

**MANAGING AMBIGUITY.  
A STUDY OF THE INTRODUCTION OF GENERAL MANAGEMENT  
IN THE NHS**

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## **ABSTRACT**

The central focus of this thesis is managing change in the National Health Service (NHS). In particular it considers the introduction of general management into the NHS - its third major reorganization and one based on the recommendations of a team of businessmen led by Sir Roy Griffiths, then managing director and deputy chairman of Sainsburys foodstores. More than previous reorganizations of the NHS in 1974 and 1982, the Griffiths changes were a conscious attempt to move away from a "boxes and charts" approach to organizational change to one which sought to disturb organizational processes and ultimately to change the beliefs and values of NHS actors.

The thesis attempts to illuminate the implications of what was viewed as a significant change in the way the NHS was managed, in three ways. Firstly it reviews the existing empirical work on health service management and considers what can be learnt about the difficulties of introducing change in the NHS. Secondly it reports fieldwork data from twenty NHS districts which explores the actions and priorities of twenty newly appointed DGMs with a variety of different occupational backgrounds as they sought to implement the agenda for change spelt out in the Griffiths Report. The thesis reports a significant gap between the aspirations of the Griffiths Report and what the introduction of general management was able to deliver and a number of unintended consequences. Thirdly the thesis draws on the work of Norbert Elias known as figural or process sociology in an attempt to illuminate the fieldwork data further. Elias is not a sociologist one associates with the study of the NHS, or indeed the management of change, yet it is argued that his writings offer much to those wishing to explore organizational and management issues in the NHS.

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## **ABBREVIATIONS**

ADMO	Association of District Medical Officers
ADO	Area Dental Officer
AHST	The Association of Health Service Treasurers
AHA	Area Health Authority
AMO	Area Medical Officer
ANA	The Association of Nurse Administrators
APO	Area Personnel Officer
ASCHEW	The Association of County Health Councils
ATO	Area Team of Officers
AWO	Area Works Officer
BMA	British Medical Association
CHC	Community Health Council
COHSE	Confederation of Health Service Employees
CPN	Community Psychiatric Nurse
DGH	District General Hospital
DGM	District General Manager
DHA	District Health Authority
DHSS	Department of Health and Social Security
DMC	District Medical Committee
DMT	District Management Team
DNS	Director of Nursing Services
DPT	District Planning Team
EMS	Emergency Medical Service
FPC	Family Practitioner Committee
GNP	Gross National Product
GP	General Practitioner
HAS	Health Advisory Service
HCPT	Health Care Planning Team
HMC	Hospital Management Committee
HVA	Health Visitors Association
IHSA	Institute of Health Service Administrators
MENCAP	National Association for Mentally Handicapped Children and Adults
MIND	National Association for Mental Health
MOH	Medical Officer of Health
NAHA	The National Association of Health Authorities
NAHSPO	The National Association of Health Service Personnel Officers
NALGO	National and Local Government Officers' Association
NHS	National Health Service
NHSTA	National Health Service Training Authority
NUPE	National Union of Employees
PIs	Performance Indicators
PRP	Performance Related Pay
RAWP	Resource Allocation Working Party
RCM	Royal College of Midwives
RCN	The Royal College of Nursing
RGM	Regional General Manager
RHA	Regional Health Authority
RHB	Regional Health Board
RHB	Regional Hospital Boards
TUC	Trades Union Congress
UGM	Unit General Manager

## **CHAPTER 1**

### **Introduction to the thesis**

#### **The concerns of the thesis**

The central focus of this thesis is managing change in the National Health Service (NHS). Specifically the thesis considers the introduction of general management into the NHS (its third major reorganization) following the publication of the Griffiths Report in 1983. This Report was the product of some nine months work, seeking to find out why the NHS continued to consume vast amounts of public resources yet failed to be, in the government's terms, either efficient or effective. The work was done by four private sector managers including the inquiry leader, Roy Griffiths, then managing director and deputy chair of Sainsbury's food store and after whom the Report was named, and was supported by two civil servants. This team was chosen because of its members' business experience. Its task was not to create further major change in the NHS but to make recommendations within the existing system.

The Report stressed what it claimed were the 'clear' similarities between the NHS and the private sector. For example, it was argued that in many organizations in the private sector, profit does not immediately impinge on large numbers of managers below board level, rather most managers are concerned primarily with levels of service, quality of product, meeting budgets, cost improvement and motivating and rewarding staff. This notion of the NHS being similar to private sector organizations set the scene for a number of observations about the organization of the NHS and its strengths and weaknesses, and some important recommendations for improving the way in which the NHS was managed.



Briefly, the Report criticized the NHS on a number of grounds, notably for what was claimed to be its lack of strategic central direction, the absence of individual managerial responsibility and the lip service paid to a consumer and performance orientation. It proposed the introduction of general management throughout the NHS. At a national policy level, a supervisory board chaired by the Secretary of State was created to concentrate on the determination of the purpose, objectives and direction of the NHS, deal with resource allocation issues and to monitor the performance of the service. The NHS management board was charged with implementing policies set by the supervisory board and with giving leadership to the NHS. It was to cover all existing NHS management responsibilities, including regional and District Health Authorities (DHAs) Family Practitioner Committees (FPCs), special health authorities and other centrally funded services. Reporting to these two bodies were general managers at regional, district and unit level. It was not assumed that these managers would necessarily have NHS backgrounds and they were seen as critical agents in moving the NHS away from an administrative culture to a general management culture, where accountabilities were clear, decisions would be taken to create a more effective and efficient organization that would meet the needs of its patients (in the Report they are referred to as customers) as well as ensuring good value for money.

The introduction of general managers responsible for local health services meant the end of the previous management arrangements where an administrator, nurse, medical officer and a treasurer along with a representative from hospital medicine and general practice worked together as a consensus team to manage health services. More than previous reorganizations of the NHS in 1974 and 1982, the Griffiths changes were a conscious attempt to move away from a "boxes and charts" approach to organizational change to one which sought to disturb organizational processes and ultimately to change the beliefs and values of NHS personnel.

The Griffiths Report, which is examined in detail in Chapter 3 of this thesis, caused a sensation in the NHS and beyond. It was damned by the health service press for a number of reasons. Firstly, it was seen to treat the NHS as a supermarket. Secondly, it was thought to reveal a lack of understanding of the difficulties of managing health services. Thirdly, it was believed to undermine the ability of professionals to treat people in need and to meet the original objectives of the NHS. Yet it was also applauded for its emphasis on better management of NHS resources - a policy aim it is difficult to take issue with. The reactions from interest groups in the NHS to the Report make interesting reading (see the appendix to Chapter 3) for they betray the threat the Griffiths Report was seen to represent to each group and, as such, constitute ideological assessments of the Report.

This knee jerk reaction by representative bodies of NHS employees is not surprising. The Griffiths Report followed close on the heels of the 1982 reorganization which, for people working in the NHS, meant change and job uncertainty. This situation, coupled with decreasing NHS monies to deal with the many and evolving demands on health services, meant morale in the service was at that time very low. The last thing people working in the NHS wanted was more change. Yet change there was to be. The then Secretary of State for Health, Norman Fowler, accepted the Griffiths Report without question, despite grave reservations of the social services committee set up to coordinate the reactions of the representatives of NHS workers to the Report. It was some two years from the establishment of the inquiry to the implementation of its key recommendations. Little time was left for public debate. Indeed the theme which dominated the health service press at the time was the unwelcome intrusion of "outsiders" into a very different and "special" organization - the NHS. How could an ex-brigadier or an industrialist possibly manage the NHS when they knew nothing about health care? In short, the debate tended to generate more heat than light.



This thesis attempts to illuminate the implications of the introduction of general management by concentrating on the implementation of general management in 20 NHS districts. It seeks to make a contribution to academic work in the field of health services management and organization in two significant ways. Firstly, the thesis offers an empirical account of a major change in the NHS - the introduction of general management at district level and its impact on the way in which health services are delivered. Relatively little work has been done in this area and what work has been done is reviewed later on in the thesis. The opportunity to do such empirical work came from fortuitous circumstances. In 1985 I left my job in the NHS to work as a Research Associate on a project funded by the National Health Service Training Authority (NHSTA) designed to produce training materials for district level general management. In order to do this, it was necessary to understand the evolving role of the District General Manager (DGM). This meant working closely with DGMs in a sample of 20 districts to understand their districts, their priorities, actions and relationships and consider what general management actually meant in practice. I was to work with four NHS experts from very different backgrounds - a professor of health care management, a senior management studies academic, an experienced management researcher and a senior registrar in community medicine. I was employed as a medical sociologist. The focus of this project changed and developed (see Chapter 5 for an account of this). In the second year of the project, an opportunity developed for individual members of the team to focus on particular issues associated with the development of general management and to manage their own work whilst continuing to contribute to the original aim of the project. It was at this point that I saw the opportunity to pursue a higher degree, returned to my sociological roots at Leicester University and sought, with my supervisor Ivan Waddington, to anchor my research material sociologically.

The second contribution the thesis seeks to make is to explore why DGMs in the sample took the actions they did and pursued the priorities they did. Cox has recently argued that the Griffiths Report caught sociology on the hop. In his ethnographic study of general management in 1986, he found little useful literature in the traditions of medical or organizational sociology that assisted him in understanding the empirical material he gathered (Cox, 1991, p.90). I venture to argue in this thesis that the work of Norbert Elias offers a useful approach for those studying health services management and health care organization. Elias is not a sociologist one finds associated with these areas. Indeed, Eliasian sociology has rarely been used in the study of organizations or management. The details of Eliasian sociology are given in Chapter 4, but a brief overview of its principle assumptions is appropriate in this introduction.

For Elias sociology is the study of people. The plural "people" highlights the critical point that human beings are social beings - they do not exist in a vacuum but we are part of a network of social relationships. Relationships are not something we can see but we know they exist because we can feel their effects, or at least some of their effects. Elias argues that if a person or a group can have an effect upon other people, then a relationship must exist. This notion contrasts with a very common conception of relationships, namely that relationships are best thought of in terms of face-to-face contacts. A great deal of the empirical work exploring NHS management considers relationships in this latter sense and makes the assumption that people with whom we have contact have the greatest impact upon us. Little significant attempt is made in this literature to anchor the actions of managers or management teams in the social context of which they are a part. Instead, managers are portrayed as free-thinking individuals working in difficult circumstances and having to cope with numerous, often conflicting government health policies and the mighty power of the medical profession. Though this contains some rudimentary recognition of the constraints



upon managers' actions, it is much too simplistic an approach and is a far cry from a properly sociological analysis.

Elias also stresses that we are affected by the activities of past generations - not only material things such as buildings, but language, educational systems and so on. Normative practice can be passed down over hundreds of years even though in the process the vast majority of people remain oblivious of its origins. A key point for Elias is, therefore, that while it is entirely legitimate to focus upon individual people, we should never lose sight of the fact that individuals cannot be understood adequately outside their social and historical context. Again existing studies of NHS management and studies seeking to understand the management of change in the NHS, can be criticised in this respect.

These complex networks Elias depicts as interdependency ties or power relationships and these relationships tend to be unequal across a range of dimensions - in terms of coercive, economic and persuasive power. These networks are by definition in process. They can be conceived of in more abstract terms as processes such as the division of labour, or nation-state formation, but it is critical to note that these processes only exist in and through the actions of people. These processes form complex figurations, hence the term given to Elias's particular approach to the study of people - figural sociology. The term figuration was used by Elias because, as a more dynamic and processual term, it highlighted the inadequacies of the existing static vocabulary of sociologists. He had little time for sociologists who argued endlessly about conceptual distinctions such as "the individual" and "the society", as though these were separate and even opposing entities. Such arguments he deemed as unproductive because we know "perfectly well that societies are composed of individuals and that individuals can only possess specifically human characteristics,



such as their abilities to speak, think and love, in and through their relationships with other people in society" (Elias, 1970, p.113).

The empirical data collected from the twenty districts will be used to consider the network of power relationships emerging in the NHS following the introduction of general management - recognising that these networks are themselves in process. These relationships are rooted in the history of the NHS and therefore the thesis considers the issues surrounding the formation of the NHS and the previous reorganizations of the NHS as reported both in the general literature on the NHS and the available ethnographies of local health services management. Particular importance is attached in the thesis to examining the actions of the sample DGMs in the social context in which they work - that is, the interdependencies they have with other people and the impact of these interdependencies on DGMs' actions and activities. The following chapters are offered as a sociological analysis of district health services management following the publication of the Griffiths Report. Let us now turn to how the thesis is organized.

### The organization of the thesis

Following this introductory chapter, Chapter 2 offers an overview of the organization and reorganizations of the NHS prior to the introduction of general management, in order that the more detailed examination of the changing network of social relationships in the NHS following the introduction of general management is set in its proper context. Specifically it documents in some detail the formation of the NHS, the emerging concerns about the way in which health services were developing, the build-up to the first reorganization of the NHS in 1974 and its core features. The chapter goes on to explore pressures for a second reorganization in 1982, as well as detailing its proposed changes. The final section of the chapter considers why the

two reorganizations of the NHS took an essentially bureaucratic form. The chapter concludes that it is entirely appropriate for some aspects of NHS management to be organized on bureaucratic lines. A bureaucratic form of organization might, for example, be held to be appropriate for the following tasks: collecting data on demographic change; monitoring technological change and advances in scientific medicine; allocating resources to the NHS and between geographical areas and measuring the outcomes of health care. However, it is suggested that a bureaucratic approach cannot deal with the complexities of health services management and ignores the power of doctors to shape patterns of health care.

Chapter 3 gives details of the Griffiths Report, its criticisms of the organization and management of the NHS and its proposals for change which lay at the heart of the third reorganization of the NHS. Specifically the chapter considers, firstly, in what ways the Griffiths Report is different from the previous reorganizations of the NHS, secondly the reactions of the various health care worker groups to the Griffiths proposals and finally the important assumptions about delivering health care that Griffiths made. It is argued that the Griffiths Report could be viewed as an act of faith, based on a brief report and very little evidence to justify the nature of the change. Clearly it is one thing to make the claim that Griffiths is an act of faith and it is another to substantiate the claim. One object of the analysis contained in this thesis is precisely to substantiate this claim.

Chapter 4 offers a fairly extensive review of the available ethnographies of local health services and the general literature on health service management. This work demonstrates the dilemmas faced by health service managers and it consistently questions the major assumption of both the 1974 and 1982 reorganizations of the NHS, namely that management is a rational process where policy is made by the Centre, transmitted to the periphery and implemented there, and that health services



are best organized on bureaucratic lines. Although appreciating the contribution of these studies in allowing us to tease out the complexity of managing local health services, it is argued that these studies represent a partial analysis of the complexity and do not constitute a properly sociological analysis because they do not adequately examine the network of relationships within which managers work. The chapter concludes by detailing what is meant by a sociological analysis. It documents in some detail the key aspects of figural or process sociology developed by Norbert Elias.

Chapter 5 documents the research process. It tells the story of how the author came to research district health services management and to focus on the research questions that lie at the heart of this thesis. This chapter is not a conventional review of the methods used in a thesis. Aside from discussing research methodology, documenting the methods used and outlining lessons to be drawn from the research process, it deals with the difficulties the author encountered working on an action research project whose funding was dependent on producing useful training materials for the Health Service general management community and raises more general questions about the constraints on researchers working in such a relationship.

Chapter 6 documents the activities of the sample DGMs in their first year in the job. Most of that year was taken up designing the new district structures, establishing themselves in the new job and establishing what they called a general management culture. The fieldwork data indicate that members of the sample were uncertain about their role and, in the absence of available guidance, resorted to their previous job histories for ideas as to what their new job actually involved. This raises questions about the appropriateness of general management and general managers as the solution to the perceived problems of the NHS. For if those individuals are

unclear about their role, how can they provide leadership and dynamic management as requested by Griffiths?

Chapter 7 considers the relevance of Elias's sociology and, in particular, his notion of game models as a tool for understanding the fieldwork data collected on DGMs' priorities and actions during the second, third and fourth year in the job, reported in this chapter. These data reveal a significant variation in the time spent by DGMs on his or her key relationships. Most time was spent dealing with the district management team and region, mostly in terms of responding to central initiatives and providing regional managers and the Centre with information for monitoring purposes. Doctors proved to be the major relationship "problem" in the sense of their ability to obstruct change; however, the time and effort spent on this relationship as opposed to complaining about doctors, was far less than the time spent on managerial relationships. DGMs spent least time with nurses, paramedical or community groups.

Chapter 8 explores the development of a mental health strategy in one of the sample districts as a case study. The detailed account of the issues surrounding the attempt to change the way in which one health service is organized demonstrates the complexity of the NHS, the interdependency of interest groups within it, the difficulties of achieving change and the inevitability of unintended consequences of change.

Chapter 9 offers an assessment of the introduction of general management into the NHS, drawing on other empirical studies of general management. The significant gap between the Griffiths aspirations for the NHS and what actually happened as reported in most of the existing empirical studies, is explored.

Following convention, the last chapter reviews the conclusions of the thesis.



## **CHAPTER 2**

### **Reorganizing the NHS: Theory and Practice**

#### **The purpose of this chapter**

The changes to the NHS which followed the Griffiths Report marked the third administrative reorganization of the NHS in ten years. The purpose of this chapter is to set these changes in context by examining the previous reorganizations of the NHS in 1974 and 1982. This analysis draws on historical data documenting the formation of the NHS, the pressures to reorganize and details of the two reorganizations. This data reveals a growing complexity in how the NHS is organized as well as an increasing interdependence of groups involved in delivering health services. The analysis is limited to England and Wales since Scotland has a significantly different health service structure. It is argued that a bureaucratic approach was adopted to managing the complex and evolving pressures on the NHS and was the preferred strategy of the government for dealing with the power of the medical profession to shape health services.

The final section of the chapter explores the possible advantages and disadvantages of a bureaucratic approach to managing health services.

#### **The formation of the NHS**

Britain's NHS began on the 5th July, 1948. It was the first health system in any western society to offer free medical care to the entire population. Furthermore, it was the first system to be based not on the insurance principle, with entitlement following contributions, but on the national provision of services available to



everyone. This involved an attempt to ensure a reasonable geographical and social distribution of adequate health facilities and services. Klein describes the NHS as a unique example of the collectivist organization of health care in a market society (Klein, 1983, p.1).

The aim of the 1946 Act was to promote:

"...the establishment in England and Wales of a comprehensive health service, designed to secure improvements in the physical and mental health of the people of England and Wales and the prevention, diagnosis and treatment of illness." (The National Health Service Act 1946. HMSO. London. Chap.81, pt.1, section 1).

The NHS was a convenient label to wrap around a very diverse collection of health services. Scrivens argues that during the 19th and early 20th centuries, five major and overlapping systems of health care had developed which paved the way for the welfare state and the NHS (Scrivens, 1986, p.197). These systems were:

1. **Fee for consultation practice.** General practitioners operated on revenue obtained from fees, although organized bodies such as friendly societies and trade unions contracted with some of them to treat skilled workers involved in insurance schemes.
2. **The Poor Law.** The 1834 Poor Law Act provided a formal system for dealing with the indigent and unemployed. The law stated that those who could not work because of no fault of their own, were entitled to care. Those who were fit were encouraged to be financially independent, through the deterrent of the workhouse. Shortly after the Act was passed, several reports published by Edwin Chadwick in

1842 highlighted the relationship between poverty, unsanitary conditions and ill health. It was gradually accepted that the ill were generally blameless for their condition, although little was done to change the Poor Law until the 1860s, except to allow outdoor relief in the case of illness. Following a series of epidemics, most notably the cholera outbreak of 1866 which took nearly 20,000 lives, a new policy was adopted under which the sick poor were treated in workhouse infirmaries, established to provide care for their sick inmates. Poor Law unions were also encouraged to form "sick asylum districts" large enough to support hospitals to which the sick could be removed from workhouses.

3. **General hospitals.** Public provision of the hospitals developed out of the workhouses provided under the Poor Law. Hospitals in the 19th-century were primarily for use by the sick poor and fell into two categories: voluntary hospitals financed by subscription where patients paid no fees for their treatment, and chartered institutions supported by endowments and fees paid by patients.

Following the outbreak of the Second World War, local authorities were made responsible for a wide range of hospitals, and the public hospitals joined the voluntary hospitals in the Emergency Medical Service (EMS), set up to cope with war casualties.

4. **Public Health Services.** The Public Health Act (1848) established a public health service with local boards of health which could appoint Medical Officers of Health (MOH) who had specific responsibilities in relation to infectious diseases, vaccination, school and factory inspection, sanitary improvements and ascertaining causes of unexpected deaths.



5. **State-administered health insurance.** In 1911 the system of state-administered health insurance was introduced, designed solely to assist lower-paid manual workers, i.e. those earning under £160 per annum. It excluded manual workers earning more than this, all dependents, agricultural workers and nearly all non-manual white collar workers. Insured people were entitled both to cash benefits and treatment which included GP care and drugs, but the cost of hospital and specialist treatment was excluded.

Scrivens's list of avenues for health care provision reveals that in various ways the state had taken on increasing responsibility for the provision of health care. Key legislative developments in this respect were the 1808 County Asylums Act, the 1867 Metropolitan Poor Act and the 1929 Local Government Act, all emphasizing the importance of public provision of hospital services. The Public Health Acts and the legislation relating to maternal and child welfare placed a duty on local authorities to develop environmental and later some personal health services. The National Insurance Act, recognized the State's responsibility in relation to primary health care (Ham, 1982, p.13).

Prior to the Second World War, a number of reports were published which called into question the efficiency of the ad hoc approach to providing health service provision. Despite this consensus, the various reports and commissions proposed different methods of improving provision. The Dawson Committee Report (1920) recommended provision of a comprehensive scheme of hospital and primary health care. Reports from the Royal Commission on National Health Insurance (1926), the Sankey Commission on Voluntary Hospitals (1937) and the British Medical Association (BMA) (1930 and 1938) all called for greater coordination of hospitals, although they differed in their views of how health care should be funded. The Royal Commission's Report argued that health service funding might be obtained from

general taxation. This view was vehemently opposed by the BMA which favoured the extension of state involvement in the provision of health services, but felt that the most appropriate way of doing this was by extending health insurance even though the BMA had vigorously opposed this principle in 1911. The Beveridge Plan (1942) provided a more detailed outline of what a reorganized health service might look like, based on the principle of state funding and state ownership of hospitals.

The eventual administrative structure of the NHS was a product of bargaining and negotiation carried out in the health policy community. (See Eckstein, 1958 and 1960; Klein, 1983, Chapter 1 and Webster, 1988 for details of the politics involved in the formation of the NHS.) The NHS represented a compromise between those involved in the negotiations (Klein, 1983, p.26.) The government made major concessions to the medical profession - for example, the option of local government control was dismissed, the independent contractor status for GPs was maintained, the principle of private practice and pay beds in NHS hospitals was accepted and consultants were eligible for distinction awards which brought large salary increases. Furthermore, the profession exercised a major role in the administration of the services. For their part, the profession lost on the issue of a state funded and, in effect, salaried service. (For GPs this was called 'independent contractor status'.) By way of contrast, local authorities lost control of their hospitals as Nye Bevan combined them with the voluntary hospitals under a single system of administration.

# The National Health Service 1948-74

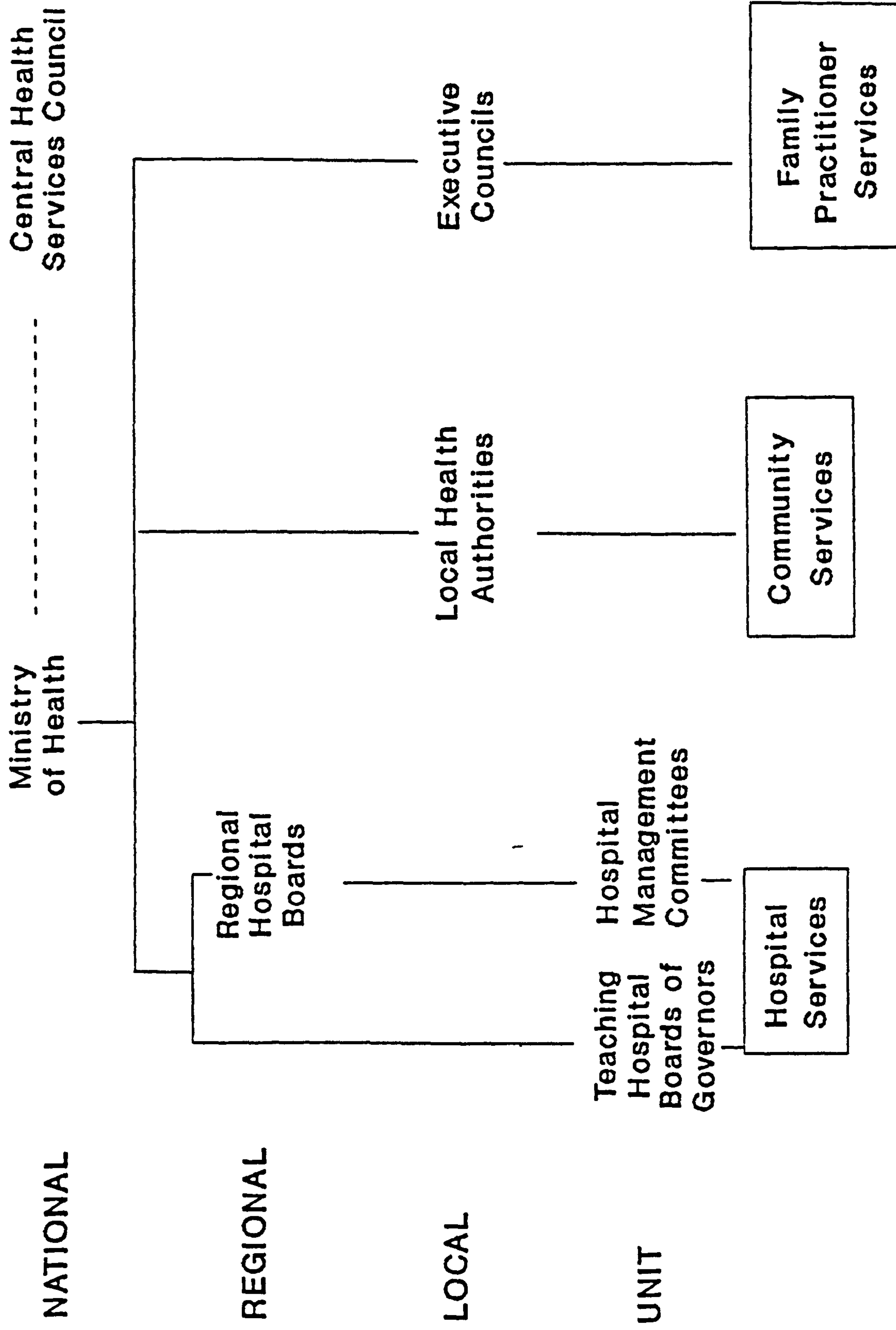


FIGURE 1

Taken from Levitt & Wall (1989). The Reorganised NHS. p7



Figure 1 above shows the responsibilities for the various parts of the NHS between 1948 and 1974. The Minister of Health was responsible to parliament for the provision of all hospital and specialist services on a national basis, for the public health laboratory service, the blood transfusion service and research concerned with the prevention, diagnosis and treatment of illness. In addition, the Minister had indirect responsibility for the family practitioner and local authority health services. The Central Health Services Council and its professional standing advisory committees were established to advise the Minister about his responsibilities and service development.

Hospitals were administered by new bodies - Regional Hospital Boards (RHBs), Hospital Management Committees (HMCs) and boards of governors. The RHBs were appointed by the Minister of Health and these bodies in turn appointed the HMCs.

Community and environmental health services, including maternal and child welfare, health visiting, home nursing, vaccination, immunization and aftercare for mental illness, were covered by local authorities (county council and borough councils) through health committees. The key local officer here was the MOH and these services were funded by central government grants and local rates.

Executive councils were successors of the old insurance committees, and they administered family practitioner services and received finance from the Ministry of Health. They were appointed, partly by local professions, partly by local authorities and partly by the Minister of Health. They administered the contracts of family practitioners, maintained lists of patients, and handled patients' complaints but were in no sense management bodies.

School medical services continued to be run by local education authorities while industrial health services were organized by the Ministry of Labour through the factory inspectorate. The armed forces retained their own health service quite separate from the NHS.

In effect, the administrative structure of the hospital sector of the NHS was composed of some 14 (later 15) RHBs, 36 boards of governors and 336 HMCs. 134 executive councils administered the services of 20,000 general practitioners, while 175 local health authorities ran the community services (Levitt, 1976, p.12). The organizational structure was often described as tripartite, since responsibilities were in fact carried out by three statutory authorities, namely, the RHBs, the local authorities and the local executive councils.

### Why reorganize the NHS?

By 1970, the NHS had achieved a great deal. In comparison to other industrialized countries, the health indicators such as specific death rates and life expectancy were average, and the costs expressed as a proportion of GNP or national income were much lower than average. Compared to Canada or the USA, the geographical spread of services was good. Prevention of illness services were being developed, and the various public surveys that were carried out at the time tended to show the NHS as a highly used and much appreciated service. Professional staff were in general supportive of the NHS, although there were demands for increased resources and better pay and working conditions. Indeed, ancillary workers took industrial action during the pay freeze of 1973. (See Draper, Grenholm and Best, 1976, p.251-258 for details of the above points and Bosanquet, 1979 and Seifert, 1992, for a review of industrial relations issues in the NHS at this time.) In general, up until the proposed reorganization in 1974, the views of patients and providers of NHS services -



although far from systematically documented - appear to reflect a positive acceptance of the NHS and a feeling that, although efforts should be made to improve it, there should be no question of dismantling or radically altering it.

There were, however, a number of concerns about the way in which health services were developing. A major issue was the growth of the hospital sector vis-à-vis general practitioner and community services. For example, capital expenditure in 1970/71 was £114m on hospitals, as compared to £5.1m for loans on health centres and £1.3m for official loans for other general practice buildings (DHSS, 1972). Furthermore staffing ratios for hospital doctors increased between 1959 and 1969 by 30%, whereas the general practitioner service staffing ratio remained the same as at the commencement of the NHS.

A more general concern was the ability of the NHS to cope with the emerging pressures being placed on it. For example, Draper, Grenholm and Best argue that by the early 1970s there were four categories of pressures for changing the existing NHS structure.

**1. Escalating costs and the changing fiscal orientation of the government.**

The rise in the proportion of Gross-National Product (GNP) spent on health care was often cited as evidence of this pressure. The UK in 1969 spent 6% of GNP on health compared to 3.5% in 1950 (Rogaly, 1973). Increased costs were related to more advanced medical technology, increased capacity to cure or curtail previously life-threatening diseases and increased demands for more long-term rehabilitation care.



2. **The changing population structure and patterns of illness.** A decline in the birth rate after the initial post-war boom and the ability to cure more acute conditions as a result of more advanced medical technology meant the population aged (in 1949, the total UK population was 48.9 million and 5.2 million were aged over 65; in 1971, the total UK population was 54 million with 7 million aged over 65). As a consequence of the aging population, the NHS had to cope with more chronic illness which added to the escalating costs.

3. **Continuing local and regional inequalities.** DHSS figures for the allocation of funds to different parts of the country suggested that the single most important factor in explaining the allocation of funds in this period was the historical legacy of each region. For example in 1950/1 South-Western (London) Metropolitan Hospital Region (the highest spending region), was allocated twice as much money per head of the population as the Sheffield Region (the lowest spending region). By 1971/2 these same regions were still respectively the top and the bottom regions and the gap had narrowed only slightly (Draper, Grenholm and Best, 1976, p.263).

4. **Recognition of neglected types of need and an evolving health care philosophy.** During the 1960s a number of scandals, prominent amongst them the Ely Mental Hospital scandal, served to alert the public to the neglect of what were to become known as the Cinderella services, i.e. mental health, psycho-geriatrics and community care services as well as the poor links between the hospital and community sectors which threatened 'comprehensive care'. The creation of the Health Advisory Service (HAS) was one response to this neglect. At the same time, there was a significant interest in the benefits to patients of institutional care in relation to its cost and the benefits afforded to patients from community care (McKeown, 1976; Powles, 1973.) Increasingly psycho-social skills were seen to be very important if

the health professions were to meet the challenges associated with the changing patterns of illness.

Draper, Grenholm and Best argue that in such a dynamic situation as that in which the NHS found itself in the 1970s, one might have expected modifications to the structure of the NHS that fostered the social processes that would enable it to grow and adapt to the changing demands being placed upon it. They argue:

"We would have looked for an organization that would tend to permit genuine devolution of power - for the decentralization of decisions that were not truly national. Equally, with the changes and conflicts over the goals of health care, we would have sought an organization that would foster the process of participation so that all providers and consumers of care could share in the determination of goals." (Draper, Grenholm and Best, 1976, p.266)

They go on to argue that 'open' organizational changes would have been a direct and logical response to the pressures discussed earlier. For example, local and regional resource inequalities imply the need for more open discussion of how resource allocation decisions are arrived at; the awareness of the need for greater co-ordination between policy areas would suggest a looser and less rigid definition of administrative and management roles; an awareness of the need for flexibility to respond to changing policies and priorities would have suggested the need to avoid anything smacking of a 'command hierarchy'. These characteristics would, argue the authors, facilitate the close monitoring of local needs and priorities and the continuous re-definition of goals - two essential conditions for the successful operation of a system as large, complex and important as the NHS. What emerged as the first reorganization of the NHS was, however, a far cry from an organizational



structure built around evolving health needs and patterns of care. A brief account of the stages leading to the first reorganization is given below.

### Moves towards the first reorganization of the NHS

The government's first move in reviewing the NHS came in 1956 with the establishment of the Guillebaud Committee, to enquire into the costs of the NHS. The medical profession had argued that it was the abuse of the service by the general public which had contributed to unexpected costs. However, when the Committee reported, it found no evidence of extravagance or inefficiency in the NHS; indeed, drawing on Richard Titmus's work (Titmus, 1968), it argued that as a proportion of GNP, the costs of the service had fallen from 3.75% in 1949/50 to 3.25% in 1953/54.

It was the Porritt Report (1962) that marked the first stage of the reorganization of the NHS. This Report was written by representatives of the medical profession who were independent of the Ministry of Health. It argued for local NHS administration under area health boards, thus promoting the administrative unification of health services at local level, and indicated the support of the medical profession for such a move. The Report reflected a major concern of the profession, namely the increasing gulf developing between GPs and their consultant colleagues. There were other sources of criticism of the division of the NHS into three parts including: The Cranbrook Report (1959), The Mental Health Act (1959) and The Bonham-Carter Report (1969).

Close on the heels of the Porritt Report was the Gillie Report (1963), which proffered a very different solution to tackling the pressures on the NHS. Rather than advocating a "unification" package, it suggested that greater efforts ought to be made to develop the role of general practitioners, so that they might contribute both to hospital and community care on behalf of their patients.



Both main political parties were at one in accepting the need for a unified structure, both were agreed that the best way of achieving this would be to transfer health services to local government, but both recognized that such a solution was not feasible in part because the medical profession was strongly opposed to this policy (Klein, 1983, p.91). There were also practical problems such as changing the boundaries of local government and the money-raising capacities of local government. Another option for the government was that of transferring local government welfare services to the NHS. However, the opposition of the local government lobby effectively ruled out this option. The main political parties were also at one concerning the need to align the boundaries of health and local authorities and to improve health service management (Klein, 1983, p.91). Interestingly, the demands for improving health service management were never more than demands. Conspicuous by its absence is any elaboration of what improved health service management meant.

The first government-led initiative to change the way health services were provided concentrated on the "tripartite problem". Kenneth Robinson, the Labour Minister of Health, announced a review of the structure of the NHS on the 6th November, 1967, which led to the Green Paper: *The Administrative Structure of Medical and Related Services in England and Wales* (HMSO, London, 1968). The main recommendations of the Report built on the Porritt Committee's suggestions. It argued for the unification of health services under an Area Health Authority (AHA) (some 50 were proposed which would be in direct contact with the Ministry of Health). A dual responsibility for planning and providing existing health services (hospitals, community and domiciliary care) was to be the distinctive feature of the AHA's. They therefore were to replace RHBs, boards of governors, HMCs and executive councils, as well as taking over various functions of the local health authorities.

Robinson proposed that the boundaries of AHAs would be coterminus with those of local government, serving populations between 750,000 and 2-3 million. Under the scheme, the Minister of Health would be the top policy-maker rather than manager of the service. Local authorities were to manage the service within the policy framework set by the Minister.

These proposals were partly shaped in anticipation of two other major inquiries at the time, namely the Committee on Local Authority and Allied Personal Social Services chaired by Frederick Seebohm (1968) and the Royal Commission on Local Government in England (1969), which recommended the creation of new local authority areas under unitary authorities grouped into eight provinces each with its own provincial council. Only the Seebohm recommendations were implemented (see The Social Services Act, 1970).

It fell to Richard Crossman, who succeeded Robinson as Secretary of State for Social Services in the new Department of Health and Social Security (DHSS), to take up the issue of reform in the second Green Paper *The Future Structure of the NHS* (HMSO, London, 1970). This Green Paper advocated the establishment of 90 AHAs which would be the main units of local administration, together with fourteen regional health councils charged with hospital and specialist planning between them and the DHSS. However in 1970, the Conservatives came to power, leaving Keith Joseph the task of working on health service legislation which was to lead, in 1974, to the first reorganization of the NHS.

The Conservatives' 1971 consultative document had a two-month consultation period and left out most of Crossman's proposals. It kept the idea of incorporating local area health services in the duties of the new area authority. It brought hospitals, health centres and community nursing services under new authorities which would, as in the



Crossman plan, match the boundaries of local authorities. There were three new proposals. Firstly, there was to be a strong regional authority to be responsible for planning, finance and building. In addition, regions were to have power to direct area authorities. Secondly, the larger AHAs were to be divided into districts, each run by a team of officers on a consensus management basis. (This is discussed in more detail on page 30.) Finally, a separate channel for local participation was proposed in the form of Community Health Councils (CHCs).

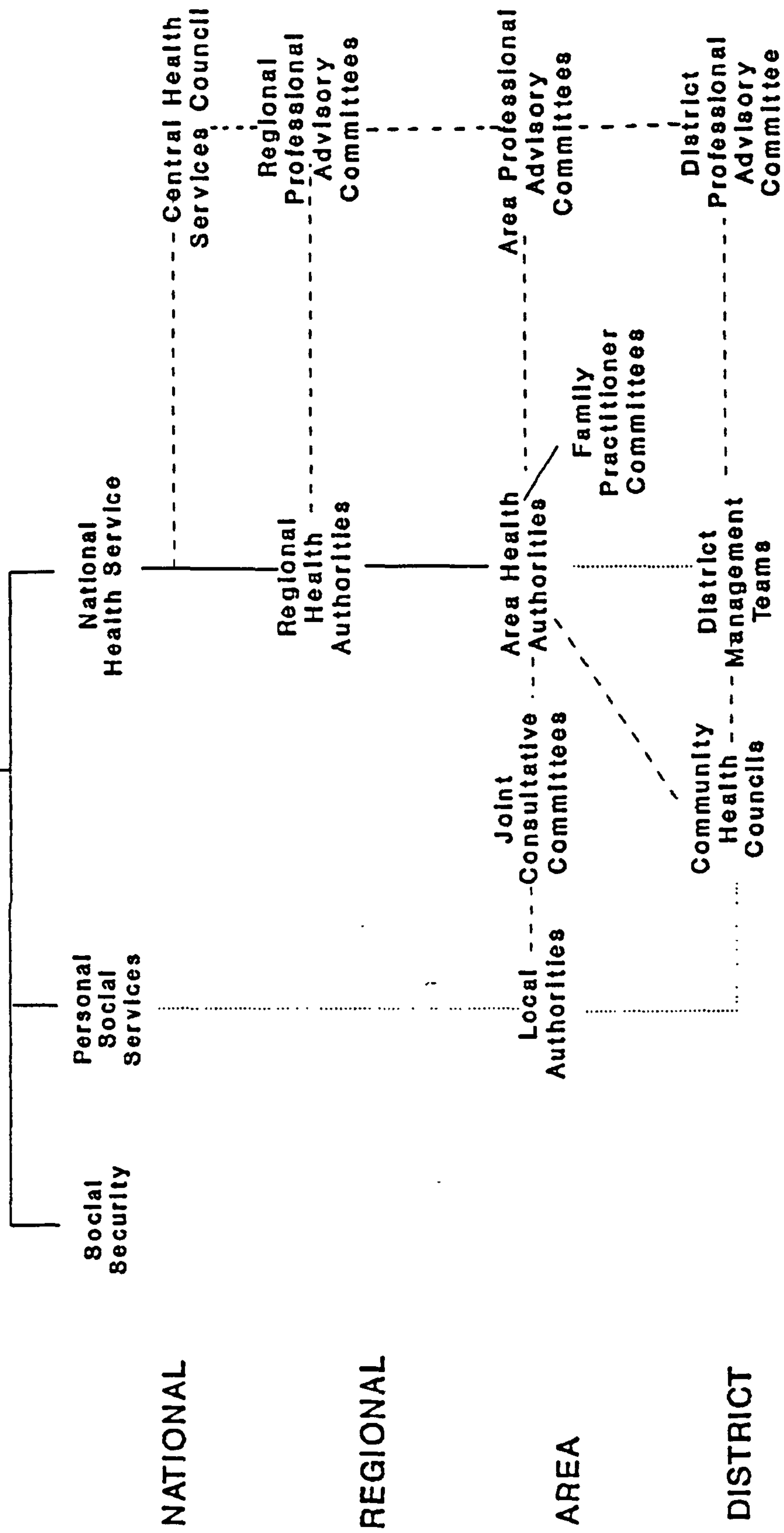
Joseph's proposals emphasized the importance of improving management efficiency in the NHS. He saw the management part of the package as his special contribution, and on describing the proposals said the main difference from earlier proposals was the emphasis they placed on effective management. Again, no clear elaboration was given as to what effective management meant. However, the clearest indication of what Keith Joseph meant by effective management is the consultative document announcement that two 'expert studies' had been commissioned by the DHSS: Brunel University's health service organization research unit was commissioned to consider detailed management arrangements for the new authorities and their staff, looking in particular at role relationships and the management consultants, McKinsey and Co. Inc. were paid to conduct trials with a few HMCs (Levitt and Wall, 1989, p.14).

The final report on the management arrangements for the reorganized NHS, known as the Grey Book, did not appear until the end of 1972. The DHSS issued a number of circulars to health authorities. These circulars and a newsheet - NHS Reorganization NAWS - were the only information available as there was very little public debate on the reorganization (Levitt and Wall, 1989, p.15). The NHS Reorganization Act was given Royal Assent on the 5th July, 1973. The final structure is shown below in Figure 2.



----- Consultation/Advice  
 ..... Other  
 \_\_\_\_\_ Accountability

Secretary of State  
for Social Services  
Department of Health  
and Social Security



Source: Management Arrangements for the Reorganised National Health Service, HMSO, 1972

FIGURE 2

The new arrangements for the NHS abolished the former tripartite administrative structure and established a structure with only parts of the environmental health services remaining under local authority control. The AHAs were corporately responsible for health care in geographical areas which were, on the whole, coterminous with the local authority metropolitan districts and non-metropolitan counties, except in the case of London AHAs where there were groupings of boroughs. In a single district AHA there was an Area Team of Officers (ATO) which supported the AHA members and held delegated executive power. Under the original 1974 arrangements, each AHA had 15 members, but in 1975 the new Labour government announced minor changes to the reorganization in the consultative paper *Democracy in the NHS*. These changes included an increase in the local authority membership of both AHAs and Regional Health Authorities (RHAs) to one-third of the total and the inclusion of two additional NHS staff members on each authority. The AHAs were responsible to RHAs for the running of services. In areas which had teaching hospitals within their boundaries, the health authorities were responsible for their administration and were known as AHA/Ts. In all there were 90 English AHAs, 16 of them in Greater London.

The AHAs were grouped together under 14 RHAs whose role was to translate national policies into a framework of regional objectives. RHAs were also charged with allocating capital revenue resources to ensure that national objectives were met as well as feeding back to the DHSS data about achievement of objectives and potential developments. The RHA's role was greatly influenced by the introduction of a national system of planning for health services in 1976, which was to be comprehensive in its coverage, encompassing all resources (physical and human) and all services. The system was to involve not only planners but also professional staff

through advisory committees, health care planning teams and the public, via CHCs. Central to the planning system were the twin concepts of guidelines and plans. Government guidelines informed regional plans and plans then informed guidelines. It was hoped that the planning system would be the vehicle to achieve the shift in the balance of care from the acute sector to community care which had become a government policy with the publication of *Priorities for Health and Personal Social Services in England* (1976). There were no direct equivalents to regions in Scotland, Wales or Northern Ireland, the equivalent to the English region being a common service agency.

The districts were intended to be the smallest units where the full range of general health and social services could be provided. Districts were to have populations of around 250,000 people. The key features of the NHS organization at district level are shown in Figure 3 below and include District Management Teams (DMTs), District Medical Committees (DMCs), Health Care Planning Teams (HCPTs) and Community Health Councils (CHCs).



# Framework of the District Organisation

Joint responsibility of team to AHA  
Individual officers accountable to AHA

**DISTRICT MANAGEMENT TEAM**

- Chairman, District Medical Committee
- Vice-Chairman District Medical Committee
- District Community Physician
- District Nursing Officer
- District Finance Officer
- District Administrator

**Medical Advice to Area Medical Advisory Committee**

- District Medical Committee
- Doctors Working in Public Health
- General Practitioners
- Medical & Dental Consultants
- Some Paramedical Services
- Dental Practitioners

**Attached by the AMOA**

- District Dental Officer
- Health Care Planning Teams

**General Administrative Services**

- Planning
- Information
- Personnel
- Secretariat etc

**Technical Accountabilities**

- Technically Accountable to the AWO: District Building & Engineering Officers
- Accountable to the APO: District Pharmaceutical Officer
- Direct AHA Appointees: Other Paramedical Services

**General Administrative Services**

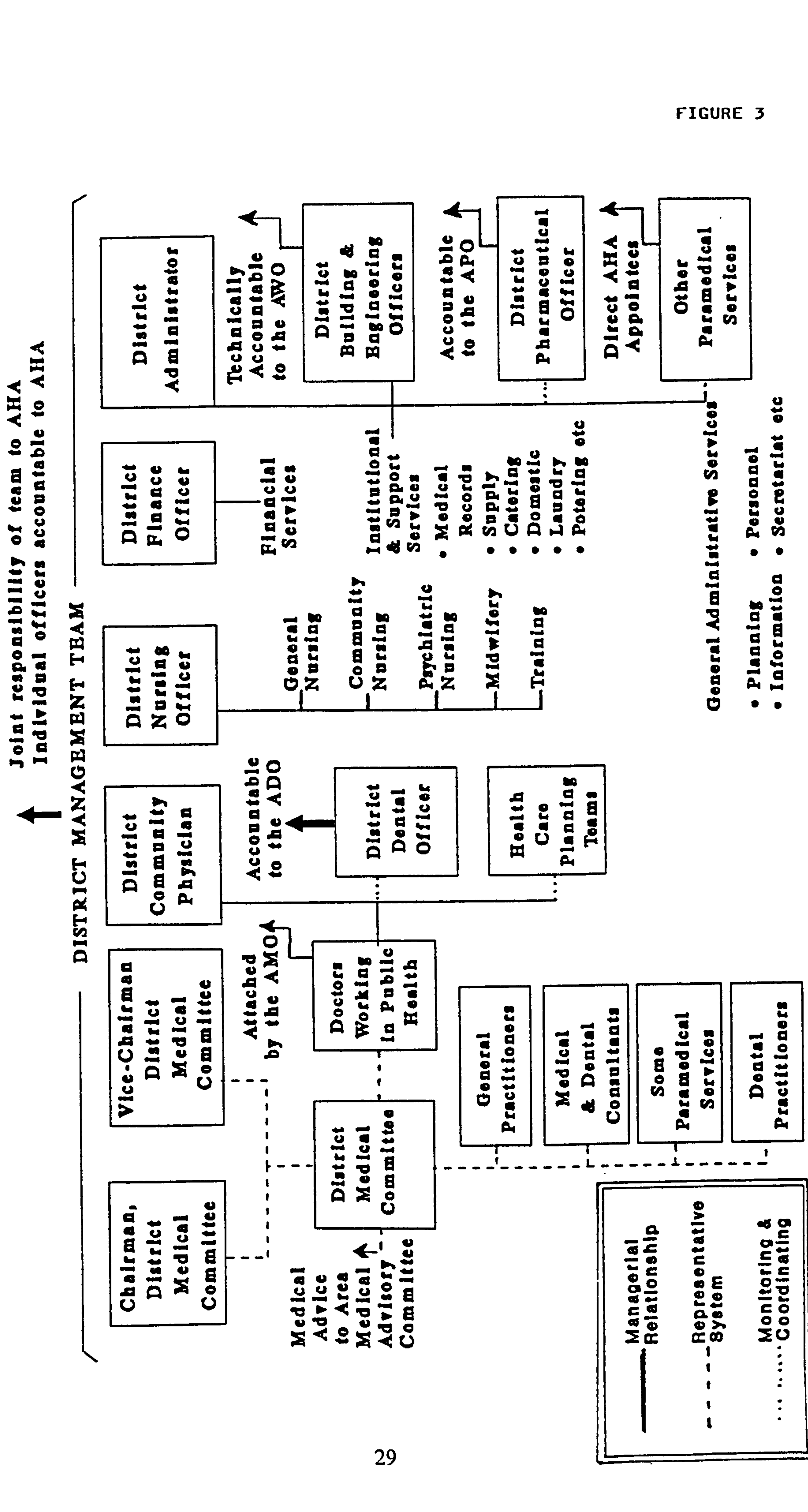
- General Nursing
- Community Nursing
- Psychiatric Nursing
- Midwifery
- Training
- Institutional & Support Services
- Medical Records
- Supply
- Catering
- Domestic
- Laundry
- Pottering etc

**Managerial Relationship**

- Representative System
- Monitoring & Coordinating

Source: Management Arrangement for the Reorganization of NHS, HMSO, 1972

FIGURE 3



Each DMT comprised a nursing officer, a finance officer, an administrator and a specialist in community medicine. It also included two members of the DMC, usually the chair and vice-chair, who represented local hospital consultants and general practitioners and who were the only members of the management team to receive special payment because it involved work outside their normal duties. These district officers were charged with managing and coordinating many of the operational aspects of NHS services within their localities and helping formulate the policies and plans for the future.

