HEALTH NEWS

Briefing

ASSOCIATION · OF

COMMUNITY HEALTH COUNCILS

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THE IMPACT OF GENERAL MANAGEMENT ON THE NATIONAL HEALTH SERVICE

THE VIEWS OF COMMUNITY HEALTH COUNCILS

March 1988

INTRODUCTION

In 1983 Sir Roy Griffiths presented to the Secretary of State for Social Services a report on management reorganisation in the NHS. The report made two main recommendations both of which were accepted. Health authorities were to replace consensus management, the sharing of accountability between the members of a management team, with the "general management function". Henceforth a single individual would be responsible for the "planning, implementation and control of performance" within units, districts and regions. Corresponding to these local changes was the development of a new administrative body in central government. The DHSS tightened its own overall management control by setting up the NHS Management Board responsible for overseeing the implementation of government policy.

The implementation of general management has necessarily been a gradual process. (In some cases, initial Unit General Manager appointments have been made only in the last year or so). Although the DHSS issued broad guidance on the nature of the general management function, health authorities worked out their own job descriptions for the appointments. The extent of the new units into which districts were to be divided and for which there would be a single budget holder were also determined locally. General managers responsible for units are perhaps the most important innovation in the new arrangements. Whereas DGMs and RGMs can be seen as representing the unification of previously distinct roles, UGMs are to a much greater extent fulfilling a newly conceived role. Hence it is not surprising that sorting out relevant job descriptions and filling the posts has taken longer than originally expected.

Pay and conditions for senior managers were changed in order to reflect the changes in management's responsiblities and to permit systematic evaluation of their work. General managers are on short-term contracts, their work is subject to systematic performance appraisal and bonuses are awarded to those who achieve designated performance targets. This system of individual performance review (IPR) is an essential feature of the new management and detailed guidance on how it should be carried out has been issued by the NHS Training Authority. Each general manager is assigned a 'parent' and a 'grandparent' who are responsible for assessing the manager's performance. This is measured against a set of objectives which are worked out beforehand between the manager and the 'parent'. For the most part, health authority chairmen occupy the key positions in this system. Performance assessment is often described in terms of "management development" in order to distinguish it as a personnel function from the theoretical accountability of District General Managers and Regional General Managers to their respective health authorities. Whether this theoretical distinction works in practice is a different matter.

The DHSS has prescribed the goal of the new management only in broad terms: it is "to achieve the management drive necessary to ensure that the standards and range of care provided in the health service are the best possible within available resources." (HC(84)13) An essential part of this is the development and application of consistent criteria for evaluating the quality, effectiveness and efficiency of the health services. As a result, there are a number of important initiatives running alongside general management largely to do with the development of various kinds of management information.

THE SURVEY

The introduction of general management has rightly been seen as a major organisational change in the NHS and the government clearly expects it to deliver real improvements. Not everyone was equally sanguine when the issues were first discussed. Fears were voiced from many different quarters: industrial relations could suffer; clinical freedom and the standing of professional health workers could suffer; the quality of care could suffer as an entrepreneurial management culture was grafted on to the health service.

The latest NHS Annual Report declares that "it is too early too attempt to assess the full benefits of the appointment by health authorities of Regional, District and Unit General Managers." It may indeed be too early to pronounce a final verdict on these organisational changes, but it is certainly not too early to monitor their progress. And so, in October 1987 ACHCEW decided that it should seek evidence and views from its 183 member community health councils on the impact of general management on (1) health authority consultation procedures (2) the influence of health authority members (3) the effectiveness and efficiency of the local health services. We also asked whether or not the original general management appointees had stayed in post. All the questions were asked in an open-ended way, as we wished to give CHCs an opportunity to speak their mind on these issues. 69 CHCs responded to the request for comment. The following report is an analysis of these replies and an attempt to compile a picture of the changes effected by general management from the perspective of CHCs. As far as possible, we have allowed CHCs to speak for themselves. For the same reason, this paper does not claim to be a full discussion of the impact of general management.

CONSULTATION WITH COMMUNITY HEALTH COUNCILS

In Sir Roy Griffith's 1983 report, he states that one of the problems which a management reorganisation in the NHS must tackle is the slow and cumbersome nature of decision-making in what is admittedly a very complex bureaucracy. Too many hoops have to be jumped through before a plan can be implemented. It would be very easy to represent consultation with CHCs as just one of

these hoops, a tiresome and time-consuming process that impedes rational decision-making and hence is in no-one's real interest. Our concern that such a view might be widespread amongst general managers led us to ask CHCs if they thought that consultation had improved or deteriorated since the advent of general management.

