of the referrals to future DMT meetings went via individual team members who were responsible for clarifying some of the points and issues to be later discussed. The scope of these contacts was generally linked to the officer's DMT responsibilites so, for example, the DT usually had financial matters to raise of fundamental concern to the district whereas the CNO focussed on nursing matters. Contacts with the RHA were with a variety of regional divisions.

Most noticeable is the domination of the clinicians in meetings both via their own MEC reports and through the presence on the DMT of one of their representatives. They were particularly vociferous when their manpower or service levels appeared to be under threat and the schemes to generate savings within the district or to rationalise services led to to some difficult meetings.

3.9 Outcomes at the DMT level

The RHA had contact with the district on a broad front as might be expected. Financial allocations from central government reach districts via the regions: the planning cycle involves close discussion and monitoring by the region; personnel matters involve it through the regional strategy on the allocation of manpower. Under the heading of operational is included 9 references to specific property matters (again through formal regional interests) and it was generally least involved with day-to-day operational matters in the district.

TABLE 7. DMT CONTACTS; SUBJECT AREA BY SOURCE

Body	Financial	Operational	Services	Personnel	Planning
RHA	9	13	12	17	7
MEC	2	6	5	10	1
Cons.	3	4	3	3	2
DMO	4	13	13	9	0
UMG	5	7	10	1	1

The MEC and Consultant representative between them formed a powerful presence on the DMT. Their prime concerns - manpower (more of it) and services (no cuts and more equipment) - was balanced by their comparative lack of interest in general matters to do with planning or finance.

The DMO focused mainly on current operational issues and on personnel and service matters with a medical orientation. He was often delegated a research function by the DMT.

Of the UMG groups it was the hospital rather than the community group which dominated the DMT discussions. Neither UMG group was in existence at the beginning of the study period (they were not constituted until halfway through 1983) and so a lot of effort went into their initial establishment. This in itself was not straightforwrd with the UMG(H) remaining unhappy over delegation arrangements for several months. These problems persisted and the group was perceived by the DMT as being "inactive" at one stage and reluctant to take on board responsibility.

The first nine months of 1983 provides the material for tables 8 and 9. Most of the discussion at the DMT resulted in actions being decided and delegated to officers and other groups to carry out. Some were deliberately deferred to later DMT meetings and some actions referred to DMT officers were for further information to be reported back to a later DMT meeting.

TABLE 8. DMT REFERRALS FOR ACTION

Body	Action	Deferred
DMT Officer	30	
DMT		10
DHA	24	
RHA	15	
MEC/Cons	13	
UMGs	10	
Planning teams	9	
Other cmmttees	9	
Other HAs	2	

The same held true for other committees, such as planning teams, where their brief was to present a fuller report at a later date along with recommendations for action. Referrals to the clinicians, on the other hand, tended to be more for matters of discussion and a general canvassing of views rather than getting them to embark on lengthy enquiries. Communications with the DHA and RHA were mainly the result of the DMT responding to requests for information and research and, usually in the case of the DHA, recommendations or advice for action.

3.10 Timetables at the DMT level

The role of the DMT is to control the short term management of the district and, by its nature, this does not give much scope for setting timetables on work. The minutes constantly request reports and work to be brought back to future meetings but the majority of these had no specific timetable attached.

TABLE 9. DMT TIMETABLES FOR ACTION

To	Financial	Operational	Services	M'power
Treasurer	6			1
DMO		1	2	1
UMG(H)	2	1		
DMT Officers	1	1		

There were about 20 timetabled items; all bar two of them to be done within one month. The onus was on the Treasurer to provide financial information, closely followed by service and operational problems requiring urgent discussions.

3.11 The DMT: A reflection on its decision-making role

The DMT in this district appeared to operate relatively efficiently. It generally responded quickly to events and worked well with the DHA and other groups both inside and outside of the district. In terms of individuals the consultant representative at times gave the impression of acting more as a spokesman for the other consultants than as a member of an administrative management team. The DMO, a position coming perhaps the closest to straddling the clinician/administrator boundary, carries a workload which often requires delicate handling. This was apparent here, sometimes leading to slippage in timetables for action set for the DMO by the DMT. The DMO is also responsible for upholding the position of the community services, but here he was often eclipsed in this by the powerful hospital services lobby. The treasurer, who acted as chairman of the team for much of the time, and the DA were more powerful figures; especially the treasurer given the constant preoccupation in the district with financial matters. He was able to translate the financial consequences of actions clearly to the DHA and was behind the financial savings initiatives. The CNO tended to concentrate attention on areas directly affecting nursing staff.