A common feature of all teams in all parts of Britain was to be their mode of decision-making: they were to be "...consensus bodies, that is, decisions...need the agreement of each of the team members" (DHSS, 1972, p.15). In the event of a difference of opinion between team members, the health authority was to be called in to resolve the issue concerned. The four non-elected DMT officers were also individually responsible to the AHA as the heads of their respective managerial hierarchies. Harrison notes that although the formal proposition for introducing consensus management was set out by a study Group of DHSS and NHS officers assisted by Messrs. McKinsey and Co. and the health services organization research unit of Brunel University, it is possible to see consensus decision-making as "an extension and formalization of a de facto practice which had been gaining ground in the NHS over a number of years". He notes competing rationales for the introduction of consensus management which he describes as unitary and pluralistic (Harrison, 1982, p.378). The unitary rationale is based on the premise that the parties involved in the decision-making process each have objectives which do not fundamentally conflict. The emphasis is thus upon joint problem-solving to solve management problems, which in itself, bears a marked resemblance to rational prescriptive models of decision-making (Hunter, 1979, p.323). The pluralistic rationale allows for the existence of legitimately differing interests within the organization. It is a pragmatic



recognition that the NHS is organized around functional and professional hierarchies and collegially organized professions, hence no practical alternative to team management exists, as a mode of decision-making by such teams (Harrison, 1982, p.379). Interestingly team management sat within a bureaucratic structure which meant that decisions from the team had to receive approval from the health authority but also from the management tier above.

Other bodies associated with the 1974 reorganization are briefly described below. The DMC consisted of ten members drawn from hospital and community medical staff (including dentists). The HCPTs were set up to draw together professionals concerned with particular groups of clients or patients. Each team was to examine the existing level of service and make recommendations to the DMT for improvements. Membership of the teams was decided by the DMT and formally approved by the AHA. Later HCPTs changed that title to District Planning Teams (DPT), but their function remained the same.

The CHCs were, in theory, to act as public watchdogs with regard to the development of health services (and hospital closures). They were not part of the formal management structure but were allowed access to NHS plans and premises. They were to meet with the AHA annually and publish reports to which the AHAs were obliged to reply. Most CHCs had between 18 and 30 members of whom half were appointed by the local authority, one-third by local voluntary organizations and the remainder selected by RHA. CHC membership was worked out principally on the basis of the resident district population. Generally each CHC had two full-time staff - the secretary and his or her assistant. Research on CHCs reviewed in Chapter 4, suggest they were relatively weak in terms of influencing the policy processes (Brown, 1975, p.193; Ham, 1977).



To recap, the 1974 reorganization was intended by government to meet four goals:

1. To unify health services by bringing under one authority all the services previously administered by the RHBs, HMCs, boards of governors, executive councils and local health authorities.
2. To improve coordination between health authorities and related government services, in order to achieve a more integrated service.
3. To improve the management of the NHS. To this end the 'Grey Book' set out very detailed notes on the functions of each tier as well as providing job descriptions for health authority officers. Other examples given by the government of the emphasis on better management included the introduction of consensus management and the principle of maximum delegation downwards, matched by accountability upwards embedded in the new planning system.
4. To provide effective central control of the money spent on the NHS thus ensuring value for money.

It is interesting to compare these goals with the major pressures for change identified by Draper, Grenholm and Best earlier in this chapter. What is missing from official documents is any commentary on how the reorganization would assist the consumers of health care - that is patients - or the communities which local health services serve. Additionally, it is difficult to imagine how the essentially mechanistic, command and control structure characteristic of the reorganization could begin to deal with the complex pressures on the provision of health care or influence existing patterns of health care delivery discussed earlier. Furthermore, Draper, Grenholm and Best argue that the 1974 reorganization constitutes a shift away from the principles of

participative democracy on which the NHS was founded, towards an authoritarian bureaucracy to which they attribute the following characteristics:

"Authoritarian bureaucracies aspire to work from the top down; decisions are made at the top of the bureaucracy and, in the bureaucratic idea, move progressively down to the working level. People at that level are not expected to make the decisions that determine their work nor the conditions under which the work is carried out. When people at working level are the recipients of services, as in the NHS, they are even less expected to contribute to the processes of deciding what those services should be. The primary obligation of both providers and recipients is to know their place, and to follow the orders of their betters, that is, the providers, in the case of the patients, and hierarchical superiors in the case of the providers." (Draper, Grenholm and Best, 1976, p.286)

In their view, the 1974 reorganization is an important indicator that society is moving away from the idea of democracy as participative and toward the idea that democracy is administered.

It is difficult to see how the eventual structure could be said to have met the specific goals of the reorganization. It is true that the reorganization went some way to producing an integrated service. For example, the new AHA boundaries were coterminous with local authority boundaries (that is, they had identical boundaries) underlying the need for close collaboration between all parts of the health service. However, there were significant anomalies. For instance, FPCs continued to have direct links with the DHSS, and continued to administer contracts of GPs, dentists, opticians and pharmacists. In addition, not all local government health services were transferred to the NHS with, most notably, environmental health services remaining



within local government. These anomalies threatened the goal of improved coordination as indeed did the indifference of the government to the psychological or social effects on health of general social and economic policies, such as those related to taxation, housing or transport and the importance of closer links with social services (Draper, Grenholm and Best, 1976, p.276).

Keith Joseph's "special contribution", that is the emphasis placed on improving the management of the NHS, drew a great deal of fire from the health service press at the time. Specifically it was criticised for reflecting an essentially out-dated concept of management based on the importance of hierarchy and control. In part, this reflects the progressive delineation of skill areas that had taken place in parallel with the moves towards reorganization (see the Salmon Report, 1966, which made recommendations for the development of a senior nursing staff structure and the Cogwheel Report, 1967, which advocated special groupings that could arrange administrative medical work more efficiently).

The emphasis on hierarchy and control is evident if one looks at the effects of the opportunities for public participation in decision-making. As a result of the reorganization, power was largely concentrated at the upper levels. Members of RHAs, regional chair and the AHA chair, were chosen by government. AHA members had to be approved by the RHA. Members of the new authorities were chosen on the basis of personal qualities rather than as representatives. In these respects, policy-control is clearly seen as the province of managers and the Centre and not those directly affected by the policies, with the consumers' voice being channeled through the CHC, a body with no executive power and which subsequently had little impact on policy decisions (Brown, 1975; Klein and Lewis, 1976; Ham, 1977; Haywood and Alazewski, 1980). Johnson, writing about CHCs, notes three key issues facing them: deciding who is the community and what the community



wants; influencing health care policy when CHCs have "no teeth" and dealing with the power relationships which separate the professional from the consumer (Johnson, 1975, p.91). The reorganization documents gave no indication of how CHCs were to find out what the public wanted or how to intervene in existing power structures.

Another example of a shift from participatory democracy towards authoritarian bureaucracy can be found in changes to the role of the MOH. This job traditionally was a professional role, with the MOH being given the brief to speak out in the public interest. Under the new arrangements, the MOH became a community physician tied into the management structure whose task it was to assess the needs of the population by technical means.

Draper, Grenholm and Best warn that it would be inaccurate to characterize all the features of the reorganization as being those of a techno-bureaucracy; some features, such as the principle of 'clinical autonomy' for doctors continued the pattern of professional organization(1). Consensus management also reveals a different approach, which sits uncomfortably alongside notions of hierarchy and control.

The question of whether the 1974 reorganization gave better value for money is difficult to gauge. I approached the Department of Health and various health economists and it seems there are no helpful figures to enable one to make an assessment.

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(1) Klein argues the reorganization set the 'voice of the expert' into the concrete of the institutional structure, even more firmly than Bevan's design had done. Doctors (and nurses) were represented on both regional and area authorities; the profession had a complex advisory machinery which was to articulate professional opinion and the DMT gave representatives of the medical profession veto rights. Klein argues such extensive concessions should be viewed not so much as a victory for the corporate organizations of the medical profession, but as an acknowledgement of medical syndicalism. (Klein, 1983, p.95)

It is important to examine the broader social context at the time of the reorganization in order to begin to understand why the reorganization took the form it did. In the late 1960s and early 1970s, scientific management principles were in vogue (see Taylor, 1947 and Fayol, 1949 for clearest examples of this). Effective management, according to this tradition was contingent on management defining the right needs and priorities for the organization as well as emphasising the importance of organizing, commanding, co-ordinating and controlling. The assumption was that organizational problems were due to the failure of the rationality of the organization and could be corrected by an array of management techniques. This tradition was mirrored in health services research at the time which consisted mainly of evaluating biological results of health services often via random control trials. There was little research done exploring how the public perceived the organizational and managerial issues of the NHS and little research of managerial processes in the NHS.

The reorganization is also indicative of the enthusiasm for structural reform prevalent in the 1960s and early 1970s, associated with the view that technology is a morally and politically neutral medium of social progress (Alaszewski, Tether and McDonnell, 1981, p.5). The common characteristics of structural change in the public sector in this period included: an emphasis on service coordination or integration, an emphasis on community involvement, attempts to incorporate professionals in management and a concern with skilled and efficient management. The similarities in the changes public sector services can be partly explained by restructurings in the public sector being overseen by a common stock - the Brunel health service organization research unit and the consultants, McKinseys.

The poor quality of the press and media coverage of the reorganization meant that some of the obvious anomalies inherent in the restructuring and the wider issues raised so cogently by Draper, Grenholm and Best, were not aired. The first BBC TV



programme on the reorganization was broadcast on the 6th July, 1973 after the Bill had received Royal Assent (Draper, Grenholm and Best, 1976). The public were, in the main, oblivious to the changes. Eskin in her survey of public knowledge of the reorganization, found that only 10 out of her 100 sample knew the reorganization had occurred (Eskin and Newton, 1977).

### Towards the second reorganization of the NHS

In May 1976, Barbara Castle, the Labour Health Minister, invited Sir Alec Merrison, Vice-Chancellor of Bristol University, to chair a Royal Commission on the NHS with the following terms of reference:

"To consider in the interests both of the patient and those who work in the National Health Service, the best use and management of the financial and manpower resources of the National Health Service." (Royal Commission on the National Health Service, HMSO, London).

The 16 members of the Royal Commission were drawn from a variety of interests. It took three years to deliberate at a cost of £918,000. Evidence was sought from a variety of sources, including six specially commissioned studies. The Commission reported in July 1979 praising the principles of the health service and its achievements but critical of the management of the NHS, in particular the number of tiers (fears about tiers was a buzz phrase at the time) and administrators, as well as the inability of those managing the NHS to produce what was considered real value for money.

Just as the incoming Labour government in 1974 had inherited a reorganization not of its own making, the new Conservative government elected in May 1979 had to



respond to a Royal Commission not of its own creation. The government issued a consultative document on the structure and management of the NHS in England and Wales: *Patients First*, in December 1979, which adopted a rather different line from the 1974 restructuring. It argued there should be more delegation so that decisions were made nearer patients, that DHAs should be strengthened and the area tier removed. In addition it argued for the simplification of the professional consultative machinery.

*Patients First* had a four-month deadline for consultation. The government's proposals were published in July 1980 in a Circular (HC (80)8). There was little change from the proposals outlined in *Patients First*. HC(80)8 set out the criteria for the establishment of DHAs:

"DHAs should be established for the smallest geographical areas within which it is possible to carry out the integrated planning, provision and development of primary care and other community health services, together with those services normally associated with the District General Hospital (DGH), including those for the elderly, mentally ill and mentally handicapped. The new authorities should not necessarily be self-sufficient in all these services. They should as far as possible comprise natural communities and the boundaries of one or more DHAs should normally be coterminus with the boundary of the social services or education authorities." (Chaplin, 1982, p.11)

To minimise disruption, the new DHAs were to follow the boundaries of existing districts or single-district areas. RHAs were required to draw up proposals for dividing their regions into districts and, after consulting local interests, submit them to the DHSS. The new DHAs were formally to take over responsibility from AHAs

on the 1st April, 1982. RHAs were unaffected by the dissolution of the AHAs and creation of the DHAs, except that a few boundary changes were made in the Thames regions where new districts were created which crossed existing regional boundaries.

In the new DHAs the management teams remained the same, namely administrator, treasurer, medical officer, nursing officer, consultant and general practitioner representative who were accountable to DHA members. The circular emphasized that consensus management must not be allowed to blur the individual responsibility of team officers for the services that they manage, and that the administrator was to have an important co-ordinating role. The new district authorities were to arrange their services into units of management (often centred on a hospital or a community unit). These were not closely defined, but the DHA was to decide what was desirable and possible within the cost limits allowed.

Instead of 90 AHAs, there were to be 190 DHAs. FPCs continued to act independently from DHAs as they had done in relation to AHAs. CHCs were to be retained, one for each district. The number of members of the health authorities at region and district was to drop from 24-30 to 18-24.

The structure of the NHS after 1982 is shown below in Figure 4.

# The Structure of the NHS after 1982

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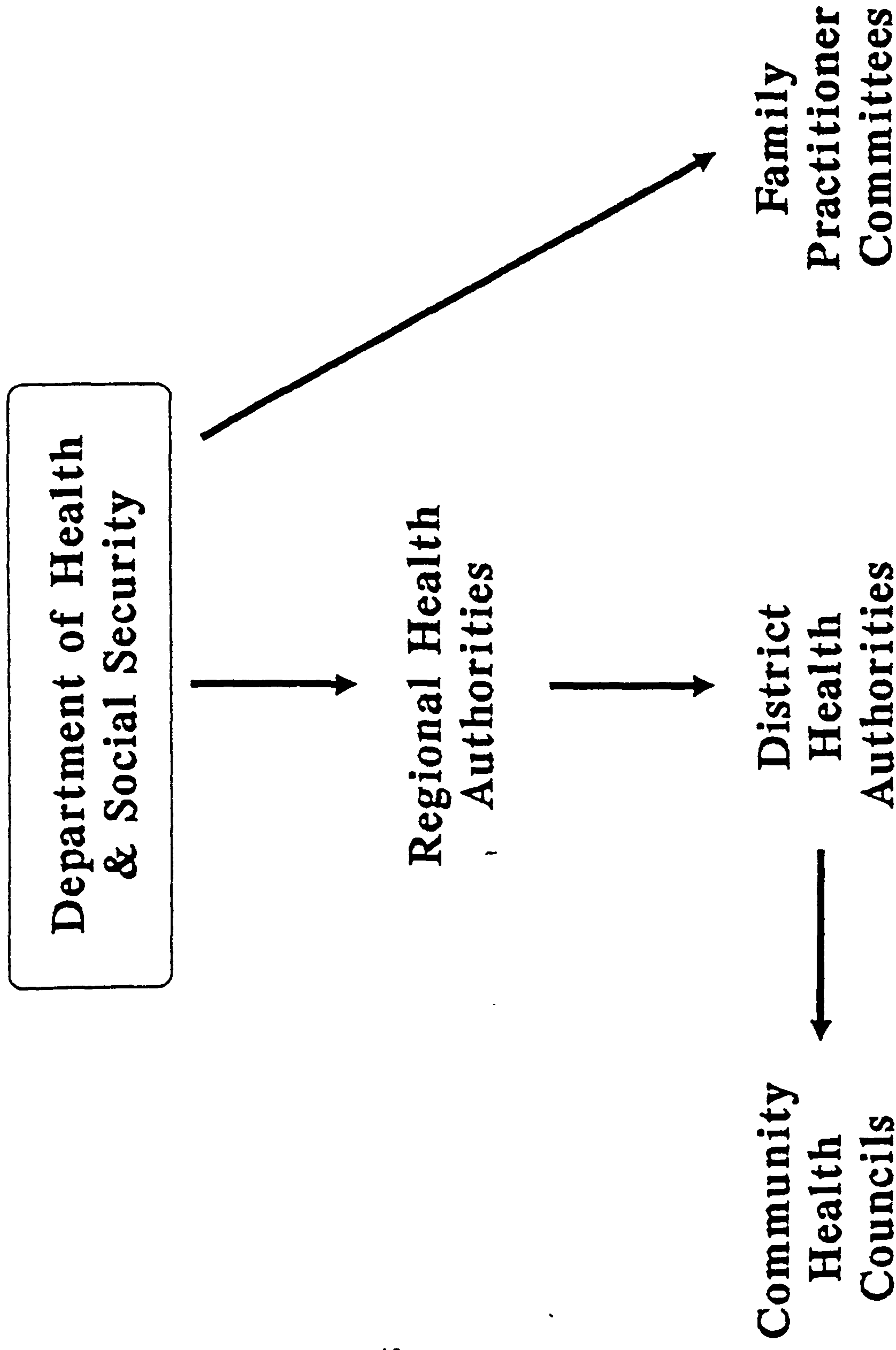


FIGURE 4



In the second reorganization documents, there was less emphasis on the ideology of rational and scientific management. Alaszewski, Tether and McDonnell highlight five areas of difference from the 1974 proposals: a greater emphasis on patients; a search for a natural community for administrative units; increased local autonomy; simplified managerial relationships and a simplified process of decision legitimation (Alaszewski, Tether and McDonnell, 1983, p.13). The authors go on to claim:

"Whereas the 1974 reorganization was about organization and efficiency, the new (restructuring) is about patients; 1974 involved centralization, the new emphasis is local autonomy, 1974 was about refined and sophisticated managerial relations, the new (restructuring)...will create simple and robust relations (Alaszewski, Tether and McDonnell, 1983, p.3).

Nonetheless both reorganizations were essentially bureaucratic attempts to manage the complex and evolving demands on health services and meant that the complex interdependencies of groups and individuals working within the NHS became more complex.

### Why a bureaucratic reorganization?

The level of debate concerning why the NHS has taken the essentially bureaucratic form it has up to 1983 is, frankly, disappointing. There are some excellent histories of the formation of the NHS (Willcocks, 1967; Foot, 1973; and Webster, 1988), some informative textbooks (Levitt and Wall, 1984 being a particularly useful one), but little analysis of the social-structural processes that have played a part in the various reforms of the NHS. In his book the "Politics of the NHS", Klein argues that the NHS emerged in 1948 as an extremely complex structure because policy-makers tried

to achieve a variety of policy aims, while seeking to preserve consensus and avoid conflict. The conflicting policy aims he spells out are: "to promote managerial efficiency, to satisfy the medical profession, to create an effective hierarchy for transmitting national policy, but also to give scope to managers at the periphery" (Klein, 1983, p.99). However, most of the debate about the reorganizations of the NHS has centred on the view that change is difficult because of the 'special' characteristics of the NHS and the complex issues involved in health care delivery as reviewed by Draper, Grenholm and Best. A brief discussion of the 'special' characteristics of the NHS is given below as well as points made as to why these characteristics render a bureaucratic response inappropriate.

Those writing in the public administration tradition highlight the following factors as increasing the difficulties of successfully introducing change: less market exposure resulting in less incentive to reduce cost or to operate efficiently; a wider stakeholder interest than the private sector, most notably politicians, taxpayers and voters; the existence of pressure group influences because resources are both finite and limited and are distributed as an act of political will and the existence of customers, clients, consumers and citizens which makes it difficult to define who the customer is. Flynn et al (1988) argue that environmental scanning is more difficult for public sector managers because of the perennial uncertainty as to which specific issue will in practice become politically significant.

Organizational constraints are often cited as yet more 'special characteristics' of the public sector that make introducing change difficult. Ring and Perry (1985) put forward five key constraints on public managers at the organizational level: policy directives tend to be more ill-defined for public than for private organizations; the relative openness of decision-making creates greater constraints; public sector policy makers are generally subject to more direct and sustained influence from interest



groups; public sector management must cope with time constraints that are more artificial than those that confront private sector management and policy legitimisation coalitions are less stable in the public sector and are more prone to disintegrate during policy implementation.

Another organizational factor impeding the implementation of change often cited in this literature is the existence of professional structures. A point often made is that since the NHS is a highly professionalized organization, relying on high-trust collaborative work relationships, the two major modes of controlling behaviour - professional and bureaucratic authority - fundamentally conflict, hence jeopardising change. Talcott Parsons has been credited with prising open the notions of profession and bureaucracy. In a much-quoted footnote inserted by Parsons into his translation of Weber's work (Weber, 1964), Parsons argues that the authority of expertise constitutes a special problem for the bureaucratic organization (Davies, 1983, p.182). Scott (1966) offers perhaps the clearest statement of the popular conception of the two institutional forms. A professional, he notes, carries out a complete task; he or she does so on the basis of special knowledge acquired through training; he or she is loyal to the company of equal professionals rather than to the bureaucratic organization; as a practitioner he or she has arrived at a terminal status and seeks no higher position within the organization. This contrasts with the caricature of the bureaucrat who is seen to carry out a limited set of tasks which must be co-ordinated with others; the training involved in becoming a bureaucrat is relatively short and accomplished within the organization; supervision of work is done by a hierarchical superior and the bureaucrat is subject to sanctions if he or she does not follow the rules. Generally loyalty and career are tied to the organization (Davies, 1983,



p.178)(2). Figure 5 below devised by Celia Davies, drawing on Scott's work, sums up these divergent perspectives.

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(2) A number of studies have been carried out looking at professionals working within bureaucracies (Wilensky, 1964) and into appropriate organizational structures, enabling the utilization of professional skills. (Litwak, 1961, Scott, 1965, Etzioni, 1974). Some of this research has demonstrated that the two institutional modes can sit comfortably side-by-side and that projected role conflicts can be dealt with by individuals. (Benson, 1973, Daniels, 1975). Rueschemeyer points out that more circumspect analysis of professionalization acknowledges that expert occupational groups have not been deprived of their knowledge-based discretion and autonomy at the workplace in either public or corporate employment (Rueschemeyer, 1986, p.126). This evidence has brought into question the idea of an incipient proletarianization of knowledge-bearing occupations. (Oppenheimer, 1973).

	BUREAUCRACY	PROFESSIONALISM
TASK	PARTIAL, INTERDEPENDENT WITH OTHERS	COMPLETE, SOLE WORK
TRAINING	SHORT, WITHIN THE ORGANISATION, A SPECIALIZED SKILL	LONG, OUTSIDE THE ORGANIZATION, A TOTAL SKILL
LEGITIMATION FOR ACT	IS FOLLOWING RULES	IS DOING WHAT IS TO THE BEST OF HIS KNOWLEDGE CORRECT
COMPLIANCE	IS SUPERVISED	IS SOCIALIZED
LOYALTY	TO THE ORGANIZATION	TO THE PROFESSION
CAREER	ASCENT IN THE ORGANIZATIONAL HIERARCHY	OFTEN NO FURTHER CAREER STEPS IN THE ORGANIZATION

A model of professional/bureaucracy conflict (after Scott 1966) - From Davies C. Professionals in Bureaucracies: The conflict thesis revisited, in Dingwall R & Lewis P. The Sociology of the Professions. 1983. pp177-194

FIGURE 5

Studies of relationships within hospitals have questioned the view that health care organizations consist of a rigidly structured set of relationships (Szasz and Hollender, 1956, Strauss, 1973, Bloor and Horobin, 1974, Jeffereys and Sachs, 1982). Although such studies can be criticized for ignoring wider structural constraints on behaviour, they are useful in pointing out the lack of a traditional bureaucratic hierarchy within certain aspects of hospital and general practice work. Strauss and his colleagues introduced the concept of "negotiated order" to elucidate hospital-life (Strauss, Ehrlich and Sabshin, 1973). Their analysis is based on the assumption that within hospitals, official rules are rarely specific enough to guide the daily or hourly interactions of people, which are therefore subject to negotiation (Morgan, Calnan and Manning, 1985, p.150). Strauss et al suggest that daily life in health care settings is organized around a series of bargains struck and forgotten, or re-negotiated from time-to-time.

Another source of support for the view that the NHS is not suited to a bureaucratic structure can be found in the organizational behaviour literature which reflects on organizational structure in the private sector. The trend since the early 1980s has been to move away from pyramidal bureaucratic structures to more flexible organizational arrangements, a more participative management style and an increased emphasis on teamwork. The catalyst for these trends has been a recognition of the increasing complexity organizations have to face, for example increased competition, political pressures for change, information technology, social pressures for change such as equal opportunities. The argument has been that flexible organizational structures are best-suited to cope with this more turbulent environment (Peters and Waterman, 1982; Handy, 1989). Health service organizational theorists as well as medical sociologists have shown a great reluctance to consider recent trends in the private sector in making their case for a change in the structure and organization of the NHS.



Finally, it has been argued that a bureaucratically structured NHS will not assist in meeting the health needs of the population served. Various authors writing in the medical sociology literature note that bureaucracy is slow in reacting to changes in health needs (Doyal, 1980; LeGrand, 1980; Townsend and Davidson, 1982) and is not sensitive to the ways in which health needs are filtered. Various studies have demonstrated that health services deal only with a small proportion of health problems present in a population at any particular time, most symptoms occurring without any contact with formal health services. The findings of Wadsworth et al (1971) reported in Figure 6, are typical of retrospective studies in this area.

# *Two-Week incidence of symptoms and subsequent behaviour in* a random sample of 1000 adults living in London

Individuals with no symptoms	49
Individuals with symptoms taking no action	188
Individuals with symptoms taking non-medical action	562
General practitioner patients	168
Hospital out-patients	28
Hospital in-patients	5
Total	1000

Adapted from Wadsworth et al. (1971)

FIGURE 6

Figure 6 shows that 95% of a sample of 1,000 adults had experienced symptoms in the fourteen days prior to interview. Only 1 in 5 people had consulted a doctor. Class, gender and age appear to be significant influences on whether a doctor is consulted (Dingwall, 1976; Cartwright and Anderson, 1981; Pill and Stott, 1982). Such studies confirm the existence of a significant clinical iceberg: that is health services treat only the tip of the sum of the total of ill-health.

We know from the medical sociology literature that health care problems pass through a series of filters. The initial filter is the person-with-the-illness who makes the judgement, perhaps after consulting family or friends, about presenting himself or herself to a health practitioner. A second filter is the GP, who is a filter in two ways. Firstly, there is research evidence that GPs may not recognize many problems presented to them (Wilkin et al, 1987). Secondly, the GP's decision to refer is a significant filter. The third filter is a hospital consultant. Once a patient reaches the hospital, it is the consultant who decides whether and how to treat the patient, what tests to request, when to admit and when to discharge. A bureaucratic system does not cope with these processes well for two main reasons. Firstly, as a formal centralized system it can only cope with conventional methods of entry and relies on the GP to trigger off processes to deal with people's demands for health care. Secondly, the lack of community participation in health care provision decisions and absence of communication channels with the community means a bureaucratic system is insensitive to many of the population's health care needs and preferences for the delivery of health care.

There are, however, various aspects of providing health care that a bureaucracy can do well. For example, collecting data on demographic change and anticipating the effects of such change on demand for health services; monitoring technological change and advances in scientific medicine; examining the consequences of scientific



advances in terms of shifts in disease prevalence and impact on the most suitable type of care, acute or community.

Bureaucracies are also well placed to oversee the allocation of resources, both to the NHS and within it. About 75% of health service expenditure is on hospital and community health services, and 25% on family practitioner services. Hospital spending accounts for 90% of the former, and community services for 10%. Spending on drugs prescribed by GPs accounts for about 45% of expenditure on family practitioner services, services provided by GPs for about 30%, dental services for 20%, and ophthalmic services for 3% (Dopson and Fitzpatrick, 1990, p.25). Up until 1983, bureaucracy has been used by the NHS to redistribute resources to promote geographical equity and to alter the priorities between services. To achieve the former, the Department of Health has been using methods recommended by the Resource Allocation Working Party (RAWP) in making allocations to regions, and regions have been making district allocations on a similar basis (although each region varies somewhat in its method for sub-regional allocations). The RAWP method of allocation is based on capitation (the number of people served by an authority or board) not by the services actually provided. But because residents of one area often use the services of another, RAWP allocations also try to take account of these cross-boundary flows. The adequacy of the capitation element and the adjustment for cross-boundary flows have been contentious.

The second form of redistribution of resources - altering the priorities between services - has similarly drawn on bureaucratic processes. For example, the 1962 NHS hospital plan introduced a programme for the building of new acute hospitals and when these hospitals were completed there was generous funding of their revenue consequences. Then, in the 1970s, new priorities emerged, in particular the need to improve services which had been neglected - services for the mentally ill and

handicapped, the elderly and children. The emphasis has been on shifting the balance of care away from institutions to the community, supported by statutory or voluntary services. This has seen an increase in the number of agencies involved, creating enormous problems of co-ordination of care and in devising suitable budgetary and financial frameworks to ensure good services.

Bureaucracies can also ensure that the need to measure outcomes of health care are put firmly on the agenda of those working in the delivery of health services. However up until 1983, remarkably little effort had gone into assessing outcomes in a systematic fashion or to examining ways of assessing client-satisfaction.

### Chapter 2 revisited

The Government in 1974, and again in 1982, chose to seek bureaucratic solutions to important value judgements such as 'what is health?' and 'what should health services do?' (Alaszewski, Tether and McDonnell, 1983, p.12) and ignored debating the complex and evolving demands facing health care services and ways in which it might be possible to meet these in the context of financial constraints. The 1974 reorganization in particular was indicative of the government's view that the problems of the NHS resulted from a failure of rationality. Bureaucratic accountability was thought to be an important way of managing clinician power, acknowledged as skewing patterns of care and one of the main factors leading to escalating costs. It has been argued by many people that a bureaucratic restructuring was an inappropriate response to dealing with the complex pressures facing the NHS and the growing interdependency of those delivering health services. Specifically the chapter documented a number of arguments put forward to this effect, notably the conflict between professional and bureaucratic authority; the lack of bureaucratic hierarchy within certain aspects of hospital or general practice work; the notion of the 'special'

characteristics of public sector organizations and the inability of bureaucracies to meet health needs. A number of positive points about bureaucracies and health care delivery were made, namely that bureaucracies may be an appropriate structure for collecting important data on demographic change, monitoring technological change and allocating resources. It remains to consider the third reorganization of the NHS and to what extent this reorganization differed from its predecessors.



## CHAPTER 3

### The Griffiths Report: An Act of Faith?

#### Purpose of the chapter

Until 1984, the NHS had two unusual organizational characteristics: the national uniformity of its senior management structures, and the practice of "consensus management". Just as the dust of the NHS's second major reorganization was beginning to settle, what was seen by the government as the inability of the NHS management to achieve significant improvements in cost containment or unit management was cited by Minister Norman Fowler as evidence of the need for further change. Four leading businessmen were to conduct an independent management inquiry into the:

"...effective use and management of manpower and related resources in the NHS from professional managers with experience in other large organizations." (DHSS 1983 NHS Management Inquiry; Press Release No 83/30 3 February)

This chapter considers the details of this inquiry, known as the Griffiths Report. It examines the critique of the NHS as developed in this Report, the Griffiths recommendations for the NHS and the reactions to the Report from the various groups who work in the NHS. The chapter argues that there are a number of important assumptions inherent in the Report which merit further study.

## Background to the Griffiths Report

The Inquiry was led by Roy Griffiths, deputy chair and managing director of Sainsbury's food stores. Other members of the team were: Jim Blyth, group finance director of United Biscuits, Sir Brian Bailey, chair of Television South-West and Mike Bett, board member for personnel at British Telecom. The team also included a number of civil servants: Cliff Graham, a senior civil servant who was involved with the Rayner scrutinies on health care expenditure (1982), Kay Barton and Tim Stephens, who came to the Inquiry from the Permanent Secretary's office.

The government justified the selection of the Griffiths' team on the basis that each member had relevant expertise in meeting the needs of the public in very different ways (Barton, 1984). However, the selection of the team was a source of controversy. Davidman, for example, argues:

"What is completely missing from the Inquiry team is grass roots representation of any kind, from all those who would be affected by the Inquiry's findings, namely doctors, nurses, technical, ancillary staff, NHS patients, the community at large, the civil service, community health councils and trade unions". (Davidman, 1984, p.3)

Members of the Griffiths team were frequently reminded by the health service press that the NHS was not a supermarket or a biscuit chain. The inquiry team were sensitive to these criticisms, and attempted in the Report to clarify their remit.

"We were brought in not to be instant experts on all aspects of the NHS, but because of our business experience, to advise on the management of the NHS" (The Griffiths Report, 1983, p.10).

This argument is taken a stage further when the Report claims that the differences between the NHS and business in management terms, "had been greatly overstated":

"The clear similarities between NHS management and business management are much more important. In many organizations in the private sector, profit does not immediately impinge on large numbers of managers below board level. They are concerned with levels of service, quality of product, meeting budgets, cost improvement, productivity, motivating and rewarding staff, research and development and 'long-term viability of the undertaking' (The Griffiths Report, 1983, p.10).

Within the 9-month limit set by the government for the Inquiry, the Griffiths' team was given a free hand in how it collected the evidence. Rather than inviting evidence formally, the team was "open to advice, invitations and written evidence". Initially many of the invitations they were offered were accepted, but the team became increasingly selective, concentrating on the DHSS, unit level, regions and districts in that order (Barton, 1984). There was no detailed examination of the interactions between GPs, hospitals and community health services in providing health care. The Report itself does not include, as do, for example, Royal Commissions, a list of visits, nor a list of those who sent evidence for the Inquiry to consider.

As a general comment, the Inquiry team seemed more definite as to what it was not, rather than what it was. Its task was not: "a manpower inquiry", "a remit to change the statutory system or organizational financing of the NHS", "a search for specific areas in which costs might be cut", "a search for areas that might be contracted out to the private sector", nor was it "to cover Scotland, Wales and Northern Ireland" (The Griffiths Report, 1983, p.24). It was definitely not intended to be a major addition to



the already "considerable library of the NHS literature"; rather the recommendations were shaped with an eye to the practicality of implementation (The Griffiths Report, 1983, p.1). Therefore, for the sake of achieving actions on its own recommendations, the Inquiry team decided not to suggest changes in legislation but confined itself to "recommendations within the existing system" (The Griffiths Report, 1983, p.2). This suggests that it is easier to achieve changes within the existing system rather than via legislation, a view contradicted by existing studies of local health care management discussed in Chapter 4.

It is interesting to note Sir Roy Griffith's account of the background to setting up the Inquiry. In a guest lecture to the Audit Commission, he stated:

"The background to the setting up of the Inquiry was the tremendous parliamentary questioning on the waste and inefficiency in the Service.(3) We were not at the outset asked to write a report, and the impression given was that we should simply advise at appropriate meetings, the whole exercise taking say a day a month for about eight months. Eight-and-a-half years and two days a week later I smile ruefully. Once we became involved, however, the noise level in the NHS reached almost unprecedented heights and Margaret Thatcher after three months requested that we should write something, however briefly, to encapsulate our observations and main recommendations. Since I and the other members were all working full-time for our respective companies we compromised by writing a 23 page letter to the Secretary of State simply saying without an exhaustive sweep of the options what we would do in his place." (Griffiths, 1991, p.2)

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(3)The Griffiths Report gives no objective evidence of waste and offers no comparison

There are some interesting clues in this quotation about the assumptions in the Report and about the constraints under which the team worked which are discussed later.

### The Griffiths critique of the NHS

The Griffiths' Report, as the Inquiry became known, was published in October 1983. It takes the form of a letter to the Secretary of State and consists of recommendations for action as well as observations and some ten pages of background notes. Although brief, the Report sparked off a surge of interest, anxiety and controversy which has continued well after the Griffiths' post mortem.

The Report points to five areas of alleged weakness, documented in the 'Observations' section of the Report.

A lack of strategic central direction.

A lack of individual managerial responsibility.

A failure to use objectives as a guide to managerial action.

A neglect of performance.

A neglect of the consumer (Hunter, Harrison, Marnoch and Pollitt, 1988, p.1).

These criticisms are elaborated but not illustrated - still less validated - by various assertions scattered in the Report.

**1. The NHS lacks strategic central direction.**

"The Centre is still too much involved in too many of the wrong things and too little involved in some that really matter. For example, local management must be allowed to determine its own needs for information, with higher management drawing on that information for its own purposes. The units and the authorities are being swamped with directives without being given direction. Lack of the general management responsibility also means that certain major initiatives are difficult to implement." (The Griffiths Report, 1983, p.12)

**2. The service suffers from the absence of individual managerial responsibility which leads to "lowest common denominator decisions"**

"If Florence Nightingale were carrying her lamp through the corridors of the NHS today, she would almost certainly be searching for somebody in charge" (The Griffiths Report, 1983, p.12).

The absence of somebody in charge was illustrated by a summary of the complexity of the existing management process:

"Management is currently provided by the Secretary of State and Minister of State, by the Permanent Secretary, and at regional and district level, by chairs appointed on a non-executive part-time basis.... Management support is given at the Centre within the DHSS by senior officials and groups, none of whom is concerned full-time with the totality of NHS management; and at regional and district level by professional officers required to work in consensus



management teams where each officer has the power of veto" (The Griffiths Report, 1983, p.11).

**3. The NHS fails to use objectives to guide managerial action thus jeopardizing the implementation of plans and policies**

"...There is no driving force seeking and accepting direct and personal responsibility for developing management plans, securing their implementation and monitoring actual achievement. It means the process of devolution of responsibility, including discharging responsibility to the units, is far too slow." (The Griffiths Report, 1983 p.12) and

"To the outsider, it appears that when change of any kind is required, the NHS is so structured as to resemble a mobile, designed to move with any breath of air, but which in fact never changes its position and gives no clear indication of direction." (The Griffiths Report, 1983, p.12).

The failure of implementation was attributed in part to the process of consultation operating within the NHS, which by any business standards was thought to be:

"...so labyrinthine and the rights of veto so considerable, that the result in many cases is institution stagnation - a result particularly enhanced by the fact that the machinery of implementation is generally weak and, as such, cannot ensure that the processes of consultation are effectively implemented and quickly brought to a conclusion." (The Griffiths Report, 1983, p.14)

The assumption in these statements is that it is possible to change organizations any way we wish, given the will to change.

**4. The NHS does not have a performance orientation and is disinclined to undertake economical, clinical evaluation, to collect the right kinds of data or to be concerned with productivity.**

"The NHS does not have a profit motive, but it is, of course, enormously concerned with the control of expenditure. Surprisingly, however, it still lacks any continuous evaluation of its performance against criteria." (The Griffiths Report, 1983, p.10)

The "criteria" cited in the Report include levels of service, quality of product, meeting budgets, cost improvement, productivity, and motivating and rewarding staff.

**5. The NHS lacks a customer orientation, and is little concerned to collect information about the views of NHS users**

"Rarely are precise measurement objectives set; there is little measurement of health output; clinical evaluation of particular practices is by no means common and economic evaluation of those practices is extremely rare. Nor can the NHS display any ready assessment of the effectiveness with which it is meeting the needs and expectations of the people it serves. Businessmen have a keen sense of how well they are looking after their customers. Whether the NHS is meeting the needs of the patient, the community and can prove that it is doing so, is open to question." (The Griffiths Report, 1983, p.10)

These criticisms imply that poor central management of the NHS has led to piecemeal strategies and ad hoc interference in local management, and secondly, that consensus



management has failed in that the requirement to "get agreement" has overshadowed the need to make decisions, resulting in long delays in the management process. All the criticisms of the NHS made in the Report suggest the NHS it is being measured, not against private companies in the real world, but against an ideal - typical model of how things "ought" to be if only people would behave sensibly! It is difficult to imagine anything less sociological. Nonetheless, from these "observations" a series of recommendations for the management of the NHS were put forward.

### The Griffiths recommendations

The Report proposed a significant reorganization of DHSS management of the NHS through the establishment of an NHS management board reporting to a health service board whose role was to give clear strategic direction. The health service supervisory board was to concentrate on the determination of the purpose, objectives and direction of the health service; approval of the overall budget and resource allocation; strategic decisions for the health service and receiving reports on performance and other evaluations from within the health service (The Griffiths Report, 1983, p.3).

Griffiths recommended that the supervisory board should be chaired by the Secretary of State and include the Minister of State for Health, a Permanent Secretary, the chief medical officer, the chair of the NHS management board and two or three non-executive members with general management skills and experience (The Griffiths Report, 1983, p.3). It was to relate to statutory and professional bodies in the same way as did Ministers in the DHSS.

The NHS management board was proposed as a way of "pushing responsibility as far as possible down the line" to where action could be taken effectively. The membership of the management board was to include: personnel, finance,



procurement, property, scientific and high technology management and the service planning function. It was proposed that it be chaired by a "strong chair" who was to be the Secretary of State's "right-hand man" and who would perform the general management function at national level (The Griffiths Report, 1983, p.4). He (this is the implication) was to hold executive authority to act on behalf of the Secretary of State and was to be accounting officer for health service expenditure. As part of the chair's role, he was charged with ensuring that regional chairs were fully consulted and involved in the discharge of responsibility reserved for the Secretary of State.

The chair and the personnel director were regarded as the key board roles in effecting change (McCarthy, 1984). The appointments, the Report argued, would best be taken from outside the NHS and the civil service to "achieve credibility in establishing the new management style". Other functions would have members drawn from business, the NHS and the civil service.

The management board was to have no separate corporate status. It would be "under the direction of the supervisory board and accountable to it and would implement the policies approved by it, give leadership to the management of the NHS; control performance and achieve consistency and drive longer term". The Griffiths Report, 1983, p.3) The board was also expected to cover all existing NHS management responsibilities in the DHSS, including regional and DHAs, FPCs, special health authorities and other centrally financed services.

The Report recommended that the DHSS should adjust its activities in order to support the management role of the supervisory management board, leading to fewer central interventions and possibly fewer staff at the Centre, since "the requirement for central, isolated initiatives should disappear once a coherent manpower process is established" (The Griffiths Report, 1983, p.16).

The general criticism of the lack of individual managerial responsibility was to be met by the introduction of general management defined in the Report as "responsibility drawn together in one person, at different levels of the organization, for planning, implementation and control of performance" and the abandonment of formal consensus decision-making. (The Griffiths Report, 1983, p.11). General managers were to be "the linchpin of dynamic management" and could be drawn from any discipline. The broad functions of the general manager are discussed in paragraphs 9 and 15 of the observation section of the Report. They were cast as chief executives, providing leadership and capitalizing on existing high levels of dedication and expertise amongst NHS staff of all disciplines. In addition, they were expected to stimulate "initiative, urgency and vitality" amongst staff, to bring about a constant search for major change and cost improvement, to motivate staff and ensure that professional functions were effectively fed into the general management process.

It was carefully stated in the Report that the appointment of general managers was not intended to weaken the professional responsibilities of other chief officers "...especially in relation to decision-making on matters within their own spheres of responsibility". (The Griffiths Report, 1983, p.17). The general manager was to be the final decision-taker for decisions normally in the province of consensus teams in the hope that delay and disagreement could be avoided. The chair of the health authority was given the task of "clarifying the general management function and identifying a general manager for every unit of management" (The Griffiths Report, 1983, p.6).

There were a number of proposals to meet the criticism of lack of objectives and poor implementation, namely: fixed contracts for general managers which were later rolling contracts; the creation of the NHS management board; the extension of the



review process to unit level; and, later, individual performance review and performance related pay.

Strengthening existing performance indicators (service performance targets devised to improve the use of resources, monitor quality and ensure accountability to the public) and developing a management budgeting approach (giving units/departments clearly-defined budgets, for which they are accountable) were regarded as vehicles for promoting the measurement of output in terms of patient care, and, dealing with the criticisms that the NHS lacked a performance orientation. The regions were also to be strengthened as part of improving the performance orientation, although the nature of this process, was not made clear.

Although doctors' involvement in management is intimately part of ensuring the NHS acquires a performance orientation, this was not explicitly tackled in the Report. Indeed the only mention of this critical aspect is on page 6 of the Report, where district and regional chairs are charged with: "...involving the clinicians more closely in the management process, consistent with clinical freedom for clinical practices". Implicit in the Report is the hope that the development of budgets at unit level would involve clinicians and allow workload and service objectives to be related to financial and manpower allocations.

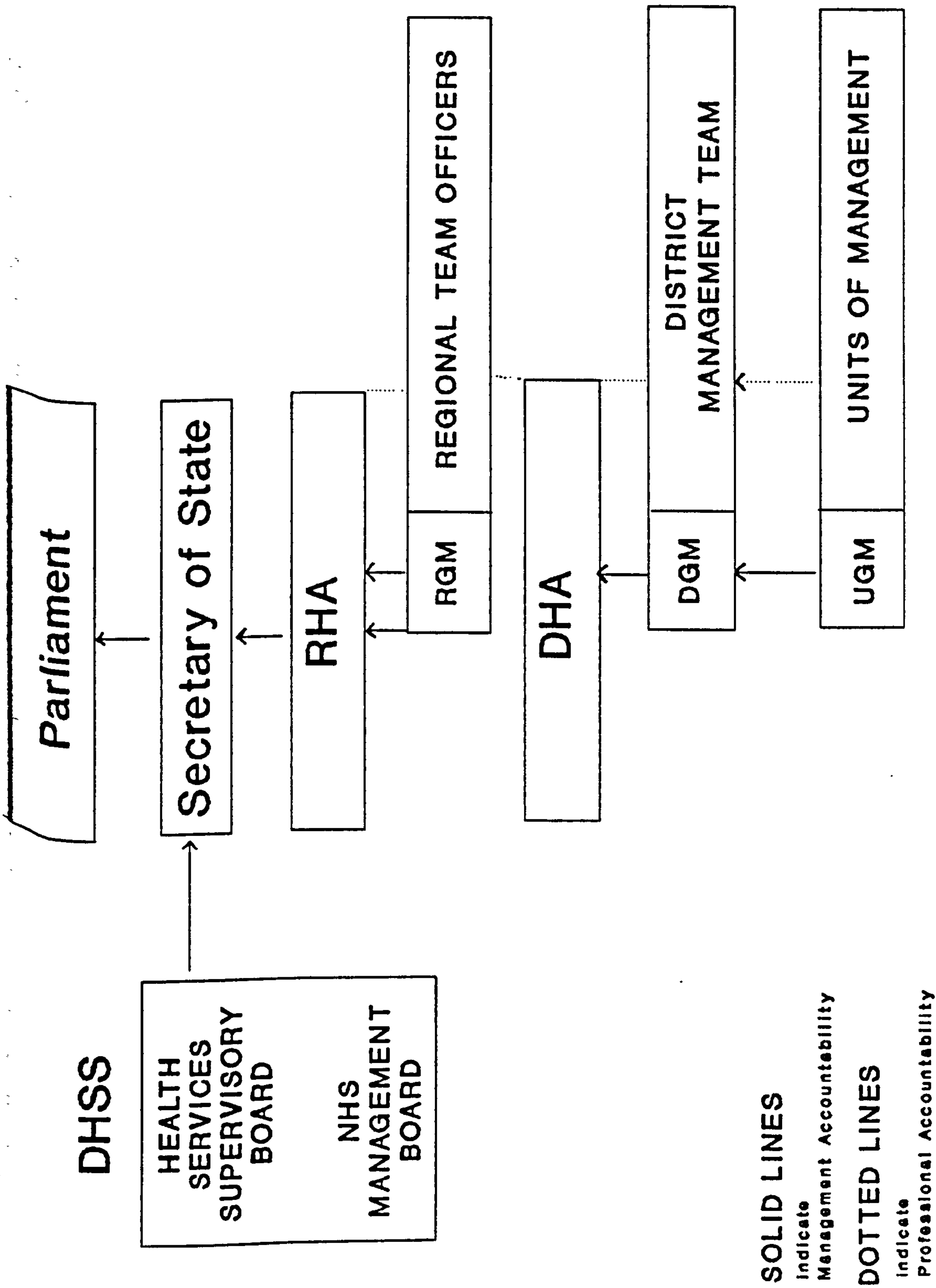
The Report stressed that patients and the community were to be the focus of the planning and delivery of services. To that end, health authorities were to ascertain, and act on, public opinion surveys and the advice of CHCs to ensure a consumer orientation for the NHS. The management board were made responsible for acting upon information regarding the experience and perceptions of patients in the community, given to them by the CHCs, market research and general practice in



formulating policy and monitoring performance against it. (The Griffiths Report, 1983, p.9)

An outline of the organizational structure proposed by Griffiths is given in Figure 7 below:

FIGURE 7



A simplified representation of future management relationships in health authorities and the DHSS

Source: The New Management Arrangements for the NHS.  
The National Health Service Training Authority. 1984.

The Secretary of State announced his acceptance of 'the general thrust' of the Report in his statement to the House of Commons on October 25th, 1983, but added three caveats. Firstly that the Report did not imply further statutory reorganization. He reiterated the point stressed by the Griffiths team regarding the need to "enhance the best of consensus management." All the recommendations, he said, were designed to take place within the existing statutory structure and without affecting the constitutional position of the patient, ministers or health authorities. Secondly, the recommendations should not add to the existing costs or staff numbers and within the Department should lead to a reduction of activities and staff. Finally, the changes must ensure that the best deal for patients and the community was secured within available resources along with the best value for the taxpayer.

As part of the House of Commons' statement, the Secretary of State announced he would be setting up within the Department, the health service supervisory board. On November 18th, 1983, he wrote to Health Authority chairs (Circular HC(84)13), to invite their views on two of the Griffiths recommendations: the general management function and the involvement of clinicians in the management process, asking for their views by January 9th, 1984, so that implementation of general management could begin from April, 1984.

### Reactions to the Griffiths recommendations

A spectrum of reaction greeted the publication of the Report and its endorsement by the Secretary of State. For some, the introduction of general management was mainly a matter of seeking economies in what were thought to be over-elaborate and time-wasting practices associated with consensus management - "cutting the administrative tail", as the Secretary of State put it at the time that the changes were being



considered. Others, however, had greater expectations. General managers, they felt, should aim to achieve the transition from a passively administered to an actively managed service.