Health authorities consult CHCs either through formal and statutory procedures or informally. Informal consultation may, by its very nature, take many forms. Within this diversity, there is nevertheless a guiding thread, that the health authority, in all stages of planning, should value the views of the CHC in its capacity as the users' representative.

The right of the CHC to be formally consulted over certain kinds of health authority decision raises two problems. On the one hand, the CHC and the DHA may disagree about appropriate matters for consultation. The authority may be reluctant to invoke statutory procedures and seek to treat a planned change as a "purely management issue". On the other hand, the process of consultation itself may be deemed inadequate by the CHC. The authority may not approach the consultation with an open mind. It will go through the motions and then reach the conclusion it wishes to reach.

Although the High Court is available as a means of enforcing statutory procedures, it is, in the nature of the case, very difficult to prove that a health authority which has gone through the motions of consultation has only gone through the motions, that despite appearances the consultation was a sham. Furthermore, the authority does have some prerogative in decidng what constitutes a "substantial change of use" and is therefore an appropriate matter for consultation.

For CHCs these problems are not new. If one of the goals of general management is to "streamline" the decision-making process in the NHS, it would be reasonable, however, to expect some weakening of the CHC's position as a result. Evidence that this has happened since the introduction of general management is limited and patchy, yet nevertheless exists. In all, 11 CHCs (16%) thought that problems over formal consultation had worsened.

> "General management has made the process of consultation between the CHC and the DHA worse - not to mention non-existent if they can get away with it!"
>
> ".....consultation of any quality has become a necessary ritual procedure implemented if and when necessary or when it is desired to legitimise a major alteration in service.."
>
> "Since the introduction of general management ....we have encountered a number of instances where the HA has deemed consultation unnecessary, claiming their proposals did not constitute a major variation in service, but were merely within the confines of day to day management of the service."

"The periods of time being allowed for consultations are far too short for CHCs adequately to fulfil their role."

The CHC isn't invariably overruled on such matters, however.

"One interesting example was the decision by the (ex) DGM to withdraw chiropody from a local community clinic, without consultation. The CHC dug its toes in on this corny subject and managed to nail the DGM, since we argued that this was a substantial variation, whereas he was saying that it was a management decision. He had omitted to inform the Chairman of the authority and the members, who learnt of it from the CHC. The decision was reversed and the DGM resigned."

"So far as formal consultation is concerned, in their desire to 'manage' they have failed to consult formally, but we kicked up a fuss and managers now have new guidance notes."

CHC comments on informal consultation can be divided into three categories. Firstly, there is the general state of the lines of communication between the CHC and management. Does the CHC have reasonable access to the managers? Do they meet frequently? Is the CHC supplied with information it needs to perform its functions?

"Regular 'informal' meetings with the DGM and other management board members have become less frequent and are used by the DGM to inform us about broad changes/policy."

"Prior to general management, a representative of the Area Management....attended all CHC monthly meetings. This has fallen off considerably..."

Secondly, there is the possibility of informal discussions on service developments (or reductions) at an early stage in the planning process or discussions on issues which will not be subject to formal consultation.

"Formal consultation by the DHA was always preceded by informal discussion usually starting at an early stage in the formulation of DHA planning. This applied to the District Plan and to special issues such as closure proposals."

In all, nine CHCs thought that there had been some deterioration in one or both of these categories. In some cases where the CHC had less access to the DGM, this was seen as compensated for by the development of a close working relationship with UGMs.

Thirdly, there is the extent of CHC involvement in HA planning teams. Problems were raised by a number of CHCs in connection with each of these last two categories of informal consultation. One CHC thought that the borderline between formal and informal consultation was too vague. An increase in the

latter could be used to justify a decrease in the former. Four CHCs mentioned their increasing involvement in health authority planning teams. All four were cautious in the welcome they gave to such a development. The reasons for this are clear. The existence of a CHC representative on a planning team may be used as a justification for less consultation with the Council as a whole. It may also be thought to weaken the position of the CHC as an independent critic of services. Finally, and this lies below the surface of events, it may present the CHC with such a massively increased workload that it has little time for any other work.

One CHC summed up its disillusionment with general management's approach to informal consultation in the following way:

> "There is no evidence that the Griffiths recommendation to ascertain how well the service is being delivered by obtaining the experience of users and to respond accordingly in formulating policy and providing appropriate service is being taken into account in this district."