3.12 The relationship between the DMT and DHA

On the whole this was very good but there were a number of instances when this was not the case. In the maternity rationalisation episode, for example, the DMT and obstetricians had meetings to attempt to draw up possible solutions. The outcome of this was that the DMT presented 5 options, briefly sketched out, for the DHA to consider. DHA members felt that they were not being sufficiently briefed on the matter and were being steered down a particular decision path rather than having the fullest possible range of actions open to them. The all-pervading importance of finance gave the DT a very important position in the DHA as well as the DMT. Whatever the discussion his advice was always sought on the financial consequences and it carried a lot of weight.

Occasionally the DMT could be regarded as deliberately dragging their feet on issues; the Well Woman clinic being a good example of this. Their lack of enthusiasm (possibly tempered by the perceived attitude of the clinicans to the subject) led to the scheme being effectively shelved for a year. In other cases referral to another committee or for "deliberation" or officers to "report back" at a later date effectively delayed some matters coming before the DHA, if only to establish some sort of priority for dealing with them. However without the agenda being set by the DHA it meant that the DMT was, in effect, setting priorities for decision-making in the district. This led to some occasions when it was perceived by the DHA as going beyond its advisory remit.

4: Examples of the Decision-making Process in Action

We illustrate our analysis of the minutes here by tracing the course of three issues which featured during the study period.

The womens' clinic was essentially an internal matter not directly involving the region or any other organisations outside the district. The savings programme, although a district level initiative, was inspired by the general financial climate of the NHS and how resources were allocated to the district from the region. Finally the case of the laundry contract shows how central government, in pursuing political objectives, can become involved in what would otherwise be regarded as a local issue.

4.1 The Womens' Clinic

DHA	July 1983	Paper presented by the Community Health Council (CHC) following proposals made by them to the DHA at the annual DHA/CHC meeting the month before. by The DHA deferred discussion pending the arrangement of a trip by some DHA members to see an example of a womens'clinic in operation in another health authorit
DHA	September 1983	Visit arrangements confirmed.
DMT	October 1983	DMT reject the idea of a womens' clinic on the grounds that suitable facilities exist already and it would merely duplicate them.
DHA	October 1983	DMT opinion passed on to DHA.
DHA	July 1984	The Womens' Action Group (WAG) and the CHC submitted a joint paper to the DHA following the annual DHA/CHC meeting, again calling for the provision of a womens' clinic. Paper sent again to the DMT for consideration.
DMT	July 1984	Correspondence on the womens' clinic discussed. To be considered during August and a reply returned to the DHA in September.

DMT	August 1984	Discussion took place on the clinic. The proposals were, in the DMT's view, "not clearly identified" and an informal working group should be set up to consider the matter further. The DMO was detailed to meet the WAG and report back.
DMT	September 1984	DMO reported that talks were in progress with the WAG.
DHA	September 1984	The same news was reported to the DHA.
DMT	October 1984	The DMO reported that there had been a change of opinion among the medical staff and that they would now support a pilot project. The DMT would now take up the matter with the UMG(C) and aim to put it on the November DHA agenda. The RHA would also be contacted on the legal aspects of use of premises, equipment, etc.
DHA	October 1984	The DMO reported the outcome of the talks to the DHA and that the UMG(C) were still considering the proposals. In the meantime the DHA was getting some bad publicity in the local Press, stirred up by the CHC.
DMT	October 1984	The UMG(C) comments on the clinic were seen as disappointing and not a suitable basis on which to base a November report to the DHA. Consequently it was removed from that agenda. The planning team was reprimanded as it was discovered to be the source of the bad publicity in the Press.
DMT	November 1984	An update on talks was reported. Despite not hearing from the region on the legal aspects it was decided that the DA should prepare a report for the December DHA.
DHA	November 1984	Noted that the womens' clinic decision would be deferred to a later DHA meeting.
DHA	December 1984	A Womens' Clinic was approved in principle and given a grant to fund it for two years.

Comment: This was an example of a decision area wholly contained within the district and with the momentum being maintained by a public pressure group. Although the DHA appeared to be receptive to the idea from the outset, the DMT were quite dismissive in their attitude largely, it would seem, due to the initial opposition of clinicians to the scheme. The DMT probably considered that it was not an issue worth pushing with the clinicians, placing a higher priority in being able to negotiate a settlement with them on the rationalisation of acute services. When,

however, the clinicians suddenly reversed their attitude in October 1984, however, the DMT just as suddenly became very enthusiastic about the idea and began to push the proposals through as quickly as possible, even becoming impatient with the UMG(C) for dragging its feet on the issue.