The eleven-week consultation period was the subject of much criticism. Before the consultation period ended, the House of Commons Social Services Committee began an Inquiry into the Griffiths recommendations. It held four public oral sessions, hearing evidence from the British Medical Association (BMA), the Association of Nurse Administrators (ANAs), the Health Visitors' Association (HVA), the Institute of Health Service Administrators (IHSA), the Association of Health Service Treasurers (AHST), the TUC Health Service Committee, the chair of regional chairs, the Nuffield Institute of Health Service Studies, Roy Griffiths and Sir Brian Bailey, the Secretary of State and his Permanent Secretary. It also invited three academic institutions to submit memoranda on the Report which were listed in the Annex. The Committee was not able to see responses from individual health authorities as the government had not laid them before the House of Commons. A brief summary of the evidence submitted to the Committee is given below and is elaborated in Appendix A to this chapter.

### *Summary of views*

<u>INTEREST GROUP</u>	<u>KEY CONCERNS FOLLOWING THE GRIFFITHS REPORT</u>	<u>POINTS OF THE REPORT ACCEPTED</u>
Administrators	<ul style="list-style-type: none"><li>*Not enough discussion time</li><li>*Understated progress made in implementing 1982 reorganization</li><li>*Understated the importance of the coordinating role of the administrator</li><li>*Unclear terms and conditions for general managers' post</li></ul>	<ul style="list-style-type: none"><li>*Need to improve the management process</li><li>*Management budgeting for clinicians.</li></ul>
Treasurers	<ul style="list-style-type: none"><li>*Appointments of general managers would be fair and equitable</li></ul>	<ul style="list-style-type: none"><li>*Better management was needed to bring about cost improvement and provide better value for money</li></ul>
Personnel	<ul style="list-style-type: none"><li>*Authorities would have freedom to organize management structures and appoint general managers fairly</li></ul>	<ul style="list-style-type: none"><li>*Backed need for a strong personnel director on the management board</li></ul>
Health Authority Members	<ul style="list-style-type: none"><li>*Health authorities ought to be free to make suitable local management arrangements</li><li>*That the benefits flowing from consensus management would be lost</li><li>*The role of the authority would be diminished in favour of the chair</li></ul>	<ul style="list-style-type: none"><li>*Need to improve managerial practice</li><li>*Involvement of doctors more closely in management</li></ul>

<u>INTEREST GROUP</u>	<u>CONCERNS</u>	<u>AGREE</u>
Nurses	<ul style="list-style-type: none"> <li>*There should be a nurse representative on the supervisory board</li> <li>*The role of nurses in management would be significantly diminished</li> <li>*Increasing the power of doctors</li> <li>*A curtailment of responsibility for the management of nursing</li> </ul>	<ul style="list-style-type: none"> <li>*Need for crisper management</li> </ul>
Public Health	<ul style="list-style-type: none"> <li>*Lack of clarity about their own role</li> </ul>	<ul style="list-style-type: none"> <li>*Local flexibility for management relationships</li> </ul>
Doctors	<ul style="list-style-type: none"> <li>*Scrapping consensus management, which was seen as the most appropriate way to manage with professions</li> <li>*Role of medical advisory machinery</li> </ul>	<ul style="list-style-type: none"> <li>*Proposals for reform of the Centre</li> <li>*Doctors are natural managers</li> </ul>
Para-professions	<ul style="list-style-type: none"> <li>*Loss of professional input into management decisions</li> <li>*General managers could overturn professional decisions of departmental managers</li> </ul>	<ul style="list-style-type: none"> <li>*Improved management</li> </ul>
Community Health Council	<ul style="list-style-type: none"> <li>*Lack of clarification of the role of consumer groups in the decision-making process</li> </ul>	
Unions	<ul style="list-style-type: none"> <li>*Griffiths fails to tackle underfunding and inequalities in health</li> </ul>	

Each of the responses to the Griffiths Report documented in this table represent the standpoint of a particular managerial or professional group. The responses are unlikely to show the degree of detachment that one might expect from less involved



groups (e.g. academics). This means that this table and Appendix A to this chapter should not be treated as objective analysis but as data and, in particular, as evidence of the complex interweaving of the multiplicity of interest groups that make up the NHS.

The Social Services Committee Report (published on 12th March 1984, some twenty days before what the Secretary of State had indicated was to be the implementation date) concluded that the reaction to the Griffiths Report had not been enthusiastic:

"It has been interpreted as an attack on NHS staff, as a threat to clinical freedom, a blow to nurse management...and a blueprint for reductions in the responsibilities of RHAs and DHAs and their members." (Social Services Committee, 1984, paras 6 and 30)

However, the Committee welcomed the emphasis on the need to devolve management to the unit level and below, its proposed extension of accountability reviews and its search for more rigorous, efficient, consistent and sensitive management. More specifically, the Committee:

1. **Supported** the proposals for the DHSS and made the additional recommendation that a RHA chair and chief nursing officer should be members of the supervisory board and asked that the degree of managerial independence of the management board should be made known to the House of Commons (*ibid.* para 49);

2. **Recommended** that RHAs and DHAs should identify how their general management function is being performed, either within the present team structure by a nominated individual, or by the identification of a separate general manager. (*ibid.* para 69);
3. **Recommended** that management at unit level should be considered separately from district and regional levels and should remain unchanged for the present; (*ibid.* para 65 and 67);
4. **Wanted more information** about and elucidation of the evidence received by the Griffiths team, its proposals and responses to the 'consultative' letter of 18th November, 1983, as well as the government's own interpretation of the recommendations. (*ibid.* para 22);
5. **Added its warning** that 'the NHS may suffer more in side-effects from the wonder-drug of general management than it gains in better management' (*ibid.* para 51).

The parliamentary debate on the Griffiths recommendations was held on the 4th May, 1984, and was not well-attended. At best, twenty MPs were present (see Russell, 1984). The Secretary of State rejected the Committee's caveats on general management at unit level, but accepted that the chief nursing officer should be a member of the supervisory board (Hansard 1984, Cols. 642-46).

Arguing that the Griffiths recommendations did not constitute another major reorganizational upheaval for the NHS, the Secretary of State authorized publication of a DHSS Circular in June 1984, requiring health authorities to establish a general management function and to identify a general manager, first in RHAs, then DHAs

and, finally, at unit level. Membership of the management board was finalized by April 1985.

By June, 1985, most DGMs had been appointed and by March, 1987, most UGMs were in post. A breakdown of the general manager appointments in England is given in Figure 8 below.



GENERAL MANAGER APPOINTMENTS IN ENGLAND

December 1986

PREVIOUS POST	REGIONAL GENERAL MANAGERS	DISTRICT GENERAL MANAGERS	UNIT GENERAL MANAGERS	TOTALS
Administrator	9	113	347	469
Nursing Officer	1	5	71	77
Consultant	-	4	82	86
Community Physician	1	11	15	27
Treasurer	1	18	5	24
Dental Officer	-	-	7	7
General Pratitioner	-	-	6	6
Professions Allied to Medicine	-	-	-	-
Ambulance Driver	-	-	2	2
Other NHS	-	-	12	12
Other Non-NHS	2	40	57	99
Vacancies	-	-	8	8
TOTALS	14	191	612	817

FIGURE 8

Source: Department of Health

### Reflection on the Report's findings

From the establishment of the Inquiry team to the implementation of its key recommendations took less than two years. The speed of implementation meant there was limited opportunity for public debate, just as was the case with the 1974 reorganization (Draper, Grenholm and Best, 1976, p.271-3).

The style of the Report, a letter of advice to the Secretary of State, provided significantly less scope than usual for effective debate of various reports in the House of Commons. The Social Services Committee commented that the proposals were so terse in their presentation that there was insufficient detail for critical analysis and many of the Committee's recommendations were concerned with the need for clarification of issues. (1984, para.52) Carrier and Kendall note:

"It is rare indeed for policy changes to follow the publication of a clearly written, thorough report which has been based on exemplary research, is subjected to extensive public consultation, and whose recommendations are first tried and tested in pilot projects before being adopted on a wider scale."  
(Carrier and Kendall, 1986, p.209)

The Inquiry's recommendations met none of the above criteria, indeed they were based on a series of observations which could not be logically deduced (Dyson, 1984, p.255) or empirically substantiated. For example, the case against consensus management consisted of the phrase: "Consensus management leads to lowest common denominator decisions" which contrasts with the Royal Commission's view that, although there were some problems with consensus management, it was working well in many areas and that there was general support for the principle. (Royal Commission on the NHS, 1979, p.229). What public debate there was had very little

impact on the views of the Secretary of State. Indeed, the chair of the Social Services Committee, Renee Short, commented that he had 'ignored what we recommended...he has gone ahead and acted against the united medical, nursing and trade union opinion'. (Russell, 1984, p.1546).

There are two explicit examples of the government's intention to accept the Griffiths' recommendations, come what may. Firstly there was no public discussion about the restructuring of the DHSS. The decision to create the supervisory board was made some nineteen days after the Griffiths team reported. Secondly, the letter of 8th February, 1984, to health authorities, instructed them that the general management process would be introduced as from 1st April, 1984. The letter was despatched four weeks before the Social Services Committee's Report and three months before the House of Commons debate.

In many senses, the Griffiths proposals were an act of faith, based on a report whose recommendations lack substantive evidence. The Report makes a number of important assumptions, which are discussed and challenged below:

1. **Politicians will deliver clear policies which general managers will implement.** This assumes politicians are aware of the complexities involved in providing health care and ignores the political capital politicians may make from the NHS which means that policy shifts can (and do) occur at any time and often reflect political rather than health care priorities.

2. **General management will not challenge existing arrangements for accountability.** Although the Secretary of State told the House of Commons that the new arrangements would not affect the constitutional position of Parliament, ministers and health authorities, the actual arrangements contradict this pledge in four



major ways. Firstly, if the management board is to be allowed to manage, then Parliament must leave it space to do so and MPs must refrain from demands for detailed information about developments. With respect to this point, Day and Klein argue the Report implies 'the NHS should be treated like a nationalized industry where members of Parliament may ask questions about overall performance but not raise specific cases or question specific decisions (Day and Klein, 1983, p.1814). Secondly, the relationship of regional chairs to ministers must change, since following Griffiths, they are now required to follow management directives from the management board. Thirdly, the Report prescribes considerable independence for health authority chairs which potentially increases their power vis à vis their members and by implication must challenge accountability arrangements. Finally, an important question not addressed by the Report, is how the general management function would dovetail with professional structures. The Report is clear that the primary reporting relationship of functional officers is to the general manager, yet the Figure 7 suggests that there will be a continuation of the functional relationship between districts and regions whereby the regional works officer relates directly to the district works officer, and so on.

3. **Private industry is more effectively managed than the public sector.** This is clearly open to question, given the relative efficiency of the NHS by comparison to other health care systems in the world and the relatively poor performance of the British private sector as compared to its international competitors.

4. **It is possible to transfer approaches employed in business management to the management of the NHS.** There are several features of the NHS which could be used to challenge this assumption (see Chapter 2's discussion of the public administration tradition). Most prominent among these are the power of the medical profession to define how health services are delivered, its cynical view of

management, and the professional orientation to meet individual patient needs without reference to price or profit.

5. **The democratic nature of the NHS leads to poor management.** The Griffiths Report ignores the ideological foundations of the NHS in making this assumption. For example, the Report deems the process of consultation as "labyrinthine" leading to "institutionalized stagnation", it gives only the briefest references to CHCs and health authority members, it plays up the role of health authority chairs to the exclusion of other members of authorities and the recommendation that consultation procedures should be simplified and speeded up indicates health authorities were to be 'more managerial and less representative in character'. (Day and Klein, 1983).

6. **The general manager can be the final decision-taker and manage the considerable power of professional groups in the NHS.** The Griffiths recommendations assume that general managers have the authority to curb the power of the medical profession and its strong ideas about the provision of services. The general manager's task is made more difficult by consultants' contracts remaining at regional level.

7. **Output measurement is straight-forward in the NHS.** Outputs of the health service are varied. It provides employment to large numbers of people. It is the major producer of medical research and of training of nurses, doctors and many other occupations. However, the most essential of health service outputs are treatments and care provided to people. An important distinction has been drawn between outputs (the treatments provided to patients) and outcomes of care (the benefits to health). Existing literature on health outcomes, quality of life and client-satisfaction indicate the complexity of these issues.



8. **The NHS consists solely of hospital services.** The community and voluntary sectors are not explicitly discussed in the Griffiths Report. This begs the question: how can general managers be responsible for the total health care of the population when the hospital sector's links with these complex important sectors are not within the scope of their authority?

The discussion of the assumptions inherent in the Griffiths Report is not meant to convey political carping but merely to illustrate the points of debate that might have been taken up following the publication of the Report, yet rarely were these points debated in the commentary and furore which followed its publication. Rather the focus was almost exclusively on either the appointment of the new general manager, or the defense of a particular interest group. Furthermore, it is not surprising that some of these assumptions were made. A team of highly regarded and highly competent business people could not be expected to get to grips with the complexities of the NHS in the time available, particularly when there was so little available analysis of this complexity. Businessmen, like civil servants, academics, or any human being, carry their own ideological baggage which is bound to influence the way in which they view problems and makes it difficult to look at issues in a detached manner. Moreover the Griffiths team did not have the luxury (as academics do) of saying they simply do not know the answer, as Sir Roy notes the noise level in the NHS reached unprecedented heights at the time he and his team made his observations (Griffiths, 1991, p.2). The Griffiths team had to come up with some analysis.



### Chapter 3 revisited

This chapter documented in some detail the critique of the NHS as developed by the Griffiths team. It was argued that the Griffiths diagnosis of the ills of the NHS reduces the complexity of the issues involved in delivering health services discussed in Chapter 2. The criticisms of the NHS made by the team, suggest it is being measured, not against private companies in the real world, but against an ideal, typical model of how things ought to be if only people would behave sensibly and, as such, its proposals for changing the NHS constitute an act of faith. The Report's recommendations were discussed, as were a number of important assumptions which underpin the Report.

The Griffiths recommendations were supplemented with a number of managerially driven changes. In 1983, the DHSS produced the first set of national NHS Performance Indicators (PIs) which enabled RHAs and DHAs to compare their performances on certain measures with national and regional norms and instructed English and Welsh health authorities to put cleaning, laundry and catering services out for tender. In 1984 annual reviews of units by DHAs were introduced and in that year, the DHSS required every DHA to include a cost-improvement programme within its short-term plan. In 1986, annual performance reviews of RHAs were to be undertaken by the NHS management board and these were to be, in addition to ministerial reviews, introduced in 1982. Finally, in 1987, Individual Performance Review (IPR) and Performance Related Pay (PRP) were introduced for general managers. (See Pollitt, 1990, for a thorough review of these changes) All of these changes were introduced against a backdrop of increasingly tough financial constraints.

Klein argues that, despite the flurry of government activity in NHS management in the early 1980s, little of substance has changed and that ideology that appears in manifestos is inevitably abandoned in practice (Klein, 1984)(4). Davies, offers a very different interpretation of these developments. She notes that changes in the structure and management of the NHS lay the foundations "for a new mix of public and private, statutory, voluntary and commercial services in the arena of health care delivery" (Davies, 1987, p.315). Additionally she argues that centralization is being pursued by means of direct and personal control and singles out the Griffiths changes as being an important step in the strategy of gaining a greater central grip by finding new people for a new perspective. Thus she concludes, centralization and the creation of a market in health care are not as opposed as they might at first seem. "The first can be a means to encourage, the second, to ensure that the lumbering giant of the NHS is nudged along the road to pluralism in welfare" (Davies, 1987, p. 309).

Unless empirical research is carried out examining the implementation of the Griffiths changes, we are likely to remain impotent in addressing the important claims made by Davies in particular. To this end, examining the position and role of the new general managers is critical. For it is they who, working within the ideological rubric of a market deregulation of public services, were to be the vehicles of the cultural revolution as outlined in the Griffiths Report. More specifically it was they who were to challenge professional privileges and the right of professional groups to speak for patients. Before embarking on this analysis it is critical to explore what we know about the nature of health services management up until 1983. To this end the next chapter considers the available empirical work on this issue. Chapter 4 also sketches out the sociology of Norbert Elias since it is the ideas of what has been called

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(4)The changes flowing from the publication of the 1989 White Paper (discussed later in the thesis) reveals Klein's view to be wrong.

figurational or process sociology that will inform the analysis of the empirical data collected on the introduction of general management in twenty NHS districts.



## **Appendix A. An elaboration of the reactions of interest groups to the Griffiths Report**

### **The Institute of Health Service Administrators (IHSA)**

In its response to the Secretary of State, the IHSA accepted the diagnosis of the Report in terms of the requirement to improve the management process. However the IHSA argued more discussion and preparation was needed if health service management were not to be weakened by the changes. The IHSA felt the Report seriously under-estimated the progress made by many authorities in implementing the changes following the 1982 reorganization, in particular devolution to unit level and the coordinating role of the administrator. They felt it important that this process be recognized and used as a basis for further development.

The Institute was keen that minimum national guidelines should be issued on the terms and conditions of general manager appointments. Amongst its concerns were: what are the advantages of fixed-term contracts? (an unusual departure for the public sector); what will be the implications of the changes to the relationship between managers and the working methods of the authority?; what would happen if the contract was not renewed?; what would severance pay be? what sort of re-entry route would there be for general managers wishing to return to their former role? A particular concern was the fate of the administrator not appointed general manager and who would carry out the administrator's responsibility for coordination, secretaryship to the health authority and management of support services.

Another concern was that general managers would be seen as a panacea. General managers, it was argued, could only be effective in the context of an "appropriate managerial framework". Ill-considered change was thought particularly dangerous at

unit level where unit management teams were trying to establish their credibility, following the 1982 changes. In view of the importance of the unit level, the IHSA argued regional and district appointments should be made first, giving the managers sufficient time to consider the success of recently established unit structure and review the management processes of the authority.

The IHSA endorsed the proposal for management budgeting, but emphasized the need for detailed consultation with medical staff at the local level. It also supported the establishment of the supervisory management board at the national level, with the proviso that NHS managers should be included as full-time members. Finally, the IHSA emphasized that better management alone would not solve the main problems of the NHS, for example, achieving priorities with limited resources, meeting the health needs of local populations, dealing with the costs of medical innovation and rising public expectations.

### **The Association of Health Service Treasurers (AHST)**

The AHST put forward similar arguments to those of the IHSA. The main concern was the way in which the new posts would be filled and that the appointments would be seen as fair. The Association supported the need for change in the management process if cost-improvements were to be made as well as ensuring better use of resources. It warned that for this to happen, the central accounting procedures would have to be scrutinized since health authorities were limited in their ability to carry forward underspending.

In its examination of the witnesses from the AHST, the Social Services Committee focused on the manpower implications of the introduction of general managers. The



AHST argued that the general manager should be able to save the authority the costs which fell on his/her appointment.

### **The National Association of Health Service Personnel Officers (NAHSPO)**

The chair of the Association warmly welcomed the flexible approach of the Report, but noted the sharp contradiction between the two themes of the Report, namely the recommendation that chairs of authorities should have greater freedom to organize management structures and the rigid prescription of general management appointments as the universal panacea for all authorities. The association emphatically supported the idea of the Griffiths proposal for a strong personnel director on the management board.

### **The National Association of Health Authorities (NAHA)**

The majority of health authorities were against the central imposition of the general management solution, although they welcomed the emphasis on improving managerial practice in the NHS, particularly the need clearly to identify responsibility and accountability. However health authorities, they argued, should be free to make arrangements which are most suitable for their local situation. In many health authorities consensus management was thought by NAHA to work well. A concern was that the introduction of general managers might harm existing management which could be strengthened by, for example, health authorities exercising more control over the appointment of the chair of a consensus management team or by strengthening the managerial authority of the administrator as coordinator of the team or unit beyond that envisaged in Circular HC(80)8. Whilst they supported the general management principle, NAHA argued general management should be introduced experimentally or health authorities should take the decision locally.



NAHA's main concern was the effects Griffiths would have on the role of authority members who they claimed over the last twelve months had seen an increasing reliance on chairs of authorities rather than the authority as a whole. Underlying such concerns was the danger that both health authority members and chairs might be bypassed by the new general management. The Report's emphasis on the health authority chair was thought "part of an increasingly centralist and authoritarian approach to the management of the health service". In their verbal evidence to the committee, NAHA warned of the danger of losing the commitment of members if they were to be eclipsed by the authority chairs.

The closer involvement of clinicians in the management process was welcomed, but NAHA expressed disappointment that the Report failed to recommend that the contracts of senior medical and dental staff should lie with DHAs rather than the region.

NAHA called for clarification of: the role of the supervisory and management board and how this would affect the relationship between the Secretary of State and regional chairs; the stronger communication links between operational authorities and the Centre; the terms and conditions of general managers; the statutory position of health authorities and a definition of the role and accountability of chairs of health authorities, for example, is the chair responsible to the Secretary of State or the authority?

### **The Royal College of Nursing (RCN)**

The RCN saw the Griffiths recommendations as 'radical' and 'unnecessary', leading to divisiveness in the service. The response from the outset was one of anger, although

support was given to the idea of crisper management, 'provided that it was in tandem with high morale'. The then Secretary of the RCN, Trevor Clay, denied that the introduction of general managers would just formalize a de facto situation. He feared that the appointments would be a disadvantage to patient care in that the chief executive would have to take more direct authoritative control given the financial pressures on the health service.

The RCN and the other nurse bodies - the Royal College of Midwives (RCM), the ANA and the HVA - stressed the importance of including the chief nursing officer at the DHSS on the supervisory board. All these bodies felt that Griffiths had downgraded the role of nurses and they feared the nursing manager's role at district level was at risk. The appointment of a personnel officer on the management board was seen as threatening the responsibilities of nurse-managers for training, personnel management, nursing appointments and nurse-manpower.

The RCN's main criticisms of the Griffiths Report centred around the lack of evidence on which the proposed changes are based and in particular, the case made by Griffiths against consensus management was thought not to have been proven.

The RCN objected to paragraph 9d on page 14 of the Griffiths Report where it was argued that the presence of a general management process would be enormously important in:

"...ensuring that the professional functions are effectively geared into the overall objectives and responsibilities of the general management process. The primary reporting relationship of the functional managers should be to the general manager, who should set, by agreement with the functional managers, the priorities and programmes for their work. The relationship with the



professions at other levels should simply be one of seeking guidance or monitoring of the professional aspects of their work. The present position leads to unnecessary duplication of staff; too many purely professional meetings, from the Centre to the unit; and the tackling of overall tasks in a fragmented and divisive manner. Any apparent advantages of the functional specialisms are nowadays more than offset by the need to establish the general management process effectively".

It was argued that the paragraph implied that the professions and functional specialism including nursing 'get in the way', that purely professional meetings cannot be part of management.

Another major objection focused on the emphasis on the involvement of doctors in management and seeming neglect of nurse interest in the efficient use of resources. The recommendation that the cogwheel system of professional representation could bring about clinical involvement was thought to carry with it a fundamental contradiction since cogwheel was a version of consensus management.

A final criticism from the RCN was the Report's naive recommendations regarding patients and the community. The RCN argued that more emphasis is required to develop realistic ideas about public perceptions and attitudes towards the NHS and health before questions of effective use of available resources can be answered.

The RCN recommended that the government should seek alternative methods of achieving better management. Suggestions included: developing the coordinating role of the district administrator while remaining within a team of equals; removing the right of veto which each member of the consensus team currently holds; establishing a more dynamic relationship between the chair of the team and the



authority chair. Finally, the RCN requested that if general managers are to be introduced, they should be piloted in two NHS regions.

### **The Association of Nurse Administrators (ANA)**

The ANA supported the improvement of the general management function, but opposed vehemently the appointment of general managers which they saw as reversing the philosophy of the 1982 reorganization of maximum delegation and consensus management. Most of the Association's other concerns mirror those of the RCN.

### **Royal College of Midwives (RCM)**

The RCM were opposed to any reduction in functional management structures in relation to midwifery and wished to retain nursing, midwifery policies, student manpower, total nursing workforce, district nursing budget and nurse/midwifery education at district level. An additional concern to those raised by the RCN was the general managers' responsibility for staff review, reward and discipline. There was some disappointment that the Report did not devolve doctors' contracts to district level.

### **Health Visitors Association (HVA)**

The HVA noted the dangers of imposing an industrial model of accountability on the NHS, particularly on the nursing profession:

"The notion of dividing professional and managerial accountability and reporting is considered to be artificial and impracticable, as the two are largely interdependent."

It is the evidence of the HVA which most clearly articulates the crux of the nurses' concerns:

"Nurses have struggled for many years to acquire full responsibility for their own management and having achieved it, at least in the reorganization of 1974, would inevitably deeply resent and strongly oppose any suggested curtailment of this."

This resentment is obvious in the Social Services Committee verbal examination of the HVA witnesses who, in an answer to a hypothetical statement that a general manager of the community unit might not be the nurse, stated "Possession is nine-tenths of the law. She is already there. If anything else comes in, it will come to her."

### **The Association of District Medical Officers (ADMO)**

The Association gave the Report a cautious welcome, particularly the scope for the local flexibility. The Association, however, wanted clarification of their own role and remained uncertain as to the benefits of managerial change.

### **The British Medical Association (BMA)**

The BMA's chair warned that the profession would not accept instructions from a lay administrator if these would damage the interests of patient-care or if professional

advice was not heeded. The BMA endorsed Griffiths' view that the best of consensus management should be maintained, but through the existing structure of the DMT, and argued the 'problems' of consensus management could be avoided if the member of the DMT "who enjoys full confidence of his colleagues" is identified as chair of the team. Consensus management was seen as the only way the health service would be able to deal with the professions. The BMA objected strongly to the word 'manager' which implies the management of other people, preferring the word 'chair' who extrapolates the decision from the team and when necessary gives the lead. (*Health and Social Services Journal*, January 26th, 1984, p.10, "Griffiths - the clinical view").

A major anxiety was that the new general manager would interfere in patient care. For this reason, the BMA thought it impractical to cut out nursing management at district level. Professional involvement in management was thought crucial "to defend the autocrat from the stupidity of their decisions".

The BMA suggested that changes arising from the Griffiths Report should only be introduced following a trial in one region at all levels of the authority, "after agreement has been reached with the profession on the way in which the trial should be set up and the means of evaluating it".

The BMA were generally positive about the Griffiths proposals for the Centre. They welcomed the chief medical officer's role as medical adviser to the Department. Their main concern at this level was the role of the personnel director in relation to the existing negotiating machinery and the review body system. The council 'could not agree' to any changes to the terms and conditions of doctors which are negotiated directly with the DHSS.



At regional and district levels, the BMA sought clarification as to the future of medical advisory machinery on which Griffiths 'was silent', and the future role of the RHA's particularly with respect to their continuing to hold the contracts of senior medical staff. At unit level, clinical budgeting on a trial basis was seen as essential before any general changes were made.

In the verbal evidence, the chair of the BMA argued strongly that at unit level doctors should be unit general managers since they "are the main spenders of resources at unit level. The nearer the management process gets to the patient, the more important it becomes for doctors to be looked upon as the natural managers".

#### **BMA Joint Consultants' Committee**

The Committee chair thought the Secretary of State optimistic if he believed general managers could make a great deal of difference in the NHS. He and the Committee wanted to see doctors involved at unit levels, but, although doctors were seen as "the most able people" to take on the job of UGM, the stable employment of a consultant post did not make a three-year contracted UGM post an attractive one (*Health and Social Services Journal*, June, 14th, 1984, p.12. 'The NHS verdict on HC4(13)')

#### **The Chartered Society for Physiotherapy**

The Society welcomed the principle objectives of the Griffiths Report for better management and greater involvement of clinicians, including physiotherapists in the management process. It underlined the need for increased professional input into corporate decision-making. It supported the proposal to appoint general managers, once the general management functions and relationships with other managers were better-defined. It recommended continuing with the consensus approach to decision-

making with general managers concentrating on the general management functions only. The Society stressed the value of functional management for district-wide physiotherapy services and its direct relationship with district general managers (Physiotherapy Feb.1984, Vol.70, No.2, p.6).

### **Society of Radiographers**

The Society were 'appalled' at the lack of consultation and were particularly concerned that the proposals came so soon after the 1982 reorganization. The Society questioned the idea that doctors are natural managers, since all managers have to be trained and, for the most part, doctors are not trained to manage.

The main objection to the Report was its apparent dismissiveness of other professional groups and in particular the idea that unit general managers could overturn professional decisions of departmental managers. Finally, the Society objected to the implication made in the Report that the NHS does not know what the needs of its patients are and that businessmen have some special gift of knowing how well they are looking after their customers.

### **The Association of Community Health Councils (ASCHEW)**

The chair of ASCHEW hoped that a general manager would provide a focus for CHC and patients' involvement. Its main concerns were that the Griffiths Report had not clarified the role of these patient groups in the decision-making process and took this to reflect the luke-warm attitude of the government to public participation.

## **The Union View**

The Social Services Committee took evidence from the TUC, The Federation of Health Service Employees (COHSE), the National Union of Employees (NUPE), and the National and Local Government Officers Association (NALGO). Unions were unanimous in their view that the Griffiths Report recommendations failed to tackle the root of the NHS's problem, namely underfunding. COHSE put it strongly:

"...the Report seems more like an essay in political expediency than a serious attempt to get to grips with the problems faced by a service groaning under pressure placed on it by an aging population, chronic underfunding and arbitrary cuts in facilities and staffing levels."

and:

"Grocers may have been successful in persuading millions of people that white bread is what they really want, but they will be unable to convince families of the thousands of kidney patients that die untreated each year that it is unrealistic to expect the provision of resources to enable them to live."

NUPE referred to the Griffiths Report's failure to tackle the inequalities in health identified by the Black Report:

"It does not seek to create the social and economic conditions that would be conducive to good health, nor does it try to tackle the unhealthy working conditions and practices which millions of people have to endure daily."



Further evidence of the government's unwillingness to tackle such issues was said to be the time assigned to consulting on the Report and only then on two of the many issues raised.

The unions wanted to retain the consensus management system as the "most suitable framework for overcoming inter-professional differences". There are, it was argued, no 'Mr Wonderful' general managers around to make that much difference. Another criticism of the Griffiths recommendations was that, given what it saw as the appalling record of British management, why should the NHS take note of the private sector?

Clinician involvement in management caused some controversy. Why should doctors merit single consideration in the Report. NUPE argued that if clinicians "took over the management function", how could anyone oversee clinician activity in relation to private medicine.

## **CHAPTER 4**

### **Towards a Sociological Analysis of Health Services Management**

#### **Purpose of the Chapter**

This chapter explores the various empirical studies of local health services management in order to explore the difficulties of introducing change in the NHS. It is argued that these studies are enormously helpful in highlighting the complexities of delivering health services. However it is concluded that the majority of these studies cannot be said to constitute a properly sociological analysis since they often imply that managers' actions can be understood without reference to the social context of which these managers are a part. In elaborating this critique I draw on the work of Norbert Elias and the frameworks he developed as part of his figurational or process sociology. It is argued that figurational or process sociology offers a fruitful framework for the analysis of health service management and issues associated with managing change in the NHS.

#### **Empirical studies of the NHS management**

Stephen Harrison has provided a summary of health service management research between 1948 and 1983 documented in Figure 9 (Harrison, 1990).

# Empirical Research in the NHS: 1948-83

AUTHOR(S) AND PUBLICATION DATE	FIELDWORK	SCALE AND SCOPE	METHODS AND SOURCES
FORSYTH (1966) ROWBOTTOM et al (1973)	1964  1966-72	One RHB & its HMCs  One RHB & 9 HMCs	Questionnaire, documents  Interviews, action research
COMMITTEE OF ENQUIRY INTO ELY HOSPITAL (1969)	1967-68	One hospital	Formal inquiry
BROWN (1979) BROWN et al (1975) HAYWOOD (1977)	1972-75	One Area Health Authority and its predecessors	Interviews, questionnaires, documents, observation
KLEIN & LEWIS (1976)	1974-75	205 CHCs	Questionnaire
HUNTER (1979, 1980, 1984)	1975-77	12 Scottish Health Boards	Questionnaire, interviews documents, observation in 2 Boards
HAM (1981)	1975-77 (re 1948/74)	One RHB	Documents, Interviews
HALLAS (1976)	1975-76	17 CHCs, 60 CHC secretaries	Action research

FIGURE 9



AUTHOR(S) AND PUBLICATION DATE	FIELDWORK	SCALE AND SCOPE	METHODS AND SOURCES
HAYWOOD et al (1979) HAYWOOD (1979) ELCOCK & HAYWOOD (1980) HAYWOOD & ALASZEWSKI (1980)	1975-78	DHSS, 2 RHAS 4 AHAs and associated Teams	Documents, Interviews, observation
BARNARD et al (1979, 1980) LEE & MILLS (1982)	1976-79	2 Area Health Authorities	Documents, Interviews,, observation
WISEMAN (1979)	1976-78	SHHD, Planning Council, One Scottish Health Board	Documents, Interviews, observation
KOGAN et al (1978)	1977	DHSS, Welsh Office, SHHD, 3 RHAs, 6 Area Authorities 8 Districts, 6 CHCs (In England, Wales, Scotland & N Ireland)	Interviews

AUTHOR(S) AND PUBLICATION DATE	FIELDWORK	SCALE AND SCOPE	METHODS AND SOURCES
COMMITTEE OF INQUIRY INTO NORMANSFIELD HOSPITAL (1978)	1978	One hospital	Formal inquiry
HARRISON (1981) BARNARD & HARRISON (1986)	1978-82	Health Authorities in England	Interviews, questionnaires documents
STEWART ET AL (1980)	1979	32 District Administrators, 9 Area Administrators	Interviews, observations
HARRISON (1981b)	1979-80	DHSS, professional associates	Interviews, documents
HARDY (1986)	1979-80	2 hospital closures	Interviews, documents
STOCKING (1986)	1980-83	22 innovations in general: 4 detailed cases in RHAs and 12 districts	Interviews, documents questionnaires
RATHWELL (1987)	1980-84	One HA	Interviews, documents

AUTHOR(S) AND PUBLICATION DATE	FIELDWORK	SCALE AND SCOPE	METHODS AND SOURCES
GLENNERSTER et al (1983)	1980-81	2 DHAs, 2 Local Authorities, London	Interviews
SCHULZ & HARRISON (1983)	1981	19 Management Teams	Interviews, documents, some observation
HAM (1986)	1981-85	2 DHAS	Action research
HARRISON et al (1984a)	1982	72 managers	Interviews, documents
THOMPSON (1986)	1982-84	7 Management Teams	Interviews, documents
HAYWOOD (1983) HAYWOOD & RANADE (1986)	1982-84	6 DHAs (Members)	Documents, interviews, observation, repertory grid
FORTE (1986)	1983-84	1 District	Documents, interviews



There are several interesting features of this table:

1. There are relatively few studies.
2. There is a relative increase in the number of studies following the 1974 reorganization.
3. Very little empirical work has been done on professional management arrangements or management at the DHSS level.
4. Studies have focused on the general management of health services rather than on professionals', specifically clinicians', role in management.
5. This body of research, small as it is, does not inform the various NHS policy documents.

A review of the existing ethnographies of local health services finds a number of areas of consensus and, interestingly, the findings of studies conducted before 1974 are remarkably similar to those of later studies. Stephen Harrison provides a neat set of propositions which he uses to discuss common research findings, namely:

1. Managers were not the most influential actors in the health service.
2. Managerial behaviour was problem-driven rather than objective-driven in character.

3. Managers were reluctant to question the value of existing patterns of service or to propose major changes in them.
4. Managers behaved as if other groups of employees, rather than the public were clients of the health service (Harrison, 1990, p.31).

These propositions are examined, drawing on the empirical studies cited by Harrison and those uncovered during my own literature search.

**Proposition 1.** Managers were not the most influential actors in the health service.

This proposition is, in one sense, not surprising since, if one looks at the formal accountability structure, managers are accountable to the local health authority, led by the chair. This would lead one to believe that members of the authority should be the most influential people in the management of local health services. However, research into the role of health authorities and, indeed, the role of the chair, reveals that health authorities are relatively impotent in terms of influencing local health care policy and chairs often lack influence over either the health authority or the management team. The Kogan Report for the Royal Commission of the NHS noted of AHA members:

"...Their impact on the service was felt to be slim. The great majority of respondents at all levels either felt that their impact was weak or recorded no comment at all about members....Many felt that members were good people with a job to do, but all the same had little impact. This feeling corresponds with members' own belief that they had no real opportunity to get a grip on the system." (Kogan, Goodwin, Henkel, Korman, Lockwood, Bush, Hoyes, Ash and Tester, 1978, p.75)

This general view is confirmed by many of the available ethnographies. Brown notes that decisions about the shape of the service, in his case study area of Humberside, were made technocratically, with the minimum of involvement by lay authority members (Brown, 1979, p.122). Ham in his longitudinal study of the role of members in two health authorities describes members as marginal participants in the policy process (Ham, 1986, p.127), as do Haywood and Alaszweski (1980, pp.84-109).

Studies have put forward a number of explanations as to why health authority members are ineffective: there are no real choices to be made locally and therefore no issues to facilitate a distinctive contribution from members; inappropriate selection; lack of preparation and poor training of members; poor information given to members and increased control by the Centre which has served to erode health authority influence (Haywood and Alaszweski, 1980; Haywood 1983; Haywood and Ranade, 1985; Ham, 1986).

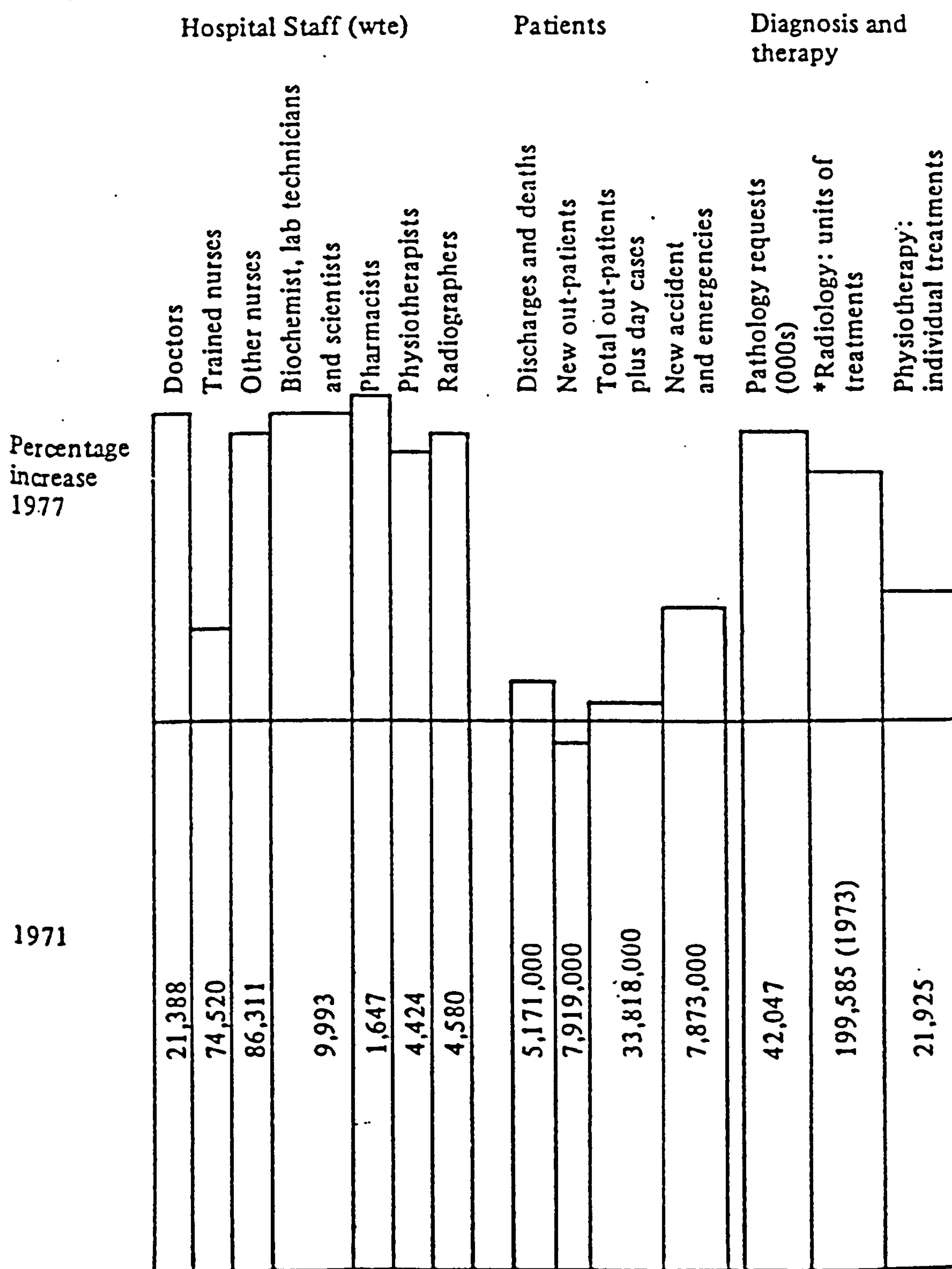
Several studies note that the key to understanding how decisions are made and resources allocated in health authorities is the power of the medical profession. Alford (1975), suggests that health politics are characterized by three sets of structural interests: professional monopolists (the dominant interest), corporate rationalizers and the community population (the repressed interest). Drawing on Alford's work, Ham suggests that in Leeds RHB:

"The history of hospital planning between 1948 and 1974 can be seen as the history of corporate rationalizers represented by regional board planners, trying to challenge the established interests of the medical profession, with the community hardly in earshot." (Ham, 1981, p.75)



A number of studies echo Ham's point. A statistically-based analysis of the influence of the medical profession on strategic issues was carried out by Haywood and Alaszweski (see Figure 10 below). They consider the use of an increment of 28% for NHS spending (the Office of Health Economics calculation) between 1970 and 1977 in order to see what that indicates about the extent of managerial control. For this reason they concentrate on the hospital services.

### Some Hospital Statistics: England, 1971-7



\*These figures refer to 1973-7 because of a significant change in units of measurement in 1973.

Sources: DHSS, Health and Personal Social Services Statistics for England (HMSO, London); Department summaries of official returns to the DHSS. Not all figures are directly comparable because of changes in definitions. Broad trends are, however, unaffected.

Haywood and Alaszweski point out the following major findings from the Figure above:

1. The increase in the numbers of hospital staff has not been matched by an equivalent increase in the number of patients.
2. Whilst some of the growth in personnel (which continued in 1977-8) was pre-empted by national decisions (e.g. shorter hours, longer holidays), the size of the increment suggests some leeway for a local say in its distribution.
3. The small rise in inpatients treated (though there were far more day patients) and the static number of outpatients (though there was a sizeable increase in the number of accidents and emergencies), reflects decisions not to use these additional resources to increase throughput.
4. Diagnostic and therapy departments were the principal beneficiaries of additional resources made available to health authorities and the number of scientists, technicians, physiotherapists and radiographers, increased significantly.
5. The major use of the increment was in diagnosis, testing and therapy, with a fairly static number of patients rather than the admission of more of them into the hospital system.

Haywood and Alaszweski conclude from their scrutiny of the data that the crucial element in local decisions on the way the increments should be spent, has been the development of clinical practice, and that management has responded to these



developments rather than controlled or directed them (Haywood and Alaszweski, 1980, p.106).

Stocking's study of four innovations (regional secure units, changing patients' waking times, rickets among Asians and day-case surgery) are fascinating examples of how need and solution as seen by those working at the Centre may not fit in with attitudes and opportunities of those at the periphery. Each case study indicates how often the need to manage a service effectively has been tempered by attitudes about clinical freedom and demonstrates the complexity of decision-making in the NHS because of the presence of many powerful, and not always compatible, individuals and interests (Stocking, 1985).

The influence of the medical profession on national arrangements for health care management is well documented (Eckstein, 1958; Forsyth, 1966; Haywood and Alaszweski, 1980). However ethnographies of local health care systems note a marked contrast between doctors' performance on a national and local stage. Nationally, doctors have taken a lead in securing a position of influence in both the formation of the NHS and subsequent reorganization (see Chapter 2). However, on the local stage, there appears to be a great reluctance on the part of doctors to get involved in local management of health services. Representatives of the profession are shown to be reluctant to give the time to the demands of a representative role (Brown, 1979, p.140) and feel vulnerable when taking decisions because of a lack of information and for fear of offending their constituency (Schultz and Harrison, 1983, p.29). In part, the reluctance to get involved in management can be explained by the overcomplicated professional advisory machinery created in 1974, but also because doctors have a great influence on the service without necessarily being in formally defined administrative roles.

The power of hospital clinicians to shape health services has been attributed to many factors including: the concessions made to the doctors in 1948 (Willocks, 1967; Eckstein, 1958 and 1960); the spread of the epidemic iatrogenesis which has cost humanity its liberty with regard to our own bodies (Illich, 1975), the role of doctors as the agents of capitalism, benefitting from a capitalist system (Navarro, 1978 and 1980); and the objectification of the body (Foucault, 1973). The origin of medical power can, however, be traced back much further. Waddington (1984) notes the importance of the 1858 Medical Act and of the formalization of codes of medical ethics in facilitating the development of a single, relatively unified profession, thus enhancing the power of all medical practitioners.

A number of studies suggest that RHAs, CHCs, local authorities and trade unions have little influence over local health policy except with respect to specific matters. Furthermore these studies suggest that second to the doctors in terms of influence over local health care policy are the administrators, primarily because of their access to information (Stewart, Smith, Blake and Wingate, 1980, pp.81-83; Haywood and Alaszewski, 1980; Ham, 1981).

**Proposition 2.** Managerial behaviour was problem-driven rather than objective-driven in character.

To examine this proposition it is helpful to consider studies which focus on the question of how NHS managers spend their time. Perhaps the most useful in this respect are Stewart's study of the district administrator (Stewart, Smith, Blake and Wingate, 1980), the study of top management teams carried out by Schultz and Harrison (1986), Haywood's study of items of business in meetings of four management teams (1979) and a study of the perceptions of NHS managers (Harrison, Haywood and Fussell, 1984).



In Stewart's study of a group of district administrators, only a few administrators dealt with strategic issues and most concerned themselves with ad hoc referred issues. Stewart uses Belbin's model of groups (Belbin, 1991) to discuss the types of roles adopted by the DA. She notes that the "shaper" role, characterized by initiation and influence towards objectives, was a role that few DAs adopted. Only a few of the DAs adopted the general manager and the innovator role and it was the role of administrator with its characteristics of servicing and maintaining on which most DAs seemed to concentrate (Stewart, Smith, Blake and Wingate, 1980, p.76).

Studies of the agendas of consensus management teams confirm a prevalence of non-strategic items, for example:

"In practice, few top managers are proactive in pursuit of these objectives (to provide services which are effective in improving health, comprehensive, accessible to all, responsive to the perceptions of users, and delivered in as efficient a manner as possible); they lack influence in relation to consultant staff (who are largely responsible for the pattern of health care services) and are in many cases reluctant to use the influence they do possess." (Schulz and Harrison, 1983, p.52).

In the course of the study of what consensus management teams do, Haywood divided the business into four categories:

- (1) Information: items where the primary purpose was the transmission of information without it being related to a particular decision.



- (2) Process: items concerned with how an issue should be handled rather than the outcome of the process.
- (3) Position taking: items concerned to establish the team's view on issues or discussions which involved other agencies, other elements within the health authority, or other health authorities.
- (4) Substantive decision items which lead to specific decisions designed to affect the level of service to patients or allocate resources to staff. A distinction is drawn between routine decisions in which well-established rules are applied to the issue in question, and non-routine in which the subject matter is less amenable to the application of general rules.

The balance between the items of business is shown in Figure 11 below, which confirms Harrison's first proposition that managers were not the most influential actors in the health service.

**Categorisation of items of business in  
meetings of four management teams:  
April 1977 — July 1977**

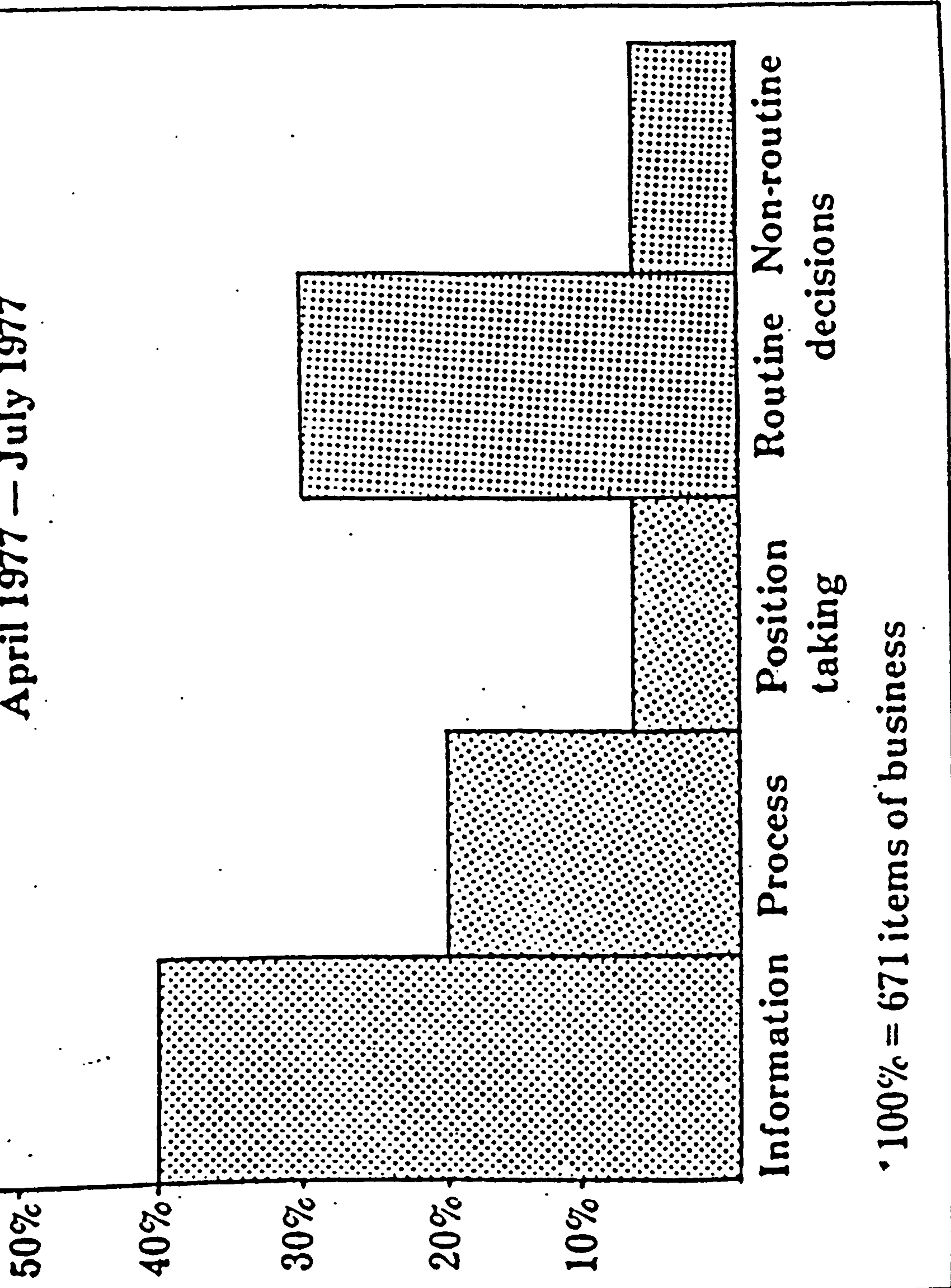


FIGURE 11

Haywood, S. Team Management in the NHS: What is it all about?  
Health and Social Services Journal, 5th October, 1979

Harrison, Haywood and Fussell found their sample of NHS middle managers saw their jobs primarily in terms of tackling problems referred to them by other people who had expressed dissatisfaction. Figure 12 below shows that this group of managers' main consideration was to satisfy complaints without creating further dissatisfactions elsewhere (Harrison, Haywood and Fussel, 1984, p.185).