A total of 22 CHCs (30%) thought that consultation, either formal or informal, had deteriorated in some way since the introduction of general management. 20 CHCs thought that it had had no effect on the process of consultation. Of these, one said that consultation remained as bad as ever. Five commented that their relationship with management had always been good, and this had not changed under general management.

The majority of respondents who said that there had been a change since general management thought that it had been a change for the better, though the tenor of their comments and the extent of the perceived change varies considerably. In some cases, it was mentioned that the CHC/DHA relationship was already good and that general management had improved it further. For the rest, the remarks ranged from fulsome praise to cautious approval.

> "Consultation has been improved by general management. It has led to a wider range of contacts with DHA managers resulting in improved communications and understanding. Previously all contact was channelled through the Chief Administrator at HQ level. Quicker and more detailed replies now received from UGMs."

> "Marginally improved consultation but we do not necessarily get told the true position of the health authority."

> "Disastrous when DGM came two and a half years ago - he said we were getting in his way. Improving now UGMs are in the saddle."

> "I am pleased to say that under this DGM consultation and communication between the CHC and the health authority has improved dramatically. Don't get the impression that the situation is ideal. It was only that things were so bad that

any improvements has been welcome!"

Not all these CHCs were explicit on the question of how consultation had been improved. Of those that were, only three mentioned that the use of formal consultation procedures had improved - there was more agreement on when and how the CHC should be consulted. For the rest, what had improved were the lines of communication to management and the extent of informal discussions at early stages of planning. In a few cases this was attributed to the DGM, in most to the UGMs. This may simply be because lines of accountability are now clearer; CHCs know whom to contact on any particular issue. It may result from a more positive approach from the UGMs.

> "Unit General Managers have now more autonomy.....to involve the CHC....and may do so at a very early stage, by sounding out ideas before they have even reached option appraisal . This attitude seems to have a knock-on effect right down the line and Council is [more] actively involved in representing consumer interests...."

Indeed the role of the UGMs and the developing relationship between them and CHCs emerged as a key factor for many of those CHCs who thought that general management had improved consultation.

HEALTH AUTHORITY MEMBERS

In the the last year or so attention has been drawn to the position of health authority members in three different reports. They share a concern with the quality of the members' contribution to the making of policy. The National Association of Health Authorities' consultation document, Acting with Authority and a King's Fund report, written by Chris Ham, Strengthening the role of health authority members both recognise the sometimes limited influence that members have and set out detailed proposals for improving the situation. As part of the NHS Training Authority's Management Development Programme, an "issues paper" was published by Templeton College, entitled DGMs and the DHA: working with members. This is one of a series of reports based on interviews and discussions with 20 DGMs. In this particular report, the DGMs themselves are occasionally very critical about DHA members.

> "They've no clear idea of what they want us to achieve"

> "I have been here a year and I still ask myself 'what's the role of the DHA?' You've got the CHC as watchdog...."

HC(81)6 states that the major function of members is "to determine policies and priorities for the district." They ought not to intervene in day to day operational management. The concern that these recent reports express about the actual performance of health authorities in this role is not new.

Nevertheless in view of the potential conflict between the theoretical accountability of the managers to the authority and the individual performance reviews which bypass the members, it is not unreasonable to look for some change in the degree of influence exerted by the membership.

63 CHCs offered comments on this issue. 23 of them thought that there had been no real change and 7 of these stated explicitly that the influence of members had always been weak.

> "There has been no noticeable effect.....in power and influence of members. Having said this, there does not seem to have been a demand from [them] to take a leading role."

> "It has always been difficult to detect whether the members have any effect upon the Officer of the Authority. Health Authority members seem not to know what powers they have,or to what extent they have influence over Officer recommendations."

> "Health Authority members do not appear to play a significant role in policy-making, but this has not changed since pre-Griffiths days. My feeling is that general management has had less impact than the failure to provide training and servicing facilities."

A further three CHCs commented that the members in their district had always retained a real and positive influence. In only one case was this point developed.

> "As a teaching district, this health authority has always had well-informed and articulate members nominated through medical channels and well-informed and politically aware members nominated by the local authority."

Of the 37 remaining CHCs, four were unsure or found it hard to pin the problem down.

> "HA members have spoken at DHA meetings about the power of the DGM and a number of papers have been requested on the extent to which he can take independent action. There have been no incidents where members have felt that he breached limits of power, just.....general voicing of worries."