4.2 The Financial Savings Scheme (DHA minutes only)

February 1983	Approval given by the DHA for the establishment of a planned programme of budget cuts (3%) to fund new developments within the district.
June 1983	A report on the savings scheme was in progress and would be available in October.
August 1983	At a special financial meeting a review of the 3% cuts sheme was presented. Favourable progress was reported from every quarter except the District Works department.
October 1983	Report by the DMT on the scheme. Further discussions were now under way with the UMGs.
June 1984	Disappointment expressed over the response of the clinicians to proposed savings to be made in the district maternity unit.
July 1984	Proposals for the maternity unit deferred pending a further report from the DMT.
September 1984	The DMT to report back the following month pending the outcome of discussions with the UMG and the obstetrics division.
October 1984	Report on the effect so far of the effects of ward closures in the maternity unit.

Comment: There was an initial resistance by the clinicians to the idea of the savings scheme, particularly as it was not being imposed from outside the district. Once, however, it was explained to them in detail at special meeting with the DHA they were more receptive to the proposals with one of the surgeons putting forward a scheme of his own for savings which he could then re-use for additional staff hours. This was a scheme for which it was essential to get co-operation with the

clinicians if it was to work. On the other hand an administrative sector - the works department - which claimed it was not able to make savings was able to be directed to do so.

The scheme was a district initiative ahead of its time by some months. It was eventually overtaken by a similar scheme imposed by the DHSS shortly afterwards.

4.3. The Laundry

DHA	March 1983	Report presented on discussions bewteen the district, region, DHSS and adjoining health district which would provide the new laundry service.
DHA	April 1983	Discussions continuing. Concern expressed by the district to the region over the implications for the laundry scheme that the DHSS contracting out proposals would have.
DMT	June 1983	DT reported on the current and future provision of laundry services in the district. New tenders were being sought and the proposals from the adjacent authority were still under consideration.
DHA	June 1983	DMT report on the laundry approved.
DMT	September 1983	Laundry discussed along with other general services in terms of the move towards the contracting out of services by the DHSS. A report was to be prepared for the DHA within the next six months. A decision on laundry arrangements was deferred pending the finalisation of plans by an adjacent authority which might provide the service.
DHA	September 1983	Report by DMT on options for providing the laundry service noted.
DHA	January 1984	DMT asked to seek competitive tenders for the laundry service.
DMT	January 1984	The DA reported that a single tender had been received from the existing laundry supplier and it was agreed to accept it at once.
DHA	June 1984	The contract format for the contracting out of the laundry services was approved.
DHA	July 1984	Discussion passed to the finance sub-committee of the DHA for consideration.

DMT	August 1984	The new laundry tender was returned to the district by their legal adviser for changes. It had originally been approved by him but now he was acting on behalf of an authority which wanted to tender.
DHA	September 1984	Finance sub-committee report back giving the go ahead on contracting out. DMT to produce a report on tenders for the laundry by the following month.
DHA	October 1984	The finance sub-committee accepted the recommendations of the DMT on the contracts tendered.
DHA	November 1984	Update report on progress of tenders.

Comment: The bulk of the discussion on the laundry contract was at the Authority level, perhaps reflecting the more political aspects of the case. The deal with the adjacent authority was quashed by the Secretary of State and the authority forced into reissuing the tender. The DMT, acting on its own, went ahead and approved the acceptance of a tender from the existing contractor without the approval of the DHA. Although not recorded in the minutes, the DHA was displeased with this action and insisted that the contract once more be opened up to other tenders.

These issues were connected with service and finance matters. In section 4 we examine the decision-making process as applied to operating the planning system in the district.

5: Decision-making and Planning

In this section we focus on how the DHA and DMT drew up the district's operational plan. It illustrates well the difficulties experienced by the district in obtaining agreement between different groups - notably the clinicians - on even medium term service development and the constraints imposed by the planning cycle itself. Of the set of plans the operational plan was the most advanced; the district's strategic plan had not been developed and the regional strategic plan only began to take effect towards the end of the study period.

5.1 The Operational Plan

1983

DMT	January	An explanation of the (recently introduced) operational planning system was given. Items - especially manpower - were discussed and a list drawn up for inclusion on the 1983/84 and 1984/85 lists. A draft document was to be prepared for the next DHA meeting in February.
DHA	February	A short summary of the DMT's ideas was presented. The idea was mooted of generating savings within the district and using them for areas in which services were lacking. The DHA approved this in principle and agreed that the DMT plan be circulated in the district with comments to be received by the March meeting in order to fit in with the RHA timetable.
DHA	April	The comments which had been received were noted. Some groups had not replied (the local social services department, for example); others, such as the CHC and MEC, complained about the lack of time which had been given for consultation. The MEC also criticised it for circulating ideas which had not even been accepted by the clinicians. The DHA requested that the DMT report its conclusions to the May DHA meeting.
DMT	April	Request noted in DMT minutes, but details of the plan not yet available.
DHA	May	Operational Plan not mentioned in the minutes of the meeting.
DHA	December	Discussion of the region's report and account of the Annual Review which had taken place with the district in September. It called for the district to undertake

a study on ways of rationalising its services.