### Typical Problems: Group of Administrators (1982)

Respondent	Summary of Problem
1	An enquiry from a nursing officer about restrictions on visiting arrangements for a 16-year-old male patient.
2	Change the method of management of porters and drivers and reorganise shift work to increase flexibility.
3	Unwillingness of staff recreation team to allow the league of friends to participate fully in hospital activities, and in particular a reluctance to hand over to them the organisation of the hospital fete.
4	Evening domestics refused cover for the absence of one of their colleagues on maternity leave.
5	New member of consultant staff requests accommodation for an out-patient clinic on a day and time when none is available in hospital.
6	Difference of interpretation about policy about terms of replacement of staff in a period when numbers of "funded" posts was being reduced in the district.
7	Claim for up-grading of post in pathology department.
8	Industrial action by sewing room ladies.
9	Reorganisation of copying facilities in district headquarters to minimise waiting time and obtain correct balance of machines at other locations.
10	Delay in re-opening of post-natal ward during building project.
11	Inappropriate siting of physiotherapy facilities on large site, occasioning treatment in wards not considered to be the "correct environment".
12	Allocation of responsibility between patient services officer and voluntary services co-ordinator for newly opened patients club run in the evening by volunteers.
13	Visit by health authority during "mild" industrial action likely to "lead to a more severe demonstration".
14	"Messy" documentation for each stage of grievance procedure for an ambulance service.

The other strong tendency which emerged in a free choice of problem, especially amongst nurse-managers, was a concern with organizational formalities as indicated in Figure 13 below.

## Typical Problems: Group of Nurse Managers (1982)

Respondent	Summary of Problem
20	Communication and role patterns in nurse education division.
21	Organisational arrangements for nursing in a geographically defined management unit.
22	Organisational arrangements for integration of midwifery with acute nursing unit.
23	Development of a model of nurse manpower demand and supply.
24	Organisational arrangements within a mental illness/geriatrics unit of management.
25	Recruitment and selection procedure for learner nurses at end of training period.
26	Relationships with administration in a hospital. Design of policy for relief staffing.
27	Formal incident reporting procedure in a hospital.



**Proposition 3.** Managers were reluctant to question the value of existing patterns of service, or to propose major changes in them.

Studies show that incrementalism was a feature of planning and the allocation of resources at local level. Several studies characterize planning in the health service as "what to do with the increment" (Glenester, Korman and Marslen-Wilson, 1983, p.264). David Hunter, in his study of the allocation of development funds in two Scottish health boards, noted there was always a tendency to seek more resources in preference to questioning the value of existing resource use. Development schemes, therefore, often meant "more of the same". He argued:

"At best allocation of development funds, reflected a compromise between simply plugging the gaps in existing services, and...initiating new services.... Often there was no choice...Pressures from existing services presented officers with little or no alternatives but to plough more funds into them to relieve the pressures." (Hunter, 1980, p.184).

Development lists were described by Hunter as 'shopping lists of deficiencies' (Hunter 1979, Ph.D, p.627) and not linked to any broad development strategy. This, he argues, leads to policy stasis. In trying to explain this situation, Hunter stresses that, faced with a situation of complexity and uncertainty, people will rely on decision-rules, rules of thumb or standard operating procedures, to make decision-making manageable. He cites a number of "decision rules" or "coping strategies" that were deployed by decision-makers in his study; these included seeking the answers to such questions: Who has done all right so far? Who has had too much in relation to the

rest? Who has over/under spent? Who will it hurt least? A policy of appeasement or fair shares seemed to be favoured by administrators. Hunter argues that when considering the incremental approach to development fund allocations, one needs to look for explanations, not only in terms of cognitive differences or insufficient information, or indeed technical problems, but also in terms of genuine puzzlement and uncertainty about what objectives the NHS ought to be pursuing. This uncertainty often leads to the pursuit of strategies and objectives that minimise risk and seems to lead to effectiveness being measured in terms of improvements in the hotel aspects of the service, rather than impact on patient care or health.

Several studies note that planning was often seen as the exploration of what to do with hospital beds (Ham, 1981, p.147; Glenester, Korman and Marslen-Wilson, 1983, p.261; Rathwell, 1987). This reflects the power of the hospital consultants discussed earlier. It seems from existing studies that comment on the role of doctors in management that consultants' attitudes to planning health services tended to be framed by concerns such as 'my work', 'my beds' and 'my unit'.

**Proposition 4.** Managers behaved as if other groups of employees, rather than the public, were clients of the health service.

The implication of this statement is that managerial behaviour is mainly producer-led rather than consumer-led. Studies which examine the involvement of the public in health services policy elaborate this point. Consumers in the NHS are formally represented by CHCs. Studies of CHCs confirm Harrison's proposition. CHCs were found to be polite and deferential (Halles, 1976, p.59), reluctant to use their powers



(Klein and Lewis, 1976, p.135), rarely consulted (Ham, 1980, p.226) and were often labelled 'watchdogs without teeth' by the health service press.

Ham notes that the contribution which CHCs are able to make to NHS planning depends on the access to information they are granted. Despite having a right to basic information from health authorities, the annual reports of CHCs studied by Ham indicate that nearly all CHCs experienced difficulties in attempting to exercising this right. He goes on to point out that only rarely do health authorities deliberately withhold information. The major reason for poor involvement, according to Ham, is the time given for CHCs to contribute to planning (they are often asked for views at a late stage in the planning cycle) and the tendency of administrators not to place a high value on CHC participation (Ham, 1980, p.226; Stewart et al, 1980).

#### Discussion of the research findings from empirical studies of NHS management up until 1983

The ethnographies of local health services summarised in this chapter are helpful in allowing one to peep into the black box of local health service management. They consistently question the assumption of the 1974 restructuring that management is a rational process and that policy is made at the Centre, transmitted to the periphery and implemented there. Those working in local health care systems can, and do, circumvent national policy (see the continuation of inherited inequalities between different parts of the country (Buxton and Klein, 1975) and the continuing dominance of hospital medicine at the expense of community care). These studies reveal that decisions affecting local health care delivery evolve in bargaining situations and that,



although policy processes at a local level are incremental and plural, the distribution of power is weighted towards the medical profession.

Several studies point to genuine uncertainty amongst health service managers as to how to prioritize the many demands on finite resources. This task is made more difficult by the absence of reliable information about the costs or benefits of various treatments, unclear central policy guidelines and the powerful emotional arguments marshalled by doctors in the name of clinical autonomy.

Yet, in spite of the usefulness of these studies in empirically demonstrating the dilemmas faced by health service managers and the actions of managers in the face of these dilemmas, such studies do not offer a convincing analysis of these findings. A number of explanations are offered for the relative failure of NHS management to meet changing health care needs. Cognitive differences between those managing health services is one such explanation, for example, the different training and socialisation processes of doctors and administrators. Technical problems are also given as an explanation, for example, poor information about health outcomes. Genuine puzzlement about what objectives the NHS should be pursuing is yet another explanation which hints at the failure of the government to provide a clear, consistent policy steer. Most explanations, however, centre on the inability of managers to challenge the long-established power of the medical profession. Notwithstanding such references to other groups within the health service, it may be argued that these explanations cannot be said to constitute a thoroughgoing sociological analysis because they do not adequately locate managers' actions in the social context (that is, the complex network of relationships) of which managers are a part. The complexity of these networks is often reduced so that managerial relationships are seen as relationships involving only those people with whom the management team or

administrator has face-to-face contact. These points are developed later on in the thesis.

Another criticism one could make of this body of empirical research is the unwillingness to consider the impact of health care management and health care reorganization on patient care and health. In this respect, researchers, like managers, could be accused of behaving as if other groups of employees rather than the public, were clients of the health service (Harrison's fourth proposition about health care management).

It is one thing to voice dissatisfaction with the analysis of these studies (recognising their important contribution), it is another to offer an alternative. A great deal of my time working on this thesis was spent looking for a more satisfactory framework to understand health care management issues and the problems associating with managing change in the NHS. Like Cox (1990), I found very little useful material in either the medical sociology literature or indeed within the area of organizational behaviour where I lecture. In discussions with my supervisor I began to study the sociology of Norbert Elias. In an extensive reading of his writings I found myself agreeing with his vision of the task of sociology and found that his comments about the needs of human beings were both perceptive and far-reaching. Moreover his perspective seemed to offer the sociologist an escape from some of the basic and long-standing theoretical dilemmas within the discipline, for example, how best to conceptualise the relationship between what is conventionally known as society and the individual, between change and structure and between purposeful action and unintended consequences.



One is always aware of the dangers of being seduced by an attractive framework that one feels will assist in bringing order to chaotic empirical material. Nevertheless, Elias's approach is distinctively different from that of most other sociologists, and the possibility of applying some of Elias's ideas to the study of health care organization and management suggested one way in which the thesis could make a contribution, not only to the study of the health service, but to sociology more generally.

The rest of this chapter considers Elias's work and argues that, though his approach has not been applied to the analysis of health care organizations<sup>(5)</sup>, it has much to offer those involved in research in the area of NHS organization and management.

### Figurational or Process Sociology

Figurational or process sociology, as Elias called his approach, is a minority standpoint amongst social scientists. Recently De Swann has gone so far as to say that Elias is seen by many social scientists as eccentric, deserving, if not of being read and quoted, at least of highest praise, but wholly outside of the mainstream of academic social science (De Swann, 1990, p.4). He goes on to say he feels this is a 'fundamental error' since:

"Elias has confronted the central task of social science in the tradition of the classical authors, and his historical, sociological investigations into state formation and the civilizing process have pointed to a new course for mainstream social science to follow." (De Swaan, 1990, p.4.)

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(5) Except for the work of De Swaan, who is more concerned with the development of health care as part of overall welfare provision, rather than with the analysis of organizational structure per se.



Goudsblom notes four themes of Elias's work which illustrate the principles of figurational or process sociology. They are:

1. Sociology is about people in the plural - human beings who are interdependent with each other in a variety of ways, and whose lives evolve in, and are significantly shaped by, the social figurations they form together. People do not exist in a vacuum or in an asocial context.
2. These figurations are continually in flux, undergoing changes of many kinds - some rapid and ephemeral, others slower but perhaps more lasting.
3. The long-term developments taking place in human figurations have been, and continue to be, largely unplanned and unforeseen.
4. The development of human knowledge takes place within human figurations and is one important aspect of their overall development (Goudsblom, 1977, p.105).

At the heart of Elias's sociology is a concern with the subject matter of sociology. Elias noted that many sociologists seek to investigate the behaviour, views and experience of individual people and then seek to process their results statistically. By focusing on component parts, sociologists hope to bring to light the characteristics of these composite units (Elias, 1970, p.71). He attributed this approach in part to the influence of the classical tradition of the physical sciences and the belief that classical physics is the model to which all other scientific studies should look for guidance (Elias, 1969, p.117). The classical tradition advocates that the way to investigate a composite unit is to dissect it into component parts, study the properties of the

component parts in isolation and then, finally, to explain the distinguishing properties of the composite unit in terms of its component parts.

Elias took issue with this view and argued that the more closely integrated are the components of a composite unit, or the higher the degree of functional interdependence, the less possible it is to explain the properties of the latter in terms of the former. In such a case it becomes necessary not just to explore a composite unit in terms of its component parts (analysis), but also to explore the way in which these individual components are bonded to each other so as to form a composite unit (synthesis).

"A study of the configuration of the unit parts, or, in other words, the structure of the composite unit, becomes a study in its own right. This is the reason why sociology cannot be reduced to psychology, biology or physics: its field of study - the figurations of interdependent human beings cannot be explained if one studies human beings singly. In many cases the opposite procedure is advisable - one can understand many aspects of the behaviour or actions of individual people only if one sets out from the study of the pattern of their interdependence, the structure of their societies, in short from the figurations they form with each other..." (Elias, 1970, p72)

For Elias, it was the interdependencies between people - in his terms figurations - which provide sociology with its field of study. According to Elias, figurations are best thought of not simply as congeries of particular individuals known by name, but also as impersonal and, to some extent, self-regulating, self-perpetuating configurations (Elias, 1970, p.56). It follows, therefore, that people are interdependent with others whom they have never met, and can therefore be affected by the activities of others whom they have never met. For example, a fundamental

constraint on the career structure of NHS managers is provided by government decisions. Elias believed that because of the conventional, dichotomous approach to thinking about the individual and society, sociologists have been trapped in unproductive arguments about whether society or the individual is more real and which should come first as a point of departure in sociological investigation. Furthermore Elias argues that much of sociology has been based on an egocentric model of society (see Figure 14) in which the isolated static individual or ego stands at the centre of a series of concentric circles, the first being me, my family, with my work-place, my town, my country, and a succession of ever-wider zones beyond (Elias, 1970, p.14).



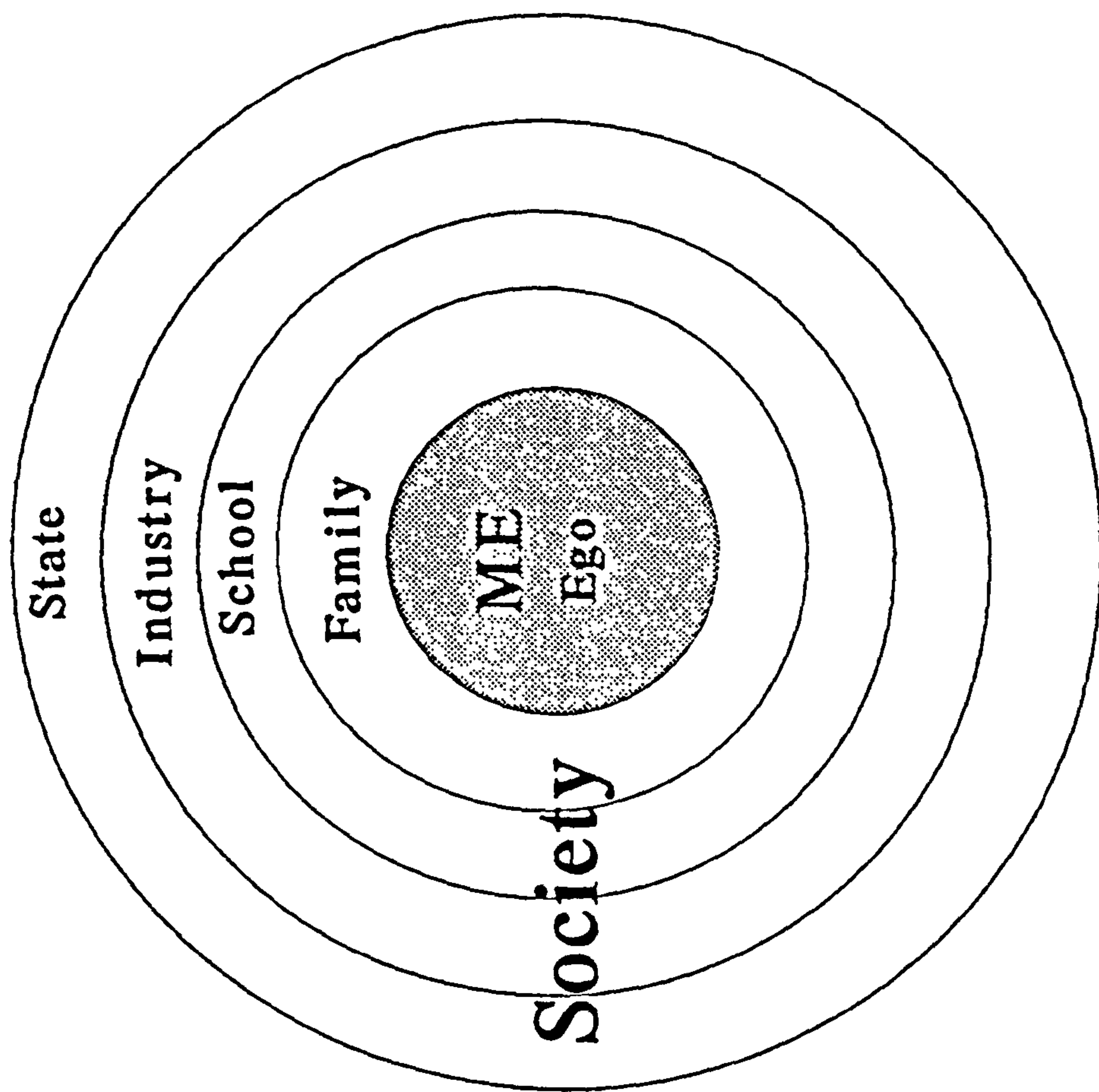


FIGURE 14

Elias, 1970, p14

Very few sociologists, Elias argued, have attempted to break away from this egocentric conception. Weber, whilst fully aware that individuals were steeped in the social, nevertheless "axiomatically" believed in the "absolute individual"... as the true social reality. (Elias, 1970, p.117). Concepts like 'state', 'family', 'army' or 'class', were seen by him as simply a particular pattern in individual people's social action. Mennell has recently argued that this led Weber into such absurdities as arguing that private prayer, an accidental collision between cyclists, or many people simultaneously putting up umbrellas when it rained, are not instances of social action - as if praying or riding a bicycle, or using an umbrella were activities that could be understood independently from the social development of religion and technology (Mennell, 1990, p.255).

Similar problems, argued Elias, beset Talcott Parsons's voluntaristic theory of action. Parsons begins from the model of interaction between two people, referred to as ego and alter (Parsons and Shils, 1951). Mennell argues:

"It is highly significant that in this famous didactic model, not only "ego", but also "alter" - the "other person" - is conceptualized as a single, isolated entity, rather than a multiplicity of other people, directly or indirectly, interdependent with "ego" and with each other (Mennell, 1990, p.255).

Elias argued that Durkheim struggled valiantly with the chicken and egg problems raised by what Elias termed homo clausus (man or woman is an isolated static individual) assumptions (Durkheim, 1938), but still fell prey to making society appear something existing over and above individuals, surrounding and penetrating them, therefore still bowed to the assumption that society and the individual can best be conceptualised as separate things.

Elias was not surprised by the trend in sociology to reduce processes conceptually to a steady state in the name of analysis, since he noted that much of our everyday language does the same.

"Our languages are constructed in such a way that we can often only express constant movement or constant change, in ways which imply that it has the character of an isolated object at rest, and then, almost as an afterthought, adding a verb which expresses the fact that the thing with this character is now changing. For example, standing by a river we see the perpetual flowing of the water, but to grasp it conceptually, and to communicate it to others, we do not think to say, "look at the perpetual flow of the water"; we say, "look how fast the river is flowing". We say "the wind is blowing", as if the wind were actually a thing at rest, which, at a given point in time, begins to move and blow. We speak as if the wind was separate from its blowing, as if a wind could exist which did not blow. And this reduction of processes to static conditions, which we shall call "process reduction", for short, appears self explanatory to people who have grown up with such language. They often imagine it is impossible to think and speak differently, but that is simply not so. Linguists have shown that many languages have structures which make it possible to assimilate such experiences differently." (Elias, 1970, pp.111-112)

Elias passionately believed that sociology needed to find a new means of speaking and thinking.

"At first it might perhaps seem that an effort to reorient our thinking might complicate the work of sociology. But the reverse is true. If this effort is made, the work becomes simpler. The complexity of many modern sociological theories is due, not to the complexity of the field of investigation



which they seek to elucidate, but the kind of concepts employed. These may be concepts which either have proved their worth in other (usually physical) sciences, or are treated as self-evident in every-day usage, but which are not at all appropriate to the investigation of specifically social functional nexuses." (Elias, 1970, p.111)

It was Elias's view that one of the most promising models for non-reifying concept formation found in our every-day language is personal pronouns. Personal pronouns, he argued, represent the elementary set of coordinates by which all human groupings can be plotted out (Elias, 1970, p.123).

"The function of the pronoun "I" in human communication can only be understood in the context of all the other positions to which the other terms in the series refer. The six other positions are absolutely inseparable, for one cannot imagine an "I" without a "he", or a "she", a "we", "you" (singular and plural) or "they" (Elias, 1970, p.123).

Elias argued that taken together, personal pronouns are an elementary expression of the fact that every person is fundamentally related to other people and that every human individual is fundamentally a social being. Using personal pronouns leads to an easy transition from the image of man or woman as homo clausus to one of homines aperti - (people in the plural) and also helps us to understand that the concept individual refers to interdependent people in the singular and the concept of society to interdependent people in the plural. The first field, he believed ought to be the concern of psychologists and psychiatrists, the second, of sociologists and social-psychologists.

Elias argued that by adopting his view of the scope of sociology, sociologists can move away from parochial specialist models of man, the best known of which is homo economicus, but which are refined versions of homo clausus, the dominant concept of man or woman in contemporary industrial society (Elias, 1969, p.122).

Elias drew on the word 'figuration' because it was a more dynamic and processual term and highlighted the inadequacies of the existing static vocabulary of sociologists.

"Looking through sociology textbooks, one finds many technical terms which convey the impression of referring to isolated and motionless objects; yet on closer scrutiny they refer to people who are or were constantly moving and constantly relating to other people. Think of concepts like norm and value, structure and function, social class or social system. The very concept of society has this character of an isolated object in a state of rest, and so has that of nature. The same goes for the concept of the individual. Consequently we always feel impelled to make quite senseless conceptual distinctions, like "the individual and society", which makes it seem that "the individual" and "the society", were two separate things, like tables and chairs or pots and pans. One can find oneself caught up in long discussions of the nature of the relationship between these two apparently separate objects. Yet, on another level of awareness, one may know perfectly well that societies are composed of individuals, and that individuals can only possess specifically human characteristics, such as their abilities to speak, think, and love, in and through their relationships with other people - "in society"." (Elias, 1970, p.113)



If one accepts that we live in a social context, that is to say we live within and are part of a network of social relationships, the question then arises, what is a relationship? There is a pervasive tendency for people, particularly citizens of western society with their emphasis on individualism, to conceive of relationship in terms of face-to-face contacts. This view is entirely understandable and based on the often unspoken assumption that the people with whom one has most contact are bound to have the greatest impact on us. While no-one would deny the influence of those closest to us, to adopt this view places an unnecessary limitation on the concept of relationship. People all over the world are constantly engaged in activities which affect the lives of other people of whose existence they are more often than not, oblivious. When we speak of relationships it is important to understand these in terms of global networks. In other words, while we may feel many of the effects of relationships, there are also some effects which impact upon us without us being aware of them. An example of the way in which we are capable of internalising a mode of behaviour without being consciously aware of the process is provided by the way in which we sleep. In western societies at least, infants tend to be transferred from cots to beds around the age of two. Initially, many youngsters have a tendency to respond to this less restricted environment by falling out of bed. Gradually, even though they are asleep, they learn to toss and turn in bed and yet remain within its bounds. Beds are social products. Their dimensions have been established by fellow human beings and adults have learnt to accept their limitations without giving them a second thought. This is quite a remarkable process because it provides an example of the way in which social morès can influence us even when we are in a state of unconsciousness.(6)

We as individuals have been, and continue to be, influenced by the activities of past generations. Not only have we inherited from them material things like buildings,

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(6)An example quoted by Patrick Murphy, a colleague of Ivan Waddington in course material for the MSc Sociology of Sport and Sport Management, University of Leicester.



roads and so on, but less tangible things like language, political ideologies, religious beliefs. Successive generations - whether they intended it or not - have passed on the social world they inherited and modified it during the course of their lives. Elias's book "The Civilising Process" (Elias 1939) is an illuminating demonstration of how normative practice can be passed down over hundreds of years even though, in the process, the vast majority of people remain oblivious of its origins. This work highlights the weakness of any perspective which assumes that all behaviour can be understood adequately in terms of conscious processes.

Central to Elias's concept of figuration is the closely related concept of power chances or balance of power. That is, people who are interdependent are not necessarily equally interdependent. The more dependent individuals are on others, the less power chances they have and vice versa.

"Where the balances of power within the web of interdependence are relatively equal, the web constrains the activities of those enmeshed in it, even more, and more evenly for all. The more extensive the web, the more probable it is that even the more powerful will be constrained by ambivalence, knowing that an uninhibited pursuit of their own desires could jeopardize the very links in the web on which they depend, bringing forth consequences which even they must fear." (Mennell, 1989, p.95)

Because people are differentially interdependent, the balance of power tends to be unequal. However, it is important not to fall into the trap that very powerful groups are all powerful, for they are inevitably dependent on other less powerful groups. An elaboration of Elias's thoughts on power will be given in Chapter 7.

Mennell notes that by the late 1980s, Elias had become irritated by the term "figurational sociology" as a label applied to his own work and that of others influenced by him (Mennell, 1990, p.251). He was concerned because figuration had become a label for another "school" of sociological thought and, perhaps more concerned, that figuration was being used in just as static and reifying a way as "social system". He preferred the term "process sociology" to describe his work because process is such an ordinary word and is therefore less susceptible to use as a "cordon sanitaire" with which to quarantine his ideas.

### The methodology appropriate to process sociology

As well as commenting on the subject matter of sociology, Elias offers views as to how it is to be researched. There has been much debate about a methodology appropriate to sociology, often considered under the term 'philosophy of science' (see Popper, 1968; Medawar, 1969; Lakatos and Musgrave, 1970; Hanson, 1975; Barnes, 1982). The problem of involvement and detachment lies at the heart of a number of debates in the social sciences. Most commonly, the discussion has been framed in terms of a static polarity between total 'objectivity' and total 'subjectivity'. Elias suggested that one of the problems with concepts like "objectivity" and "subjectivity" - concepts which are perhaps more characteristic of a philosophical rather than of a properly sociological approach to problems of knowledge - is that they tend to suggest a static and unbridgeable divide between two entities, "subject" and "object", as though these were "two inert figures standing at a distance from each other at opposite sides of a great divide" (Elias, 1987, p.112). Closely associated with this is the almost ubiquitous tendency, among those who use these terms, to describe research in all-or-nothing terms, that is to describe it as either totally "objective" or, conversely, as completely lacking objectivity, that is, as being "subjective" in an absolute sense.



Furthermore, Elias argued, it is not possible in these terms adequately to describe the development of modern science, for this development was a long term process, and there was not a single historic, moment when "objective" scientific knowledge suddenly emerged, full formed, out of what had formerly been wholly "subjective" forms of knowledge. Elias argued that what is required is more adequate conceptualisation of our ways of thinking about the world, and of the processes as a result of which our present ways of thinking about the world have come into being. Elias's conceptualisation of the problem in terms of degrees of involvement and detachment is, in my view, more adequate than conventional arguments because it does not involve a radical dichotomy between categories such as "objective" and "subjective", as though these were mutually exclusive categories; and this conceptualisation is relational and processual. It allows social scientists to make statements about the changing relationships between "objects" and "subjects", whether the objects be in the "natural" world or the "social" world, and it provides us with a framework with which we can examine the development, over time, of more scientific (or what Elias called more object-adequate or alternatively more reality-congruent) knowledge.

To elaborate on Elias's conceptualisation of degrees of involvement and detachment. Elias emphatically denied the possibility that the outlook of any sane adult can be either wholly detached or wholly involved. Normally, he notes, adult behaviour lies on a scale somewhere between these two extremes.

"One cannot say of a man's outlook in any absolute sense that it is detached or involved (or, if one prefers, 'rational' or 'irrational', 'objective' or 'subjective'). Only small babies, and among adults perhaps only insane people, become



involved in whatever they experience with complete abandon to their feelings here and now; and again only insane people can remain totally unmoved by what goes on around them (Elias, 1956, p.226).

Thus the concepts of involvement and detachment "do not refer to two separate classes of objects...what we observe are people and people's manifestations, such as patterns of speech or of thought...some of which bear the stamp of higher, others of lesser detachment or involvement" (Elias, 1987, p.4). Clearly, therefore, Elias is not suggesting that it is possible for us to obtain "ultimate truth", or complete detachment. Some critics of figurational sociology have alleged that advocates of this approach claim to be able to offer "objective" analyses of social processes. From what has been said, it should be clear that this was never Elias's position and, indeed, it is a position which he explicitly rejected.

Elias noted that sociologists, like everyone else, are members of many social groups outside of their academic communities - families, clubs, political parties and so on - and they cannot cease to take part in, or to be affected by, the social and political affairs of their groups and their time. In this sense, they cannot be wholly detached. However, Elias goes on to note that there is at least one sense in which it would not be desirable, in terms of the development of sociology, for them to be wholly detached, even if this were possible. For while one need not know, in order to understand the structure of a molecule, what it feels like to be one of its atoms, in order to understand the way in which human groups work one needs to know from "inside" how human beings experience their own and other groups, and one cannot know this without active participation and involvement. The problem for sociologists, then, is not the problem of how to be completely detached, but of how to maintain an appropriate balance between these two roles of everyday participant and

scientific inquirer and, as a professional group, to establish in their work the undisputed dominance of the latter.

The question then arises, how is it possible to determine the position of specific attitudes or ways of thinking on this involvement/detachment continuum? In other words, how can we differentiate between attitudes or knowledge which reflect a relatively high degree of involvement, and those which reflect a higher degree of detachment? Why should we, as sociologists, seek to achieve a higher degree of detachment in our work? And what are the processes which, over a long period of time and as part of the process of social development, have gradually enabled people to think, first about the "natural" world, and then, more slowly, about the "social" world, in more detached terms? These questions can be best explored *via* a consideration of Elias's essay "The Fishermen in the Maelstrom".

Elias begins his essay by retelling an episode from Edgar Allen Poe's famous story about the descent into the maelstrom. Two brothers who were fishermen were caught in a storm and were slowly being drawn into a whirlpool. At first, both brothers - a third brother had already been lost overboard - were too terrified to think clearly and to observe accurately what was going on around them. Gradually, however, the younger brother began to control his fear. While the elder brother remained paralysed by his fear, the younger man collected himself and began to observe what was happening around him, almost as if he were not involved. It was then that he became aware of certain regularities in the movement of objects in the water which were being driven around in circles before sinking into the whirlpool. In short, while observing and reflecting, he began to build up an elementary "theory" relating to the movement of objects in the whirlpool. He came to the conclusion that cylindrical objects sank more slowly than objects of any other shape, and that smaller objects sank more slowly than larger ones. On the basis of his observations and of his



elementary "theory", he took appropriate action. While his brother remained immobilized by fear, he lashed himself to a cask and, after vainly encouraging his brother to do the same, leapt overboard. The boat, with his brother in it, descended rapidly into the whirlpool. However, the younger brother survived, for the cask to which he had lashed himself sank much more slowly, and the storm eventually blew itself out before the cask was sucked down into the whirlpool.

The story of the fishermen points up very clearly a kind of circularity - Elias also referred to it as a physio-psychological and socio-psychological double-bind - which is by no means uncommon in the development of human societies. Both brothers found themselves involved in processes - a storm and the associated whirlpool - which appeared wholly beyond their control. Not surprisingly, their emotional involvement in their situation paralysed their reactions, making it difficult for them to analyse what was happening to them, or to take effective action to maximise their chances of survival. Perhaps for a time they may have clutched at imaginary straws, hoping for a miraculous intervention of some kind. After a while, however, one of the brothers began, to some degree, to calm down. As he did so, he began to think more coolly. By standing back, by controlling his fear, by seeing his situation, as it were, from a distance - in other words, by seeing himself and his situation in a rather more detached way - he was able to identify certain patterns within the whirlpool. Within the general uncontrollable processes of the whirlpool, he was then able to use his new-found knowledge of these patterns in a way which gave him a sufficient degree of control to secure his own survival. In this situation, one sees very clearly that the level of emotional self-control, of detachment, and the levels of process control and of the development of more "realistic" knowledge are all interdependent and complementary.



This same kind of circularity can also be seen in the reaction of the older brother, who perished in the whirlpool. High exposure to the dangers of a process tends to increase the emotivity of human responses. High emotivity of response lessens the chance of a realistic understanding of the critical process and, hence, of a realistic practice in relation to it. In turn, relatively unrealistic practice under the pressure of strong emotional involvement lessens the chance of bringing the critical process under control. In short, inability to control tends to go hand in hand with high emotivity of response, which minimizes the chance of controlling the dangers of the process, which keeps at a high level the emotivity of the response, and so forth.

Insofar, therefore, as we are able to control our emotional involvement with the processes we are studying, we are more likely to develop a more realistic or "reality-congruent" analysis of those processes. Conversely, the more emotionally involved we are, the more likely it is that our strong emotional involvement will distort our understanding. It is this consideration which constitutes the primary rationale for Elias's argument that we should seek, when engaged in research, to obtain the highest level of detachment. He describes this as a "detour *via* detachment".

What this means is not that we should cease to be concerned about solving practical problems which concern us but that, at least for the duration of the research, we try, as sociologists, to put these practical and personal concerns to one side, in order that we can study the relevant processes in as detached a manner as possible. A relatively detached analysis is more likely to result in a relatively realistic or object-adequate analysis, and this in turn will provide a more adequate basis for the formulation of relevant policy. In contrast, policy which is formulated in a highly emotionally charged situation, and where the policy-makers feel under political or other pressure to "do something", is rather less likely to be based on a cool, calm and reflective - in short, a relatively detached - examination of the situation.

It is the case that some individuals are more able than others to adopt a relatively detached perspective when making observations about either the "natural" or the "social" world. Usually, for example, adults are able to be more detached about the world around them than are children. It is also the case that some adults - for a variety of reasons - find it easier than others to adopt a relatively detached perspective. Notwithstanding these variations between one individual and another, it was a fundamental point of Elias's argument that the development of more object-adequate forms of knowledge, and the associated development of more detached perspectives in the sciences, have to be understood as social processes, that is, as aspects of changing patterns of interdependence, of figurations.

Elias noted that the processes which facilitate what he called a "*detour via detachment*" are more firmly established in the physical and biological sciences than in the social sciences. For example, medical scientists may have a strong commitment, perhaps based on religious or humanitarian convictions, to reducing human pain and suffering, but this does not prevent them, in their capacity as scientists, from studying biological processes with a relatively high degree of detachment. The level of detachment characteristic of the perspective of physical scientists such as physicists or astronomers is probably even more pronounced. How, then, do we account for the differing levels of detachment which are characteristic of the different sciences? Can these differences be explained in terms of the intrinsically different characteristics of objects in the physical, the biological and the social worlds? Is it inherently easier to be relatively detached about natural than about social processes? And how does one account for the fact that people in more complex societies tend, on the whole, to adopt a rather more detached perspective in relation to the world around them than do people in less complex societies? Elias argues that a



more adequate understanding of these issues can be developed if we adopt a processual or developmental model such as that provided by figurational sociology.

People living in pre-scientific societies are, to a much greater extent than those in scientific societies, exposed to the blind vagaries of nature, including their own. Their capacity for controlling, and therefore for protecting themselves from, unwelcome natural processes such as floods or storms is comparatively limited. In contrast, the members of more developed societies enjoy the benefit of a vast social fund of knowledge. The rapid growth of knowledge in the last four or five hundred years has meant that the fund of knowledge available to people living in the modern-day scientific societies has become both more comprehensive and, at least with regard to the non-human levels, more realistic or more reality - congruent - that is, more congruent with the factual course of events than with the promptings of people's wishes, fears and the fantasies associated with them. In conjunction with this growth in knowledge, what Elias called the "safety area" which people build for themselves, that is the area amenable to their control, has become very much larger than it used to be. As a consequence, people in those societies are now able, at least in certain areas, to steer their way through the flow of blind and unmanageable processes better than their forebears - at least at the physical levels, if less so at the human levels, just as people aboard ships are able to steer their way through the unmanageable waters of the oceans.(7)

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(7)It is important to note that while the social fund of knowledge has grown rapidly in the last four or five hundred years, the problems which confront people living in the most developed societies have also become considerably more complex over that period. Thus, while our knowledge of economic processes is much greater than it was in the eighteenth century, it is the case that the structure of our economy is also much more complex than it was then and, in that respect, modern economies are more difficult to control. Much the same is true in relation to other, more obviously technically-based aspects of modern societies. Thus while developments in physics have, in important respects, increased our ability to control certain critical processes, they have also given rise to new problems such as the problem of the safe disposal of nuclear waste.



This growth in the social fund of knowledge has, then, enabled people in more developed societies to expand their control within the uncontrollable flow of events, thus providing themselves with a "protective shell" which helps to keep out the dangers emanating from the non-human levels of the overall process.(8) However, even in the most developed of societies, in which a scientific approach is most highly institutionalised, people have not yet developed an equally comprehensive and realistic fund of knowledge relating to social processes, that is, to the way humans behave towards and relate with each other. As a consequence, they do not have the same degree of control in relation to social processes - and perhaps most notably in relation to the dangers which humans constitute for each other, for example in terms of war and other forms of conflict - as they have in relation to many natural processes. In that respect the double-bind situation, in which low ability to control dangers and a high fantasy-content of knowledge reinforce each other, still prevails to a considerable degree in relation to social processes, even in the most developed societies.

Elias points out that people living in more developed societies usually take for granted the vast social fund of scientific knowledge which they have inherited. Rarely, for example, do they try to imagine what it was like to cope with the necessities of life and to struggle for survival equipped with a fund of knowledge which was much smaller and much less certain than that to which they have access in their daily lives. Indeed, many people living in developed societies appear to believe that the lower fantasy-content and greater realism of their knowledge are due, not to the fact that they live in relatively highly developed societies, but to some superior personal qualities - of "rationality", or "civilization" - which they possess by virtue of

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(8) While the development of a "protective shell" is dependent on the growth of knowledge, it is of course also dependent on a number of other processes, one of the most important of which is the accumulation of other resources such as capital which may be required to construct such "protective shells", e.g. in the construction of reservoirs and irrigation projects to overcome problems associated with drought.

their own nature and which people in earlier or less developed societies did not or do not possess, or possess only in smaller doses. They might describe such people as "superstitious" or "irrational", which they may regard as an explanation but which, in fact, explains nothing. It simply means: "We are better". Such a claim is, of course, quite wrong, for we cannot take any personal credit from the fact that we happen to have been born into a society in which scientific modes of thinking have been institutionalised to a relatively high degree.

In order to understand something of the way in which human knowledge has developed, it is important to understand that people living in earlier and relatively simple societies could not possibly have thought in the same way that we do, for they had not inherited the results of a more or less rapid growth of knowledge over hundreds of years, and their social fund of knowledge, and especially the knowledge of what we call "nature", was very much smaller than ours. Their standard modes of thinking were, to a much greater extent, permeated by their own wishes and fears. They were to a greater extent geared to fantasies, both of a collective and of an individual kind. Because of their smaller and less reality - congruent fund of knowledge, their capacity for controlling the dangers to which they were exposed - and also for controlling their own destiny - was also smaller. Greater, therefore, was the insecurity in which they lived and greater, too, was their concern with questions like "What does it mean for me or for us?", and "Is it good or bad for me or for us?" The questions they asked were more self-centred, and involved higher levels of affectivity of all experiences, all concepts and operations of thinking. The strength and depth of people's involvement in all events which, in their view, could affect their lives, left little room for concern with those problems characteristic of a higher level of detachment and emotional restraint - with questions such as "What



is it, and how has it come about?" and "What is it per se", independently of "What it means for me or for us?"

Elias's work offers a genuinely sociological theory of knowledge which does not assume that one can understand the way knowledge develops without reference to human emotions. In particular, his analysis of double-bind processes, in which relative inability to control critical processes is associated with high emotivity, with low levels of detachment and with explanations characterised by low levels of reality-congruence, enables us better to understand the different levels of detachment characteristic of the natural and the social sciences and, in examining the development of science as a social process, it also takes us considerably beyond what is a relatively sterile debate couched in dichotomous terms such as "objectivity versus subjectivity".

As for the loosening of the double-bind process, the simple example of the fishermen in the maelstrom does not of itself provide an instant solution, but it does point us, at least some way, in the direction of a solution. Simply to increase our understanding and our awareness of these problems of involvement and detachment, and of the nature of double-bind circularities, may be of some assistance in breaking into the double-bind process, and thereby easing the constraint which this kind of process puts upon people in thinking and in acting. Such a process is a long and slow and difficult process, not least because, the development of more object-adequate knowledge may threaten deeply cherished beliefs. It is however, important that sociologists make an attempt to attain a greater degree of detachment, for only by doing



so will they be in a position significantly to enhance our understanding of the social world.(9)

### Applications of Figural or Process Sociology

Various research themes have been inspired by Elias's work. A great deal of effort has gone into applying the theory of the civilizing process into areas not covered by Elias (Kapteyn, 1975; Brinkgreve, 1976; Wouters, 1986; De Swaan, 1988). Another common theme relates to the continuation of the state formation process in the 19th and 20th centuries, which raises questions about the modern welfare state and its implications for personality structure (Van Stolk, 1980; Wouters, 1982; De Swaan,

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(9) There have been a number of critiques of Elias's work. Although this is not the place to engage in philosophical debate, it is worth recording the flavour of the criticisms. The most frequent criticism is well articulated by Pels. He argues that Elias neglects the work of other sociologists and thus reduces the complexity of the outside intellectual world: "Elias himself, and many of his most prominent disciples, have never been particularly concerned with what other people do, preferring to 'go it alone' and wrestle with 'the evidence' without stopping to ask where the other wrestlers were carrying their booty." (Pels, 1991, p.179). Thus Pels concludes, Elias himself has been homo-clausus, turning his back upon an intellectual world which would never listen to this particular stranger's voice, (Pels, 1991, p.182). Layder (1977) offers a biting critique of Elias's work saying there is, in fact, nothing new in his work. Mennel gives a useful summary of the common criticisms. Briefly they include: 1. *The argument from cultural relativism*. At its most extreme, this argument calls in question whether it is valid to think in terms of development processes at all - civilizing, decivilizing or any other kind. 2. *The argument from 'stateless civilizations'*. This is in effect a less extreme form of the first argument: it is simply that 'civilized' modes of behaviour and personality formation are found in societies where the conditions by which Elias explains their development in Europe - principally state monopolies of violence and advanced division of social functions - are absent. 3. *The 'permissive society' argument*. This is usually deployed by critics who, while prepared perhaps to accept Elias's picture of the civilizing of manners in Europe from the Middle Ages to the early twentieth century, nevertheless point to the 'permissive society' which has emerged since then, and argue that the civilizing process has gone into reverse and thus invalidated at least some aspects of Elias's theory. 4. *The 'barbarization' argument*. This could also be called 'the death camp' argument, for the Nazi period in Germany comes immediately to critics' minds. Sir Edmund Leach (1986) is typical of many in arguing that at the very time that Elias was formulating his thesis, 'Hitler was refuting the argument on the grandest scale'. In effect, this argument is yet another variant on cultural relativism: the contention is that, whatever may be true of superficial matters like table manners, fundamental qualities like the propensity to aggression and sex drives do not change much. 'Civilized' modern men and women are as capable of violence, bloodshed and cruelty as Stone Age tribal people of New Guinea. (Mennel, 1989, p.227-230)

1988). However as Kranendonk points out in his bibliography of figurational sociology in the Netherlands:

"...Research teams tend to range widely, as they do in Elias's own work, with regard to time, space and to topic. By and large, the linking characteristics are rather to be found in the general approach, in the use and avoidance of particular concepts and terms of phrase, and the style which tends to be more literary and polished than the average standard in sociology." (Kranendonk, 1989, p.21)

Very little has been written about organizational conflict and change within an Eliasian framework and nothing specifically on managerialism and the NHS. As a result of a literature search and conversations with academics working in the tradition of Eliasian sociology, I discovered four pieces of work broadly considering organizational issues, namely Dunning and Sheard's study of the Bi-furcation of Rugby Union and Rugby League (1976), De Swaan's study of Welfare State (1988), Ivan Waddington's study of the campaign for medical registration in Britain (1987) and a series of consultancy techniques based on the sociology of Elias written by Masternbroek (1987). These studies have in common a commitment to get behind the institutional facade at various stages of the organization's history. They consider institutions as part of a wide figuration or network of ever-changing human relationships. At this point in the thesis it is helpful to pause and consider what, in general terms, figurational or process sociology can offer those studying the organization and management of the NHS and those charged with planning and managing change in health services.

Firstly, one is made aware of the dangers of viewing the NHS as an organization which has been purposefully constructed or structured in order to pursue specific



goals. The NHS as an organization is the result of a number of complex social processes (see Chapter 2 for a flavour of that complexity). Like other organizations, the NHS has fallen, and will invariably fall, prey to what Merton has called unanticipated consequences of purposive social actions (Merton, 1957). Indeed the development of the NHS organizations may itself be part of what Elias calls "blind processes", that is:

"Human beings may not be aware of the figuration of which they are a part, of the nature of prevailing interdependencies and therefore may ignore or misunderstand the results of their actions. It is because of these unintended consequences of human actions that developments may occur as a 'blind process'." (De Swaan, 1990, p.7)

It is not, therefore, appropriate to view any of the three reorganizations of the NHS discussed so far in this thesis simply as rational attempts to meet the single goal of improving the way in which health services are delivered. Because of the sheer complexity and dynamic nature of the relational network - labelled the NHS - the resulting interactions generate a whole series of unintended consequences or outcomes. Each reorganization could be said to be dealing with unintended consequences or outcomes of the formation of the NHS. Therefore to begin to understand developments in the organization of the NHS, it is important to avoid conceiving the NHS as a social structure which provides an external constraint without which social life takes place. Elias urges us to see social structure as the network of relationships themselves. These networks are not something separate from the social life of the people who make up the network, but are in process. The NHS is not a static organization. A more sociological view of organizations is developed by Dunning and Sheard who, drawing on Elias, see organizations as:



"...Configurations of interdependent human beings who have been socialized into the norms and values of a given culture, perhaps into those of a given specific sub-culture. Moreover, the personnel, at least in complex societies, have multiple memberships and hence, very often, conflicting allegiances. They also tend to be subjected to conflicting pressures. As a result, no organization can ever be insulated from the wider society within which it is set. Organizations, that is to say, do not have impermeable boundaries. Even "total institutions" are not completely closed, but have relations of various kinds with the outside world..." (Dunning and Sheard, 1976, p.35)

Secondly, one is made aware of the flaw in the literature on the organization of the NHS that speaks of the failure of the organization of the NHS to meet the goals of the NHS. To pursue this line of argument ignores the fact that individuals have goals, organizations do not, only their individual members for as Dunning and Sheard point out:

"To think of organizational goals is to involve the reification of the concept of organization and renders it "consensualist" and "harmonistic" (Dunning and Sheard, 1976, p.33).

Thirdly, Elias alerts us to the point that figurations, including organizations, which are a particular type of figuration, are complex networks of social relationships, and cannot be adequately conceived simply as face-to-face contacts. Many of the studies of health care management which focus on the relationships of the various groups within the NHS make this assumption. As noted earlier this reflects the pervasive tendency for people, perhaps particularly citizens of western societies with their emphasis on individualism, to conceive of relationships in terms of face-to-face contacts. However, this is a dangerous assumption. For example, government

ministers have far more influence on our lives than do many people whom we meet regularly in face-to-face contact. People working within the NHS have relationships with people they have never met and indeed are affected by relationships without them necessarily being aware of them. In addition these relationships are inexorably linked to past generations of NHS workers in a variety of ways, for example, the power of doctors today can only be understood in terms of the actions of past generations of doctors. Not only have present day NHS workers inherited material things, such as the preponderance of hospitals as a centre for providing care, but also less tangible things such as language, methods of working, the division of labour in health care and so on. People working within an organization such as the NHS, internalize norms in an unquestioning way, therefore researchers cannot assume that all behaviour can be adequately understood in terms of conscious processes.

Fourthly, although many of the studies of local health services management assume that the most powerful groups in the NHS are doctors. Elias reminds us not to fall into the trap of assuming that doctors are all-powerful in the sense that they wield absolute power. Even the most powerful group's attempts to achieve their goals are being mediated by other groups - knowingly or otherwise. This point is developed in Chapter 7.

Fifthly, Eliasian sociology highlights the importance of giving up the search for single causes. They are too simplistic though this is, of course, their attraction. In order to understand social processes, it is not sufficient to focus upon individuals or the subjective perceptions of individuals as much of the existing literature on health care management does. We need to focus on the emerging network which is characterised by both the intended and unintended consequences of human action. If it were possible to understand social development solely in terms of motives and meanings of individuals, then there would be no need for a sociological perspective.



It is the unintended consequences or outcomes flowing from complex human interaction which makes a sociological perspective imperative.