This leaves 33 CHCs who thought that there had been some change since the advent of general management. 24 of these said that members' influence had declined, though a few of these thought the connection was adventitious. A number of different concerns emerged.

1. Chairman's power. The chairman's role as the DGM's 'parent' or 'grandparent' in performance reviews and hence in the setting of management objectives appears to be represent at least a formal accretion of power. Four CHCs mentioned that there had been an increase in the power of the Chairman of the health authority at the expense of the rest of the membership. In one

case, this power seems clearly to have been abused.

"Member power is limited by their information and interest - both fairly low in the majority of cases. Chairman of HA does her best to keep as much as possible from the new members who are interested."

2. Autocracy.

"The power and influence of.....members appears to have declined, but this may be as much due to the autocratic personality of the DGM as to general management."

"The DGM intervenes much more than hitherto in the deliberations of the health authority. The whole range of officers attend the DHA meetings, which can be intimidating and some generalist members would appear reluctant to contribute."

3. Control of information.

"We notice an increase in 'member-proof' documents being presented at DHA meetings, where the officers provide only the information to bring about the decision they want. On some occasions, we have sent additional material directly to the members and considerably modified the outcome."

4. Organisational change.

"Decision making, hitheto a province of the.....members, appears to have been removed and vested in the Management Advisory Group, which contains general managers and their subordinate management personnel. The influence of the rank and file member on proposals presented through the GM is almost non-existent and that which [may exist] is being exercised through an inner cabal of members meeting in private with managers, entitled special interest groups."

5. The external environment.

"National policies and directives have directly overturned local decision and deflected concentration away from locally defined priorities. NHS management is becoming more and more complex and lay members have real difficulty in grasping the issues. This has not been assisted by the need of managers to look downwards towards managing services at the expense of looking upwards to give time to and work with their membership."

For many CHCs these issues may all merge into a general concern over "rubber stamping".

"Most HA members have simply become rubber stamps at meetings - very little real discussion at public meetings; but this may be more to do with the fact that the DHA conducts its real business by private committee."

Only nine CHCs (14%) detected some improvement in the position of members, most often because they were better informed than previously. Although this is a precondition of their exerting a proper influence over policy-making, it is, of course, by no means the same thing.

> "Members have been given more information and seminars have been arranged, but is hard to decide if their power is any different from previously. The structure certainly makes it diificult for them, with the Chairman and the General Manager having authority and direct links with the RHA."

The increased influence of members is attributed by two CHCs to structural change at district level, in particular to new sub-committees.

> "There is now a stronger tendency for.....members to 'fight their corners' for their particular units/hospitals when the question of resources is being discussed at authority meetings."

> "The influence of.....members has increased considerably as functioning sub-committees of the authority have been set up."

A BETTER SERVICE?

To ask CHCs whether or not they detect the benign influence of general management on services against what is for many of them the malign background of financial stringency is admittedly a difficult question. Futhermore, as the DHSS and other commentators have argued, it is early days yet.

11 CHCs thought that it was decidedly too early to pass judgement on general management in this respect. Although some weight must be given to this opinion, such reticence was nevertheless the minority view. The remaining respondents split fairly evenly between those who thought there had been some improvement (18), those who did not (19) and those who answered "Yes, but....." (22).

Not all of the CHCs in the first group explained the reasons behind their judgement. Those that did identified clearer lines of accountability, more "direct" decision making and increased cost-efficiency as either the improvement itself or as the cause of an improvement in patient services.

> "There is much more evidence of proper management i.e. a shortage of money does not necessarily mean closures, but an appraisal of whether resources can be used better."

The other side of Griffiths, the spirit of consumerism, was reflected in two comments from this group.

"General management post Griffiths is more sensitive to public relations and has also established a series of priorities which has led to a more effective service..."

"The philosophy of general management in this district is to improve services to patients, and this is shown in part by a hospital services monitoring scheme which has only just left the springboard (sic)."

The 22 CHCs who qualified this positive view of the impact of general management offered four main kinds of reason.

1. *Efficiency v. effectiveness*

"The service appears to have become more efficient, but the resulting increase in throughput has triggered a major financial crisis; the effectiveness of services remains to be properly assessed; it may be that readmission rates have increased but this is not certain." (Was not an increase in overall costs a predictable consequence of increasing patient throughput?)

2. Financial constraints and lack of freedom

"Finance obviously dominates the current situation and staying within budgets seems to be more important....than examining relative needs and sorting out priorities within the overall budget. There does however seem to have been an increased willingness to research and examine problems in more detail than previously."