1984

DMT Jan 11 — The review of acute and elderly services needed to be taken before the next annual review with the region. It was hoped to obtain constructive comments from the clinicians. Also noted that the timescale for the review was different to that of the Operational Plan. A DMT/MEC meeting was to be arranged to discuss the rationalisation of the acute services, and the DMO's draft document on the elderly services was also discussed.

DHA Jan — The review of the mentally ill and ESMI services was approved for submission to the region and an invitation extended to the region's officers to explain their plans for this service in the district. The elderly review was also approved for submission. Progress on the acute review was limited. This was blamed on the pressures of working to a different timetable from the Operational Plan. It was agreed that the review details would be presented in the next Operational Plan.

DMT Jan 25 — The elderly review document was to be sent to the region and a letter explaining the difficulties being experienced with the acute review. The DHA chairman's approval was to be sought in advance of the next DHA meeting for the submission to the region of the mentally handicapped services review document. The Operational Plan was itself discussed with the DMT noting their awareness of the region steering them in the direction of expansion of the community sector rather than the acute. Within the next ten days it was decided that the DMO would prepare a draft "written philosophy" which could be used as a basis for a "structured discussion" in a future DHA meeting.

DMT Feb 8 — The need for "urgent discussions with all concerned" over the 1984/85 operational plan was recognised. The consultant representative had prepared a paper outlining the effects on acute services of the proposed rationalisation. The DMO's paper was not yet ready so both were deferred for discussion until the next DMT meeting. An intensive programme of meetings was to be held before then. The responses to the review consultation document had now been received but as they had largely been overtaken by events, it was decided to forward them to the March DHA meeting for information purposes only.

DHA Feb — Arrangements were made for a clinicians/DHA meeting to be held to discuss the acute rationalisation plans. The mentally handicapped review paper was retrospectively approved for submission to the region.

DMT Feb 22 — The consultant's paper (deferred from the previous meeting was discussed and received a good response. (No mention was made of the DMO's paper).

DHA March — Progress on the acute review was considered and the DA outlined its constantly changing fortunes. The time pressure created by the end of April deadline was also causing problems. The region had also slipped behind on the timetable and the whole process was running late. The DMT was to report back to the DHA in May prior to submission to the region.

DMT Mar 24 — Notes of the meeting between the DHA and the clinicians were to be forwarded to the DMAC and the April DHA meeting.

DMT Apr 4 — The outcome of the DHA/clinicians' meeting was discussed as was that of the most recent DHA/DMAC meeting. The senior clinicians were clearer on some items but wanted further research done on others before committing themselves. Agreement was obtained on the plan to concentrate acute services at on general hospital site, leaving the other with elective surgical facilities, and to introduce 5-day wards at that site. Flexible use of a male ward at the main othopaedic hospital was also agreed and, provided agreement was reached with the obstetricians, a reduction in the number of maternity beds could go ahead with the space being used for isolation and preconvalescent acute facilities. Decisions on the early closure of the small orthopaedic convalescent hospital and the concentration of general medicine at one hospital site were put aside for the time being. The DHA could proceed with authorising the agreed policies for inclusion in the Operational Plan. The meeting between the DHA and clinicians had been regarded as a useful precedent.

DHA May — The 1984/85 and 1985/86 annual planning programmes were approved and forwarded onto the region. The Cost Improvement Programme (CIP) was deferred until the next DHA meeting although it was noted that problems existed over maternity service provision. This was the subject of a forthcoming meeting between the DMT, obstetricians and the UMG(H), the outcome of which was to be circulated as quickly as possible.

DMT May 16 — The CIP problems were discussed. No agreement had been reached at the DMT/obstetricians'/UMG(H) meeting and another had been urgently convened. The DMO reported that the clinicians had decided that it was not possible after all to concentrate general medicine at one hospital site; as a result of this it would not now be possible to embark on a 5-day ward scheme either. The flexible bed usage and decreas in maternity provision could still proceed however. The first section of the Operational Plan was to be circulated with the remainder - featuring the CIP - to be circulated in June.