These general points will inform the analysis of the data collected on the introduction of general management in the NHS - its third reorganization. More specifically, Elias's discussion of game models will be used in that analysis. A more detailed discussion of the game models will be given in Chapter 7.

#### Chapter 4 revisited

This chapter reviewed the existing empirical work on NHS management up until 1983. This literature offers helpful insights into the black box of health services management. Specifically this work consistently questions the assumptions of both the 1974 and 1982 restructuring that management is a rational process and that policy is made by the Centre, transmitted to the periphery and implemented there. Those working in local health care systems can and do circumvent national policy effectively. These studies reveal that local health policy evolves in bargaining situations with the distribution of power weighted towards the medical profession.

Drawing on the work of Norbert Elias, several concerns were raised about the theoretical and methodological assumptions made in this work. It was argued that Elias offers those interested in understanding health services management and the difficulties of implementing change in the NHS a fruitful framework for the exploration of the complexity of the NHS.

The next chapter documents the thesis research process and sets the scene for the presentation of fieldwork data painting a picture of the introduction of general



management in twenty health districts and the attempt to explore this data, drawing on Eliasian sociology.

## **CHAPTER 5**

### **The Research Process**

#### **Purpose of the chapter**

As part of my research fellowship duties at Templeton College, I am required to give a series of lectures on research methodology designed to introduce students to a menu of research methods in preparation for their Master's dissertation. I, along with colleagues, stress the need for students to give a detailed exposition of their approach to research, including a clear rendition of what they did, why, and what the experience of carrying out their research taught them. The students tend not to document how they carried out their research, and in one sense this is understandable as a majority of articles and books claiming to be research-based studies of management issues, display a similar reluctance to be "up front" about the methodology used, the assumptions made in carrying out the research and the difficulties of doing so (Dopson and Stewart, 1990). Consequently, it becomes very difficult for the reader to disentangle findings from the armchair theorizing of the author.

I hope in this chapter to take my own advice and intend to document the various stages of my research, reflecting on the tensions inherent in working as a paid researcher on an action research funded project, yet interested in developing a sociological understanding of the introduction of general management into the NHS.

### A study of District General Managers (DGMs): an action research project

In May 1985 I was appointed as research associate at Templeton College, the Oxford Centre of Management Studies. I, along with another research associate, was employed to assist in a two-and-a-half year project, funded by the National Health Service Training Authority (NHSTA) to the value of £250,000. The project had three main aims:

1. To understand the DGM's job and identify the strengths and weakness of different approaches.
2. To shed light on key issues for effective management in the NHS.
3. To draw lessons which will help in the selection, development, evaluation and performance of general managers.

The project was directed by Rosemary Stewart, a highly respected management analyst in health service circles, who has written extensively about managerial behaviour (Stewart, 1976; Stewart, 1982 and Stewart, 1988). There were also two part-time advisers to the study: Professor Derek Williams, management development adviser to the NHSTA and Professor of health service management, University of Birmingham and Peter Smith, tutor and researcher, Ashridge Management College.

The research project was seen by both the funding body and the research group as action research and not consultancy. Figure 15 is helpful in highlighting the characteristics of action research and in offering a comparison between consultancy and pure research. It also highlights some of the constraints on the researcher engaging in action research.



# 'Action' research, consultancy and 'pure' research

Stages	Action Research	Consultancy	Pure research
Entry	Client or researcher presents problem. Mutual or agreed goals.	Client presents problem and defines goals	Researcher presents problem and defines goals
Contracting	Business and psychological contracting. Mutual control	Business contract. Consultant 'controls client'	Researcher controls client as expert. Keeps client happy. Minimal contracting
Diagnosis	Joint diagnosis client data/ researcher's concepts	Consultant diagnoses. Often Minimal. Sells package	Researcher carries out expert diagnosis. Client provides data
Action	Feedback dissonance. Joint action with support. Published	Consultant prescribes action. Not published	Report often designed to impress client how much has been learned and how competent the researcher is. Published
Evaluation	New Problems emerge. Recycled generalizations emerge	Rarely undertaken by neutrals	Rarely undertaken
Withdrawal	Client self-supporting	Client dependant	Client dependant

*Source: Gill, 1982, Research as Action: An Experiment in Utilizing the Social Sciences, Personnel Review, Vol.11, No.2, p.20*

FIGURE 15

At its simplest, action research is designed to provide information in a useful and usable form. The plan was that any research findings were to be fed back to the DGMs participating in the research and then to the NHS general management population as a whole. Although the actual mechanics for disseminating relevant information from the research had not been decided, the research team thought that articles in health service journals and workshops for the participating DGMs would be the most appropriate dissemination method.

A steering committee for the research was set up by the NHSTA to assist the research team in both the research process and, in particular, dissemination. Its terms of reference were:

"...to provide advice, ideas and comments on the progress utility and relevance of the research and dissemination of the findings." (Paper 85/1, NHSTA)

Its composition is given below:

Tina Townsend	- Director NHSTA
Steve Annandale	- Project Manager NHSTA
John Burgoyne	- Academic Centre for Management Learning, Lancaster University
Steve Fox	- Academic Centre for Management Learning, Lancaster University
Colin Hayton	- DGM (not in the sample)
Nick Busk	- DGM (not in the sample)
Austin McNally	- DGM (not in the sample)
Beverley Alban-Metcalf	- Management Development Academic, Leeds University

### Selecting the sample

In selecting the sample the Templeton research team considered the recruitment figures of DGMs in September 1985. The first five DGMs in the sample were selected from a management programme at Templeton College run by the research director and before the other members of the team were appointed. The other fifteen DGMs were a stratified, sample, designed to give the sample maximum coverage of background and type of district. The sample was deliberately biased to enable the study of DGMs from varied backgrounds. The eventual sample consisted of seven former NHS administrators, five non-NHS (three armed forces), two treasurers, two community physicians, two nurses and two hospital consultants.

The criteria for sampling included: professional background; the appointment date (the earliest appointment was September 1984, the latest June 1985); the region (there was at least one DGM from each region in England and one from Wales); teaching



and non-teaching districts (four DGMs were from teaching districts); population (the district populations were relatively evenly spread from just over 100,000 to well over 500,000); budget, (revenue budgets ranged from under £20m to over £100m, with 15 receiving between £20m and £60m). The demographic characteristics of the districts were represented in almost the same proportion as the Office of Population, Censuses and Surveys (OPCS) clusters of demographic families of the country as a whole.

### Choosing an appropriate research method

There is a long-standing debate in the social sciences about the most appropriate philosophical position from which methods should be derived. This has typically been discussed in terms of phenomenology and positivism. Although it is now possible to draw up comprehensive lists of assumptions and methodological implications associated with each position, it is not possible to identify any one philosopher who ascribes to all aspects of one particular view (Easterby-Smith, Thorpe and Lowe, 1991, p.22). The key features of the positivist and phenomenological paradigm are given below:

	Positivist paradigm	Phenomenological paradigm
Basic beliefs:	<p>the world is external and objective</p> <p>observer is independent</p> <p>science is value-free</p>	<p>the world is socially constructed and subjective</p> <p>observer is part of what observed</p> <p>science is driven by human interests</p>
Researcher should:	<p>focus on facts look for causality and fundamental laws</p> <p>reduce phenomena to simplest elements</p> <p>formulate hypotheses and then test them</p>	<p>focus on meanings try to understand what is happening</p> <p>look at the totality of each situation</p> <p>develop ideas through induction from data</p>
Preferred methods include:	<p>operationalising concepts so that they can be measured</p> <p>taking large samples</p>	<p>using multiple methods to establish different views of phenomena</p> <p>small samples investigated in depth or over time</p>

Source: Key features of positivist and phenomenological paradigms. Management Research: An introduction, Easterby-Smith, Thorpe and Lowe, 1991, p.27

Allied to these philosophical positions are different research designs:

Positivist paradigm		Phenomenological paradigm
Researcher is independent	vs	Researcher is involved
Large samples	vs	Small numbers
Testing theories	vs	Generating theories
Experimental design	vs	Fieldwork methods
Verification	vs	Falsification

Source: Key choices of research design. Management Research: An Introduction, Easterby-Smith, Thorpe and Lowe, 1991, p.33

and different views on questions of reliability, validity and generalisability

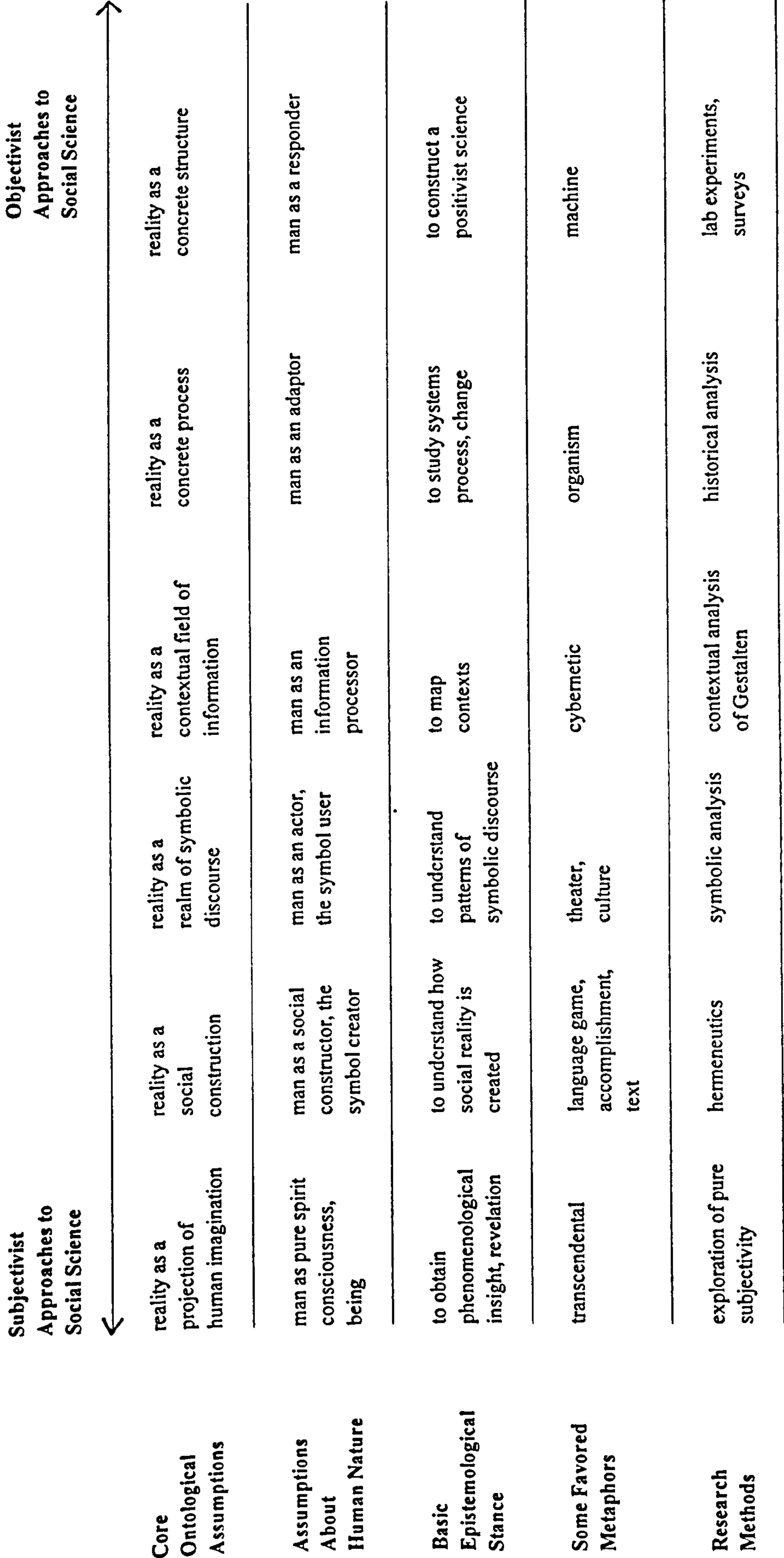
	Positivist viewpoint	Phenomenological viewpoint
Validity	Does an instrument measure what it is supposed to measure?	Has the researcher gained full access to the knowledge and meanings of informants?
Reliability	Will the measure yield the same results on different occasions (assuming no real change in what is to be measured?)	Will similar observations be made by different researchers on different occasions?
Generalisability	What is the probability that patterns observed in a sample will also be present in the wider population from which the sample is drawn?	How likely is it that ideas and theories generated in one setting will also apply in other settings?

Source: Validity and generalisability. Management Research: An Introduction, Easterby-Smith, Thorpe and Lowe, 1991, p.41

To consider methodology in terms of any of these dichotomies trivialises the complex maze of methodological choices available to the researcher (Hammersley, 1992, chapter 7, elaborates this point). Morgan and Smircich (1980) provide a general overview of possible approaches to social science based on inter-related sets of assumptions regarding ontology, human nature and epistemology (see Figure 16 below).



# Network of Basic Assumptions Characterizing The Subjective-Objective Debate within Social Science



Source: Morgan, G. and Smircich, L. 1980, p.492

In order to meet the aims of the project, the research team decided that the research questions would best be answered by pursuing a phenomenological paradigm and in particular qualitative methods would be most appropriate. Qualitative research is an umbrella term for a number of qualitative methods, for example the case study, longitudinal studies, interviews, surveys, observation and diary methods (see Lazarsfeld, 1972; Strauss, 1987; Gummesson, 1988; Marshall and Rossman, 1989; Easterby Smith, Thorpe and Lowe, 1991, for excellent reviews of the qualitative approach). Van Maanen defines qualitative methods as "an array of interpretive techniques which seek to describe, decode, translate and otherwise come to terms with meaning, not the frequency of certain more or less naturally occurring phenomena in the social world" (Van Maanen, 1983, p.9). A qualitative approach is of use where the emphasis in the research is description and explanation rather than prediction and where the research is concerned with individuals' accounts of their attitudes, motivation and behaviour. Indeed as Hakim argues:

"...if one is looking at the way people respond to external social realities (social structural determinants of people's behaviour)(10) at the micro level, accommodating themselves to the inevitable redefining of a situation until it is acceptable or comfortable, kicking against the constraints or fighting to break out of them, or even change them, then qualitative research is necessary."  
(Hakim, 1989, p.28)

At the heart of the qualitative approach is a reliance on the skills of the researcher as an empathic observer or interviewer (Beattie, 1989, p.24-28 and Jary and Jary 1991, p.513).

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(10) This view of qualitative research constitutes a non-Eliasian formulation.



The Templeton research was to adopt a prospective, longitudinal qualitative approach, focusing on the DGMs' changing views of the job, a central interest of the project director. Data was to be collected from four sources. Firstly, district documents, for example, strategic plans, restructuring proposals, meeting agendas and minutes. Secondly, long face-to-face interviews with each of the DGMs every three months and telephone interviews with them fortnightly. Thirdly observation of the DGMs. Some of the sample DGMs were to be shadowed for up to two days. In addition, we were to observe, where possible, the DGM at the DHA and district board meetings. Finally some DGMs were to keep detailed diaries of their activities. A diary sheet is given as Appendix I at the end of this thesis.

The interviews were to be the main vehicle of data collection. Cannel and Kahn describe the interview as "a conversation with a purpose" (Cannel and Kahn, 1954). There are many different ways one can get information from a conversation. In practice there are three main choices, the semi-structured interview, which covers broader topics that act as triggers for gaining information, the more tightly-structured interview, consisting of a set of questions with a clear boundary around them and the telephone interview, which can be structured or semi-structured. Cannel and Kahn argue that the type of interview approach depends on the task in hand. For our purposes the non-scheduled, standardized interview seemed to be the most appropriate (Richardson, 1965). This approach rejects the idea that identically-worded questions and sequences for all respondents achieve the goal of standardization. Rather, in order to attain any degree of standardization, questions must have the same meaning for each respondent, therefore must be formulated as appropriate for each respondent. Given the diversity of the backgrounds of the sample of DGMs, this seemed to be a very important point. The additional advantage of this type of interview was that the more flexible interview schedule gave one the opportunity to pursue interesting issues as they arose during the interview. The



interviews were to be tape recorded, seeking permission for use through assurances of confidentiality.

As mentioned earlier, we were also to act as participant observers wherever possible. Participant observation has its roots in anthropology, where researchers attempt to understand the practices of the various tribes. Participant observation is based upon the belief that the social world cannot be understood by studying artificial simulation of it in experiments or interviews, because the use of such methods only shows how people behave in these artificial experimental and interview situations. This commitment to 'naturalism' implies that in order to explain the actions of people working within organizations, it is necessary to arrive at an understanding of the various cultures and sub-cultures, in particular organizational settings because it is out of these systems of meanings, beliefs and values that action arises which is the subject of the research. The main advice of the literature on participant observation is that the researcher must be clear about the kind of observation role he or she is adopting. There are numerous aspects to the field role which an ethnographer may adopt. The most important is the decision by the researcher to participate in 'the natural setting' of the subjects of the research and the extent to which the identity and purposes of the ethnographer are revealed to those subjects.

In essence the choice to be a participant or a spectator may be conceptualized as varying from the observer's complete immersion in a social setting, by adopting a role of full participant in the every-day lives of subjects, to that of spectator, in which the researcher only observes events and processes and thereby avoids becoming involved in interaction with subjects. As a full participant, the researcher attempts to participate fully in the lives and activities of subjects and thus becomes a member of their group, organization or community. This enables the researcher to share their experiences by not merely observing what is happening, but also feeling it. This field

role enables a great deal of depth in the research as the researcher has to get close to the phenomena he or she is interested in and therefore catches the hidden experience of its members. There is, however, the imminent danger that by becoming embroiled in the every-day lives of subjects, the researcher internalizes the subjects' culture and becomes unable to take a dispassionate view of events and unintentionally discards the researcher element of the field role. That is they actually become a member of the organization and "go native".

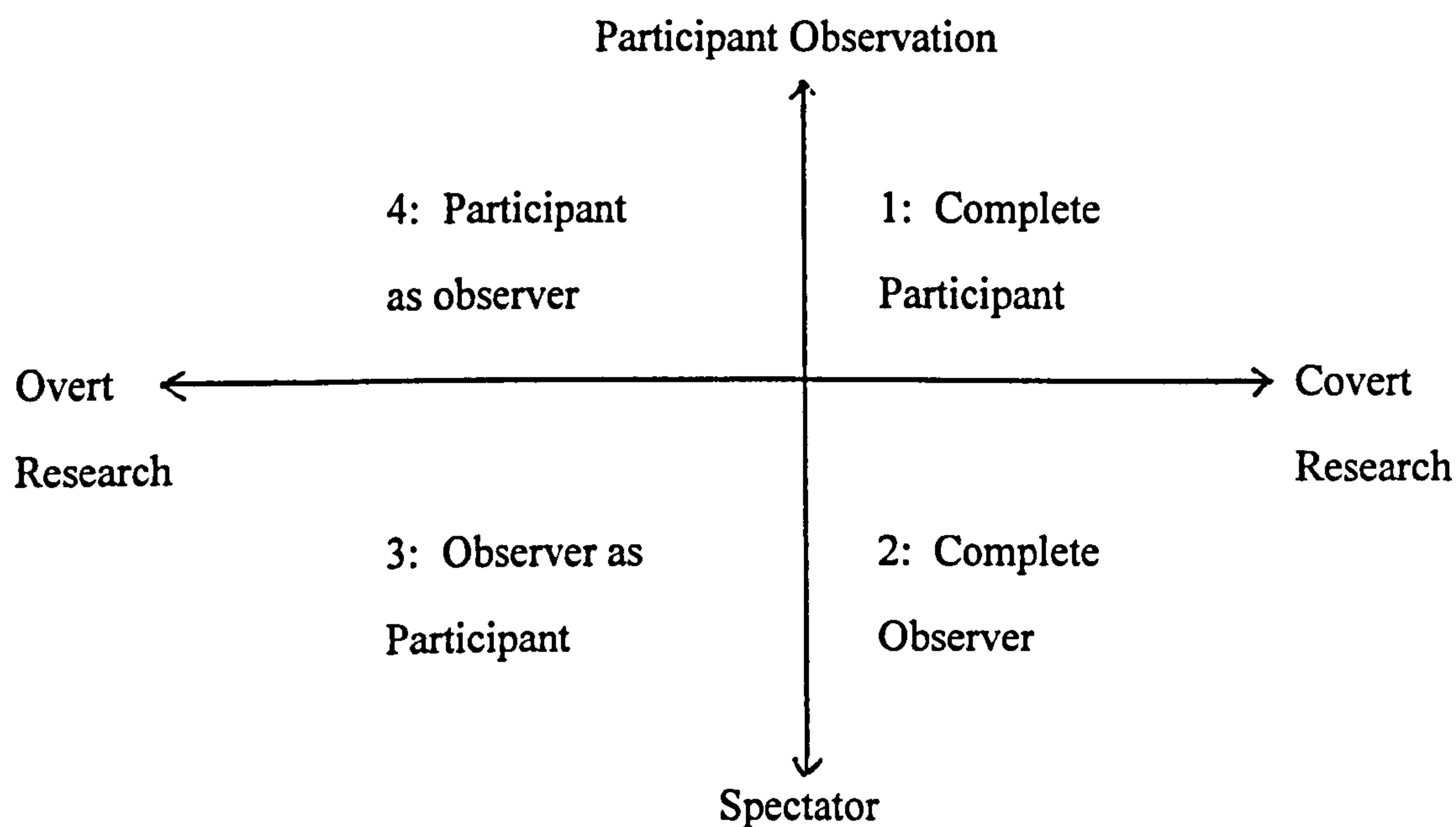
On the other hand, where the field role is limited to that of a spectator, the consequent lack of interaction with subjects can raise the opposite problem of ethnocentricity, that is, the observer fails to gain access to and to understand the cultural underpinnings of subjects overt behaviour and actions. The observer may inadvertently analyse and evaluate those events and processes from the perspectives and rationality of his or her own culture - thus invalidating the data.

Another decision confronting the researcher drawing on participant observation is whether to alert the subjects to the presence of a researcher or whether to hide the actual purpose of the observation. There are two main rationales behind the use of covert observation. Firstly people may behave quite differently when aware they are under observation. Secondly it may be impossible to obtain access to do the research if the subjects knew one was a researcher, or the true nature of the research. In such circumstances some degree of deception may be ethically defensible.

In covert participant observation, the researcher is publicly perceived as an ordinary member, inevitably his or her freedom may be curtailed since it affects the freedom of the researcher to move in all the social settings he or she might be interested in. In practice, then, four roles are possible. The complete participant role where the researcher's activities are concealed and the investigator joins the organization as a



normal member but carries out the research covertly. The complete observer where the researcher has no contact with those being observed. However, most research roles fall into the category of participant as observer and observer as participant. As participant as observer, the primary role is that of participant, but both fieldworker and informant are aware theirs is a field relationship and usually some feedback is initiated. The observer as participant role often involves the reseacher interviewing informants about events the researcher has been unable to observe. A diagrammatic representation of the possible choice of roles is given below:



Source: Gill and Johnson 1991, p.112.

The observation work I did fell into the observer as participant category. The observation was explained to those I was to observe. However, I was sometimes asked for my views on a variety of issues at the smaller policy meetings, hence on these occasions I moved into the role of observer as participant. (This happened more often towards the end of the research).



Diaries were used in two districts. They proved an interesting way of collecting data about what the DGMs did during a working week. However, for the purpose of the thesis, this data was not used because I considered it to be partial descriptive data and to be not particularly helpful data for developing a sociological analysis.

On commencing paid work on the study, I found that I was to be charged with the personal in-depth study of eight DGMs: one hospital consultant, two from the army, two former district administrators, two from industry and one community physician. I was also expected to read the interviews done by colleagues in order that I play a full part in research discussions. However during the course of the research I interviewed all 20 of the DGMs in the sample at least once and was responsible for all additional interviews with other key actors in the twenty districts.

The interview schedule to be used had been drawn up by the director of the project (see Appendix II of the thesis) and based on a model she had developed over many years of studying managerial jobs. The model is known as the demand, constraints and choices model. It argues that a management job is a flexible space in two senses. Firstly, there is always more work to be done in a management job than it is physically possible for a single individual to do. Secondly, it is flexible because managers do jobs differently even if they share the same job title, indicating that there are significant choices to be made. In Stewart's terms, jobs have three main elements. The demands are the core of the job, that is the work that anyone in the job has to do because they could not survive in the job unless it was done. These are the tasks you cannot neglect or delegate. A boundary of constraints limits what the job-holder can do and, finally, there is an area of choices, that is the work that one jobholder may do and another may not (Stewart, 1989, p.167). The model is illustrated in Figure 17.

# WHAT KIND OF JOB DO YOU HAVE?

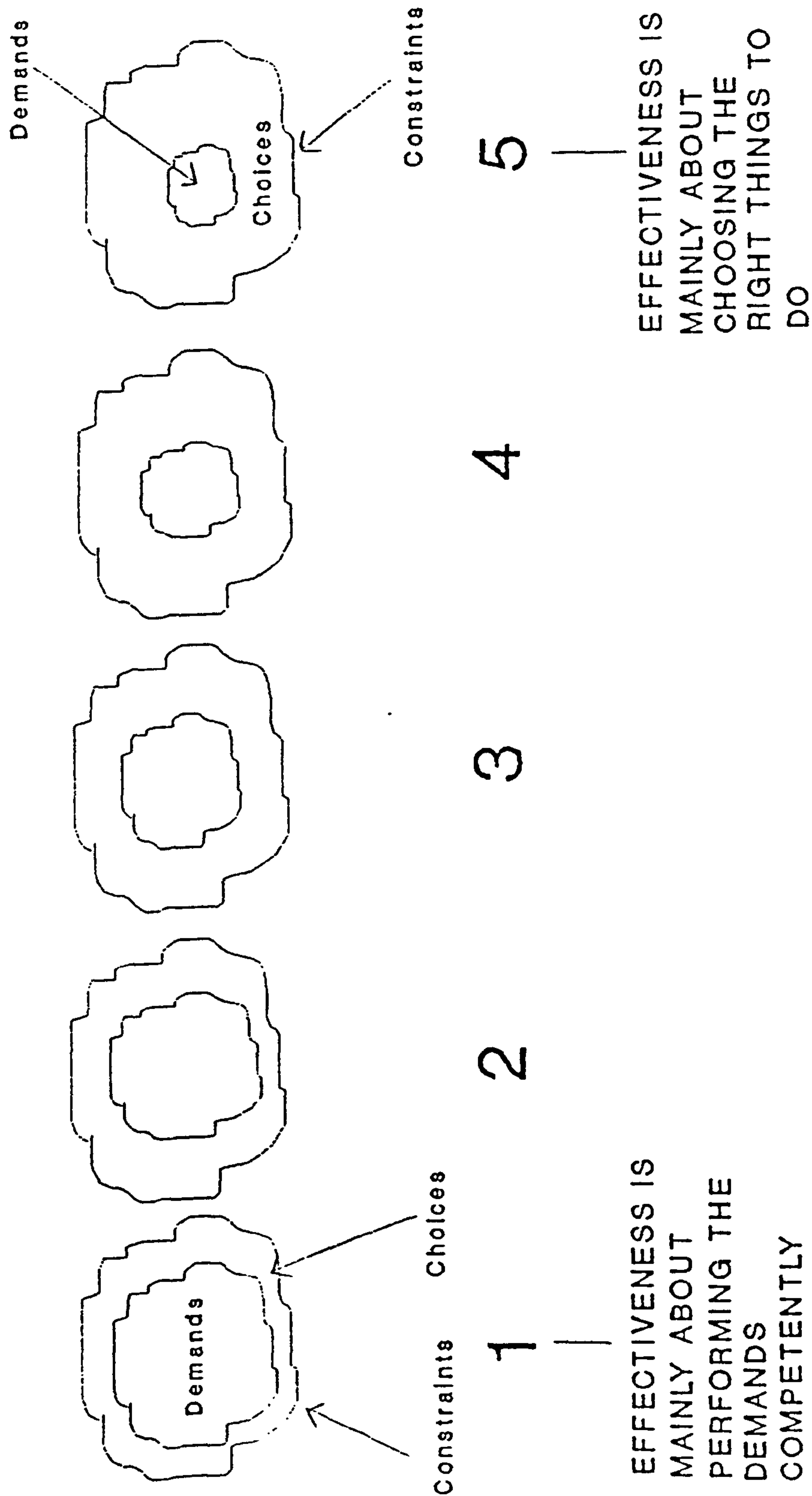


FIGURE 17

Although this model was to be the main tool for analysing the DGMs job, a number of models were suggested by the project director for analysing the data(11).

### Reflection on the first year of the research

I found myself in an anomic situation in the first year of the job. There seemed to be a very steep learning curve to climb. I had to keep up with the evolving changes associated with the Griffiths Report as well as health service reactions to them, I had to sell myself and the project to busy, fraught DGMs, I had to assimilate management speak, as well as build relations with colleagues at Templeton College. (I later found out that this was known as networking in management circles (Kotter, 1982)). Nonetheless the project seemed to be going well in the sense that after a year we had in the filing cabinet three long interviews with each member of the sample and a number of interim telephone calls, all of which offered rich data on how this group felt on starting their new job, how they decided to restructure their districts, the sort of culture they wanted for their districts, and some comments on emerging problems. The interview schedule seemed to work well and the DGMs found the interviews useful and stimulating.

After a year, I felt more confident about the job and took time to reflect on the research methodology adopted by the project and, indeed, the aims of the project. A major strength of the action research approach was that it assisted the research team

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(11)Models included (1)John Kotter's idea that the two key features of a manager's work are: (a) the managers agenda (the priorities of the manager) and (b) the manager's network (those who he/she relates to in order to get things done), (Kotter, 1982). The implication of the model seemed to be that one could understand the priorities of the manager by asking him or her about their priorities and by talking to the key people who they related to and who the manager needed to influence to get these implemented. (2)Gabarro's model of starting in a new job. (Gabarro, 1985) Here the implication was that managers entering a new job went through a number of stages and these stages could be used to predict activity.



in obtaining access - often a major problem for social science researchers (Gummeson, 1988, chapter 2) - since the sample felt they would get some pay-back. The privileged access was in part a reflection of the reputation of the project director within the NHS. In addition, the promise of feedback facilitated the cooperation of the DGMs. The sample saw the project as a way of allowing them to take stock of their approach to the job over time. It also offered them an opportunity to hear about how other DGMs were approaching the job.

We did not have to face anti-academic attitudes which are so often a problem for social science researchers and particularly prevalent in management research. Often when managers think of the term 'social science', they associate it with long timescales, esoteric non-applicable, highly theoretical findings and loss of control of data that may threaten the status quo. Moreover, they often complain that simple ideas are expressed in jargon, which makes it very difficult to relate research findings to practice. Such attitudes are particularly prevalent in management studies. The basis of managers' scepticism regarding management research is nicely captured in Figure 18.

# Comparisons of the orientation of researchers in management and practising managers

Researchers in management	Practising managers
Theoretically and Idealstcally Inclined	Orlentation towards action
Hlgh tolerance of preference for complexity	'Down to earth' reality
Hlgh emphasis on reflective observation and low emphasis on active experimentation	High emphasis on active experimentation and low emphasis on reflective observation
Sulted to the world of knowledge and Ideas	Sulted to the world of doing and getting involved - accommodations
Strength in assimilation of disparate observations into models that can be generalized	Strength In adapting to speciflc, often immediate, circumstances; solving problems: intuitive, trial-and-error
Ideas Judged less by their practical value and more by logical soundness and precision	Ideas Judged by their practical value

Source: Stuart, R (1986) *Academic Finding Out In Management*, In Chapman, A. (Ed.) *What has management got to do with Managers? Assocation of Teachers In Management*, adapted by and quoted In Easterby-Smith et al. (1990)

Yet another strength of the research was the rich data generated by the interviews. The three-hourly face-to-face interviews produced a lot of thoughtful, sensitive data that enabled us to build up a picture of how individuals in these new roles were tackling the job. I did, at this stage of the research however, have a number of concerns about various aspects of the project.

The composition of the research sample was skewed by the five DGMs invited to participate in the research by the research director whilst attending a management programme for which she acted as course director. This programme, which is still running (albeit in a different form), at Templeton College, began life as a forum for new managers to discuss their hopes and concerns as the Griffith's recommendations were implemented. In opting for this type of programme, the DGMs indicated a willingness to reflect on their role and management style, which may not have been typical. This subset of the sample received some criticism from commentators on the project. However the additional contact at Templeton College with the five DGMs assisted the researchers in building up more of a picture of the individual manager and what he/she hoped to achieve.

Another emerging concern was the pressure of the deadlines imposed by the steering committee in order to ensure that the research was giving "value for money". Whilst this is a laudable objective, one felt one was forced to follow a more positivistic model, placing as much structure as possible on the research. This precluded research processes that attempt to deconstruct behaviour (see Gowler and Legge, 1984, for a summary of deconstruction methodology and Clegg, 1990 and Hassard, 1993 for an overview of post-modernism and its implications for methodology).

Yet another concern I had was the emerging politics surrounding the project. As part of the project's dissemination activity in the first year, the research team between



them had written up three very general papers based on the first workshop presentation of the early findings of the research to our sample of DGMs. The articles focused on the new structures and DGMs views of the new cultures they wanted for their districts, learning what is different about the new job and, finally, some of the problems inherent in starting in the new job of the DGM. The steering committee felt the articles were too sensitive and they were vetoed. I have put as Appendix III of the thesis one of these articles for the reader to make up his or her mind on its "sensitivity".

This incident demonstrates one of the difficulties for researchers working on an action research project which has some kind of evaluation element attached to it and raises issues of academic freedom. Blalock and Blalock alert researchers to:

"...the social and political environment of social research with its intriguing collection of public interests, anxieties and political priorities, which strongly affects the nature of social research in important and continuing ways: the research problem selected, the goals of the research, its assumptions, the subjects to be studied, the inferences to be drawn from its findings and its use." (Blalock and Blalock, 1982, p.4)

Blalock and Blalock (1982) argue that one of the consequences of the shift to much shorter research contracts, away from grants for studies seeking information on generic social science issues, is that policy makers and others may be deprived of critical influences and insights in identifying and resolving social problems. One can see evidence to support this view in the particular incident I have just recounted. The articles were shelved, but were eventually published in the Health and Social Service Journal the following year (Dopson and Stewart, 1986; Stewart and Smith, 1987).

However my greatest concern was the general non-sociological nature of our findings and - since we were relying on the DGMs view alone - their validity. In addition I was worried about the proposed frameworks for analysis which were focused on individual choices or individuals' own reports of their priorities without exploring the social context in which those choices or priorities were forged. The research strategy planned for the next year was exactly the same, except that there were plans to talk to the role set of a few of the DGMs at the end of the study. I felt that in all probability, the research would lead to more of the same, that is, rich data from individual DGMs which needed to be explained. The research team at this point and in my view, lacked any theoretical frameworks to offer any satisfactory explanation for our data and it was questionable whether the data that we were collecting would enable us to draw valid conclusions.

I began to read the literature on validity in an attempt to reflect on the methods of the project. Validity has been defined as:

"...The extent to which an instrument and the rules for its use, measure what they purport to measure." (Cannel and Kahn, 1954, p.532)

The main threats to validity have been identified as follows:

1. Error traced to those being studied, for example due to the awareness of being studied.
2. Errors due to the investigator, for example, bias resulting from variations in responses to interviewers as a result of their age, sex, race, social class, etc. They also result from how skilfully the research instrument is designed and used.



3. Errors associated with sampling imperfections, for example, problems of population stability over time, population stability over areas and population restrictions. In addition validity can be threatened by certain selection procedures, i.e. getting a sample from a telephone directory (Cannel and Kahn, 1954; Denzin, 1970).

This reading offered a number of sensible pointers with respect to research design, but the main conclusion I drew was that triangulation was perhaps the best context within which validity could be enhanced and assessed. In describing the strategy of triangulation, Denzin notes that different methods represent lines of action towards the empirical world and can therefore exhibit different elements of reality. Methodological triangulation, that is, the use of as many different methods as possible to research a problem, reduces the uncertainty of uncertain measures and consequently increases certainty (Denzin, 1970). There are three possibilities which arise from triangulation: that the measures agree; that there is modest agreement between measures and that the measures contradict each other. In the end, the degree of certainty is the critical notion. As Webb notes:

"...The most fertile search for validity comes from a combination of different measurers...When a hypothesis can survive the confrontation of a series of complementary methods of testing, it contains a degree of validity unobtainable through single method testing." (Webb et al, 1966, p.174.)

Webb is not attempting to replace or denigrate particular research instruments, but is arguing that each instrument should be cross-validated with other measures which have different methodological weaknesses.



In the Templeton research, there were some opportunities to practise a triangulation strategy. We could in part, check the validity of the DGMs' perspective by the observation of the various policy meetings we attended. There were also the district documents written by the DGMs which displayed elements of their philosophy. However, it seemed to me imperative that we talked to those affected by the implementation of general management in the district in order to check out our understanding of general management, its implications and impact and to triangulate our data further.

My concerns about the data generated by the project's research methods were shared with my research associate colleague. We put together a paper to the research team, putting forward some of the strengths and weaknesses of the research and plans for a new dissemination strategy. The joint paper is attached for reference as Appendix IV of the thesis. The main recommendations of the paper were as follows:

1. We should focus our research efforts on the key issues about which the DGMs were talking to us.
2. We should use telephone interviews to obtain more specific data about these issues.
3. We should talk to the central people involved in the issues in order to triangulate our data.

4. We should produce issue studies for dissemination to the key figures in health service management (chair, general managers at region, district and unit level) and those involved in training health service managers. These might consist of an overview of the research findings on the issue, some ideas on how readers might analyze the issue, and, finally, some suggestions for how they might make progress.

These proposals were put to the steering committee (see Appendix V of the thesis) and were accepted.

The change in direction of the research meant that each member of the team could bid for areas of research for which they would be held responsible. Issue-based areas were derived from what the sample of DGMs thought were key issues, namely: relationships between DGMs and chairs, DGMs and the DHA and DGMs and doctors; improving quality; differing methods of keeping in touch with what was going on in their patch; devolution and the relationship between districts and units and district relationships with the region and the Centre; how to ensure DGMs continued learning on the job and, finally, how much progress had the DGM made in implementing the Griffiths agenda for change. This list is interesting for what it does not contain, in particular nurses and the community!

I was the lead researcher responsible for the study of the doctors, quality, the relationship between districts and units and the relationship with the region and the Centre, and I was expected to play a role in the other topics. It was at this point that I realized that there was an opportunity to pursue a higher research degree. It was, after all, unlikely that I would be able to pursue full-time study in the next ten years, having taken on willingly the mortgage and marriage (and latterly, parent) package. After eighteen months of working on the project, I discussed the possibility of a part-

time research degree with Leicester and worked with my supervisor to focus the research questions sociologically.

The latter process was, frankly, time-consuming but absolutely valuable. We addressed some of the tensions I was experiencing as a sociologist, trained to consider social structural processes, and yet now employed to work on a management project with a focus on the individual actions of managers. I sought with my supervisor's help, a framework with which to analyze the rich data I had already collected and would be collecting. After a frustrating foray into frameworks used by other researchers interested in health care management issues, I was directed by my supervisor to the work of Norbert Elias. Elias was a welcome life-line in trying to anchor my material sociologically, as well as providing useful insights into some of the methodological dilemmas I was reading about and struggling with.

Armed with an Eliasian framework for considering my data on the introduction of general management in the NHS, a belief that triangulation of methods was the most appropriate way to deal with threats to validity and my own clearly defined research areas within the project, I began data collection for my higher degree.

This thesis draws on the following data I collected myself:

- \* **80 face-to-face interviews and 196 telephone interviews with the eight DGMs I worked closely with over approximately two-and-a-half years;**
- \* **22 face-to-face interviews and 20 telephone interviews with the other 12 DGM members of the sample;**



- \* 20 interviews with the district chairs;
- \* 36 face-to-face interviews and 44 telephone interviews with UGMs in all 20 districts and 35 telephone interviews with members of the board in all 20 districts, as well as 12 face-to-face interviews with RGMs;
- \* observation of 26 DHA meetings in the sample districts during which a number of informal interviews were conducted;
- \* observation of 15 district board meetings;
- \* district documents, for example, strategic and operational plans, restructuring documents and various policy documents from all twenty districts(12);
- \* telephone interviews with clinicians (30) and unit general managers (23), in all twenty districts concentrating on the relationship between DGMs and doctors and the involvement of doctors in management generally;
- \* interviews with quality assurance managers (20) in all twenty districts as part of quality assurance issue study;
- \* performance appraisal documents from the twenty DGMs in the sample;

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(12)Durkerley (1988) observes that although almost all social science disciplines make extensive use of an historical perspective, organizational analysis has tended to be an exception, concentrating on contemporary empirical data.

- \* a case study carried out by the author after the main paid research had finished, the details of which along with a discussion of the case study method are documented in Chapter 8.

I also had access to all the interviews and observation reports carried out by my colleagues with the remaining twelve members of the sample which documented general issues that emerged in the implementation of general management (96 face-to-face interviews and some 80 telephone interviews) as well as the data that related to issue studies where the lead was taken by one of my colleagues.

### Unpacking of the data for the thesis

This stage of a qualitative research design is often neglected, yet it is a critical stage of research since it is all too easy to collect large amounts of data that do not get analysed or are inappropriate. Marshall and Rossman argue:

"Data analysis is the process of bringing order, structure and meaning to the mass of collected data." (Marshall and Rossman, 1989, p.112)

In practice, this statement is impractical and some writers would argue inappropriate for social science (see in particular the post-modernist debate on methodology - Clegg, 1990; Hassard, 1993). Data collection and analysis go hand in hand, such that theory often becomes grounded in empirical data (Glaser and Strauss, 1967; Vidich, 1969, expand on this process). Grounded theory provides a more open approach to data analysis which is particularly good for dealing with interview transcripts. It recognises that the large amounts of non-standard data produced by qualitative studies makes data analysis problematic. In quantitative data analysis an external structure is imposed on the data, which makes analysis more straightforward. With qualitative

data, however, the structure used has first to be derived from the data, which means teasing out themes and categories.

Various computer packages are now available to assist the researcher in analysing qualitative data. These are well-documented by Bryan Pfaffenberger (1988). However, I wanted to avoid mechanistic data analysis, a weakness of which is to counter serendipity. I went through all my data, coding it if it was relevant to one of the issues we, as a research team (or I as an individual), had highlighted as meriting further data collection. My coding scheme was as follows:

Chair	Ch
District Health Authority	DHA
Quality	Q
Doctors	Cl
Role and Progress of the DGM	P
Learning Needs of DGMs	
District/Unit Relationships	U
Relations with the Region/Centre	R
Nurses	N
Community Issues	Co

I, of course, noted other points relevant to the research questions of the thesis, for example references to managing change, power, uncertainty and so on. In reading and rereading my data, I became very familiar with it. As I went along, I made notes, jotted down ideas and engaged in a more systematic analysis of the emerging issues relevant to my Ph.D research interest and the Templeton project requirements. From these notes, I developed a data recording sheet for each area of interest, namely ways in which DGMs established their new role, the DGMs' relationships with established



NHS groups such as doctors, chairs and members, unit management, regional management, nurses and community representatives, the nature of the interdependencies between groups and how DGMs tackled the requirement to improve the quality of health care. An example of a data recording sheet is given in the Appendix VI of the thesis. I then used the data recording sheet to collect the raw data under the headings I had drawn up. Useful quotations were referenced on these sheets. However a data recording sheet does not constitute the end of data analysis. In fact these sheets enabled me to build up a picture of general management in practice. What this thesis attempts to offer is not an analysis of the data collected, but a synthesis.

#### Lessons drawn from the research process

I have drawn many lessons about the complexities of carrying out research. The ones most obvious to me I have documented below.

#### The politics of research

My training in methodology had not prepared me for this aspect of the research process. Researchers working within the current funding environment are rightly held accountable for the research product. However, the evaluation/dissemination element of research projects bring with them dangers such as the ones documented earlier with the steering committee's challenge to academic freedom. In addition, researchers need to manage the politics that can occur within research teams where there are diverse research interests.

## **Ethical dilemmas**

Smith (1975, p.3) notes that in the relatively short time that the social and behavioural sciences have claimed to be part of scientific tradition, little concern has been given to ethics. He explains this lack of interest in terms of the emphasis placed on the idea that social science is somehow value-free or value-neutral. Ethical issues arise inevitably from the kind of questions we, as social scientists, ask, as well as the methods used to obtain answers, the nature of the setting in which research is conducted and the kinds of people acting as research participants. There were several occasions where major scandals were kept off the DHA agendas and financial positions were fudged and blurred to avoid a detailed investigation by the DHA. Policy issues were often dealt with in pre-meetings of the DHA rather than in the public forum itself. I had to observe these incidents and see them as data rather than actively expose them as injustices(13).

Ethical problems are probably more prominent in policy research activities, partly because of the tensions between research purposes and loyalties to funders and clients.

## **How unhelpful it is to agonise about the problem of involvement and detachment**

This is not meant to denigrate the wealth of literature on this issue which I, like many other researchers, have spent a good deal of time reading. As discussed earlier, Elias notes that representing the debate in terms of a static polarity between total objectivity and total subjectivity is unhelpful since the existence of order in social life depends on the interplay of involvement and detachment. As a human being I could

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(13) Galliher (1973) argues that no right to privacy should be applied to research on subjects involving roles accountable to the public.

not help but be affected by my involvement with the DGMs and others I interviewed or observed. From time to time I wanted to indulge in the sort of doctor-bashing (and management-bashing) Phil Strong has criticised many sociologists for (Strong, 1981). This involvement was, however, crucial to enhancing my understanding of the 'problem' I was exploring. It was however possible to take a "detour *via* detachment" to use Elias terms by using the data I collected to build a synoptic picture of the complex and evolving set of relationships I was observing. I can well understand why individuals working in organizations often find this detour difficult. They, after all, can only look at what happens to them from their narrow pressured location in the system. This underlines the importance of viewing interview data as data that needs to be explained.

More specifically, Elias's work on involvement and detachment, although often discussed as a contribution to the theory of knowledge, does offer a number of helpful pointers for researchers. Firstly it is important to avoid the retreat to the present. By considering the objects of one's research historically and in the wider system of social interdependencies in which they are embedded, it is possible to obtain greater detachment. Secondly, exploring connections and regularities, structures and processes for their own sake assists in avoiding bias. Thirdly, it is vital if one is to contribute to the social fund of knowledge, that observations are related to theory and theory to observations. Finally, in order to ensure detachment is suitably tempered by an equally necessary involvement, it is useful to work in areas in which one is personally interested and may have practical experience.



### **The need to adopt an opportunistic approach to research**

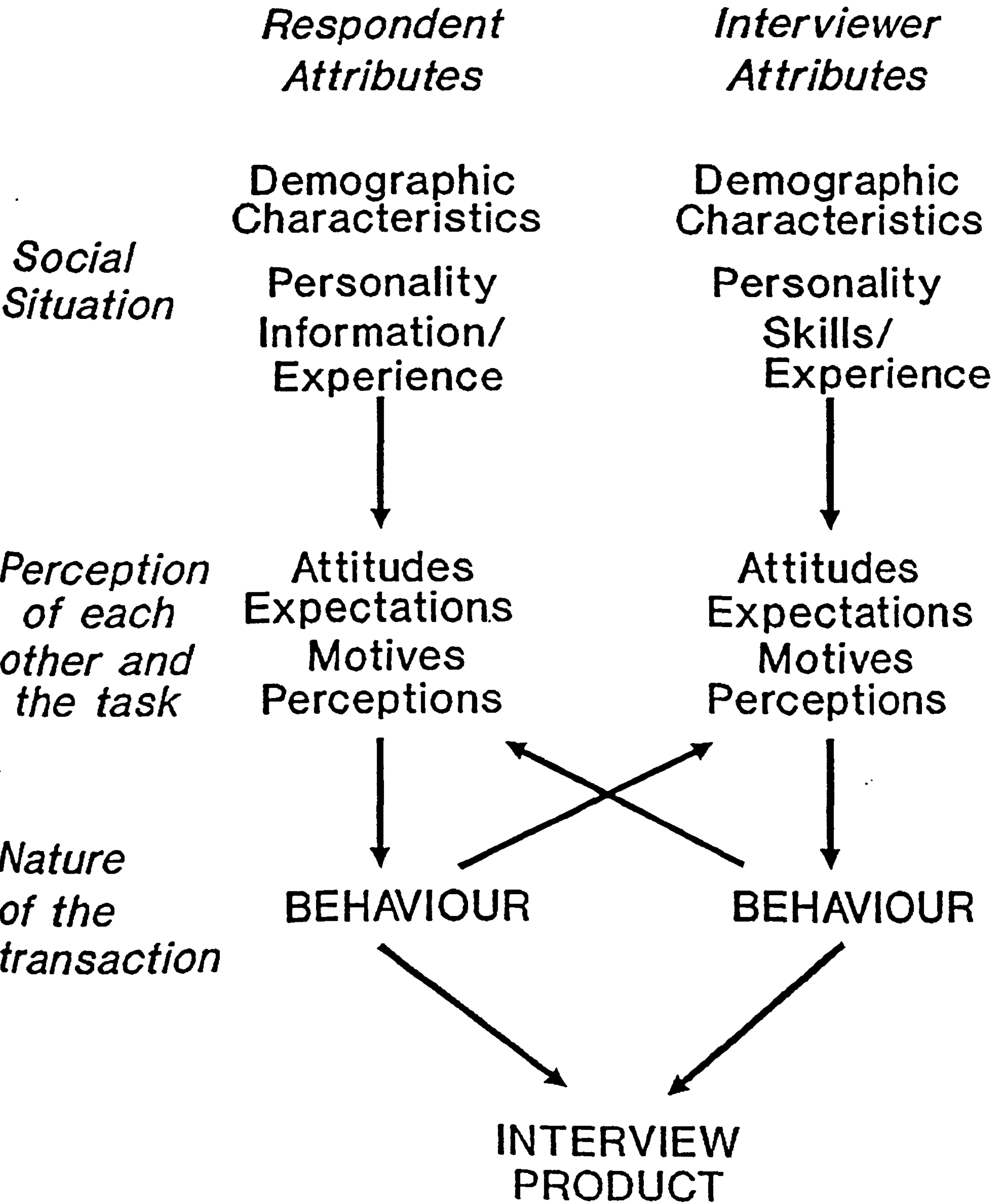
Research is a far cry from the rational process one reads about in the textbooks. I have cited the rather long quotation below because, in my view, it nicely captures a neglected aspect of the research process:

"Fieldwork is permeated with a conflict between what is theoretically desirable on the one hand and what is practically possible on the other. It is desirable to ensure representativeness in the sample, uniformity of interview procedures, adequate data collection across a range of topics to be explained, and so on. But the members of the organizations block access to information, constrain the time allowed for interviews, lose your questionnaires, go on holiday, join other organizations in the middle of your unfinished study. In the conflict between the desirable and the possible, the possible always wins, so whatever carefully constructed views a researcher has of the nature of social science research, of the process of theory development, of data collection methods, or of the status of different types of data, those views are constantly compromised by the practical realities, opportunities and constraints presented by organization research...the practice of field research is the art of the possible, it is necessary to exploit the opportunities offered in the circumstances." (Buchanan, Boddy and McCallum, 1988, p.53)

### **The complexity of the interview process**

I, like many naive qualitative researchers, thought that interviewing was a fairly straightforward process. It is, in fact, a very complicated and essentially social process as Figure 19 below indicates.