"The only advances here have been in areas where savings have been made or those improvments which require effective decision making but no funds. For example, the District and Unit General Managers have weekly meetings and take decisions on priorities for ever-reducing resources. This is considerably more effective than trying to get agreement from various committees."

"Any savings derived from increased cost-efficiency have been swallowed up by increasing demand and by making good previously identified deficiencies. There has been no reduction in waiting lists, no expansion of services that can be attributed to general management. The average patient is probably unaware of the changes."

"The flaw in the system is quite simply that there is so much direction coming down from Region and the Department that the GM's freedom of movement is severely curtailed. The search for cost improvements is increasingly difficult and burdensome and too much of the DGM's time is taken up with ever more desperate attempts to balance the budget."

3. Relations with the medical profession

"....Acute services are working well and [managing] to integrate services across hospitals....No-one really seems to manage the Mental Health Unit - consultants refuse to be integrated in the new structure and don't have any managerial responsibility, so no-one directs them."

"Relationships beween the DGM and the consultant body are generally poor.....The introduction of locality management has in the main been successful and will, given time and resources, produce a service more responsive to patient needs in specific localities."

4. Accountability

"General management certainly achieves faster decisions and faster action once a decision is taken. However there are fewer checks against bad decisions."

Of the 19 CHCs who claimed to have seen no improvement in services since the introduction of general management, almost half went no further than the bare statement of opinion - "no discernible effect". Occasionally the CHC finds it hard to judge.

".....very few signs of this within this health district. All that appears to have happened is the introduction of smoke screen tactics, making it increasingly difficult to obtain a clear understanding of what is actually occurring.."

The following remarks are typical of those CHCs who were not faced with any such difficulties. Morale may have suffered...

"..many people working in the Health Service, consultants, nurses and other staff...feel that there is now a real divide between the people giving the service and those who have been put there to manage it.."

- or management may be short-sighted...

"The short-term contract nature of general management has meant that short-term policies are followed to the detriment of long-term needs. Acute services dominate."

- or simply ineffective...

"No increase in consumer sensitivity.."

CHANGES IN PERSONNEL

The majority of CHCs in this sample had seen no change in senior management personnel since the appointment of the first general managers. In 7 cases, the new DGM was the old District

Administrator. In a further 45 districts the DGM had stayed in post. 10 had moved to other jobs and 3 had retired. The position with UGMs was very similar. 45 districts had all the original UGM appointees in post, though in some cases these appointments were very recent. In 15 districts, one or more UGM had retired or moved. 9 CHCs gave no information.

CONCLUSION

A majority of CHCs thought that consultation (72%), the influence of HA members (59%) and the service itself (73%) had all changed since the introduction of general management. There was, on the whole, much less agreement about the desirability of the changes. The highest level of agreement was in respect of the influence of HA members. Over two-thirds of those who believed the situation to have changed thought that it had changed for the worse.

Many of the CHCs who responded to our request for information pointed out that even though changes had occurred since the introduction of general management, it was not necessarily the case that general management or general managers had caused these changes. The same point applies when all the CHC responses are aggregated. This caution was exercised by those CHCs who welcomed general management as well as those who did not. There were, however, many CHCs who were convinced that a strong causal link existed between whatever changes had taken place and the new management structure.

The CHCs who were reluctant to identify these structural changes as key causal factors referred either to changes in "personality" or to the financial environment as alternative explanations for the changed conditions in the Health Authority.

> "The style of the previous District Administrator and the District General Manager are totally different and a lot of the changes would probably have taken place with the new DGM in a District Administrator post."

> "It is perhaps too easy to be hypercritical of the way general managers react and operate, given the very strict guidelines and financial constraints with which they must continue to work."

It is almost always with reference to changes in the consultation process or the influence of HA members that the alternative explanation of a new personality is offered. Clearly, with respect to consultation, an "autocratic" DGM will have a very different impact on CHCs from one who is enthusiastic about the "consumerist" spirit of the Griffiths report. There are nevertheless good reasons for holding on to the idea of general management as an important factor in change. Firtly, some CHCs mentioned that such changes had occurred even though the new DGM was the same person as the old District Administrator. Secondly, one of aims of the general management pay structure was to

attract "new blood" into the health services. Appointment boards will be looking for the appropriate personality or "style" as well as appropriate qualifications. In this case, it might be useful to think of the DGMs as embodying different strands of thought in the Griffiths report. On the one hand, there are some DGMs who fail to relate the consumerism of Griffiths to the kind of positive contribution that a CHC can make. Or perhaps they neglect altogether this aspect of the report and concentrate on the letter of the law as it comes down to them in DHSS circulars. Their priority is organisational efficiency. On the other hand, there are clearly some who are taking to heart what has been said on the need for a consumer perspective if the service is to be effective.