DMT May 30	The draft CIP was discussed and the obstetricians invited to put their case directly to the DHA at their next meeting.
DMT Jun 13	It was indicated that the obstetricians would not be present at the next DHA meeting.
DHA June	The CIP proposals were discussed and it was decided to inform the region that until the new hospital was commissioned it would not be possible to undertake any large-scale rationalisation proposals. Only the flexible use of beds and the rationalisation of the maternity services would appear to be possible in the immediate term. Following the outcome of DMT/Obstetricians' discussions, five options for a reduced maternity service were presented to the DHA. Disappointment was expressed over the attitude of the clinicians who went for the option which saved the least and disrupted the unit the least. Their second choice, which would produce more substantive rationalisation was the one chosen by the DHA for approval. The obstetricians were also asked to consider other ways of reducing the length of stay and to report back. The flexible beds scheme was approved and the DMT asked to pursue further the possibility of a 5 day ward scheme.
DMT Jun 27	The UMG(H) were unhappy with the proposals concerning the maternity unit and were drafting a set of their own.
DHA July	The obstetricians were complaining about the decision taken in the previous DHA meeting. The matter was deferred pending further DMT consideration.
DMT Aug 8	A general agreement on the fate of the maternity unit was agreed upon. The DMT was to elaborate on it and report back to the DHA in September.
DMT Aug 22	A report was prepared for the Members' Personnel Panel to discuss the staffing implications for the maternity unit.
DHA Sep	June DHA decision confirmed and action to be taken on closure of 12 beds in the maternity unit and the temporary closure of others, with the DMT to report back in a month on the outcome.
DMT Sep 19	UMG proposals on CIP and manpower overtaken by events.
DHA October	Recorded that the new arrangements in the maternity unit appeared to be working satisfactorily so far.
DMT Dec 12	Letter received from the region asking for more quantification in cost improvement programmes in the 1985/86 operational plan.

The Operational Plan was the most advanced and took up the majority of DHA and DMT discussion on planning in the district.Strategic planning, which we turn to look at next, was not so advanced by comparison.

5.2 Strategic plans

The introduction of a formal district level strategic plan only came towards the end of the study period when the DMT presented an outline timetable to the DHA in September 1984 with detailed proposals to be ready for early in 1985.

The regional strategic plan was first mentioned in a district meeting at the end of December in 1983 when the outline strategy was sent to the district with comments on it requested by the year end. This was delegated to the DSPT to carry out.

The next reference to it does not appear until the September of the following year when the outline strategy was received for discussion by the DMT. Discussion was deferred until a joint DSPT/DMT meeting in November.

5.3 Comments on decision-making and the planning process

The picture gained from studying the planning system in operation is that it is unco-ordinated. There are a variety of reasons for this and not all of them lie with the district. First, the planning system itself had only been recently altered. Planning structures and personnel were still being set up or reorganised at all levels in the health service and this had a knock-on effect when it came to producing

the plans themselves with timetables slipping and some planning teams unclear as to the type of document they should be producing. On top of this came the financial and manpower restrictions imposed by the DHSS which further hindered the establishment of the system. Secondly, uncertainty over planned revenue allocations provided plenty of opportunity for delay (both genuine and contrived) as time progressed.

Strategic planning was virtually non-existent during the study period apart from the regional strategic plan being offered for comment to the district at the end of 1983. No more was mentioned in either DMT or DHA minutes until September of the following year when an outline strategy document was received. This was passed to the DSPT for comment in November of that year and no further discussion was recorded. The district's own strategic plan first emerged only in September 1984 when an outline timetable for its preparation was presented to the DHA. This gave the February of the following year (1985) given as the target date for its completion.

Of the three formal plans referenced over the two years, the district's own operational plan the most important of these. The regional strategic plan was late appearing (not until the end of 1983) and the consultation time given to the district woefully inadequate (the month of December in that year) which did not give time for full discussion of its potential consequences for the district at either the DHA or DMT level. This trait of leaving inadequate time for formal discussion was commented upon several times by participants in the debate. Considering the emphasis which was placed on the importance of consulting interested parties when the planning system was revised in 1982 it is an alarming trend to note.

The Operational Plan was the main vehicle for planning in the district. One had already been prepared before the 1982 changes to the planning system so the district was already familiar with its preparation. During the course of 1983/84, however, it also became used as a focus for financial savings which the district started on its own initiative. This was in turn overtaken by the DHSS adopting a similar strategy - the so-called "efficiency savings". This move from self-imposed savings which would then be re-distributed within the district to enforced savings from central government where the money saved was deducted in advance from the district's revenue allocation led to a more unco-operative attitude to savings in general on the part of the consultants. This alone considerably delayed the completion of the plan in 1984 and highlighted how important was the need for a degree of certainty in finance levels in the longer term as the feasibility of schemes very much depended on reasonable estimates of the cash and manpower available to carry them out.

It also showed the power of the clinicians in the decision process. They were able to delay implementation of the plan when they reneged on an important part of the agreement drawn up to rationalise acute services in the district. On this occasion they put on a united front under a perceived common threat, but it is interesting to note that when the obstetricians tried to hold out against the reduction in the size of the maternity unit they were not backed up in the same way by their clinical colleagues; probably because the other acute services stood to gain bed space as a result. The direct outcome for the Authority was that they were able to force the obstetricians to accept a plan which produced real rather than merely cosmetic savings.