# The Interview as a Social Process



Source: Developed as part of the M.Phil. in management studies (methods) course

I learned a great deal about how one constructs interview schedules and the attention it is necessary to pay to question wording, since it is this that is the potential source of control for the researcher so often thwarted by problems in this area. Cannel and Kahn (1954) argue that in question formulation, the burden is on the researcher to provide questions that contribute to conditions of cognition, accessibility and motivation. For the most part, the questions I used in the issue-based stage of the research were open-ended. Careful attention was paid to avoid pitfalls in question design, for example, strongly polarized alternatives, e.g. "Should the US end its cold war commitment quickly by obliterating Russia with H-bombs, or should we immediately withdraw our troops from Europe?"; leading questions, e.g. "Aside from murder, under what other circumstances do you feel the death penalty should be used?" and double-barrelled questions, e.g. "Do you prefer to smoke pot in a small group or hash in a large group?".

Given that I was exploring complex issues, I often used a battery of questions rather than a single question and found probing questions particularly useful. I discovered how important it was to pay attention to the sequence of questions with the less controversial question used at the beginning. I also ensured that I went on some courses to attain skills in managing the process of the interview. There I learned about the importance of projecting a competent image and the impact of first impressions; to be aware of the impact on the interview process of non-verbal behaviour and ensuring that your tape recorder is reliable.

I also discovered how important it was to be able to control the interview in the sense of making use of the time available. Often one is only given a limited time with busy respondents, therefore the onus is on the interviewer to make use of it. In terms of controlling the interview, I drew on tactics such as clarification, summarizing, the art



of tactful interruption and used the leading question at times where the respondent was reluctant to divulge information. Finally one cannot stress the importance of general preparation enough. A great deal of time was spent too, examining the district position and reading of relevant documents in order to make use of the time in the field effectively.

### **The tensions involved in interpreting data using two different frameworks**

From my description of the research process, it is clear that at times there were tensions within the research team because of our different backgrounds and that at times this caused me personally a lot of heartache (not to mention headaches). I was employed to do a job, working in a new exciting, expanding and well-funded area. Compared to many of my medical sociology colleagues working in the NHS, I was in a privileged position: nice venue, good facilities, secure funding and so on. Yet - to use Elias's terms - the social relationships in which I found myself meant that in the first year of the job I unwittingly collected and analysed data not as a sociologist but in a journalistic fashion, using what DGMs said to me to construct explanations of their behaviour. Furthermore, the only way I managed to ease my unease with this situation was to register for this Ph.D and think about the findings from the research project sociologically.

With the wonderful gift of hindsight I can see that these tensions were partly generated by the remit of the funding body but mainly because the assumption at the beginning of the research project (and one made by other research teams) was that it was possible to both understand and explain the actions and activities of DGMs by studying their perception of their actions and activities. It soon became clear from considering the literature on the organization of the NHS, that the NHS is such a

complex organization that DGMs' actions and activities cannot be understood as something separate from the context in which they work.

### Chapter 5 Revisited

In this chapter, I have attempted to document the research process that I went through in order to be able to write this Ph.D. I have highlighted some of the difficulties working on an action research project, dealing with a politically sensitive area and the lessons I drew about conducting research. The remaining chapters of this thesis document some of the issues surrounding the introduction of general management in twenty NHS districts. Chapter 6 considers some of the early changes made by DGMs and discusses how they felt about the new job and the Griffiths agenda for changing the way the NHS was managed. Chapter 7 explores the DGMs' priorities for change and seeks to explain these drawing on Elias's notion of game models. Chapter 8 looks in more detail at the problems DGMs had in achieving change by considering one DGM's attempt at reviewing his district's mental health services. Chapter 9 reviews what we know about the impact of general management on health services from other studies of general management. These chapters represent a significantly different interpretation of the data generated as part of the Templeton study of DGMs ('The Templeton Series on District General Managers', NHSTA, 1988, Stewart, 1989).

## **CHAPTER 6**

### **Tackling the Griffiths Agenda for Change.**

#### **The First Year**

##### **Purpose of the Chapter**

As we saw in Chapter 3, a key assumption made by the Griffiths Report was that newly appointed general managers would be the catalyst for significant major change that would overcome some of the alleged weaknesses of the NHS as identified in the Report. This chapter explores the first year of general management in twenty NHS districts. It is argued that in contrast to the confident rhetoric of the Griffiths Report, DGMs were very uncertain about their role, spending most of their time designing new organizational structures and exploring what general management actually meant in practice. Furthermore, the backgrounds of DGMs had a significant influence on their views about the possibilities for the job and the changes they planned to make. The chapter begins by outlining the reasons the sample DGMs gave for taking on the job.

##### **Reasons for taking on the job of DGM**

There were a number of reasons why those coming from outside the NHS took on the job of DGM. The two ex-army DGMs faced the prospect of early retirement and wanted a new challenge before fully retiring. Two of the three industrialists were unemployed. One, however, had made a positive career change, having become disillusioned with his company. The two hospital consultant DGMs saw the role as a sacrifice. They openly stated that they would rather be undertaking medical work, but felt that a clinical viewpoint was critical in the general management process. The two district medical officers in the sample were concerned that general management



addressed the improvement of the health status of the population and this they gave as the main reason for taking on the job as did the two nurse members of the sample. The former district administrators were keen to continue a management role in the district and a career in the NHS. They saw general management as enhancing their status amongst other health care workers and felt best placed to tackle the challenge of managing significant change. All members of the sample spoke of a great respect for those working in the NHS and the principles on which the NHS was based.

### Coping with uncertainty

Those of the sample already working in the NHS were united in their hope that general management would be the vehicle to solve what they saw as some of the fundamental flaws in the way the NHS was managed. For example they spoke of: "lack of team management"; the unhelpful view that "wisdom is the prerogative of a higher headquarters"; "the orientation of the NHS towards employing people and not providing patient care", "the compartmentalization of professions" and the unhelpful bureaucracy that meant not being able to deal with those people/departments who could "make things happen at local level". These themes were echoed and elaborated by the newcomers to the NHS as they discovered more about the ways in which the NHS was organized.

Not surprisingly, the sample supported the Griffiths Report's cry for stronger and crisper management of the NHS. However, as the following quotations suggest, when pressed to comment on what stronger management of the NHS actually meant the replies lacked clarity. For example:

"It is difficult to say what general management is about. A key objective ought to be to ask what the district is all about and what they are going to do for the next 10 years." (Former DA)

"I find it slightly intangible groping about with the notion of general management. We are much more accustomed to self-contained departments with a job description. What I want to encourage is simply the use of skills and expertise to achieve certain objectives that are essentially support activities, away from the notion that it is someone in charge of a big self-contained unit." (Former DA)

"Griffiths recognized that the health service had become a series of separate health services. I believe one health service is right. I believe the concept of the generalist is right. Other than this belief, I'm not sure what general management is about." (Former consultant)

"I wasn't quite sure at the time how to get across the general management concept which I still have great difficulty putting into words." (Former treasurer)

Those from outside the NHS seemed to be clearer about the nature of general management in the sense that they were able to fall back on well-rehearsed phrases from their previous management jobs, for example: ensuring decisions are taken, being accountable, leadership, creating a vision, providing a strategic direction, monitoring and making sure things get done. These phrases were common in the health service press at the time, fuelled by a number of American management gurus (notably Tom Peters, Rosabeth Moss-Kanter and Richard Beckhardt) and reflect the

unsubstantiated assumption that private sector management language and practices could make a difference to the effectiveness of the NHS.

The views of DGMs in the sample about the scope of their role were again characterised by uncertainty. The sentiments expressed in the quotations below were common in the sample.

"General management and the role of general manager challenges everyone's perception because it is a new concept, but it must mould itself to the district's historical and cultural factors." (Former DA)

"As DGM you are going to be sending up a lot of balloons at this particular time. You have got to do the predicting and the projecting. Unless these balloons are shot down in a way you can't salvage, it is going to be your vision that sets in the district and in a couple of years' time, you will know how accurate that vision was." (Former DA)

"Who knows what the general manager's supposed to do? Griffiths has all these broad aims but no advice about how to tackle them." (Former nurse)

Such uncertainty is not surprising, given that the DGM role was a new one and as such those who filled the role had to establish their own credibility. Additionally, as the nurse member of the sample noted, the Griffiths Report gave little practical help to general managers as to what steps they ought to take first. In fact, the only practical advice DGMs were given was that they were to harness "the best of the consensus management approach" and avoid "the worst of the problems it can present" (The Griffiths Report, 1983, p.17), and they were to tackle the problems of the NHS as described by Griffiths. Furthermore, general managers had to deal with



numerous assumptions in the Griffiths Report which, as was discussed in Chapter 3, seductively simplify the complexities associated with managing health care. Early comments from the sample, about what the role of DGM might involve, suggest that the background of DGMs was an important variable in helping to explain how individual members of the sample sought to cope with uncertainty.

Former district administrators stressed the need for the general manager to facilitate making things happen rather than imposing a view. This was a pivotal task of the old district administrator working within a consensus management framework. For example one former DA argued:

"My view is that something like the health service can't work without a very considerable degree of consensus and agreement. If a general manager were to impose his view, we'd have a less than satisfactory health service."

Most former administrators in the sample felt they could not bring about significant change as an individual but needed to ensure they built teams of people who could. For example:

"My view of general management isn't that I as general manager should make things happen, but my job is making people feel they have made things happen."

"General management has been so far a matter of moving in and out of issues at key points and then leaving it to other people to maintain the momentum."

"The general manager's job is to deal with different perceptions of the truth and channel these so they relate sensibly to each other."

"I am not very good at ideas myself. I find that one of the skills of a DGM is making the best use of other people's ideas."

As a result, most of this group looked to make incremental changes; as one put it:

"All my natural inclinations are to concern myself with the next step."

Former DAs also talked about the importance of general managers monitoring health care, although they were hesitant in specifying the aspects of health care they would monitor. For example:

"The work general managers should be doing is to monitor things, and if something isn't reasonably satisfactory and working in the right direction, then action should be taken."

Former DAs also stressed the importance of continuing to work with the health authority:

"I am sure a key aspect of the role is to keep the authority running, presenting both to them and for them to the outside, a confident and fixed facade."

Amongst former DAs in the sample, there was one clear exception to the general stance taken. This particular DA relished his new role, seeing it as allowing him to tackle the issues consensus management had never been able to do, most notably the power of doctors. He saw general management as "about driving and shaping". He argued:

"Provided I am doing something that the authority accepts is reasonable, the individuals concerned, I think, have no redress, which is quite significantly a more powerful position than anything before."

All former DAs were aware of the need to be seen to occupy a significantly different role:

"I am conscious of the need to avoid being seen as a new version of the district administrator. I am responsible for the management of the organization and everybody should know it."

The two hospital consultants in the sample viewed the role as a sacrifice:

"It is a sacrifice. I would far rather be investigating people's urinary tracts. I look upon it as an effort." and

"My real job is in the labs."

They were firm in their belief that doctors had to recognise that they had to manage scarce resources. As one consultant put it:

"I would like to bring the district into the real world. It must be good for everybody if we harness the enormous intellectual ability in this district to the problems we have instead of the problems we would like to have."

The consultants were profoundly suspicious and dismissive of management and the furore surrounding the Griffiths Report, for example:



"I think management in the Griffiths Report is grossly over-rated. What you have got to do is to get the right people in who know where they are going, to get others to go there and motivate the people who have got to do the job, to want to do it. You haven't got any management at all if people enjoy it and recognize their work as important. If you have somebody watching them and watching the watcher, you can actually generate a whole management industry that isn't doing anything."

Both consultants saw their role as "much more in getting things done than in doing them" and felt they ought to concentrate on policy or problem-solving. Two examples are given below:

"I don't want to bother with the detail, I don't want to spend my time looking at barium meals. Griffiths didn't say anything about a general manager having to do it all. He said being personally accountable. I keep in touch more at authority level."

"I think a general manager should break down problems and deal with them in a factual manner."

The two former nurses in the sample stressed the importance of DGMs providing a service.

"A general manager needs to make the organization everywhere appear to be about providing a service... Though I have been told general management is about bringing back the matron."

One, a woman, was consistently scathing of the concept of general management.

"General management is a simplistic idea. I am not sure anyone is ever in charge or ever should be....I think I have an impact on the direction of the organization, a very sound knowledge of where the organization might be going...but I can't run the place like Sainsburys, it is too complex....Some of the new breed of DAs - however able - believe there is something called strategic thinking that is a higher plane activity and I personally don't believe that. I believe the best general manager in British Rail would be somebody who understands railways."

In her view:

"If general management is going to work in the health service, then it has got to be about facilitating, enabling and encouraging people - a multi-disciplinary, multiplicity approach, rather than through one individual."

One nurse member of the sample, although sharing the view that general management required a team and not an individual approach, was unusual in his interest in organizational development (OD). He employed a personal OD consultant. He hoped general management would bring a "macro-vision" by which he meant a shared vision of where the NHS should be going. In his view:

"A general manager should keep the organization healthy and developing" and he believed that:

"...Chief officers are probably looking for me to broaden the areas of influence that they have in a way which will allow them to operate more effectively."

Newcomers to the health service recognised the opportunity they had as newcomers to challenge "the way we do things round here".

"Being an outsider is a good thing. You are not an ex-doctor or an ex-nurse, or an ex-anything. You can stand in the middle of these people and knock their heads together and verbally pull it off...I am the only one without a no-go area."

Ex-army DGMs spoke of the role being to "stabilize the district"; of being "the boss"; of setting up "sensible organizational frameworks within which to work and systems to make things happen."

A former industrialist saw his role as one of "reassurance" and felt he was "the chief quality assurance officer". Another, used to working in a project management setting, saw himself as a focal point in creating change and said: "I am making the bricks to build the house on rather than getting involved in day-to-day things."

Former treasurers found the change of role unsettling. One admitted that:

"Rather than being a cog in the system, I am now floating in a vacuum at the top of the organization."



Both former treasurers agreed with the sentiments in the following quotation:

"A general managers' card is money, it is the ace card, the whip-hand. I don't think that is the treasurer coming out in me, but that is the common denominator."

Former district medical officers stressed their role was to improve the health status of the local population.

"I am not out to dismantle anything but simply to change attitudes about management and change views about what people are doing, so that health improves."

The preceding comments by new DGMs in the sample give a flavour of their views about the characteristics of general management and the nature of the role of the general manager. As noted earlier the comments made were often hesitant and vague revealing a lack of clarity about the DGMs' perception of their role. Faced with the absence of guidance in the Griffiths Report as to how to manage the complexity of health services and the apparent failure of those to whom they were accountable (district health authorities, regions, management board, or the DHSS) to fill this vacuum, members of the sample appear to have fallen back on their previous backgrounds in an attempt to define their new role in improving health services. Below is a brief summary of this point.

BACKGROUND OF DGM    VIEWS OF ROLE OF DGM

Administrator	<ul style="list-style-type: none"><li>*Achieving a consensus</li><li>*Monitoring activity</li><li>*Team-building</li><li>*Incremental change</li><li>*Health authority business</li></ul>
Consultant	<ul style="list-style-type: none"><li>*Manage scarce resources</li><li>*Policy</li><li>*Problem solving</li></ul>
Nurses	<ul style="list-style-type: none"><li>*To provide a service</li><li>*Facilitate a team approach to providing health care</li></ul>
Army	<ul style="list-style-type: none"><li>*The boss</li><li>*Set up sensible organizational frameworks</li></ul>
Industrialists	<ul style="list-style-type: none"><li>*Chief quality assurance officer</li><li>*Change agent</li></ul>
Treasurers	<ul style="list-style-type: none"><li>*Manages the 'ace card' money</li></ul>
Community medicine	<ul style="list-style-type: none"><li>*Improve the health of the local population</li></ul>

The tendency for human beings to fall back on more comforting, familiar ways of seeing the world when faced with uncertainty has been interestingly discussed in the

medical sociology literature which deals with illness behaviour and the doctor-patient relationship (Szaz and Hollender, 1956; Friedson, 1961; Bloor and Horobin, 1975 and Calnan, 1984). Fred Davies, for example, explored the way parents defined the early symptoms of their child's polio by assimilating the symptoms to a known condition, for example, 'flu. Only when this diagnosis became manifestly untenable (for example, when the child lost the power to walk) did they redefine the condition in terms of new categories (Davies, 1960).

One could also argue that the pervasive uncertainty as to the scope of the role and their management task may be partly explained because DGMs were struggling to understand the figuration of which they were now a part. Elias notes that people find it understandably difficult to see how they fit into the larger pattern of which they are a part. In seeking to construct an adequate explanation for themselves, individuals are forced to select some data and discard other data and do so on the basis of a set of assumptions often derived from their past.

The sample group of DGMs, like most of us when faced with uncertainty, were less concerned with trying to understand why things have come to be and more concerned with what does change mean for me and what do I need to do differently, if anything. These points are also in evidence if we consider how they went about establishing the new role and the new structures they choose for their districts.

### Establishing a new role

A central problem facing all DGMs was that of how they could establish themselves in their new role. Not surprisingly, given the uncertainty about what their role involved, different DGMs employed different strategies in an attempt to establish their credibility with those with whom they came into contact. Many felt that they



should show that things were now different. Career NHS DGMs, particularly some of the former DAs, felt the most need to do this partly because of the fear that others might think there had been no real change in their role, only one of title. This was a particular problem for the DA coming from another district, where the incumbent DA was to retire or was leaving. Many of the DGMs with NHS backgrounds felt that they had to distance themselves from their fellow professionals, so that they would be seen as general manager, not as members of a particular professional group who would show preference to fellow members of that group.

In the early months, many of the DGMs had problems with one or more of their senior officers and those new to the NHS often clashed with former DAs who had been unsuccessful in getting the job. Some encouraged senior officers to leave or made it clear that their post would not be central to the priorities of the district.

There were three main ways by which the sample DGMs sought to establish their new role. The first was by visibly taking over as the boss; those from outside the NHS attached more importance to this than DGMs from inside the NHS. Examples include:

taking over the chairship of the DMT (all the sample did this);

moving into a suitable office which sometimes caused conflict with the incumbent district administrator (all the sample did this!);

meeting a wide range of staff, particularly in their own place of work, and, for some during the night as well as the day. (Mostly newcomers to the NHS who saw this as having a symbolic value and demonstrating a change, as well as a practical one of learning about the district and what goes on.)

All the sample attached importance to particular incidents in which they felt that they had demonstrated that they were the boss. These ranged from sacking a misbehaving senior officer, to ways of showing that they required different behaviour, such as ignoring communications from a particular member of staff until he behaved in the way that the DGM had asked. Quite trivial incidents were used, such as, in one case, insisting that something was done by a dilatory officer to get a window repaired.

The second way the sample DGMs sought to highlight and establish their new role was by making changes in what was done and how it was done. The examples below were cited by one or more of the sample as actions in their first year by which they aimed to show that their new role meant changes:

- \* changing the jobs/officers
- \* changing the agenda of the DMT
- \* setting objectives, with dates to ensure implementation of those objectives
- \* getting an officer to tackle the problem outside his or her profession
- \* establishing a task-force with differing professions to troubleshoot problems
- \* insisting on different methods of communication, particularly shorter papers (generally the desire was for less formal meetings and less writing)
- \* involving those who had not been previously asked an opinion, for example more junior staff
- \* taking over ultimate responsibility for finance
- \* trying to raise the public profile of the district and
- \* ensuring that long-standing problems were tackled

This last point was seen by a few of the DGMs to be particularly important in the early days. It was sometimes, they thought, a way in which they were being tested.

People were bringing skeletons out of the cupboard to see if the new DGM could do anything about them. Some response was essential in order to meet what they saw as a challenge to the new role.

The final way DGMs sought to establish the new role was through the creation of a new district management structure. This took most of the first year. Typically the DGM would produce a draft structure proposal, containing some statement of the philosophy behind the structure (often referred to as the new culture of the organization), structure diagrams specifying accountability arrangements and some job descriptions. Shifting the culture of the district through designing a new structure was a key objective of the 20 DGMs in their first year. This can partly be explained in terms of the pressures placed on DGMs by the DHSS to produce an acceptable new structure but also it reflects a well-established NHS tradition that management involves restructuring (see Chapter 2). The rest of this chapter considers the sample's vision of the new district general management culture and the structures they felt would assist the vision to become a reality.

### The new district culture

In my review of all 20 districts' structure documents, the most frequent call was for **greater clarity, crispness, directness and responsiveness, within the organization.** What this appears to have meant is that people should know exactly what is expected of them, by whom and by when, so that when things needed doing, they get done. As one manager put it the aim was to ensure that: "an implementation cycle matched the NHS planning cycle", a perceived failure of the old culture.

**Personal responsibility and personal accountability** were also key aspects of the new culture. Structures were to be designed so that if a managerial decision really



was impossible at a certain grade, the buck gets passed, not up and down the old professional and functional hierarchies, but through to general managers who were to make the decision and be accountable for it. The hope was that this would ensure decisions got taken and were not fudged as was alleged in the old consensus management era.

Another common aspect of the new culture was an emphasis on **devolution**. At one extreme this represented the passionate belief that those who were working at the sharp end in the units needed to make major decisions about not only the day-to-day operational matters, but also strategic issues. Some DGMs, however, were wary of devolving too much power to units. This group of DGMs was inclined to the view that people in units were "the chaps who do the actual work" and wanted to minimize the unit's contribution to district strategy. Between the two extremes lay most of the DGMs, some distinguishing different levels of strategic and operational management, some refusing on principle, to separate them. (Chapter 7 considers district-unit relations and examines this element of the new culture in more detail.)

The **breaking down of old professional barriers** was another theme running through DGMs' discussions of the new culture and was present in most of the structure documents. No DGM talked publicly of curbing the power of the medical profession, yet, when pressed as to what breaking down old professional barriers actually meant, it was this they referred to. Publicly they talked about team-work and about professionals working on managerial issues, for example, the idea that it should be perfectly possible for a nursing officer to be given the task of sorting out a problem in the catering department. As this suggests, **task-oriented management** was a relatively common 'buzz-word' in the structure documents.

Other management precepts occurred less frequently in the DGMs' discussions about the new culture. A number put great stress on effective communication and information. Seasoned NHS managers set great store by involvement of clinicians - usually through management budgeting (where clinicians are expected to manage the budgets of their departments). Former DMOs insisted on continuing flexibility in the culture and management structures so as to meet the changing health care needs. Only two of the sample gave prominence to organizational development, the former manager of a big industrial unit and the former nurse who employed a consultant to assist him in managing the change.

A striking feature of the individual DGM's vision of the new culture is how similar the key themes are to the Griffiths critique of the NHS and the Report's concern with management per se. Conspicuous by their absence are any statements about the object of better management - namely to improve health services and health.

### The new structures

There were essential differences between DGMs as to the degree of ruthlessness with which they wanted to change the organizational structure of their district in order to facilitate the new culture, and the degree of opposition they faced in so doing. The actual changes in the structure are given as an appendix to this chapter and are differentiated by professional background.

One of the consequences of the introduction of general management, seems to have been a significant reduction in the number of units per district. All but one of the districts in the sample established corporate management groups which embraced the core functions of the DMT. In other words, nearly all the new district management groups included a community physician, a nurse, a treasurer and two clinical

representatives. The exception was a district led by a former industrialist where there was a non-executive review group of nominees and representatives of the main professional interests in the district, together with the health authority chair, DGM and UGMs. In most districts the new teams were called 'boards', although in five DHAs the term 'district management team' was preserved. In six others the word 'management' was retained in the title, but in six districts it was replaced by 'advisory' and in two others by 'executive'.

In most districts there were a number of differences between the new arrangements and the old, apart from the obvious one that the new boards were no longer bound to observe the principles of consensus management. Former DMT members were often given particular functions to manage alongside their professional responsibilities. In eight districts, for example, the medical officer was put in charge of planning; in six districts the nursing officer took responsibility for 'consumer affairs', a function that was often linked to quality assurance. Most DGMs also took the opportunity to give board status to other functions that they considered to be important: those most commonly recognised in this way were personnel management (in eleven districts) and works (nine districts). Most boards therefore had more members than the old DMTs. The variation in size of the boards was due to two main factors. Firstly, in some districts UGMs were members of the boards, in others they were not. Secondly, a factor was the complexity and size of the district: in some teaching districts, for example, the Dean of the Medical School was a board member.

The effectiveness of their district boards was a cause for concern to most DGMs in the first year (and later). In the words of one, "The problem of the district board is, I think, common to most districts. Nobody seems to know what to do with it, or how to make the best use of it." Most DGMs recognised the board as a source of advice on policy. Some allowed their boards to retain strong corporate executive



responsibilities similar to those previously held by DMTs, e.g. to define and review strategy, or to allocate resources within the district. Other DGMs explicitly withheld these powers from their boards.

The role of clinical representatives on boards was, in many districts, a cause for concern. Several DGMs referred to the dissatisfaction of clinicians with what they believed to be their loss of power after the passing of consensus management and the devolution of responsibility to units. DGMs also complained of what they termed irresponsible clinician behaviour at board meetings: intervening, for example, in matters on which they had little knowledge, or dwelling on details the DGMs considered inappropriate to that forum, whilst being negligent or ineffectual, in the DGMs' view, in discharging their duties as representatives. This might be viewed as a symptom of the manager/professional conflict discussed in Chapter 2. In some districts the managers were so concerned about the clinical representative role that they began to meet regularly without him or her.

Originally, six of the twenty districts excluded UGMs although, during the course of the research, they were admitted to board membership in two districts. Some DGMs explained their exclusion as a concern to protect inexperienced UGMs from powerful district directors. One region vetoed proposals to include UGMs as full members of district boards. The general argument for their inclusion was that, to manage their units effectively, UGMs had to be aware of the wider aims and priorities of the district and involved in decisions that affected the pursuit of these aims. Their presence was also thought by some to be a potent symbol of change from the previous regime.

Some districts established, formally in some cases and informally in others, a 'split' arrangement - for example a 'policy' or 'corporate' board of DGM and district

directors; and an 'executive' board of DGM and UGMs. Such an arrangement tended, for various reasons, to be unpopular with UGMs. "It institutionalises the split between the thinkers and the doers" said one, "...it pushes you back to looking like a unit administrator, particularly with the (health authority) members." This is partly because corporate board members seemed tempted to try to impose their authority on members of the executive board. "I sometimes feel like I have five bosses not one", said a UGM in another district with a 'split board' arrangement. Moreover corporate board members usually attended DHA meetings, executive board members usually did not. This irritated some UGMs, who felt that their influence and status was thereby undermined, and their capacity to take a broad view of district affairs diminished. Generally, therefore, UGMs seemed to regard the 'split board' arrangement as an inadequate substitute for full district board membership. Those who expressed the strongest concern about their exclusion from board membership tended to be those who had only infrequent personal contact with the DGM. "I feel blinkered in my unit," said one.

There were marked differences between the way DGMs consulted over their structure proposals. At one extreme were the DGMs (namely doctors and treasurers) who talked to a few people to confirm ideas, wrote the document themselves, showed it to the chair and one or two members and senior managers, and made no material changes before submitting it to the region. At the other extreme were a group who went through a long, structured series of discussions, produced formal drafts for consideration by the DMT and panels of members, and further drafts for formal consultation and then chose the final options before further drafting with key members and officers. In between was a wealth of different styles, some where the main discussions took place after the document was drafted, some before, and some where the talking and drafting were an integral evolutionary process throughout. In one instance, the first draft was actually written by the chair. Some DGMs,

particularly the outsiders, tried to use flip-chart presentations, slide shows or study days, to stimulate interest and discussion. They tended to find these methods, whilst common in many companies, were considered inappropriate for the health service, and they eventually had to rely on more time-honoured NHS consultative mechanisms.

It is difficult to quantify the opposition DGMs ran into over their structural proposals. It is difficult to define opposition, let alone compare the DGMs' objective perceptions, or distinguish opposition specific to the structures from any general background resistance to Griffiths. Nevertheless, using both interview data and the questionnaire sent to the DGMs specifically asking them to rank the scale of opposition, it seems that there was a wide spectrum of opposition to the proposals. Generally the nurses were much the most resistant to the proposed structure changes and were concerned largely about their role on the district management board and the implications that this had for nurse-management in general. This is not surprising since, as a less powerful profession, nurses saw general managers as new, powerful people able to influence their status and power. Professions allied to medicine objected mainly to the new reporting relationship of their district officers to managers. Though less strong than the nurses, there was substantial opposition from region and DHSS, mainly in terms of the proposals not giving enough detail about posts, the structure of boards, or costs of restructuring. Hospital consultants who complained did so about local issues such as the rearrangement of units. The scale of opposition from consultants was in one sense surprising, given their powerful position in shaping health services, yet it partly reflects doctors' view that management is irrelevant to what they do, so what is there to get angry about? Most doctors did not see managers as in any way a part of their network of relationships.



Health authority members sometimes argued about specific local issues and sometimes took up cudgels on behalf of professional or other interest groups. Other groups such as community physicians, administrators, GPs, unit management teams, and to a lesser extent, treasurers and trade unionists, raised a moderate number of objections, CHCs local authorities, rarely objected. Local authorities may have been less involved, seeing health services as less central to their main interests, e.g. housing, schools, etc.

### Chapter 6 Revisited

The first year of the job was taken up mainly with designing the new structures for the district, settling into the job as well as trying to establish a new culture for the district along the lines of the Griffiths Report. In practice, getting the district structure approved and dealing with individual and group fears about the structural changes in particular and the Griffiths changes in general, took the whole of the first year, in some cases longer. By the end of the year, most DGMs were keen to forget structures and get on with tackling pressing health service problems and priorities within the district.

A fascinating aspect of the interview data in the first year is the uncertainty surrounding the concept of general management and the role of the general manager. DGMs resorted to management clichés, phrases from the Griffiths Report, or the many management gurus around in the mid-to-late-1980s, when pressed to describe general management, their role, or the details of the cultural change they were to oversee. In the absence of guidance from the Department, the management board, the regions, their own health authorities or the Griffiths Report, DGMs seem to have fallen back on their previous experience to assist them in coping with this uncertainty. This highlights another problem with the Griffiths analysis of managing health

services. The document published by the Griffiths team assumes that general managers do not have a past that might influence not only the way they interpret the requirements of the new role, but what priorities they choose to pursue. General managers are not free-floating individuals. Individuals have a history, they grow up within quite complex figurations of social relationships which affect the way they view the world - or to use Elias's words, "the psychogenesis of the adult personality make-up cannot be understood in isolation from the socio-genesis of our civilization" (Elias, 1939, p.286).

The next chapter considers the second, third and fourth year of general management in the NHS in the twenty districts. It looks in particular at the priorities of DGMs and seeks to understand these by drawing on Elias's notion of game models.

# The New Structures

Key:

- "Similar job" refers to posts with roles and responsibilities similar to those pre-Griffiths, and may have different reporting relationships
- "Re-vamped" refers to posts held by ex-DMT members, which include elements of their pre-Griffiths roles and responsibilities, but with a distinct new emphasis or element to the job (eg DMO becoming DMO/Director of Planning and Information).
- "New" refers to posts which did not exist as such on the old DMT, and which are not combined with old DMT chief-officer duties.

A	Administrator
T	Treasurer
N	Nursing Officer
M	Medical Officer
C	Consultant
G	GP
*	DGM
U	UGM
O	Board Member attending only as required
X	Board Member with executive responsibilities
x	Advisory member of board
→	Appointed from within district
←	Appointed from outside district



Background of DGM  
Title of Management Board

Administrator  
DMT

No Longer on Board		Jobs on New Board			Notes
Left District	Left Board	Similar	Re-vamped	New	
X	A T N M C G	X x x	X    X	*    U U U U	Finance & Manpower      New Chief Nurse Director of Education and Training

Change in Number of Units 4 → 4

Background of DGM  
Title of Management Board

Administrator  
District Management Board

No Longer on Board		Jobs on New Board			Notes
Left District	Left Board	Similar	Re-vamped	New	
	A T N M C G	x x	X  X	*    → X (U) (U) (U) (X) (X)	Finance & Information  DMO/Planning  Personnel  Works Admin./Planning

Change in Number of Units 3 → 3

Background of DGM                      Administrator  
Title of Management Board    Policy Advisory Board

No Longer on Board		Jobs on New Board			Notes
Left District	Left Board	Similar	Re-vamped	New	
	A T  N M C G	  X  x x	X X  X	     * X	Treasurer/Director of Resources  UGM  (Ex-Administrator) Planning/Estates

Change in Number of Units 6 → 4  
(Separate board for UGMs, DMO one of UGMS)

Background of DGM                      Administrator  
Title of Management Board    Management Advisory Board

No Longer on Board		Jobs on New Board			Notes
Left District	Left Board	Similar	Re-vamped	New	
X	A T N M C G	   x x	X  X	*    X X U U U	Finance & Information  Performance/Standards  Planning Manpower

Change in Number of Units 3 → 3

Background of DGM  
Title of Management Board

Administrator  
DMT

No Longer on Board		Jobs on New Board			Notes
Left District	Left Board	Similar	Re-vamped	New	
X X X	A T N M C G	X x x  X		*  X X U U U  X x	(Ex-Administrator) New Treasurer Personnel Planning & Information     Nurse Adviser Works Dean

Change in Number of Units 4 → 3

Background of DGM  
Title of Management Board

Administrator  
Corporate Management Board

No Longer on Board		Jobs on New Board			Notes
Left District	Left Board	Similar	Re-vamped	New	
	A T  N  M C G		X  X  X	*       x  X	AGM Finance & Operational Control AGM Quality Promotion/DNO AGM/Planning/DMO   Dean AGM Policy & Personnel Personnel

Change in Number of Units 6 → 5  
(5 UGMs are the Executive Board which meets separately)



Background of DGM  
Title of Management Board

Administrator  
District Advisory Council

No Longer on Board		Jobs on New Board			Notes
Left District	Left Board	Similar	Re-vamped	New	
	A T  N  M  C G		X  X  X	*       X U U U	Finance & Personnel ( <del>H</del> /TUGM) Consumer Interest/ Nurse Education Service Evaluation & Planning  Admin. & Estates

Change in Number of Units 4 → 3

Background of DGM      Consultant  
Title of Management Board    Group of Executives

No Longer on Board		Jobs on New Board			Notes
Left District	Left Board	Similar	Re-vamped	New	
X	A		X		District Treasurer/ Dir of Resource
X	T				
	N		X		Planning/DMO
	M	(x)		*	
	C	→(x)		X	New Consultant
	G			X	Manpower
				X	Secretariat
				U	Commercial
				U	
			(X)	(x)	Dean of Medical School
				(x)	Nurse
					Profs. Allied to Med.

Change in Number of Units 7 → 2

Background of DGM      Consultant  
Title of Management Board    District Advisory Board

No Longer on Board		Jobs on New Board			Notes
Left District	Left Board	Similar	Re-vamped	New	
X	A		x		
	T		x		
	N		x		
	M			*	
	C	(x)			
	G	(x)			
				x	New Consultant Planning & Information

Change in Number of Units 3 → 3  
(Separate UGM Management Group)

Background of DGM            Ex Army  
Title of Management Board   DMT

No Longer on Board			Jobs on New Board			Notes
Left District	Left Board		Similar	Re-vamped	New	
X	X	A T N M C G	X x x	X	    * X X ← U U (X) (X)	Consumer Relations           (Army) Estates New Treasurer     Personnel 'Staff Officer'

Change in Number of Units 6 → 3



Background of DGM                      Army  
Title of Management Board    District Executive Board

No Longer on Board		Jobs on New Board			Notes
Left District	Left Board	Similar	Re-vamped	New	
X	A T N  M C G D	X  X x x x	X  x	          * X X U U U U U (X) (X) (X)	Inspector of Patient services          Dean Industry/Army Planning Chief of Staff       Personnel Works Supplies

Change in Number of Units 5 —→ 4

Background of DGM

Title of Management Board

Army

District Executive Board

No Longer on Board		Jobs on New Board			Notes
Left District	Left Board	Similar	Re-vamped	New	
X	A T N M  C G	X   x x	  x x	      x  * U U U U (X)	Treasurer/Director of Res. Quality Assurance/CANO CAMO/Director of Planning      Works/Dir of Infrastructure (Army)     Staff Officer

Change in Number of Units 7 → 3

Background of DGM  
Title of Management Board

Nurse  
District Advisory Board

No Longer on Board		Jobs on New Board			Notes
Left District	Left Board	Similar	Re-vamped	New	
	X A T N M C G	x x	X  X	*   X ← → X	Finance & Information  Planning/Clinical Policy  Manpower & Consumer Relations (Nurse) Estates and Properties

Change in Number of Units 5 → 3  
(Separate UGM Group Meeting)

Background of DGM  
Title of Management Board

Nurse  
DMT

No Longer on Board		Jobs on New Board			Notes
Left District	Left Board	Similar	Re-vamped	New	
X X	A T N M C G	X X x x		* → X → X X U U U  X ← X ←	Estates Personnel/Manpower Hotel Services  Planning & Business Finance & Information

Change in Number of Units 7 → 3



Background of DGM  
Title of Management Board

Community Medicine  
District Management Group

No Longer on Board		Jobs on New Board			Notes
Left District	Left Board	Similar	Re-vamped	New	
X	A T N M C G	X	X	*	Consumer Affairs
X					
		x			New DMO
		x			
		X ←			Works
			→	X	
				U	
				U	
				U	

Change in Number of Units 3 → 3

Background of DGM  
Title of Management Board

Community Medicine  
DMT

No Longer on Board		Jobs on New Board			Notes
Left District	Left Board	Similar	Re-vamped	New	
X	A		X	*	AGM Finance/Strategy Monitoring AGM Qual. Assur. & Corporate Image DGM/Planning & Information DMO
	T				
	N		X		
	M				
	C	x			Works Dental Officer Personnel Planning
	G	x			
	W	X			
	D	X			
			→	X	
				X	←

Change in Number of Units 3 → 3  
(2 UGMs have a separate Board)

Background of DGM  
Title of Management Board

Treasurer  
District Management Board

No Longer on Board		Jobs on New Board			Notes
Left District	Left Board	Similar	Re-vamped	New	
X				*	New Treasurer Planning Personnel & Admin Quality & Evaluation (Community Medicine)
X				U	
	X				
	X	X			
				X	
				X	
				X	
				U	
				U	

Change in Number of Units 4 → 3  
(2 UGMs have a separate Board)

Background of DGM  
Title of Management Board

Treasurer  
Advisory Board

No Longer on Board		Jobs on New Board			Notes
Left District	Left Board	Similar	Re-vamped	New	
	A		x		Sec to Authority/ Health Care Services Personnel Planning
	T			*	
	N		x		
	M				
	C	x			
	G	x			
		x			
				(x)	New Treasurer Works

Change in Number of Units 6 → 5  
(UGMS separate Board)

Background of DGM  
Title of Management Board

Industrialist  
Non-Executive Review Group

No Longer on Board		Jobs on New Board			Notes
Left District	Left Board	Similar	Re-vamped	New	
	X X X X				
	A T N M C G	x x		*	
			x x	*	Industry Advisory Community M Adviser Nursing Adviser P.A.M. Personnel & Staff development Manager
				x x U U U U X U	District Chairman! (later joined)

Change in Number of Units 4 → 5



Background of DGM  
Title of Management Board

Industrialist  
Corporate Management Group

No Longer on Board		Jobs on New Board			Notes
Left District	Left Board	Similar	Re-vamped	New	
X X	X A T N M C G	x x	X	*  * X U (x :)	Director of Resources/IT  Industry Planning  Community Med Adviser Other Professional Groups

Change in Number of Units 4 → 2

## **CHAPTER 7**

### **DGMs' Priorities and Actions: An Eliasian Analysis**

#### **Purpose of the Chapter**

Earlier chapters of this thesis discussed the complexity of health services in terms of the variety of groups involved, the different ways in which these groups organize their work and the difficulties associated with managing change within the context of the democratic ideals underpinning the NHS. It was argued that such complexity challenges many of the assumptions made by the Griffiths team. This chapter considers the attempts by DGMs in the sample to implement the Griffiths manifesto for change in the second and third year of the job and, in doing so, explores empirically the assumptions made by the Griffiths team.

A striking finding of this chapter is the varying time and effort spent by the DGMs on what they perceived to be their key relationships. Most time was spent dealing with district management (either with district directors and unit managers as individuals, or with them as a district management board) and region (mainly the RGM), mostly because of the need to respond to Central initiatives and provide regional managers with information for monitoring purposes. The next most time-consuming relationship was with the chair, followed closely by DHA officials (mainly because of the need to feed the monthly DHA meeting agenda). Although doctors were considered a major management problem because of their ability to obstruct change, the time and effort spent directly working with doctors (as opposed to complaining about doctors) was far less than the time spent on managerial relationships. Managers, however, spent a great deal of time dealing with the financial consequences of the activity of doctors. Finally, significantly less time and effort was spent with nurses or with community groups.

The chapter also draws on figurational or process sociology and in particular Elias's notion of game models to help understand the priorities and actions of the sample DGMs in their first four years as general managers. Firstly an overview of game models and their usefulness to the researcher interested in understanding NHS management issues is given.

### The nature of game models

Game models are put forward by Elias to explore the question:

"How exactly does it come about that people, because of their interdependence and the way their actions and experience intermesh, form a type of figuration, a kind of order which is relatively autonomous from the type of order encountered if, like biologists or psychologists, one investigates individual people either as representatives of their species or as isolated persons?" (Elias, 1970, p.72)

Elias sees game models as a possible vehicle for understanding the way in which human aims and actions intertwine by temporarily isolating them in close focus. They are meant as simplified analogies to real social processes which enable social scientists to map the complex figurations they seek to study but also map the games people think they are playing. The models are models of contests which (in the simpler forms at least) resemble real games like chess, bridge, football or tennis. They represent contests played out - more or less - according to rules (Elias, 1970, p.73).

Elias's discussion of game models are prefaced by what he calls the primal contest, which is a far cry from a game in that it represents a real and deadly contest between two groups. Briefly he describes two tribes, both hunters and gatherers who draw on



the same land for food. Food is scarce and becoming scarcer as drought and other natural forces take their toll. The tribespeople do not understand why food continues to become scarcer. Conflict breaks out, one tribe raids the other and kills a number of its members and this tribe then retaliates. Elias argues this "enduring antagonism" reveals itself as a form of functional interdependence because, as rivals for shrinking food resources, they are dependent on one another as in a game of chess (which was originally a war game). Each move of one group limits the possibilities of each move of the other group and vice-versa such that:

"...The internal arrangements in each group are determined to a greater or lesser extent by what each group thinks the other might do next. Fierce antagonists, in other words, perform a function for each other, because the interdependence of human beings due to their hostility is no less a functional relationship than due to their position as friends, allies and specialists bonded to each other through the division of labour." (Elias, 1970, p.77)

A possible danger of using game models is that it would be easy to assume that rules are essential and it is the rules that pattern social life. If this assumption were made, then the game models would be open to the criticisms made of Parsons consensual model of didactic interaction (Parsons, 1951) for example, the failure to deal with power and conflict and the fact that people do not enter social interaction untouched by upbringing and previous social relationships. Elias's point is that there are always rules, however not all the players understand them in the same way. The empirical challenge is to understand the players' view of the rules and the areas of ambiguity.

The primal contest demonstrates that it is not possible to explain the actions, plans and aims of groups if they are conceptualised as the freely chosen decisions, plans and aims of each group considered on its own, independently of the other group. It is only by considering the constraints the groups exert upon each other by reason of

their interdependence, "their bilateral function for each other as enemies", that an adequate explanation can be put forward.

The game models are all based on two or more people measuring their strength against each other. Strength or power in the game is not a "thing" which one person or group "has", but rather a quality of the relationship in question. Elias argues that the awareness of the power element in social relationships is often suppressed when people reflect on human relationships, partly because the offensive connotations which cling to the concept of power may prevent people distinguishing the factual data to which the concept of power refers from the evaluation of that data. Game models are a way of considering factual data to which the concept of power refers. Whether power differentials are large or small, balances of power are an ever-present aspect of figurations, or functional interdependence, between people.

"Power is not an amulet possessed by one person and not another; it is a structural characteristic of human relationships - of all human relationships."  
(Elias, 1970, p.74)

The models which are outlined below demonstrate the relational character of power in a simplified form. A key strength of such models is that they enable us better to understand power balances, *not as extraordinary but as everyday occurrences*. To facilitate bringing power figurations into close focus Elias uses the term relative strength of the players and 'power ratios'.

### Two-person games

Elias invites us to imagine a game played by two people, one of whom is a much stronger player than the other. The stronger player can force the weaker to make certain moves. Yet at the same time, the weaker player has some degree of control

over the stronger for, in planning his or her own moves, the stronger player has at least to take the weaker's into account. Both players have 'strength' or there could be no game; however, because one player's strength or skill is greater, that player significantly controls the course of the game - not only by winning, but also by dictating the terms of the victory and the length of time taken.

A different scenario is possible if, for whatever reason, the strengths of the two players become more equal. Then the stronger player's moves and ability to determine the course of the game diminishes and the weaker player's chances of control over the stronger increase. But, as the disparity between the players' strengths is reduced, the course of the game increasingly passes beyond the control of either. To quote Elias:

"Both players will have correspondingly less chance to control the changing figuration of the game; and the less dependent will be the changing figuration of the game on the aims and plans for the course of the game which each player has formed by himself. The stronger, conversely, becomes the dependence of each of the two players' overall plans and of each of their moves on the changing figuration of the game - on the game process. The more the game comes to resemble a social process, the less it comes to resemble the implementation of an individual plan. In other words, to the extent that the inequality in the strengths of the two players diminishes, there will result from the interweaving of moves of two individual people a game process *which neither of them has planned.*" (Elias, 1970, p.82)

### Multi-person games at one level

In this model, the number of players are increased, making it possible for more complicated figurations to occur. Elias outlines a number of contests. Firstly, where



a strong player simultaneously plays separate games against a number of less skilled opponents. While this player has an advantage in relation to each separate game considered in isolation, this is at risk as the number of separate games increases because it becomes more difficult for an individual to maintain many effective separate relationships.

A second contest may occur if the weaker players form a coalition against the strong. The balance of power is then much more indeterminate and is dependent on the nature and strength of the coalition. If the coalition is strong, then its members' degree of control over their opponent's moves may be enhanced. If, however, the coalition is beset by tensions, then the coalition will be considerably weakened and indeed, individuals may be more disadvantaged than prior to the coalition.

A third contest involves a game in which two groups of roughly equal strength play against each other, and neither side can determine the other side's tactics or the course of the game. In this situation the moves of one player can be understood neither alone nor solely in relation to fellow team members but only with respect to the whole game. Episodes acquire a structure of their own and often a distinct vocabulary comes to be used to describe the patterns and phases in the game.

#### Multi-person games on several levels

In this third group of game models, the numbers of players increase and the game is one of elaborate social processes. There is an increase in pressure on the players to change their grouping and organization. Not only does an individual player have to wait longer and longer for his or her turn to move, it also becomes more difficult for a player to put together a mental picture of the course of the game and the figuration. Indeed, the absence of the picture can cause individuals to become disoriented and it is difficult to plan the next move. As Elias notes:

"The figuration of interdependent players and of the game which they play together is the framework for each individual's moves. He must be in a position to picture this figuration so that he may decide which move will give him the best chance of winning or of defending himself against his opponent's attacks. But there is a limit to the span of the web of interdependence within which an individual player can orient himself suitably and plan his personal strategy over a series of moves. If the numbers of interdependent players grows, the figuration, development and direction of the game will become more and more opaque to the individual player. From the point of view of the individual player, therefore, an intertwining network of more and more players functions increasingly as though it had a life of its own." (Elias, 1970, p.85)

So, as the numbers of players grows, the individual player finds the game increasingly opaque and uncontrollable and, indeed, individuals gradually become aware of this fact. The critical point made by Elias is that the figuration of the game and the individual players picture of it change together in a specific direction or to use his words, "they change in functional interdependence, as two inseparable dimensions of the same process. They can be considered separately, but not as being separate". (Elias, 1970, p.85)

As in previous models, the multi-person game is no more than a game played by many individuals. The difference is that, as the number of players grows and the chains of interdependence lengthen, individuals becomes more conscious of the figuration's opacity and of their inability to understand and control it. In a situation where the game is difficult to map out, a state of disorganization and chaos is likely. This creates pressure on the players to reorganize themselves. Groups may segment and move further apart and play the game quite independently of every other group,

or they may make up a new figuration of interdependent groups, each playing more or less autonomously, though they remain rivals for certain chances equally sought after by all groups, or the group of players may remain integrated but move into a highly complex figuration, or a two-tier group can develop out of the one-tier group.