The same may be said of alternative explanations for the declining influence of HA members. Although a DGM's "style" will be very important in determining the conduct and content of health authority meetings, this itself needs to be seen in context. Furthermore, two organisational factors emerged as significant, the increased power of the chairman and the development of sub-committee structures which in some cases may effectively exclude members, but in others may allow greater involvment.

In assessing the impact of general management on the effectiveness and efficiency of services, the complicating factors are financial stringency and the tightness of the reins held by the DHSS. This may not only prevent the best efforts of management from securing real improvements in services, it may also confuse the explanation when there is a perceived deterioration of service. Equally, when improvements are detected they could be ascribed to the calibre of new staff rather than to new structures, though this view was held by only two CHCs.

To what extent then can general management be said to have achieved the goals laid out for it? It is possible only to offer a cautious reply to this question. A majority of CHCs thought that some kind of improvement had been made, though in most cases this was not an actual improvement in <u>services</u>. They were mostly "managerial" improvements or evidence of increased cost-efficiency (which may bring its own problems in a cash-limited service). This is in line with what the managers themselves said in the Templeton tracer study of 20 district managers.

> "In discussing their achievements, most DGMs found it easier to point to progress in managerial changes than to output or outcome measures.....The majority of DGMs believed decision making was faster."
>
> (HSJ. 10.12.87 pp1444-5)

It could plausibly be argued that the failure to achieve improvements in services was due to an adverse financial environment or that more time was needed for the effects of "managerial" changes to filter through to patient services. Indeed this is a position taken by many CHCs.

Not everyone agreed, however, about the impact of such changes on patient services. In some cases, there was scepticism about the connection between increased efficiency and a "better" service; in others, it was felt that the "improvements" could actually have a detrimental effect on services.

> "We feel that their concentration on efficiency i.e. bed throughput, length of stay etc. does not necessarily give evidence of an effective service as far as patients are concerned and we would like to see the HA carry out an in-depth study into admission rates."

> "..we feel that the service is being marred by too many changes and too great a financial emphasis which always looks at the bottom line. This is leading to very low staff morale in the service."

It is also significant that only three CHCs explicitly mentioned improvements which could be taken to indicate increased "consumer sensitivity." These changes relate not so much to the ability to treat those who require treatment, but to the way in which the service is delivered, that is, the quality of the service. It is only fair to point out however that information on "quality initiatives" was not explicitly sought from CHCs, so we should not be overhasty in drawing conclusions from its relative absence.

A great deal has been written and said on quality initiatives and quality assurance in the last year or so. Ensuring high standards of service is undoubtedly seen as an essential part of the role of general management. Health authorities have had their consumer surveys reviewed in the professional press; NAHA, the IHSM and the King's Fund have all undertaken work in this area; and the last round of annual regional reviews all contained some reference to the development of quality initiatives by the regions. The Department has not however agreed with the all regions on formal targets for such initiatives. Nor has any formal pronouncement yet been issued by the DHSS or the NHS Management Board. The development of the consumerist side of the Griffiths' report remains at an embryonic stage. Action on this is surely needed to counterbalance the emphasis that has so far been placed on cost-efficiency. This means a more positive effort on the part of the health authorities to listen to and take account of the views of the users of the health service.

Alongside this concern with the evaluation of the quality of services, there is also evidence of the declining influence of HA members and deteriorating relationships with CHCs. Together these tell us something about the management approach to accountability and sensitivity to local needs. In determining its priorities, an effective local health service must be mindful of and responsive to local wishes and needs. The strengthening of the bonds between management and central government should not serve as an excuse for weakening the ties with the local community.

It would be churlish not to give proper acknowledgement to the fact that a large number of CHCs see general management as, on the whole, a good thing. It would be equally wrong not to be aware that there are quite likely to be problems inherent in the system which need to be guarded against. Whilst the evidence from CHCs by no means shows these to be endemic, they are nevertheless sufficiently widespread to be a real cause for concern. Increased cost-efficiency, speedier decision-making, the monitoring of management performance are all means to an end, a better service for users. So also is the proper participation of the user in the evaluation and planning of services. Attention to one set of means should not lead management to neglect the other.