6: Uncertainty and Decision-making in a District Health Authority

Uncertainty is a fundamental determinant of the outcome of a decision and it provides an interesting basis for interpreting the findings from the minutes analysis. On simple issues, where matters are clear cut, it is comparatively easy to give quick and decisive responses but as the amount of uncertainty increases with the complexity of the issue at hand so decision-making can be considerably slowed down. This is particularly the case where finance is concerned as levels of funding - crucial to the majority of operational decisions - are subject to chronic uncertainty in the medium to long term. Other areas of uncertainty are generated by problems in information supply or where the administrative structure is insensitive to the different types of decisions being taken within it and whether they are being handled appropriately or not. Again we confine ourselves to the district level but note that the the concepts can readily be generalised to examine different levels in the administration.

One framework for interpreting uncertainty is provided by Friend and Jessop (1969). They pointed to five basic operational problems of in decision making, all of which may be operating simultaneously in a given decision area:

1. finding solutions;
2. expressing preferences;
3. exposing latent uncertainties;
4. selecting exploratory actions;
5. selecting immediate commitments.

They also identified three principal components of uncertainty connected with decion-making arising from externalities, choice and value judgements. We consider each of these in turn.

6.1 Uncertainty in the external planning environment

This type of uncertainty concerns what might be loosely described as "outside the control" of the decision-maker. In our case we take the DHA level as the most convenient self-contained unit for argument but we could equally have taken individuals or the entire health service. Whichever level is adopted, however, none are entirely closed systems. They are subject to constraints and interactions with other organisations. The DHA is most notably affected by what goes on at higher administrative levels in the health service itself (RHA, DHSS), but also from professional bodies (eg. the British Medical Association), and other organisations such as local authorities. Of these the RHA and the DHSS are the most influential, particularly as they are the principal sources of finance and they control the overall direction of health service provision at national and regional levels to which the district must relate.

Changes in these parameters can have significant implications for a district, notably on the level of resources it can plan on having but also in terms of policy and operational directives. During the study period there were a number of examples of this type of uncertainty. One was the DHSS initiative on psychogeriatric provision which was sprung on the district and left it little time to put together a plan to bid for the extra resources being made available. Another case where external uncertainty led to decisions being taken under duress and, in fact, more by default than design, was the regional strategy. This, with its

medium term service consequences for the district, was sent to the district for consultation and reply within a 2 week time period in December 1983. The DHA had to rely on their planning staff to formulate a response to be sent to the region before the DHA had time to consider it themselves. Finally, the efficiency savings and manpower cuts imposed by the DHSS had to be observed even though the district had not finished recruiting their administrative staff. This led to difficulties in completing work to schedule and created difficulties in providing clinical and administrative support for clinicians, staff upgrading and other personnel matters. Apart from anything else it did little to aid staff morale.

Major external inputs such as these, especially when they occur at very short notice, create uncertainty in the district. Usually there is little option but to cobble together a reply or submission however unsatisfactory. Friend and Jessop observed in their study that a typical reaction to this type of uncertainty was the deferring of decisions pending "more research" or clarification. This is exactly what happened in many of these instances in the district. Manpower and resource allocation decisions especially were often deferred to later meetings. This was partly to consolidate their consideration to get a clearer view of staff requirements over the district, but also because they had to await more definite signals from the region as to levels of funding which might be available.

6.2 Uncertainty in related fields.

Here uncertainty develops from not being aware of how decisions in taken in one subject area will affect those taken in related areas. The sheer complexity of the health service guarantees these situations

happening and it is the classic position that health service managers find themselves in today.

As with externally created uncertainty, related field uncertainty varies with the authority invested in that decision-maker in the first place. This underlines the importance of a formal hierarchical structure of administration with clearly identifiable lines of communication and accountability as a means of maintaining its overall direction. Given the accountability structure of the NHS we have already outlined, it is inevitable that uncertainty of this type will occur. It will be more prone in some parts of the district than others, however, such as the JCC where the health and local authority services jointly decided on may have unforseen consequences for individual authority plans. Abuse of clinical freedom can also present serious problems. In the district one of the consultants insisted on prescribing large amounts of very expensive drugs which resulted in the pharmacy budget being massively overspent. He could not be persuaded to change his prescribing habits and the administration could not enforce him to change.

One response to this type of uncertainty is to form a complicated administrative committee structure which, as we have seen, is typical of a district. Committees alone are not enough, however. Without a coherent structure for them relate to and a system for monitoring the outcomes of the decisions they reach, there is the danger that they will conflict. The beta-scanner appeal is a case in point. Here the clinicians, approached by the charity to advise on a suitable focus for an appeal, recommended a beta-scanner without consulting the DMT. The clinicians failed to appreciate (or chose to ignore) both the manpower implications and its long term revenue costs. Another example was in

planning for the elderly. The planning team set up for that ran into difficulties because the planning timetable for elderly services in the operational plan was completely different. Also, over the study period as a whole and affecting both clinical and ancillary service sectors, was the uncertainty posed by the requirements of the new hospital.