### Multi-layered group models

In this contest, not all the players play directly with each other. Opposing sides still play against each other and test their relative strengths. But the moves are made by specialized functionaries on a higher-tier - leaders, delegates, committees, elites and governments. These groups play directly with and against each other but do not exist independent of lower-tier players, and are, in fact, involved in subsidiary game contests with the lower-tiers. When there is a relatively small circle of higher-tier players, and they are very much stronger than the lower-tiers, the game is an oligarchic one. That is, each player on the higher-tier is able to see the figuration of players and the development of the game and is thus able to plan a coherent strategy through it for himself or herself. However, the interdependence of the two tiers imposes limitations on every player, even on those at the higher-tier.

Where the strength of the lower-tier players grows steadily in relation to the higher-tier players, then the balance of power will become more flexible and elastic. Elias notes that manifest signs of their latent strength are the never-ending vigilance of the higher-tier players and the closely-woven net of precautions servicing to keep the lower-tier players under control (Elias, 1970, p.89). If power differentials between the levels decrease, then the dependencies which bind the higher to the lower-tier will become stronger and participants will be more aware of them. If power differentials diminish still further, the functions of higher-tier players change and in the end the players themselves change.



As the influence of the lower-tier players over the game grows, the game becomes increasingly complex for all players on the higher tier. Each player's strategy vis-a-vis the lower-tier players becomes an important aspect of the strategy in relation to the higher-tier players. Each individual player is now constrained and confined to a much greater degree, kept in check by the number of simultaneous interdependent games he or she must play with players or groups of players who are becoming more powerful. The overall figuration which Elias calls the simplified increasingly democratic type, becomes so highly differentiated that it often cannot be clearly surveyed even by the most gifted player. As a result, it becomes more and more difficult for a player to decide entirely on his or her own which will be the most suitable next move. Indeed:

"It becomes clear how much the course of the game - which is the product of the interweaving moves of a large number of players, between whom there is a diminished and diminishing power differential - determines in its turn the structure of the moves of every single player." (Elias, 1970, p.91)

Furthermore, as the view players have of the game will change, so will their 'ideas' and the means of speech and thought by which they try to master their experience of the game.

"Instead of players believing that the game takes its shape from the individual moves of individual people, there is a slowly growing tendency for impersonal concepts to be developed to master their experience of the game. These impersonal concepts take into account the relative autonomy of the game process from the intentions of individual players. A long and laborious process is involved, working out communicable means of thought which will correspond to the character of the game as something not immediately controllable, even by the players themselves. Metaphors are used which

oscillate constantly between the idea that the course of the game can be reduced to the actions of individual players and the other idea that it is of a supra-personal nature." (Elias, 1970, p.91)

### The utility of game models

The overarching purpose of the game models is to stimulate the sociological imagination. Elias does not claim they are theoretical in the customary sense of the word, but rather he sees them as didactic models. In part, the discussion of game models is an attempt to elaborate his view of the task of sociology discussed earlier. For example:

"People say that the task of sociology is to investigate society. But it is not made at all clear what we are to understand by 'society'. In many ways sociology seems to be a science in search of a subject. This is partly because the verbal materials and conceptual tools our language puts at our disposal for defining and investigating this subject are not flexible enough. Any attempt to develop them further so that they correspond to the peculiarity of this subject matter will cause difficulties in communication. These didactic models are a means of overcoming such difficulties." (Elias, 1970, p.92)

Above all, Elias believes that these models enable social scientists to explore the problem of power as a central part of all human relationships.

"We depend on others; others depend on us. In so far as we are more dependent on others than they are on us, more directed by others than they are by us, they have power over us, whether we have become dependent on them by their use of naked force or by our need to be loved, our need for money, healing, status, a career, or simply for excitement." (Elias, 1970, p.93)

Games models also help us avoid using the concept of relationship as a static concept and remind us that all relationships - like human games - are processes, and, importantly, game models highlight the fact that unintentional human interdependencies lie at the root of every intentional interaction. In this respect the primal contest model is a graphic example.

It is helpful to apply some of the insights offered by game models to the discussion of the formation and reorganization of the NHS in England and Wales contained in Chapter 2. To recap briefly, the organization of the NHS has moved from a situation where health services were delivered largely by the hospital based medical profession, as well as the *mêlée* of community and preventative care services, in a context of what were generally considered to be relatively adequate finances, to a situation where medicine's capacity to cure and prevent illness has improved such that the costs of providing health care has soared and, at the same time, the dominance of acute health services has become less and less appropriate for the population's changing health needs. By the 1970s, government increasingly saw its task as seeking ways to curb the increasing costs of health care. The course of action open to government was by no means clear, partly because of lack of information about the effectiveness of various interventions and partly because of the numbers of interdependent groups involved in health care, most of whom had, and continue to have, differing views about the appropriateness and effectiveness of treatments, how health services ought to be delivered and who represented varying interest groups with a diversity of agendas and differing powers to influence health policy. (The strength of the medical profession *vis à vis* other occupational groups and indeed the profession's power to avoid accountability to the State has been well documented elsewhere (Jamous and Peloille, 1970; Johnson, 1972; Jewson, 1974; Larson, 1977; Waddington, 1987; Larkin, 1988)). For all of these reasons, governments have found it increasingly difficult to gain an accurate picture of how to improve the delivery of



health care in order to ensure that health care meets the often-stated, if unclear, criteria - effective, efficient and economical.

The overall figuration in the early 1970s is akin to what Elias calls the simplified increasingly democratic type. Groups and individuals in the NHS got on with administering health services in accordance with the demands of those who were the main spenders of the resources - doctors. A diverse range of groups also sought to improve their position in terms of status, pay and/or security. What occupational groups and the government seemed most unhappy about was that the medical profession had moved so far apart from other groups and were able to dictate how health care was delivered and were playing a game quite independently of every other group and according to different rules.

In an attempt to control the game, government adopted managerialism as a means of speech and thought to get some control over health services. However, the nature of managerialism has changed over time. As discussed in Chapter 2, bureaucracy was the dominant strategy devised to deal with the evolving pressures on the NHS in the 1970s, along with certain other themes, for example, devolution downwards, accountability upwards. Empirical studies of local health care management at this time demonstrate the ability of local health services to ignore the policies and priorities of the Centre, primarily because of the power of doctors to resist attempts to manage their activity and because of uncertainty as to how to change health services so that they met accepted priorities for health care. These studies also highlight the relative strengths of different players. For example we are told that the most influential actors after doctors are administrators, with the health authority and community groups lagging a good way behind. In these studies the Centre or region are depicted as players who have little influence on the periphery and are largely ignored as players. General management could be seen as another brand of

managerialism adopted by the government to deal with the evolving pressures on the NHS and to try to gain control of a complex game.

Before exploring the utility or otherwise of game models in enhancing our understanding of the issues faced by general managers trying to implement the Griffiths' agenda for change, it is pertinent to consider how general managers in the sample viewed the figuration of which they were a part. In this respect, Chapter 6 offers some important clues. For, as discussed, the philosophy of general management and the structures the sample DGMs formed to facilitate the implementation of that philosophy, were not focussed on health services delivery or patients, or the community, but were, in the main, administrative and managerial statements, echoing the key themes of the Griffiths Report. These statements were made against a background of uncertainty on the part of DGMs about the nature and scope of their role. In subsequent years, a great deal of the sample DGMs' time was spent on what they saw as improving district management which involved clarifying the nature of the relationship between districts and units, coping with an array of demands from region and the Centre and dealing with the DHA and the question of who they were accountable to. This is not to imply that DGMs ignored questions of how health services were delivered or the appropriateness of health services, but merely to say that these were not what the majority of their time was directly focused on.

Furthermore, improving health care was an area in which most DGMs felt they had not made the progress they would have liked. Tackling improving health care meant working with doctors. This was a relationship that DGMs talked endlessly about in terms of the consequences of doctors' activity on the districts' financial and strategic position, but it was not a relationship they concentrated on with any determination. The next section of this chapter considers what DGMs did in the first four years of the job in more depth and in part begins to explore in more depth the figuration (the

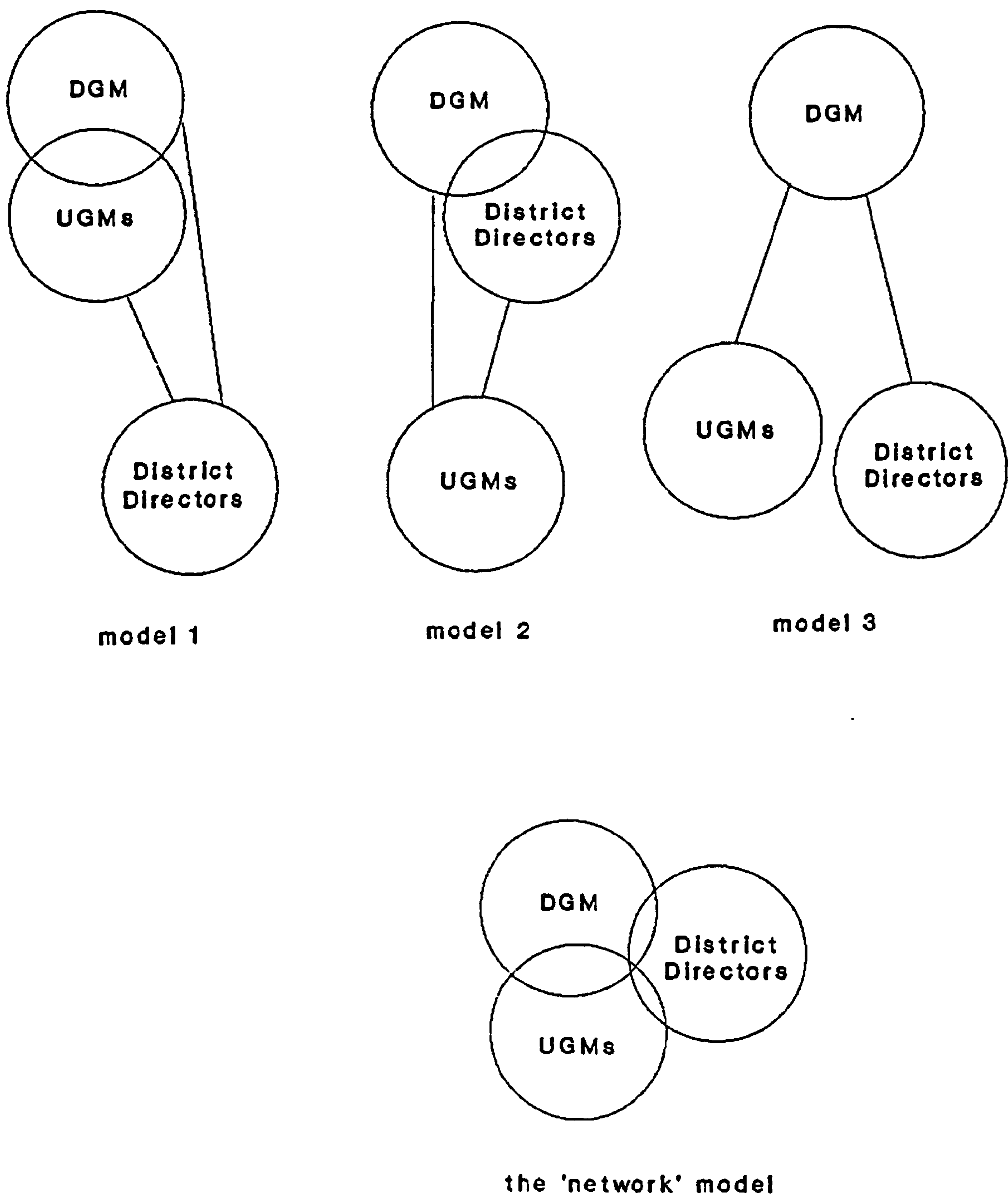
network of social relationships) of which DGMs were a part. It draws on data collected using the methods discussed in Chapter 5.

### District management issues

As was noted in Chapter 6, a great deal of the DGMs' time was spent on designing structures and a new management board. Clarifying the relationships between members of the board and between districts and units continued to consume vast amounts of the DGMs' time. Members of the board struggled with understanding the scope of their role and their ability to influence the DGM and UGMs and UGMs struggled with assessing their ability to influence the DGM and board members. This confusion was in part caused by the variation amongst DGMs across the country, in their basic assumptions on how to organize, lead and control the local health services and about the parts general managers and others played in that process. Such diversity of views was not anticipated in the Griffiths Report. It is possible to present these differences in diagrammatic forms.



Models of relative status and influence



Model 1 illustrates the view held by some DGMs that the introduction of general management had fundamentally altered the balance of power in the NHS, away from district specialists to general managers. This group of DGMs often felt greatest affinity with UGMS - as one put it:

"I have a common sense of direction with the UGMs, they are my people. I just don't seem to have that same sense of directional relationship with the district directors." (Former district administrator)

One DGM argued that he and the UGMs were the core of management in his district and to mark their elite status, another toasted his newly appointed UGMs with champagne.

Others in the sample inclined towards model 2. This group generally valued and sought to preserve the corporate influence of the district board and expected UGMs to act as its agent. As a former hospital consultant put it:

"It is the district's job to provide direction and leadership: the UGMs are the chaps who do the actual work."

Those DGMs adopting model 3, had a sharper view of the DGM as the embodiment of district strategy in action. They stressed the virtues of structural clarity and quick and confident decision-making, clear differentiation between roles and levels of management and unambiguous targets and deadlines. One DGM (ex-army), for example, aimed to ensure that "other people leave my office and they know what they have to do". Another, a consultant, said:

"The ideal situation is me sitting here and going out and visiting people occasionally, with nothing actually coming up from the unit that needs solving. I am going to institute a system of brownie points where managers will lose a point every time unit managers bring me a problem."

This group of DGMs were particularly critical of the previous experience of consensus management. Other DGMs accepted and even encouraged negotiation of objectives, and accountability within a team management structure, (the network model).

According to my observations, the analysis of documents and interviews with other people in the district, most of the sample seemed to take greater care in specifying the objectives for unit general managers and newly appointed district directors than did those directors who were in post before the DGMs' appointment. This can partly be explained by the fact that it was far easier to discuss aims and easier to agree them with those who shared an enthusiasm for general management than it was to discuss and agree with those who may have opposed general management, and who may have felt that their careers had been damaged by its introduction, usually nurses and public health physicians. It also meant that the relationship between 'old' directors and UGMs were strained.

The nature of the relationship between DGM and UGM was partly determined by the latter's professional background. Generally UGMs who were former administrators needed less guidance and encouragement and had fewer problems in securing acceptance, than did UGMs with other backgrounds. DGMs expressed particular concern about the pressures on, and performance of, some part-time clinician UGMs. Several believed that those with a clinical background expected more autonomy than the other UGMs.



Despite the amount of time spent by DGMs on district management issues, the question of which specialist management services were best located at unit level and which at district level, and why, was often not taken seriously. For example, the task of quality improvement was often given to a former DMT member (usually a nurse) with some 'slack' in their duties but without much regard to their qualifications, or the long-term implications for the delivery of health care.

The time DGMs spent on district management issues could be explained in a number of ways. For example, DGMs may have felt more comfortable in this area, or these relationship issues were more immediate and they may have felt these relationships had to be clarified before they could make wider changes, or they may have believed managerial relationships to be critical to improving health care. These possibilities are explored later on in the chapter.

### The problem of regions

Most DGMs argued that devolving power to units was hampered by the failure of regional managers to devolve power to the districts or to leave them alone to get on with managing local health services. For example:

"I must say that DGMs are feeling more and more Centre-directed. Whatever happened to the idea that there was going to be more peripheral room for manoeuvre? Region like to say that they are doing just what the management board tells them, but they themselves do interfere in an excessive degree over such things as staff grading. It is not sensible that we should have to refer everything from grade 9 upwards to them." (DGM)

Only four of the sample had a predominantly favourable view of regional managers; two of these attributed this, at least in part, to having worked at region and therefore

understanding the constraints under which regions work. There were a number of common criticisms made of regions. Firstly, regions were seen as over-bureaucratic. The strength of feeling amongst DGMs on this point can be seen in a selection of quotations from DGMs listed below:

"The lingering bureaucracy at region and the DHSS may leave us fighting with one hand tied behind our backs."

"I am irritated by region. On the one hand I am exalted because I am charismatic and imaginative, but I am held back by their petty restrictions on gradings of posts."

"I am very worried that the district will become a postbox between region and units."

"There are too many paper memoranda and not enough communication direct."

The increasing emphasis on bureaucracy was not matched by information about what priorities DGMs ought to be pursuing or any sensible statements about the strategic direction the NHS was to follow. As the Figure 21 below indicates, in one region DGMs were set 42 priorities to achieve.

## OXFORD REGIONAL HEALTH AUTHORITY

## CURRENT GOVERNMENT MANAGERIAL AND PLANNING PRIORITIES

1	Development of Mental Handicap Services	
2	Development of Elderly Services	)
3	Development of EMI Services	)
4	Development of Mental Illness Services	) Priority Groups
5	Development of Services in the Physically Disabled and Sensorily Handicapped	)
6	Neonatal Care and Maternity Services	)
7	Primary Care Services	) Priority Services
8	Services for Young Children at risk	)
9	Drug Misuse	
10	Aids	
11	Cervical Cancer Screening	
12	Health Promotion	
13	Joint Replacement	
14	Coronary Artery Surgery	
15	Renal Dialysis	
16	Bone Marrow Transplantation	
17	Collaboration with Local Authorities	
18	Community Care	
19	Implementation of New Management Arrangements	
20	Management Budgetting	
21	Containing Management costs particularly A & C staff	
22	Implementation of Korner Systems	
23	Data Protection Act	
24	Regional and District Review Tasks	
25	Appraisal of Performance Indicators	
26	Land Sales and Estate Rationalisation	
27	Cost Improvements	
28	Use of Non-Ambulance Transport	)
29	Non Emergency Ambulance Service	)
30	Central Stores Policy	)
31	Residential Accommodation	)
32	Recruitment Advertising	) Rayner Scrutinies
33	Collection of Income	)
34	Cost of Catering	)
35	Collection of RTA Fees	)
36	Use of Forms	)
37	Kitchen Hygiene	
38	Review and Reduction of Waiting Lists	
39	Option Appraisals for Capital Schemes	
40	Getting Mentally Handicapped Children out of Hospital	
41	Competitive Tendering	
42	Collaboration with the Private Sector	



Some DGMs argued: "the region seems to think its only responsible for dishing out money and monitoring what the districts do." Most felt "unable to penetrate the treacle which permeates down all levels within the region" and were unsure if there was "a lot of thinking going on behind closed doors or just no thinking at all." There were concerns that what strategic planning there was, was not linked to the district's own plans and that districts were not involved in contributing to the formation of these plans:

"We are all too remote, even allowing for the necessarily wider view at region...region should be using district's own drafts and forming the strategic plan."

The region's role in resource allocation invoked criticisms as one might expect in a period of financial constraints. These included not recognizing the operational effects of budget reductions, not listening to district managers so that policies were produced that districts could not afford to implement, and the exercise of favouritism, particularly towards teaching districts. In short, common complaints were:

"They seem to react more to pressure than to reasoned arguments when giving out resources" and

"There is no evidence that districts that have overspent are called to heel. Clinicians in my district are beginning to get fed up with being good boys, when other districts seem to get away with murder."

The region's role in relation to the Centre was often criticized. There were fears that region was not sufficiently conveying district views about the difficulties caused by the numerous national priorities. There were fears, too, that regions failed to

challenge the Centre sufficiently and that region was not filtering out enough material from the DHSS. For example:

"I find myself increasingly irritated by region, there is a continual constraint by very tight rules and procedures and their need for information which does not get used...It is the opposite to what I see general management to be, it is a reflection of political requirements."

"It is a pity that the management board isn't protecting the Health Service from being a political football."

"I am very worried that if general management doesn't work at the Centre, it will give a bad name at the periphery where it may well be working."

There were complaints from DGMs and other district managers both of over-monitoring and the impact this had on region's performance of their strategic role, for example:

"It is really not clear why they (the region) need to come between us (the district) and the architects. And does region really need to have a say in where the light bulbs go?"

"We are jumping through hoops in order to demonstrate we can jump through hoops, without anyone pointing out that the hoops aren't actually achieving anything for the NHS."

Finally, regions were also criticised because of their continued holding of consultants' contracts.

"If region are the employers of that group of consultants, then they ought bloody well to get their act together and not get us to flog away doing the foreman's job without having any authority to do it."

These criticisms need to be balanced by the references made by some DGMs to improvements at region and with the fact that many of the sample were not involved in regional work. As one DGM noted:

"We can all throw hand-grenades over regional sandbags, but unless you are prepared to contribute, you can't complain... You get the region and the Department that you deserve."

The largely negative attitudes to region, particularly those DGMs from within the NHS, appear to have been affected by changes which increased the power of region to hold districts to account. These changes included: the development of the review process by which the Centre monitored progress on national priorities; the introduction of individual performance review and performance-related pay, with the "grandparent" role at region giving the RGM a direct relationship with UGMs; and the development of information at region about district and unit performance, thus enhancing region's capacity and hence power to monitor.

RGMs I interviewed put forward similar criticisms of the management board as those levelled at the region by the sample DGMs and other managers. For example:

#### *Lack of strategic leadership*

"The management board is not proving to be a force in general management terms, they are piggy in the middle. (Reference to Ministers and the Department of Health) Unless the management style changes, this will always



be the situation. That means being honest in parliament and accepting that they are a strategic authority and that the details that parliament sometimes required is (sic) not accessible to them." (RGM)

"My region is interventionist, and that is partly because the chair chooses to play it that way. It is also difficult to be any other way, given the impossibly crowded agenda that comes down from the Department... It takes a few seconds for them to think of things up there, it takes us a few minutes to elaborate them, but when it hits the interface of clinicians, it is impossible." (RGM)

"One of the main problems with the Centre is that the agendas that come out of there are all about management process and not patient-care policies." (RGM)

"There are, in practice, very few Central initiatives, I can't think of one. I have had some very stern policy steers but no directives." (RGM)

### *Too much bureaucracy*

"I sense that there aren't enough resources or skills to make this change happen. I feel that the pressure from the Centre has slackened off and all the old complacencies, all the old bureaucracy are anxious to rush round the door and come in again." (RGM)

"I don't think the management board have developed a corporate role... They are two years behind everyone else and they are less general management oriented and have less of a corporate feel working in the department than is the case at region and districts. What you need is general management in the

Department. The regional general managers call the management board 'Noah's Ark' because there are two of everything." (RGM)

In the view of this sample of DGMs and RGMs, as well as other managers and DHA members interviewed, the leadership from the Centre through the management board and regions promised by the Griffiths Report failed to materialise. Such leadership, Griffiths had argued, was pivotal to ensuring a successful general management process. There is no doubt that district management spent a great deal of time responding to requests from the Centre (communicated and elaborated by region). These requests often could be traced to a political debarcle, the need to make a political point or justify existing policy or the need to cover a politician's "gaff".

#### The accountability question

The Griffiths Report was silent about the role of the DHA and public accountability more generally. Accountability was, however, an issue for DGMs in the second, third and fourth years of their job. Many DGMs spoke of the need to balance pressures from the management board and from region to whom they were managerially accountable and from their chair and the DHA, to whom they were publically accountable. The 13 RGMs interviewed (12 by myself) echoed the theme of being squeezed by two sets of accountability structures.

"I feel torn in half between what is expected of me as an agent of the management board and the total needs for my region, particularly within a deprived region." (RGM)

"One of the biggest conflicts is with my regional chair, who after all, is a political appointment. He sees the region as an operating division HQ of the region and the district are the subsidiaries. I want a corporate view." (RGM)

Personalities proved to be important in resolving such issues. For example, the nature of the relationship between the district and regional chair could be an important influence on the relationship between RGM and DGM and posed particular problems for DGMs who did not have a good relationship with their own chair. The influence of personalities is in part related to the uncertainty surrounding the relative roles and power of general management and public representatives following Griffiths.

An interesting finding of the research is the variation in the roles that district chairs played in their relationship with the DGM and in the time spent by chairs on their work for the NHS. Most chairs performed the roles described in the following two quotations:

"The chairman represents the authority. He interprets the authority's aims and wishes. He judges how it will react; he is the sounding board for the DGM."  
(DGM)

"The chairman is to make sure that all appropriate matters go before the authority to study; that a policy is arrived at which must be within the rules and regulations laid down." (DGM)

Some chairs saw themselves as merely waiting to hear when the DGM wanted them to become involved. Others saw themselves complementing the DGM's skills in a very cooperative relationship. A few thought the DGM's role was to manage the district and their role to take the flak. Many argued that chairs were the key interface between district and region and had the job of ensuring that regional managers understood the problems of the district. The majority of the sample wanted a chair who could understand the broad issues in health care, challenge their ideas and act as

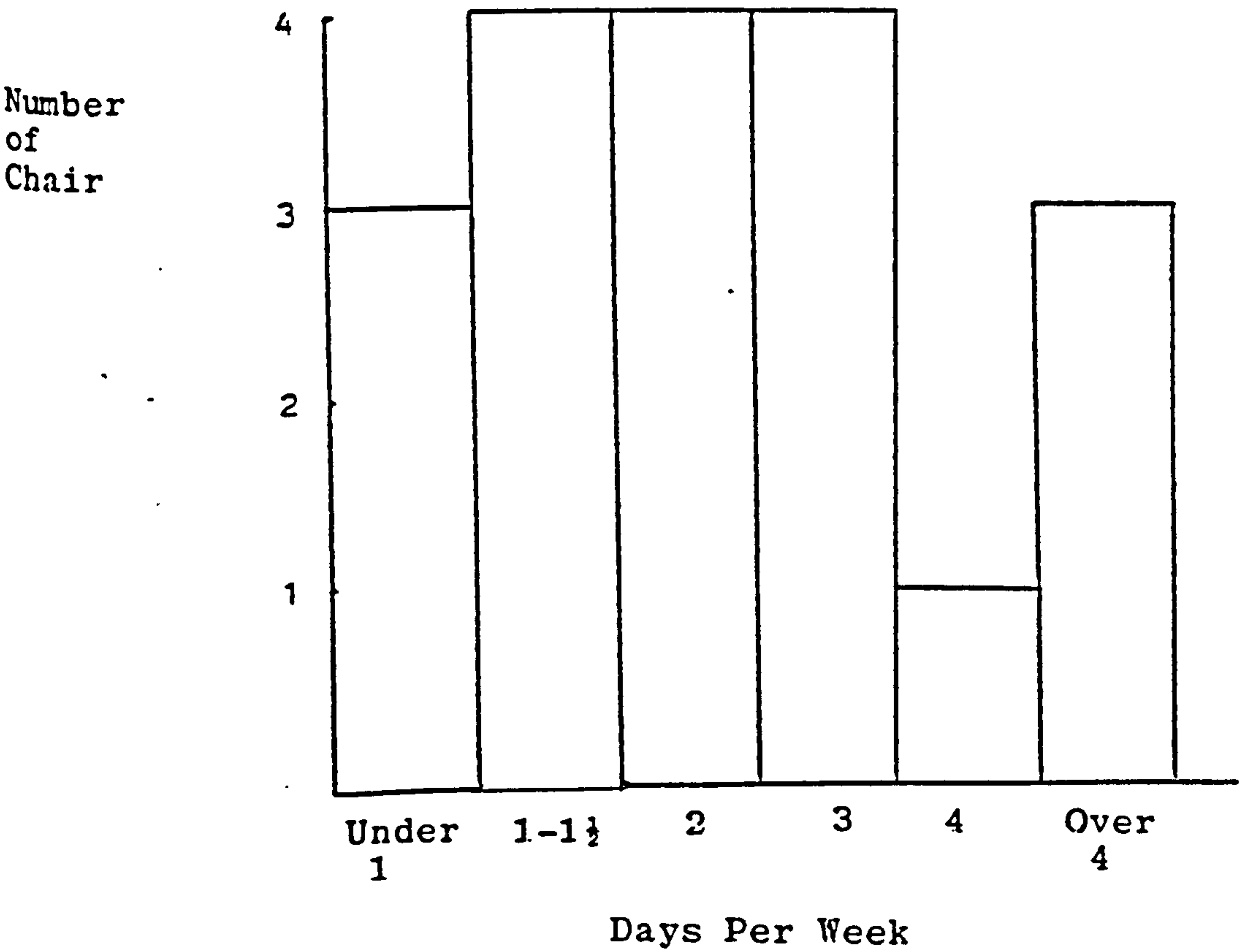


a sounding board. Most acknowledged the figure-head role the chair had, but all wanted to be left alone to get on with the job.

The time spent by the chairs in the sample districts on their work for the NHS differed as the Figure 22 below demonstrates. Time ranges from less than a day a week to full-time.

FIGURE 22

Time Chairs Spend on NHS Work \*



\* It is always difficult to estimate time spent in jobs like this because of the thinking about the job that may go on at other times.

Source: Templeton Series on District General Managers,  
Issue Study No.1: DGMs and Chairmen\* A Productive  
Relationship.

DGMs also differed in their views of the importance of the DHA as a vehicle of public accountability and the time they should devote to it. The attitude amongst the sample towards the DHA could be described as ambivalent. This is well expressed by the following quotation:

"I don't feel driven by their views... I suppose we all play a game of 'we have got to get it through the DHA', and, whilst I value the opinions of some of the individual members, I am not sure that we really need collective views on any major decision facing us. But that worries me because it is not what I personally believe in. I think the DHA is an important institution, it is just that ours doesn't work that way." (DGM)

No DGM, however sceptical, dismissed the DHA. Those who failed to keep on good terms with members had considerable trouble rebuilding the relationship. There was also ambivalence about the time and effort DGMs and other managers spent in preparing for DHA meetings. Some found it an unwelcome burden while others, mostly former administrators, welcomed it because servicing the DHA was a useful source of influence and the cycle of monthly meetings provided a useful discipline for keeping projects on target. At one extreme was a former administrator for whom the development of his DHA members was a top priority, at the other, another former administrator regarded the DHA as "not being worth the time and effort". In nearly all the districts there was a gap between what the DGM thought the DHA ought to be doing and how they judged it operated in practice. The range of roles played by DHA members, as reported by those DHA members and chairs interviewed, can be divided into four groups of activities:

1. Setting political/philosophical values.
2. Making decisions about policies and priorities.



3. Planned involvement in implementation or planning.
4. Ad hoc or one-off interventions.

DGMs argued most activity of the DHA fell within category 4, whereas most members saw their performance equally in 2/3 and 4. Very few saw themselves in 1. Several DGMs spoke of the DHA's failure to tackle health care issues, preferring to concentrate on hotel service issues:

"I want them to stop thinking about dirty duvets and start thinking about how my district should develop a psychiatric service."

In short, DHA's were characterised by most of the sample as being interested in "how things should be done, never what should be done" and lacking clear ideas of what they wanted DGMs to achieve."

"They want to be led by the nose, and I don't want that from them, it is the uninformed leading the blind."

and some went so far as to say:

"There were times when their behaviour was a disgrace to major public service, consuming resources on this scale."(14)

DGMs gave three reasons for this situation. Firstly, some felt the DHA was not up to the job of making policy because of the poor quality of members.

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(14)It was fairly common practice for members to play to the gallery at DHA meetings and to make political points in public which, on occasions, undermined agreements they had made in private.

"I don't want members making policy if they are not equipped to do so. Their role is to challenge the policy put to them. I want to make them feel more positive, without raising their expectations too much as to their role. Their traditional refuge is to take up small causes."

Secondly, about half the sample believed DHAs ought to challenge government policy more and act as representatives of the local communities they served.

"I am frustrated that the government line is followed so easily by DHA members."

One consequence of the perception of the ineffectiveness of the DHA was that most DGMs, even if believing strongly in the principle of public and open accountability, often secured decisions outside the formal DHA meeting.

A final reason given by DGMs for the ineffectiveness of the DHA was confusion surrounding the role of members following the Griffiths Report. DGMs (and often members) seemed unsure if they were there to check the details, shape the principles, or to be lay-managers themselves or the public watchdog of professional managers. In short, there seemed to be a lack of clarity amongst the sample and the chairs, about the appropriate mechanism of public accountability.

In many of the sample districts, a 'them' and 'us' situation existed with many DHA members disaffected. This view is supported by the findings of Christopher Ham (Ham, 1986). In the sample, rather than searching for a role, many of the DHA members were suffering from a massive erosion of morale. A major impact on the decline of morale was the pincer movement between the Centre (region or the DHSS) and the managers, which members believed was squeezing them out of the real role.

Manpower targets, competitive tendering, accountability reviews, cost improvement programmes, waiting list initiatives, were all seen as testimony to this.

In observing the DHA meetings, the impression I had was that they resulted in very few policy shifts. But that did not necessarily mean that they were the rubber stamps they were sometimes accused of being. Many of the DGMs assessed what was likely to be acceptable to the DHA at an early stage of policy-making. It was always there in the background, as a conglomerate of local pressures that set strong limits around what managers could seek to change (Templeton Research Paper No.3, 1988). The chair often played an important role as broker, allowing the DGM and members to assimilate and take account of each others' views. So - and in contrast to - many of the conclusions from academics examining the role of the DHA post Griffiths Report, where the DHA has been seen as impotent (Ham, 1986; Haywood 1987) - my data suggest that the DHA did have a significant role and did affect policy. So, whilst it might seem surprising that DGMs and their staff spent a great deal of time and effort on a body of little apparent influence, unclear roles and a host of problems, the reality is that the DHA, either informally or just by its very existence, did exert considerable influence on DGMs' actions and activities.

From the preceding discussion of the empirical findings relating to district management, regions and the accountability question, one begins to get a flavour of the complexity of the social relationships of which DGMs were a part. The effects of these relationships on the way in which DGMs pursued their job were immense in that region, the Centre, the DHA and the chair, created an enormous amount of paperwork for the DGM and his or her team, either in the name of public accountability or because of the need to respond to the consequences of the game played by higher-tier members (e.g. the government, DHSS and region). The power struggles between the UGM's, district directors and DGMs also were time-consuming if the DGM was at all sensitive to such issues.



### The "Problem of Doctors"

Not surprisingly, the power of doctors was the issue the sample talked about most in the second, third and fourth year of the job. All of the sample faced the difficult task of getting doctors to accept the management view that their clinical freedom should be counterbalanced by an awareness of, and responsibility for, the effective management of resources. Their task was made more difficult by various problems and uncertainties. Firstly, they often did not know the exact nature of the doctors' contractual obligations because contracts were with the region. Secondly, the majority lacked relevant clinical knowledge and were often hesitant to discuss professional and technical standards and indeed felt vulnerable in such discussions with doctors. Thirdly, there were few incentives available to encourage doctors to become more involved in management outside their group or department. A management post took doctors away from a well-trodden and well-rewarded career path. Some of the medical representatives in the sample districts I spoke to often referred to the price of their involvement in management in terms of increased workload, financial loss and tensions with other colleagues.

A few quotations illustrate the difficulty the sample DGMs found in implementing the Griffiths recommendation to involve doctors more closely in management.

"The doctors lead the technology, and therefore the pattern of service. Unless managers get the doctors with them, everything else is just window-dressing. That's where you have got to get change...there never will be a better time."

"The success or failure of optimizing health care ultimately depends on doctors."

"The glorious Griffiths image of the DGM cutting through the bureaucratic undergrowth is just hogwash. You can cut through it as much as you like, but when you have done it, you are just left there against the consultants who are saying 'no'."

"The consultants are a devoted bunch, but I bet no-one warned the outsider DGMs how little control they would have over this major resource."

### The "Problem of managers". The Doctors' View

If doctors were "a problem" for managers, it is equally true that, from the perspective of doctors, it was managers who were "the problem". DGMs were often not aware of how suspicious and fearful the consultant body was of general management. In particular, those doctors I interviewed feared that general managers would try to encroach on their professional independence, their freedom to determine their working patterns, even their clinical freedom. They also feared that managers would remove them from the decision-making machinery, leaving the managers free to ignore medical advice. A related fear was that general management would entail an erosion of what doctors considered to be 'special' NHS values. "Thank God we didn't get someone from Sainsbury's", said one medical informant, giving voice to many in the Health Service who assert that there is something special and different about health that is not amenable to a managerial or commercial approach. Again, while there is undoubtedly some validity in this argument, it is also overlain with strong ideological overtones which are called into play in conflict situations of this kind.

Most medical informants felt that discussions of resources were somehow improper, and believed such discussions conflicted with their responsibility to the individual patient. There was a related fear that general management may lead to a finance-led view of health care which would force doctors to make decisions on economic rather

than clinical grounds. One group of consultants, in response to a budget deficiency, invoked the Hippocratic Oath, refusing to have anything to do with decisions about priorities.

Doctors were also afraid that their autonomy would be curtailed. They often suspected managers of being appointed as bureaucratic henchmen, put in post to carry out dictates from the Centre(15). Doctors tend to have a poor grasp of, and little respect for, managerial skills or structures. For example:

"The unit general managers are just too junior to be accepted by us as a group. We prefer to relate to the chair".

They also believed general managers were out of touch with what actually goes on in the NHS.

"It is the doctors who know the problems and who are patient oriented. Administrators(16) do not have the background, so will never be able to relate properly to us. They need us, we don't need them." (Consultant from a sample district)

Some believed:

"Most doctors are more intelligent than DGMs and they tend to know it."  
(Consultant from a sample district)

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(15) Individual performance reviews exacerbated fears that the DGMs, worried about an adverse personal review, were more likely to act as tools of the Centre. Individual performance reviews (IPR) were introduced in the third year of general management. A flow chart of the review is given as Appendix VIII of the thesis.

(16) Most doctors referred to general managers as administrators. This was a constant source of irritation to the managers.



Doctor interviewees often found managerial phrases uncomfortable to use and generally distasteful. For example one consultant argued:

"I hate the word 'customer', it conjures up images of baked beans on a shelf."

A few doctor interviewees admitted (confidentially) that they had no idea what some of the managerial jargon meant and found themselves arguing with managers in order to cover up their ignorance. Sometimes medical informants admitted that they misunderstood the role of advice and negotiation and were ineffective in the medical advisory machinery. In one district, for example, they expected to appoint the acute unit general management by a consultants' ballot. Doctors often stated quite clearly that in their view, managers were there to oil the wheels and ensure adequate facilities and equipment as they were needed. When it came to influencing policy they preferred to deal with the district chair believing him or her to have power. They had no clear idea as to what regions or the management board did. Some had never heard of the management board, let alone the Griffiths Report.

#### Examining the 'problem' of managers and doctors

The sample DGMs all agreed that one of their prime tasks was to involve doctors more effectively in the management of health services. Few, however, clearly expressed what that actually meant. The following can be seen as common aspirations:

"There would be no barriers and no mutual suspicions between doctors and managers. We have got to get to know and understand each other as people. Even though they must offer a countervailing perspective to management, we ought to be able to go in the same direction and pull together."

"Doctors would accept that managers need to match services to resources for the whole organization and understand what that means."

"Doctors would play a key part in management by participation and negotiation and not by veto. They would make choices with managers about running the service and not have managers make them on their behalf. They would realize that the scarcity of resources is real and their work has major implications for the whole of the organization."

"I want doctors to be able to sit down and look at the impact of their activities on the total health care of the district and get them to see those activities in the context of the broader system, and not just of the sick physiology in front of them. Then I would like them to make sensible allocations of resources, for example, as to what kind of doctors we need. The sort of thing I have in mind is that one day a group of surgeons and obstetricians will sit down together and agree that they need to divert some of their resources to fund a new radiologist."

The existence of the very different interests and perspectives of doctors and managers makes the establishment of harmonious relations of this kind very difficult to achieve. Although many empirical studies have highlighted this as a key issue in health care management, very little progress has been made in understanding the problem (Harrison et al, 1993). One way of analysing these differences is in terms of Ludwick Fleck's concept of "thought style". Fleck argues that any kind of cognition is a social process. Truth is neither relative and subjective nor absolute and objective, but essentially determined and measured by a given thought style (Denkstil). A thought style functions by constraining, inhibiting and determining the way of thinking of individuals. Under the influence of a thought style, one cannot think in any other way, for it excludes alternative modes of perception. Accordingly, no proper

communication can arise between those who exhibit different thought styles. A thought style functions at such a fundamental level that the individual is generally unaware of it and its constraining character.

Fleck notes that thought collectives are communal carriers of a given thought style. He defines the thought collective as "a community of persons mutually exchanging ideas or maintaining intellectual interaction" (Fleck, 1979, p.38). What links the individuals of a thought collective together is the thought style they share. Considered in its collective function, a thought style is a "special carrier for the historical development of any field of thought, as well as for the given stock of knowledge and level of culture" (Fleck, 1979, p.39).

Doctors and managers have very different 'thought styles' arising from membership of different 'thought collectives'. The sample DGMs tended to stress the virtues of interpersonal skills and of enlisting the cooperation of others. They expected to subsume individual interests to those of the organization. They were also trained to be aware of the wider implications of any activity within the organization. They also expected to make optimal use of limited resources and were used to working towards long-term goals. Doctors, in contrast, expected to strive for the best available evidence before making a decision. They are used to working to short-term operational goals. Furthermore, doctors are hardened by a career-progression which makes tough physical and emotional demands on them and tends to limit their social contacts to people working in the hospital. They rarely receive any training in management or organizational skills until they are quite senior. It is interesting to contrast the relatively detached perspective that doctors develop towards clinical issues as a result of training, with the relative lack of detachment in relation to social processes and their own position within those processes, as demonstrated in the previous discussion of the doctors' view of the problem of managers.



From the preceding discussion it is clear that there is a fundamental conflict of interest between doctors and managers on a social structural level, yet DGMs, doctors and health service policy-makers and commentators seem to regard the conflict between doctors and managers as simply a conflict on the level of ideas about the relative merits or demerits of general management. Furthermore, DGMs tended to resort to conventional management ideology in dealing with these differences, for example, arguing for a change in management strategies. The differing perspectives of doctors and managers and, indeed, other groups need to be understood as complex social processes.

There were, however, differences in how DGMs saw their aspirations for an improved relationship with doctors being realized and the role of general management in this. Former district administrators, nurses and treasurers were united in seeing general management as an opportunity to harness the power of doctors, either to tackle specific health care issues or manage their own service. Of this group, two DGMs (a treasurer and a district administrator) wanted to harness doctors more in the sense of reining them in to ensure that the district plans were achieved. As the former district administrator put it:

"I have quite openly said that one of the messages of Griffiths is to push the professions back."

The two former consultants saw their role with doctors exclusively as one of convincing them that discussions of resources were entirely compatible with their more caring for patients.

"Consultants don't understand management. They believe the Health Service is there for them to exercise their skills. The idea that they could be managers they feel suspicious of. Yet in other ways they are the easiest group that I deal with because they are highly intelligent and articulate, highly skilled and totally unworldly. The real problem is that they see discussions of resources as somehow improper."

Those DGMs new to the NHS considered the doctors to be too powerful, inconsiderate and 'generally disagreeable'. For example:

"I see doctors as the medical mafia. They don't do their bit. I intend to show them what I can do and they will be shamed into doing their part."

"Initially I was gullible, I was spellbound by their talent. They really are gods in white coats and act like spoilt children."

One former industrialist recognised that the power of doctors to influence health care required a change in his management style:

"You can push nurses around managerially, but you have to persuade consultants."

This statement shows a keen recognition of power differentials.

If one examines the strategies adopted by the sample to address the 'problem' of doctors, then some interesting patterns emerge which confirm a point made in Chapter 6 - that in the face of uncertainty as to how to cope with a variety of issues, people resort to their previous experience of handling those issues and make alliances that in the past had enabled them to get things done. In the main, former district

administrators used the health authority and the chair to try to get doctors to cooperate with their plans:

"If the consultants can't be persuaded, negotiated, coerced or seduced to accept change, then I'll have to take some of these issues to the Authority."

"You need to keep your chair briefed as to the tactics of the consultants, or this has repercussions because generally they prefer to relate to chairs."

All but one former district administrator spoke of the importance of general managers courting opinion leaders amongst the profession.

"I use opinion leaders, I try to explain their roles so they don't see it as a diminution of their power.... Doctors have a habit of wanting to avoid conflict, they are great conciliators, but bloody awful decision-makers."

"You only get the message over to medical staff if it hurts. You need to identify the opinion-makers and it is surprising how small and influential that group is. I would say in my case about 6 out of about 180 consultants."

Former DMOs and consultants were wary of being seen by doctors as a "back door" to getting things done because of their medical backgrounds. Their main strategy for dealing with doctors is nicely summarised in the following quotation from a DMO DGM:

"I play on the doctors' fear of civil servants, in other words I say 'you must allow us to sort it out, because otherwise it will be done by someone from outside of the district.'"



The DGMs with a nursing background, like the former DAs highlighted the importance of dealing with opinion leaders amongst the doctors:

"When I spent about 80% of my time with doctors, it's with 20% of the doctors. I never see an anaesthetist."

However, they were more keen to use incentives which, in their experience, could influence doctors' behaviour:

"The average consultant is not interested in macro authoritarian structures, but in what the organization allows them to do. So if they tow the line, I let them have a sweetie, for example, a new piece of equipment."

Newcomers to the NHS found themselves bruised in their early dealings with doctors and were forced to rethink their assumption (and that of Griffiths) that doctors would see themselves as accountable to them as the managers responsible for the local health service.

Former treasurers preferred strategy in dealing with the 'problem' of doctors is nicely captured in the following quote:

"Managing consultants is all about finding the right financial hook to haul them in."

Common strategies for enlisting the cooperation of doctors amongst the sample included improving the medical advisory structure, providing information packages for consultants and attempting to organize clinical services into clinical resource management groups where the relationship between activity, resources and effectiveness could be discussed.

The data presented concerning the relationship between doctors and managers clearly questions the assumptions made by Griffiths that the general manager could be the final decision-taker in terms of health services. DGMs in all 20 districts struggled with managing the power of doctors, found it difficult to engage with them as a group and to cope with their very different view of what management was there to do, that is, provide them with facilities, equipment and resources in order that they practice medicine. Some managers did report progress, although it is important to recognize that managers' perceptions of progress may be very different from progress as defined by some relatively objective, external index. Below are some of the actions of DGMs which, in their view, seemed to improve their relationship with doctors.

#### Making progress with doctors

The following are the criteria which were given by DGMs to indicate the degree to which they believed consultants had become involved in management:

##### Consultants:

- came to managers with ideas for changing the service;
- accepted the need to review their working practices to see whether they made the best use of resources;
- recognized resource limitations and the need for shifts in priorities, and helped to develop strategies;
- used clinical resource budgeting to make more effective use of resources and were interested in extending its development;

- made contributions in district or unit meetings rather than simply fighting their own corner and
- were willing to tackle conflicts between consultants that affected patient care.

Below are summaries of what the sample saw as useful methods for enlisting medical support and involvement in management.

### **Understanding the doctors' point of view**

Some DGMs tried to develop their understanding of doctors' viewpoints. In other words, they tried to detach themselves from the position of manager to see the medical world from the perspective of a clinician. A number of methods were used to gain this knowledge. In approximate order of frequency amongst the sample they were:

- developing a very close relationship with one or more key representatives;
- establishing early on in their job a deliberate programme of wide-ranging discussions with doctors;
- cultivating in the long-term, a wide network of key consultant contacts;
- attending formal meetings such as the Medical Executive Committee (MEC);
- observing doctors at work, on ward rounds, clinics, etc. and
- attending meetings with consultants and other managers outside the district.



Some DGMs spoke of the importance of attending the MEC to keep the discussions well informed and to recognize how, as several DGMs put it, "the reasonableness of consultants as individuals contrasts with their unreasonableness as a group". Such attendance sometimes helped to show consultants that the DGM was interested and took their deliberations seriously. It provided, too, an opportunity to be available before and after the meeting for informal chats.

### **Developing networks**

"Unless you develop an informal and real relationship, then you might just as well forget it. I can't stress too much how important it is to be able to drop in and chat to consultants in a relaxed way. Where I've not done that, thinking perhaps that the issue was sufficiently straightforward or that I didn't have time, it's nearly always come unstuck or had a rough passage.... You can't run this job from the office desk, you've got to get out there and talk to the people informally all the time."

Some DGMs believed that such contacts informed them who the opinion leaders were and how the power groups within the profession may affect any desired changes.

### **Recognizing individual contributions**

Only a few of the DGMs looked at the consultants as a source of talent for project developments outside their own specialties. Some DGMs who sought to take, in Elias's terms, a "detour *via* detachment", recognized that the nature of the doctors' training means that doctors often relish, and are good at, problem-solving. Often this group of DGMs couched managerial problems in the form, "I think we both recognize that this is a problem; can you help us solve it?" Those with medical knowledge

often stated the problem as a clinical metaphor. Some DGMs suggested possible solutions and offered all the necessary technical and administrative support to facilitate the doctors' deliberations. DGMs found that a major advantage of this approach was that the consultants not only "own the problem but also the agreed solution, which goes a long way towards assuring its implementation". As a district medical officer commented:

"They'll come up with a solution and this solution will work because it's theirs. If you try and impose a solution, an unholy alliance will occur. There are very few things that will unify the profession, any threat to their 'clinical freedom' and they are bound to unite."

### **Recognizing doctors' management ability**

Although my medical informants were not a representative sample of the consultant body, many argued that "the consultants are not (managerial) Luddites anymore, they are interested in change". Some DGMs who had worked in the service for some years were surprised at what they judged to be the aptitude of consultants for management and admitted they had underrated their abilities in the past. Even doctors who eschew management have a major responsibility for leadership - of the consultants' 'firm'; on the ward, clinic or operating theatre; in medical committees; with patients and their relatives. They manage, often quite subtly, such things as clinical motivation or getting medical innovations accepted by the medical community.

### **Developing doctors' management ability**

Apart from funding some doctors to go on management courses (they were in the main, reluctant to go), some DGMs sought to improve doctors' understanding of management by arranging special seminars and meetings with key speakers, or took

their consultants to meetings outside the district to learn about, for example, clinical resource budgeting. These meetings had three advantages: learning about developments elsewhere saved reinventing the wheel; meetings were designed to demonstrate to doctors that managers took seriously the need to find the best solutions for that particular district, rather than jumping at the first scheme that came along; and finally, enthusiastic doctors from other districts who had gained from successful managerial initiatives went further than almost anyone else in persuading doctors to cooperate in such initiatives.