Another tendency of this type of uncertainty noted by Friend and Jessop was the development and adherence to a fixed "blueprint" plan of action as a means of uniting different groups involved in decision-making. The result can lead to rigidity in planning, ie. an inability to change to new circumstances quickly without putting the whole plan in jeopardy. This type of thinking was apparent in the works division of the district which, due to the manpower freeze, was unable to recruit its full complement after reorganisation. Instead of accepting this in the short term, a long and fruitless period was spent in negotiating for more staff with the DMT. The works officer was could not envisage carrying out his tasks without the pre-planned staff.

This attitude was probably more noticeable in the local authority organisation which Friend and Jessop studied and which would have had an established planning system. On the whole, the complexity of the NHS makes it virtually impossible to adopt that sort of approach which was more prevalent in the early years of the town planning system. The technological support to planners has also been improving in recent years with the advent of micro-computers and it might even be argued that in some ways it has been an advantage that the health service has come late to comprehensive planning. However, even if the plans themselves are not so inflexible, patterns of thinking and reactions to events may well be and this has watched out for.

6.3 Uncertainty in value judgements

This type of uncertainty is linked with achieving the appropriate levels of autonomy in decision-making for the efficient operation of the system and what we were saying at the end of the second section is directly related to this. It is directly linked to the relative degree of importance decision-makers must attach to the expected outcomes of decisions but which they cannot do because there is no common scale of comparison. Any decision is, of course, going to be subjective whether taken by an individual or a committee. The problem of uncertainty arises where the decision-makers lack the competence (either technical or authoritative) to take that decision. The main consequence of this is constant reference of issues for advice on how they should be handled to a higher level which clutters the working of that level with matters that should not really be occupying its time.

A very good example of this type of uncertainty occurred in the district where the Unit Management Group for hospitals (UMGH) was reluctant to take on the responsibilities delegated to it by the DMT. The delegation was to avoid the DMT having its time taken up with day-to-day hospital management which it kept having referred to them but the UMGH felt that it was basically not confident to handle these matters and prevaricated against having the powers delegated to it. This rarely happened between the DMT and DHA; if anything there were occasions, such as the laundry contract tender, where the balance swung the other way and the DMT was perceived by the DHA as over-reaching itself.

Elements of all of these types of uncertainty can, of course, be present at any one time depending on the nature of the issue involved,

the locus of the issue within the administrative hierarchy and the ability of the decision-makers concerned to handle it. Moreover its extent may not be fully recognised (if at all) and further complicated by the dominance of one group over others. Yet despite that it is possible to begin to approach resolution of some of these problems and, in the final section, we turn to discuss ways in which this set might be done.

7: Conclusions and Recommendations

7.1 Conclusions

The decision-making process in any organisation is prone to uncertainty and, using the framework provided by Friend and Jessop (1969), we have examined this hypothesis in the context of a district health authority in an effort to shed light on the complexities of the health care delivery system and decision-making therein.

In the district the DMT had a crucial role to play acting as a filter in the flow of information to and from the DHA. This they appeared to do efficiently, in terms of meeting deadlines imposed on them but, on a number of occasions, the quality of this information and advice was not regarded as wholly satisfactory by the DHA. Information which was "too little too late" left them short of both options for action and time for full consideration of some important issues such as the rationalisation of the maternity unit. This was partly due to pressures on the DMT from other bodies, especially the region, but there may have also been an element of them playing down areas of potential conflict with clinicians in order to secure an easier working relationship. This meant avoiding issues where the DHA would have preferred to take more of a stand. On the whole, however, the relationship between the DMT and DHA was relatively efficient and effective.

The DHA did largely fulfill its role as the main policy making committee for the district and managed to launch a number of initiatives in the areas of service development and finance. However, it was sometimes hindered in this by the strictures imposed on it by the RHA

and DHSS, often at short notice, and the cautious view which the DMT placed on issues at times.

Among the other district committees the MEC was the most important. The clinicians tended to adopt a rather narrow, sectoral view with a short-term perspective dominating much of their action. It proved possible to win them over to a broader, more long-term view with careful persuasion - as was eventually the case with the district's financial savings scheme - although when this was subsumed by the DHSS as part of their "efficiency savings" programme, the clinicians were less keen to support it.

What emerges clearly from the analysis of the relationships between these decision-making groups was that, however efficiently they coped with the day-to-day management of the district's services, they much were less able to handle decisions with medium to long term implications, even when the need for such a perspective was recognised. Neither were they able to accommodate unexpected changes to plans; the response to the effects of the manpower cuts is a good example here. One of the main reasons for this inability was that the planning system was not being properly used as the focus for decision-making. This was despite its already having been in operation for several years. It was treated more as an exercise in its own right and detached from issues of service management and development rather than forming the basis for their discussion and action and matters were exacerbated by the lack of either a district or a regional strategic plan to act as a basis for the operational plan. The consequence was that decision-making was largely incremental with operational plan objectives being altered and adapted in reaction to unexpected changes rather than helping to guide and evaluate the consequences of those changes.

7.2 Recommendations

Uncertainty can never be entirely eliminated but, once it is recognised, steps can be taken to minimise it. What we offer here is an approach to reducing that uncertainty through improving the ability of the planning system to act as a focus for decision-making. One way of achieving this is to develop a more rigorous planning framework incorporating models which can be used to test different assumptions on future resource or service requirements and so form a substantive backbone to plan documents. Such an approach can be used to structure planning decisions and formalise the recognition of uncertainty. This has been the theme of the Main Report and we repeat some of the proposals made there in the context of our discussion on uncertainty.

A start can be made by improving the quality of the data collected in the health service and widening its dissemination and appreciation among clinicians and administrators. This is already under way through such schemes as the DHSS Performance Indicator package, which presents existing data in a more meaningful way to managers, and the longer term proposals for revising the statistics collected in the NHS as envisaged by the Korner report (1983). It is only a first step, however, and the planning system will not become more of a focus for decision-making solely on the strength of it.

The potential impact of micro-computer planning and information systems in decision-making is enormous. First, the technology is proven, cheap and readily available. Powerful models encompassing a wide range of decision areas can now be developed and designed to be user-friendly. Usage by non-technical people is a primary consideration

and a crucial one as it opens the door to the prospect of actual resource consumers and suppliers, such as the Authority members and clinicians, becoming more closely involved with the implications of their decision-making. Models can provide a logical structure to decision areas, giving a framework on which to consider a variety of issues and options. At the same time they are able to accommodate known information on relationships between the different elements involved. Although uncertainty, especially from external environments, will always remain a problem, the existence of a strong planning framework at the district level to which the management can relate its organisation will enable it to be recognised and help to overcome its impact.

Alongside the greater use of such models and approaches in support of the planning framework should be closer assessment and monitoring of information flows and the where and how of decision-making in different areas of the district. Information from this type of exercise would help to identify if the decision-making process is actually working in the way it is intended and at levels in the system commensurate with delegated powers and responsibilites. This would help to forestall future areas of uncertainty within the district.

The above recommendations, as discussed here and in the Main Report, are essential to the improvement of planning and decision-making in the NHS and are particularly relevant for the "general manager" concept in administration recently introduced into the health service. If the aims of their introduction are to begin to be realised then they need more relevant information to help them in that task. The way to achieve this lies through reducing uncertainty by strengthening the planning process.

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Appendix

The following is a list of organisations and individual officers whose contributions were recorded in the minutes of the DHA and DMT.

	Age Concern
AHA	Area health authority
ALC	Ambulance Liaison Committee
	Area Supplies Officer
	Asian Liaison Officer
	Baby Foods Working Party
CCWG	Computer Contingency Working Group
CHC	Community health authority
CNO	Chief Nursing Officer
	Chaplains
	Community Mental Health Team
	Crossroads Care Attendent Scheme
	Crown Car Working Party
DA	District Administrator
DDAC	District Dental Advisory Committee
DDO	District Dental Officer
DHA	District Health Authority
DHSS	Department of Health and Social Security
DMAC	District Medical Advisory Committee
DMO	District Medical Officer
DMT	District Management Team
DPTCH	District Planning Team Child Health
DPTMH	District Planning Team, Mental Handicap
DPTPC	District Planning Team Primary Care
DSPT	District Support Palnning Team
DWO	District Works Officer
	Electricity Board
	Environmental Health Department
	Fire Precautions Committee
FPC	Family Practitioner Committee
HA	Health Authority
	Health and Safety Committee
HEO	Health Education Officer
	Infection Control Committee
JCC	Joint Consultative Committee
JSCC	Joint Staffs Consultative Committee
	Local Authority
LMC	Local Medical Committee
	Maternity Service Advisory Committee
	Maternity Working Group
MEC	Medical Executive Committee
NHSTA	NHS Training Authority
NMAC	Nursing/Midwife Advisory Committee
	Occupational Health Committee
	Personnel Working Party
	Postgraduate Medical Centre Committee
RC	Radiological Protection Committee
	School of Chiropody
	Study Leave Committee
UMGC	Unit Management Group, Community
UMGH	Unit Management Group, Hospitals Water authority