### **Demonstrating the utility of general management**

DGMs often deliberately made great efforts to deal with some long-standing thorn in the consultants' flesh so as to demonstrate the potential for further benefits and the need for change. Those who were more successful in improving their relationships with doctors sought to demonstrate the utility of general management in terms that were relevant to doctors.

### **Non-problematic relationships**

There were a number of relationships that DGMs found non-problematic in the sense that these groups did not take up a great deal of the DGMs' time, and were not troublesome. They were often dealt with in terms of being one of the many groups the DGM had to send consultation documents to.

There were very few spontaneous comments from the sample on nursing or, indeed, other para-medical professions. Rarely did nursing figure in any of the policy discussions I observed. Most of the interview comments on nursing centred on difficulties the DGMs had in finding a role for the former district nursing officer, most of whom went into the quality assurance posts.



A number of local interest groups were referred to over the period of the study without DGMs reporting them to significantly influence their activities. In general DGMs, whatever their background, did not want to ride rough-shod over the CHC, and acknowledged them as "the voice of the community", but in practice deemed them ineffective, suffering from a bureaucratic committee structure and warring factions and described the CHC as "tame", "passive", "tedious", "a complaint-collecting organization" and "political". Very little time was spent on this relationship, indeed only two DGMs - both former administrators - regularly attended the CHC's meetings. CHCs were on the mailing list for consultation documents, but were never considered by the sample as a body that had to be actively influenced to get policies agreed.

Similarly, little comment was made about the role of the local authority. Most districts seemed to be building bridges, but usually this was through the DGM and director of social services meeting on a regular basis, mainly to exchange information rather than negotiate policy. The overall conclusion that one can draw from the data on this relationship is that there was great confusion about the relative responsibilities of the health authority and the local authority.

The trade unions were another local group occasionally mentioned. Most DGMs delegated industrial relations matters to either the personnel manager or to the units with DGMs being a last resort. Some DGMs were more active in courting their local MPs than others, although MPs were regarded by all DGMs as important people to keep informed of local issues relating to health. Only two DGMs mentioned forging relationships with the private health sector. GPs were rarely mentioned, except in the context of the district board where there was a representative, although some DGMs had made efforts to meet with the chair of the family practitioner committee.

Voluntary groups and patient groups were also very rarely mentioned, but some DGMs did attend various meetings and gave talks to community bodies.

Outsiders were surprised at the number of diverse interests associated with health care and seemed to make more overtures to local community groups than those previously working within the health service. The attitude of more seasoned NHS managers was to keep an eye on local groups and make sure they didn't do any harm. Most of the sample claimed (when asked), that they cared about community views, but were very cynical about the mechanisms available to represent them.

Several DGMs made efforts to inform the public of what was happening within the NHS, either through press briefings (the usual stimulation for this was a financial crisis) and the production of annual reports. One district appointed a public relations manager to "put money in the bank with the community in times of crises". Only one DGM mentioned the role of the health service as employer and was active in careers activities within schools. Occasionally in the interviews or during observation periods, there were comments made about the importance of the public driving the direction of the health service rather than professionals, but given the lack of effort put into debating this issue, this concern could be seen as lip-service.

It seems, from my data, that local groups, nurses, paraprofessions, GPs and trade unions were not important relationships to DGMs in the sense of influencing their management activity. They were relatively powerless within the figuration of relationships which involved DGMs and were monitored relationships rather than influential relationships. Furthermore, despite the Griffiths Report's emphasis on the importance of the consumers of health care, very little attention was paid to consumer representatives or consumers as people whom the service should involve in decisions about what health services should be provided. Rather, most DGMs sought to deal with the 'consumer issue' as defined by Griffiths by making efforts to improve the

quality of health care, as defined by general management. This is discussed in the next section.

### Improving quality

As we saw in Chapter 3, the Griffiths Report placed great emphasis on improving quality. General management was thought by the Griffiths team to be capable of facilitating improvements in service delivery and that it was possible to measure such improvements. Most DGMs, however, were cynical as to whether quality improvement or quality assurance really represented new concepts, or were merely labels for what was happening already. The general feeling amongst the sample was that whilst there had been no explicit policy on quality before Griffiths, improving the quality of health care had been a central objective of consensus management. DGMs with experience of the NHS said there had been a "complacent", rather than a "negative" attitude towards quality; of "quality being partly around, but no-one positively asking what the quality of the service was like"; "of targets being in numbers and finance but not in quality"; "of an assumption that someone else is dealing with the standards of care, but that quality is provided". Newcomers to the service, although sharing some of the concerns about a complacent attitude to quality, were impressed by the degree of commitment amongst NHS staff to give a good service in very difficult circumstances and with inadequate resources.

Certainly in the months following the government's acceptance of the Griffiths recommendations, quality had become a catch phrase and there was an increase in activity explicitly in this area. DGMs in the sample attributed this partly to the emphasis placed on the importance of the consumer in the Griffiths Report, but also recognized other factors. These included: the general consumer movement which impacted on many service industries in the United Kingdom; the need for professions, particularly doctors, to take a more active part in management which required



managers to become involved in issues of professional and technical standards; the government's priority care areas, for example, mental health and geriatrics, which demanded a rethink of what services should be available and how they should be provided, and the government's demand to ensure value for money and to measure performance against effectiveness.

However, there were varying views amongst sample members as to what quality improvement involved and these views often reflected the previous professional background. For the former administrators, quality was commented upon as an inescapable part of the job or as a way of "curbing the egocentricity of disciplines", or "a way of testing if doctors are doing their job."

The former consultants and nurses in the sample saw quality as "everyone's business". This group of DGMs did not believe that one individual could be responsible for quality, rather:

"Quality must be an attitude of mind which permeates the organization, it must be a part of everyone's job and everybody's performance must be judged by the extent to which they have contributed to improving the quality of the service."

Those DGMs new to the NHS had a significantly different view of what quality as an issue involved. For five of the six, quality involved inspection, "a dirty word in the NHS." A former industrialist argued that his ultimate aim was to "put ourselves out of business. I want people to lead happy, helpful lives and to keep out of doctors' clutches." Another former industrialist simply felt that "Quality has to take a backseat to the need to keep things going."

Former community physicians saw quality as democratizing care and "asking what real health needs are" and former treasurers consistently raised the theme that quality was inextricably linked with ensuring value for money:

"The general manager's role has to be to make the most effective and efficient use of resources available, but also make a judgement about the right balance between providing the quantity of service to patients and wishes of others to provide quality."

The overriding characteristic of these different views is vagueness. When pushed, DGMs were incapable of spelling out what the phrases that tripped so elegantly and automatically off their tongues, actually meant. In the face of this uncertainty DGMs appear to have relied on their past experience.

There were three main approaches to improving quality.

1. The assignment of one individual as the quality assurance manager, usually a nurse, a community physician or an administrator. The ambit of the post varied. In some districts the focus was consumer affairs or hotel services. In one district the role was overtly split between consumer relations and service evaluation, each forming part of one senior manager's job. The rationale for that split was that what pleases the consumer does not necessarily lead to a better quality of clinical care. (Though this clearly was not recognised in those areas where the focus was on consumer affairs). Another district split the responsibility between two managers, one taking a strategic role, and the other linking in with clinical professions to focus on day-to-day quality improvements.

2. A quality assurance group, either a steering group comprising a number of professions, or general management based. These groups were often involved in drawing up the strategy for quality improvement, or to review a particular area of service.

3. A quality assurance consultancy which operated as a district resource to help unit managers and other service providers to concentrate on quality issues.

About half the sample did not routinely mention "quality" in the interviews despite setting in motion a number of changes in the organization and delivery of health care. Some former DAs and health professionals were very cynical and questioned whether the recent emphasis on quality improvement was merely a way of diffusing the debate on the lack of money in the health service. One manager argued that staff working in chronically bad working conditions who had not got the money or tools to do a good job, would think it "hot air" and resent being asked to improve the quality of the service they provide, given the obstacles with which they had to contend.

About a quarter of the sample, despite being strong on rhetoric, sparked few if any quality improvement initiatives, claiming that quality improvement had taken a back seat to keep things going and responding to external pressures from the department, region and the chair. One former industrialist deliberately marked time until he knew what quality initiatives had produced results in other districts.

From the data collected from the districts, quality initiatives spanned four broad areas: consumerism, professional and technical standards, establishing an appropriate balance of services in line with national priorities and ensuring value for money. Most effort which was overtly recognized as being in quality improvement was in the area of consumerism. Hotel services like reception, laundry, catering were reviewed. "Shop window" jobs were examined to ensure that staff were attentive to patients.



Many districts sought to improve the style of care and held staff communication training courses. Quality circles and quality suggestions schemes were introduced in order to tap staff ideas. Complaints procedures were often reviewed and some districts used patient satisfaction surveys to assess whether the customer was receiving an acceptable service. Improving patient information was also made a priority in most districts. In justifying the emphasis on hotel services, comparisons were often made to private health care. As a former nurse put it:

"It is the task of general management to make the organization everywhere appear to be providing a service and to be welcoming people. That happens in private health care. To some extent that is because they have the money, but some of it is the organization saying it is important to do that."

There was significantly less effort put into improving professional and technical standards. While some DGMs spent time with clinical professions, and sought to put across the message that "better doctoring and nursing consider questions of quality", for most for reasons outlined earlier, it was simply a no-go area.

Most DGMs considered quality issues and the balance of health services and talked about this under planning and the poor guidance on priorities given by those at the Centre. A dilemma for all of them was at what point do managers say that they can not improve quality, but must change the quantity. "When do we say we have to live with the current quality to have quantity?" Value for money and the link to quality was mainly talked about in relation to living within existing and, in the sample's view, inadequate budgets.

The emphasis DGMs placed on consumerism and the hotel aspects of health care may be explained in a number of ways. Firstly, it was an area where the DGM could take a lead and make a tangible contribution to improving quality without having to

engage in battles with doctors. Secondly, DGMs found it easier to apply the Griffiths agenda to hotel services, for, by making improvements in this area, they were visibly doing something for consumers. Thirdly, DGMs were diffident in entering the clinical profession's domain because of the powerful medical arguments doctors could marshal. Improving medical care was sidestepped and became part of the largely nascent desire to include doctors in management. Fourthly, most DGMs lacked tools (that made sense to them) with which to measure quality and quality improvements. Some claimed that they needed help from community physicians which, for one reason or another, they were not getting. Finally, one former industrialist saw the hotel and consumer side of quality as a means by which he could influence clinical outcomes. He believed an alliance with consumers would enable him to exert public pressure on professions to think more carefully about their service. The next section of the chapter attempts to explore the adequacy of these explanations and draws on Elias's game models in offering a sociological analysis of DGMs' attempts to manage change.

### An analysis of DGMs' attempts to manage change

In the main, the presentation of the fieldwork data has been descriptive. The intention has been to report the nature of the implementation of general management. In the rest of the chapter I want to consider the achievements of general management in the sample districts, DGMs spoke mostly of improvements in managerial processes and the emergence of what they called a managerial culture rather than an administrative culture. Rarely were improvements in health services spontaneously mentioned. The most common phrases used to describe improvements in managerial processes included "focusing us on what we are aiming to do", "enabling us to stay within the budget", "freeing up units to manage", "clarifying roles and responsibilities", "providing clear structures", "better staff appraisal systems", "providing a focus for decisions" and "symbolising an approach to management".

Such statements about improvements are vague and not measurable in any precise way but what is particularly interesting about these claims is that, insofar as they can be tested, the interview data derived from DGM and other health care workers do not support them. Thus DGMs were far from clear about both their own roles and the roles of other health care actors in the general management process (see discussion in Chapter 6). Similarly, units were rarely free to manage and, if districts did stay within their budget, it was often at the expense of some aspect of service. (This is not to denigrate the importance of proper budget management).

Improving the quality of the hotel services was often given by sample DGMs as a non-managerial accomplishment of general management. In some districts, specific services were cited as being improved - orthopaedics in one district, psychiatric services in three districts and, in one teaching district, the DGM claimed the introduction of clinical directorates (where clinicians had to manage their service within a budget) would in time mean great improvements in the service. Two managers gave improved involvement of the DHA as an accomplishment.

Whilst the sample was (not surprisingly) united in believing general management to be a good thing for the NHS, largely because of the introduction of what they saw as personal responsibility and accountability, over half the sample (all of whom were career NHS people), believed that general management had not meant significant changes in the delivery of services or the improvement of patient care. The following quotations provide some illustrations of this point:

"A major way of judging if general management had made a difference would be if the people of this district were healthier and there is no sign of that."  
(DMO)



"My main disappointment is that the patients are probably no better off than when I arrived." (Nurse)

"I have great difficulty in seeing anything that is a significant result from the change in general management". (administrator)

"A lot of the changes in my district would have happened anyway because we had a good DMT." (administrator)

"It is hard to see how general management has affected outcomes, but that may be because community medicine as a discipline is so weak and outcomes are notoriously difficult to measure in the NHS." (nurse)

We know, of course, that health services are but one of many influences on health status. Life style and material living conditions influence health and vary with socio-economic status. Nonetheless the sample DGMs' view that general management had not meant significant changes in the delivery of services or the improvement of patient care is supported by available epidemiological data. Evidence presented in "The Health Divide", edited by Margaret Whitehead, confirms very little change in the 1980s on any of a number of indicators of health. Serious social inequalities in health persisted throughout the 1980s whether social position is measured by occupational class, or by assets such as house and car ownership, or by employment status. Those at the bottom of the social scale have much higher death rates than those at the top. This applies to every stage of life from birth through to adulthood and well into old age (Whitehead, 1992, p.394). All major killer diseases affect the poor more than the rich. Lower occupational classes also experience higher rates of chronic sickness and their children tend to have lower birth-weights, shorter stature and other indicators suggesting poorer health (Whitehead, 1992, p.395).

Striking regional disparities in health are still observed - death rates being highest in Scotland, followed by the North and North-West regions of England, and were lowest in the South-East of England and East Anglia, confirming the North/South gradient. On the issues of the availability and the quality of services, these tend to be less good in more deprived areas, although no overall picture of the extent of inequality around the country is available. There is general agreement that semi-skilled and unskilled manual groups still make less use of preventive services than professional and managerial groups, but have higher rates of GP consultation (Whitehead, 1992, p.396). There is therefore no evidence to suggest, nor any reason to suppose, that managerial changes have affected patterns of use of services, or medical outcomes.

Other disappointments for the sample DGMs are listed below in rank order, beginning with what managers considered their greatest failures or disappointments.

#### 1. *Dealing with Doctors*

All DGMs in the sample felt they had failed to involve doctors in management within the district, although they may have made some progress with individual consultants. Some quotations to make the point:

"I am disappointed both at some measure of pusillanimity in management through the service as a whole, and at the continued strength of the medical profession in terms of being able to preserve all its privileges."  
(administrator)

"My main disappointment is not getting support for establishing authority in dealing with doctors." (administrator)

"My main disappointment is not having kept the medics on board." (nurse)

"My main disappointment is not getting the medical staff in the real world as quickly as I would have liked." (consultant)

2. *Quality and consumer relations*

Three quarters of the sample felt that, although hotel services had improved, clinical quality was as before dictated by individual doctors.

3. *Region's role*

Three quarters of the sample were disappointed that regions and the management board had not provided a strong, consistent managerial steer or strong leadership for the Service.

4. *Managing with the DHA*

DHAs were regarded by thirteen of the sample as time-consuming, ineffective and unhelpful in managing local health services.

5. *Failing to manage the chair*

In nine of the districts the chair was viewed as unhelpful in managing local health services.

6. *The time general management takes to achieve things*

This was given by eight of the twenty as a disappointment. Managers' expectations of how quickly it was possible to make changes in the NHS were often unrealistic. This



relates to the complexity of the figuration in which DGMs work, having a significant influence on their capacity to influence change.

7. *The split board (separating UGMs and district directors) not having worked*

The separation of the two boards was seen as unhelpful and those who had such an arrangement (4 of the 20) and they had either scrapped it or were thinking of scrapping it by the end of the research period.

8. *The appointment of clinicians as part-time unit general managers was generally perceived to have failed*

Although DGMs were 'encouraged' by the regions and the management board to appoint clinicians as UGMs, the difficulties of combining a managerial and professional role often proved too much for individual consultant UGMs.

9. *DGMs had not formed an elite group*

This was a disappointment for one DGM who said:

"The quality of response from fellow DGMs on the need to assert oneself, identify ourselves and form ourselves together...I can't understand why other general managers don't see the importance of using their status and power in a constructive way as a group." (administrator)

For a few, all insiders, there were some negative effects of the introduction of general management including the trauma the change had generated, coming as it did so soon after the 1982 reorganization, the sense of distrust entering the management arena, the

loss of multi-disciplinary responsibility and for two managers, the "castration of the DHA".

The RGMs I interviewed echoed the view expressed by the DGM sample that general management after three years had not made a significant difference to health, but pointed to managerial improvements which were hard to substantiate. The following quotations from RGMs speak to these points:

"It is hard to be specific about what general management has done in terms of the effect on patients. There is a change in the climate in which people are working. They are beginning to realize that there are people who they can turn to for action and decisions."

"It is very difficult to see what general management has achieved at the district level. I think the speed of decision-making has improved as has the quality, but these are generalities."

"The impact of general management has been that it forces people to think. Their roles are more clearly defined and quality is now on the agenda."

"A significant improvement of general management has been in the efficiency of health services: much less waste, much better organization of throughput, tighter money-management, better manpower control...Another improvement in most places is a better corporate feeling."

"Truly faster decisions are made and I think individuals know that it is down to them. However, there is a lot of pressure to secure short-term results at the expense of team-building with critical relationships... Another concern is that the expectations may be unreal in meeting the agendas that politicians set, but

my biggest concern is that the doctors may go off-side. I am not happy that they will play the game with the current rules."

A few RGMs pointed to negative effects of the introduction of general management:

"General management has improved decision-making and ensured closer financial control. It has also improved the approach to information and, I think, industrial relations. On the negative side, the nursing profession has suffered and, I think, general management itself is very over-burdened with the bureaucratic approach to management, which we had hoped to avoid... Career prospects have also become less certain because of the very sluggish way in which training and career opportunities have come to fruition."

"I think general management has had a lot of impact on the RHA; responsibilities are clearer, we don't have the interdepartmental boundary rows we used to, and decision-making is sharper... On the negative side, nursing has suffered, some units are building walls because it is easier to do that with general management because there is only one person."

"Whilst general management has sharpened things up, it has led to a feeling of big brother being more acute than it was."

Two important concerns about the way in which the service was developing were often mentioned by RGMs and echoed by some in this DGM sample. The first of these was that managers in the NHS were not using their energies in managing the parts of the organization which were considered of primary importance.



"What we are doing at present is pfaffing around with things like competitive tendering. We are agonizing about how to develop our laundry services and how to reduce our drugs bill, but there is a whole host of issues in the middle, for example, trying to persuade people to debate what we should be doing about services for the mentally ill; are we sure that our strategies will take us through to the next century, or are we just creating as bureaucrats, a monster with no concern about what happens?"

The second concern was that the whole of the organization seemed to be based on increasing volume:

"We began to wonder as RGMs, whether increased out-patients is a sign of success or failure and we still don't know the answer."

Given these disappointments articulated by DGMs and RGMs and echoed in the data from clinicians, nurses, DHA members, chairs and district officers about the achievements and disappointments associated with general management, the question then arises why is it that the introduction of general management proved in these districts not to have achieved what DGMs hoped it would? One could argue that the Griffiths report and its recommendations were fatally flawed because of the assumptions on which it was based (see Chapter 3). In part this is correct, though it does not, on its own, constitute an adequate explanation. For a further explanation it is useful to draw upon Elias's game models, outlined earlier.

In the first instance, and using the largely descriptive data presented in this chapter, we can begin to map out the figuration of which DGMs were a part. Crudely such a map would be as follows:

# A Typical Figuration for a District General Manager

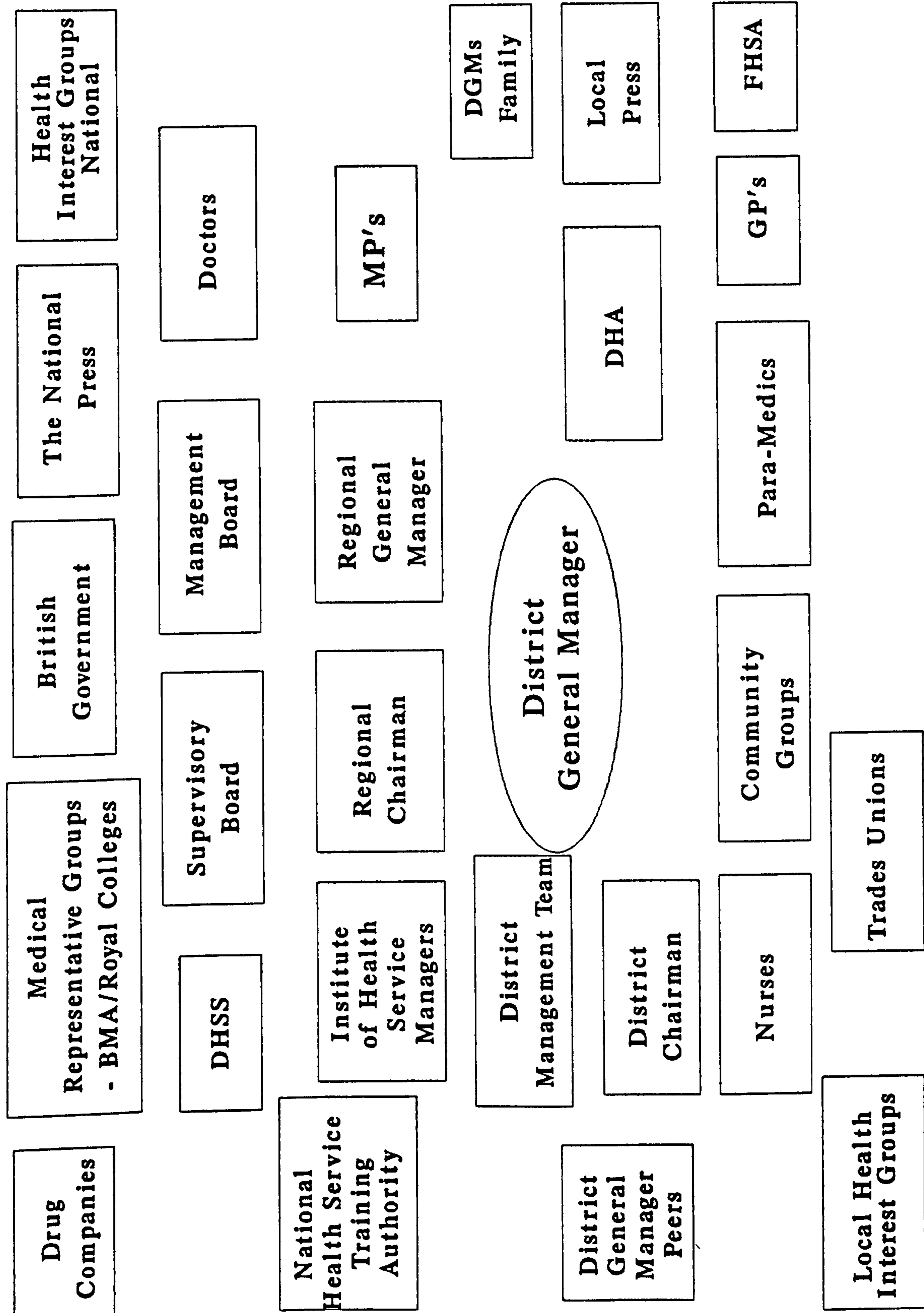


FIGURE 23

Figure 23 oversimplifies the complexity of the network in at least three ways. Firstly, it is a snapshot of a complex moving situation. Secondly, it focuses on the immediate chains of interdependence and there are no doubt other relationships which impact on the social context in which DGMs are a part. Finally, it takes no account of conditions specific to individual districts. An obvious point to make is that individual DGMs are situated in different figurations, where some actors are more powerful in some districts than others. It follows therefore, that DGMs' priorities and actions will be different, depending on the figuration of which they are a part. For example, a powerful chair meant that one DGM, a former industrialist, spent significantly less time on health authority business and district management than others in the sample because his main task was trying to find out what the chair was doing (the chair spent five days a week in the district) and fighting to establish his own authority within the district. Furthermore the ability of a DGM to take a detour *via* detachment with respect to doctors seems to improve the influence they had over the profession and the activity of doctors.

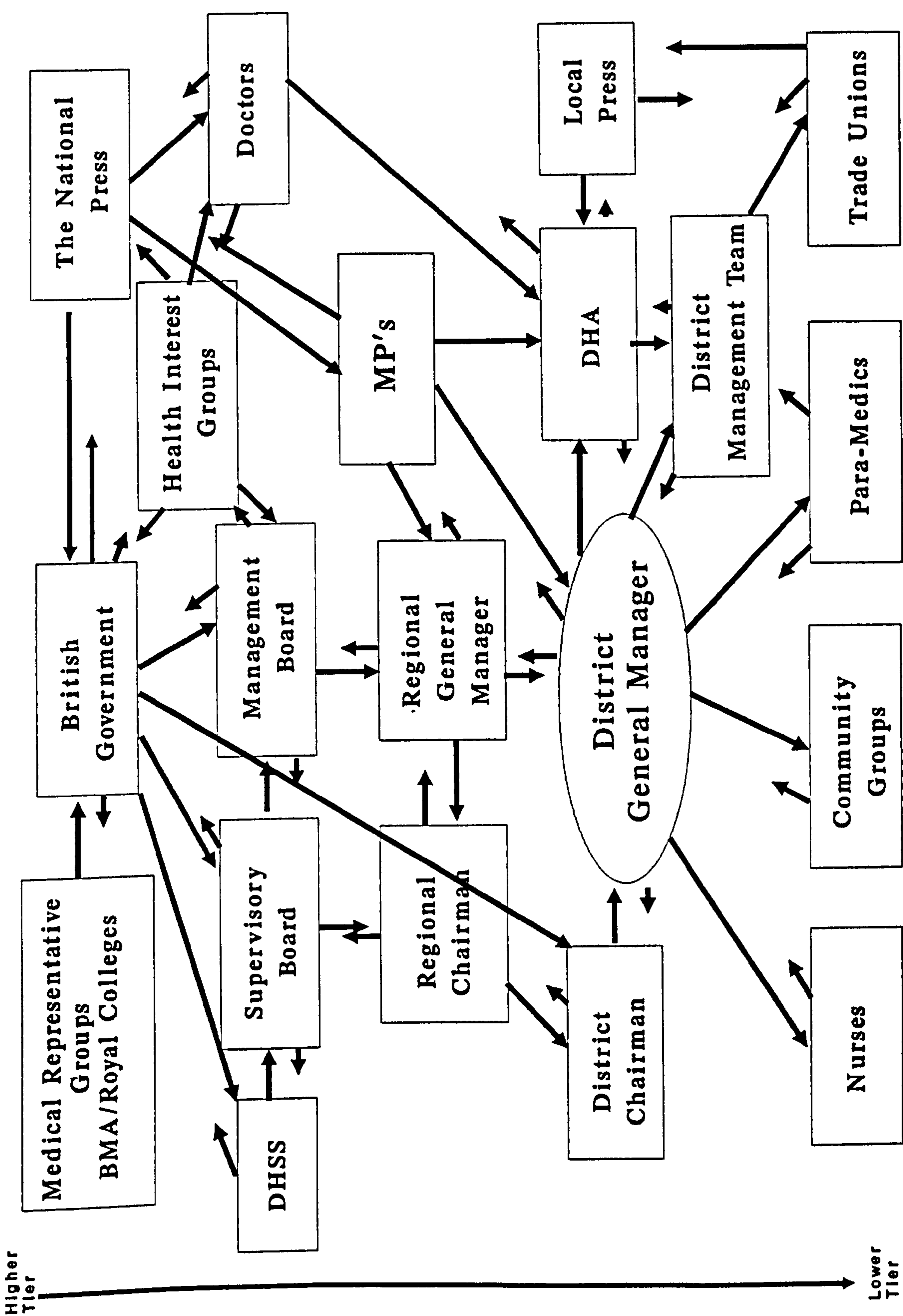
This map of a figuration adds weight to a central point made during the review of the existing empirical studies of local management of health services, namely that it is not possible to explain the actions, plans and aims of people if they are conceptualised as the freely-chosen decisions, plans and aims of each person or group considered on their own, independently of other people. An adequate explanation requires, at a minimum, that investigators consider the constraints each group exerts upon others by reason of their interdependence.

The figuration of interdependent players is the framework for the game. Quite simply, it is the existence of other players which serves to muddy the rules of the game for the general manager. Particularly powerful in this respect, are the government, medical profession and its representative groups, the press (national and local) and MPs. Figure 24 attempts to consider the power balances of key players



within the figuration, though, again, it should be noted that this is an oversimplification. For example, there will also be relationships between trade unions and paramedics, between MPs and the local press etc., though it would be impossible to represent all possible relationships diagrammatically.

# Power Balances of Key Players within the Figuration



Length of arrows signifies the power of people/groups in this figuration

Doctors and their professional bodies have a wide array of powerful arguments that can be marshalled to counter health policy and priorities for health services, for example, those concerned with increasing community care and preventive health services, and reducing acute services. Doctors may cite individual cases where a patient has not been able to have access to expensive treatment because of inadequate health care budgets, or they may publicise the existence of advanced medical technology that could have prolonged a patient's life if only the funds had been made available. Such arguments have a significant emotional impact and are beloved of the press who, in narrating such cases, may stir up local communities and MPs to bring individual cases to the attention of Parliament and, in so doing, may scupper a district's spending plans geared towards meeting the evolving health needs of the district population. Health interest groups also lobby government and use the press to influence policy. This dynamic at the higher-tier has profound effects on district management and on the web of social relationships within the districts. It means that planning and issues of strategy are open to compromise at any time. Furthermore managing change is vastly more difficult. Another profound higher-tier influence on district management is the time-honoured tradition of changing either funding projections for health care or some aspect of health policy in order to win support of voters as a general election looms large, and again the press - a game player almost wholly beyond the control of local health service managers - is centrally involved.

The findings about district general management as reported in this chapter suggest that dealing with this higher-tier dynamic takes a great deal of the DGMs' time and one consequence of this is that very little time and effort is spent with what Elias would term lower-tier players such as nurses, community groups, GPs, trades unions, local authorities and paramedics. Even though these groups may be valued by individual DGMs they are not powerful enough to influence the DGMs' agenda and hence remain largely ignored. Furthermore, dealing with the higher-tier dynamic means that variable time is spent on the DHA, often depending on either its



composition (for example in one district a prospective MP as a member of the DHA meant general management had to spend a great deal of time on this relationship, while in another district a predominantly Labour health authority used DHA meetings to voice their dislike of Tory policies) or competence or the power of the chair over the membership or the DGM. However, it is important to recognize that, despite the relative powerlessness of lower-tier players to impact on the DGMs' agenda, they do have some power. For example, it was noted earlier in this chapter that, although the DHA was in the main perceived by DGMs in this sample to be a cumbersome, largely ineffective, body, the existence of the DHA did influence the way in which DGMs worked and was a factor in their decisions as to what type of work to concentrate on.

The point of game models is not just that they facilitate a relatively detached description of the situation as seen by social scientists but they also enable one to explore the games players think they are playing, or try to persuade other people to play. Drawing on the fieldwork data, it is possible, albeit crudely, to tease out players' appreciation of the complexity of the social relationships of which they are a part, and to examine their own views of the game.

The formally stated object of the game - which in this case is a policy process game - is that players should engage in forms of action that substantially improve the health of the population of the UK and the quality of health care delivery, whilst ensuring that public funds are used so that value for money is delivered. However, players may have different and varied opinions as to how these laudable objectives are to be achieved. Moreover, they may not see these issues as the most important and they may also define terms such as 'efficiency' and 'effectiveness' very differently. In this case, although all players are nominally playing the same game, there may be "games within games", with different groups having different agendas, and each seeking to impose their agenda on others. The "games within the game" of the key NHS players

are discussed below, albeit in a simplified fashion. It should be noted that some players play games independently of others.

The game for the Centre (government, management board, supervisory board) is affected by a desire to keep clear of the press, deal with a myriad of powerful interest groups who lobby the Centre at every opportunity and make sure the pot of public money is not swallowed up by health care. Recognising the public's affection for the NHS, those at the Centre also clearly wish to avoid any criticism of their handling of health policy or of the management of health services. Those at the Centre need, therefore, to ensure that health services are delivered in accordance with these points and have tried with every NHS reorganization to gain a level of control over this process.

Those people working at the region and the RGM in particular, were involved in a difficult balancing act - that is, balancing what is expected of them as agents of the Centre with their accountability to a large population represented by a regional chair and RHA who are, in the main, political appointments.

DHA members often saw general management as increasing the power of the district chair at their expense. Furthermore, the majority of members saw their districts as being squeezed financially by the region and the Centre. The game for them, therefore, involves trying to preserve their powers in the policy-making process.

Doctors, on the whole, rejected the objectives of the game, and sought to continue to play an historically much older game in which the dominance of the doctors was a central aspect. They preferred to deal with the district chair rather than the DGM if concerned with a managerial issue, indicating their views of where the power to change lies. Managers varied in the extent to which they tried to engage doctors in management's game.

CHCs saw the game, following the introduction of general management, as being one designed to reduce community involvement in the planning and delivery of health services. People working for the CHC fought against a centrally driven health service which they believed was unlikely to be responsive to local needs.

Nurses saw the game as being characterised by "unfair" rules which placed them at a disadvantage. They resented the threat general management constituted to their hard-won professional status and they also resented being managed by non-nurses.

These summaries of some views of the game are generalizations and are data to be explained. In order to understand the game, it is important not to see the Griffiths reorganization as simply an implementation of a plan, as a wholly rational process. Rather the game is a complex social process involving both cognitively-based and emotional resistances to change and an interweaving of the actions of many different groups in such a way that the outcome will almost certainly not be one which was intended by any one group. This may be seen even in the simplest game-models, for example the outcome of two chess players striving to defeat each other may actually be a stalemate. If this can happen, even in very simple two-person games, then it is even more likely - indeed almost inevitable, that in complex games, such as that involved in reorganizing a huge and complex organization like the NHS, there were outcomes which no-one intended. There is some similarity here with Robert Merton's concept of unintended consequences. Robert Merton (1936) noted that the idea of unintended or unanticipated consequences of social actions has a long ancestry in the writings of sociologists and philosophers. Mennell, however, is critical of Merton's discussion of unintended consequences, believing it to have led to too narrow an interpretation of their sociological significance (Mennell, 1989, p.258). He goes on to argue that much more clearly than Merton's concept of unintended consequences, Elias's notion of "blind social processes" (discussed in Chapter 4) recognizes that



people's knowledge of the figurations in which they are caught up is virtually always imperfect, incomplete and inaccurate. As a consequence, their strategies of action, based on this inadequate knowledge, almost invariably have consequences which they do not foresee. It follows that unanticipated consequences or outcomes are not a curious effect of unusual situations but are universal in social life. Mennell summarises this point by saying:

"For Merton, the self-fulfilling prophecy is like a boomerang. The consequences of men's actions rebound upon their initiators. For Elias, the analogy is much less exotic and much more commonplace: like the effect of a stone dropped into a pool, the consequences of people's actions ripple outwards through society until they are lost from sight, their effects are felt, not at random, but according to the construction of the figuration in which they are enmeshed, by people who may well be quite unknown to each other and unaware of their mutual independence." (Mennell, 1989, p.258)

The empirical data presented suggest several respects in which the process of organizational change may be seen as a "blind social process", with consequences which no-one anticipated; indeed, some consequences were the very reverse of what was intended. Among the more important consequences of this kind, we might point to the following: firstly, there appears to have been a trend towards greater centralization of power within the health service. A consistent comment, not to say complaint, of DGMs, RGMs, chairs and members of DHAs, was the increase of bureaucracy from the Centre, a proliferation of bewildering policy objectives and a shrinkage of resources, all of which served to curtail the freedom of the district to meet the needs of its local population.

Secondly, there seems to be more, rather than less, confusion in terms of accountability structures in the NHS. At the beginning of their appointments, general

managers were extremely clear that they were accountable to their DHA and, through them, to the community. The data in this chapter suggest that in practice, three channels of accountability weighed heavily on the DGMs: (1) The Secretary of State, regional chair and district chair; (2) DHSS, RHA, DHAs and (3) The management board and RGM. These three channels combined to obscure general management's accountability to the public and also led them to play down, in relative terms, the importance of nurses, trade unions and other local groups.

Thirdly, within districts, very different models existed of district/unit relationships. DGMs differed in their views of their leadership role and the place of professional advice in the implementation of the general management change agenda.

Fourthly, the status and power of the nursing profession appears to have declined. Nurses were often given quality assurance roles, often seen as 'non' jobs, which reduced their credibility in shaping policy decisions.

Fifthly, because general management was introduced at a time when the Government, led by Margaret Thatcher, was seeking dramatically to reduce public expenditure, general management and cuts became inextricably linked such that notions of improving the management process were greeted cynically.

Sixthly doctors, as an established group in the NHS, united against the introduction of general management and saw it as a tool of Government to undermine the NHS. They did not flock to take up general management posts as government had hoped and were deeply suspicious of general management as a vehicle to improve health services. They did not see themselves as 'natural managers' as Griffiths believed would be the case.

Seventhly, improvements in quality mainly took the form of improvements in hotel services, rather than improvements in the quality of medical care.

Finally, more or less independent groups within the NHS become more interdependent. This situation occurred partly as a result of a general management system replacing the old functional professional hierarchies and partly because static resources, numerous new priorities for health care, an increase in monitoring and poor information meant there had to be more dialogue between groups if a health service was to be provided at all.

### Chapter 7 Revisited

This chapter has documented at some length data relating to what the sample DGMs did in the second, third and fourth year of their job. It is argued that it is important to consider the actions of local health service managers in the social context of which they are a part. This involves appreciating the social structural issues associated with the development of the NHS and the figurations in which DGMs find themselves. It has been suggested that game models can be useful in this respect. The next chapter looks in more detail at the difficulties of managing change imposed by the complex figuration of which the DGM is a part.



## **CHAPTER 8**

### **A Case Study of the Development of a Mental Health Strategy**

#### **Purpose of the Chapter**

Previous chapters have highlighted the complexity of the NHS, the variety of interest groups within it and the inevitability of unintended outcomes of change. This chapter offers a case study to illustrate and concretise these points. It documents how a district general manager sought to improve mental health services in his district and the problems he encountered. Part of the analysis will counterpose the DGM's own relatively involved perception and understanding of these problems with an understanding of these problems as revealed by a relatively detached, sociological analysis. The chapter begins by briefly considering case study methodology.

#### **Case study methodology**

Case studies have been used more in sociology than they have been written about. It is not necessary to detail the debate on the usefulness of case studies here, partly because it has been done so well by Jennifer Platt in her article 'What can case studies do? (Platt, 1981). Her paper deals succinctly with the recent general discussion of the case study method (p.2-5)(17). She points out that case study material gives aesthetic appeal by providing 'human interest', good stories and a more humanistic mode of presentation than that of the traditional scientific/quantitative style. However she argues there are a number of "logical functions":

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(17) Other useful references for those wishing to consider the case study method include: Barton, A.(1955); Becker, H.S.(1968); Campbell, D.T.(1975); Eckstein, H. (1975); Goldthorpe, J.H.(1969); Homans, G.C.(1951); Mitchell, J.C.(1983); Platt, J.(1981); Yin, R.K.(1984). Obviously there are many good textbooks that discuss case study method, a particularly useful one is Burgess, R.(1984).

1. A case study may suggest hypotheses, interpretations and empirical uniformities that merit further research.
2. A case study is a useful source of description or historical material which may be inherently interesting in its own right.
3. A case study highlights the context of a problem.
4. A case study can assist in the prediction of future developments.
5. A case study can provide material, which is inaccessible or less easily obtainable by other means and which documents a complex set of factors which interact to produce real-life outcomes.
6. A case study can provide a basis for inference to points not directly demonstrated and with relevance to cases not studied.

In this chapter, the case study of the development of a mental health strategy is used in all of the ways outlined by Platt. Specifically the case seeks to document the way in which the complex interweaving of the actions of managers and interrelated people produced an outcome which was a far cry from what the DGM intended.

The initiative which is the object of study here, and which was designed to improve mental health services, started three months after the DGM was appointed. It was therefore, a subject of most of the 28 interviews (face-to-face and telephone) that I carried out with him over four years and offered a rich source of data with which to examine the formation and implementation of one particular strategy. In addition to these data, the case draws on related documents outlining the strategy: these include minutes of DHA meetings and those of the corporate management group (the district's

successor to the DMT) as well as confidential correspondence between the DGM and the health authority chair and the interest groups involved.

Twenty-nine interviews were carried out with the following key actors involved in the strategy:

Chair

Vice-Chair

General Practitioner

Director of Community Nursing Services

Unit General Manager (2)

District Treasurer

Health Services Planning Manager

District Resources Planning Manager

Chair, MEC

Unit General Manager, District Hospitals

Consultant Pathologist

Assistant Director of Social Services

Administrator, FPC

CHC Observer at DHA

Director of Social Services

Financial Accountant (Joint Planning)

Special Projects Manager

District Estates Manager

Director of Nursing Services

Director of Nursing Services (Psychiatry)

District Chiropodist

District Clinical Psychologist

Consultant Psychiatrist



Consultant General Surgeon

Consultant Physician

Consultant Radiologist

RCN Representative

Area Officer, NUPE

The five consultant psychiatrists refused to be interviewed face-to-face but did complete an open-ended questionnaire, the results of which were analysed and form part of the text.

### **The District**

The services provided by the DHA are centred on three large sites and three smaller sites. Part of the strategic plan for the district is to reduce services to two main sites. There are no long-stay mental illness or mental handicap hospitals in the district, psychiatric services being provided within two medium-sized hospitals, one at each end of the district. However, the district has to plan for the development of community services to receive "clients" from neighbouring districts. The resident population is 308,000 and there are five consultant psychiatrists in post.

### **The DGM**

The DGM is in his early 40s. Following a natural science first degree and a doctorate in metallurgy, he held a variety of general management posts in manufacturing industries. Richard (a pseudonym), described himself as "a high energy person who likes causing people to work" and whose "natural penchant is to think long-term and get the broad things going". He sees his particular skills lying in the selection of key items for change - "exploiting pockets of opportunity and testing out possibilities" - as well as listening to the views of others.

## **Background to the development of the strategy**

The DHA was obliged to resettle up to 70 residents of a long-stay psychiatric hospital. The district had no psychiatric hospitals itself, and has in the past transferred those people in need of long-term care to hospitals outside the district. There were 121 acute beds, 134 elderly beds, 45 rehabilitation beds (300 in total), and 244 day hospital places for adults and for the elderly in psychiatry.

Establishing a comprehensive mental health service became a priority for the district as a consequence of government policy and the region's strategy. The DHA received severe criticism from a Health Advisory Service (HAS) report for its mental illness services three months after Richard started the job. Also, at this time, a new Director of Nursing Services (DNS) psychiatry was appointed and he had experience from another district in developing psychiatric services with a strong community aspect.

Relations with the consultants prior to the introduction of general management were described as "strained without being hostile". The consultant psychiatrists shared their consultant colleagues' concern about the introduction of general management and in particular were suspicious of the role of the DGM and how he would "interfere in the running of the district". The DGM believed his appointment had in fact caused less anxiety amongst the medical profession than was the case in relation to other DGMs and other districts in his region, because many of the consultants had assumed his title Doctor to mean he had a medical background. Indeed it was some time before the consultant body realised he was not a medical doctor, which may be taken as an indication of their largely apathetic attitude to management within the district.

The psychiatrists were not a cohesive group and, indeed, many informants spoke of their difficulty in agreeing amongst themselves as to the running and development of their service. The psychiatric division had a poor reputation amongst the consultant body within the district. They were considered to be "awkward colleagues", "lazy" and "unhelpful in pushing medical interests".

### **The production of the strategy**

There was general dissatisfaction with the psychiatric services. The psychiatrists were by no means satisfied with the service they provided, complaining of "a lack of resources", a comment echoed by other professional staff. The psychiatrists, in particular, wanted a "better library" and most vociferously campaigned for "more wards and beds". They were anxious to ensure that both sites where services were currently provided were of equal status with respect to beds and were particularly unhappy with the local authority's provision of Part 3 accommodation. In the DGMs view this accommodation was essential for a balanced mental health service. It comprises part-supervised community-based homes for those who cannot manage on their own and yet whose condition does not warrant longer care in a hospital setting. Richard believed that part of the reason for the consultant psychiatrists dissatisfaction with the Part 3 accommodation was that the patients would not be effectively under their control, as they would be in hospital.

The nursing profession complained that they were denied a "proper voice" in the provision of the service. The paramedic professions also believed their opinions to be "devalued, particularly by the doctors" and were particularly frustrated because they were unable to provide the service where their skills could be utilized. The local authority were also dissatisfied with the relationship with the health authority which, in their view, hindered service provision. The local authority believed the DHA to be "too secretive", investing too little in mental health - both in beds and in community



staff - and to be lacking in any sense of direction or drive for the mental health service.

Another group dissatisfied with the service was the DHA. The independent HAS report which severely criticised the district had shocked the members of the health authority who had not appreciated the severity of the problem. The Royal College of Psychiatrists had also expressed their dissatisfaction with the status of training within the district and had threatened to take action unless a significant improvement occurred. Rather surprisingly, neither the CHC nor the National Association for Mental Health (MIND) were involved in seeking change.

Three months into his job, Richard took what he described as an "intuitive decision to act". He spoke of "a need to do something", particularly to respond to the critical HAS report, and of "wanting to perform in the light of the regional requirements for resettlement". He did not seek advice at this point because "I knew if I did, nothing would have happened." Richard wanted to establish himself as "the general manager and as someone who could bring about change". He saw the reform and improvement of the mental health services as "an opportunity for a big bang approach" which would fulfill several of his objectives:

to enhance his credibility as a manager in the eyes of region and the DHA;

to show the district the potential of general management to achieve change;

to show that general management constituted a significant improvement on the old system of consensus management;

to improve the embarrassingly poor mental health services and

to give a sense of direction to the consultant psychiatrists and "win over consultant opinion."

His desire for change coincided with the appointment of a new male DNS, described by Richard as "bright and innovative" and "fired with enthusiasm" for a particular approach to community care which he had helped introduce in his last job. He canvassed the DGM to adopt this approach in the district and used his recent experience to argue that the district services could be run in a "different and more effective way". Richard was struck by the DNS's passion and enthusiasm for the project and said:

"I saw the DNS as the instrument to implement, review and change the mental health services."

He decided to make the DNS project manager for the mental health strategy. Project management was an approach Richard had been particularly keen to introduce into his district on his arrival as it had been a management tool he had successfully used in his previous job in the private sector. The DNS was charged with the task of managing the project. At the time Richard claimed, "Griffiths didn't really enter my mind, I was driven by my own approach to management". Nevertheless it provided an essential backcloth for his actions and, whether he realised it or not, may have been associated with the hostility of the psychiatrists towards management. The strategy had also become Richard's "vehicle to change the relationships with doctors".

The need for improvement of the mental health services of the district, and for action, was conveyed to the psychiatric division during a routine meeting to discuss the HAS report. No real commitment to change was sought from the consultant psychiatrists at this stage as it was felt "to be self-evident that something must be done". The chair of the psychiatric division, a psychiatrist, was, Richard admitted, "told rather than

asked" to be involved in the planning and restructuring of mental health services. He went on to say: "there was never a sense of going to the psychiatrist with the HAS report and saying 'what will we do about it?'. I took command of the situation and said "something must be done"". Richard later suggested that this was possibly the start of the rift with the chair of the psychiatric division. Richard assumed him to be enthusiastic about a change in the direction of the service following his display of interest at a "change planning conference" held in the September following Richard's appointment at which he outlined some of the changes he hoped to bring to the district - his "vision of the future".

With the approval and support of his top management team, Richard formed a core group which was charged with the task of formulating a draft strategy for a district comprehensive mental health service covering the range of mental health problems. The core group was kept deliberately small because Richard wanted to avoid what he saw as the problems of the old NHS where, because everyone was represented on the management team, nothing got done. As he said: "I went for a small core team to get a positive course of action which would then be 'sold' to the rest of the organization." It consisted of a specialist in community medicine - the health authority chair, a consultant psychiatrist, the then district administrator, the assistant director of social services, and the DNS psychiatry, who was the project manager. A GP representative for the core group was invited but no name was put forward.

The planned strategy was divided into five services/client groups:

**acute**, meeting the needs of people who require crisis intervention, assessment, acute psychiatric illness, mental health education and prevention;



**rehabilitation** for people with demonstrable psychiatric illness which is likely to cause them difficulties in living independently in the community. Skilled care and specialised services needed to be developed to meet these needs;

**elderly mentally ill**, in particular people who have psychiatric problems associated with ageing. The service here was to focus on community support, early recognition of psychiatric problems and inadequate accommodation in the community, backed up by assessment facilities and some long-stay care in in-patient units;

**child and adolescent psychiatry**, a specialist service for people under the age of 18 and

**drug and alcohol abuse**, a specialised community based service for people with problems related to alcohol and drug abuse.

This was the first time in the district's history that the district mental health services had been considered as a whole, and it was the first time that such an approach had been undertaken in the region concerned, by a "receiving" district. Richard argued that this was a reflection of the weakness of the previous psychiatric unit management group (consisting of a unit administrator, a consultant and a nurse), formed following the 1982 reorganization, and poor regional management. In addition to these changes, the strategy sought to address the resettlement of the long-stay patients, and create a balanced, comprehensive service involving both District General Hospital (DGH) based facilities and community based facilities.

Richard hoped that the strategy would be available six months later for consideration by the DHA and the local authority. To assist in this planning of a major programme of change, the services of a change management consultant from the NHSTA were

purchased. Richard asked the core group to establish, in a two day workshop, the base "philosophy" for the strategy which outlined the requirements for a comprehensive mental health service and was kept informed primarily by the DNS psychiatry as project manager.

The strategy formation team felt that in order to provide an effective mental health service, the service should be:

Local:

- the service was to be organised to serve natural population groups of about 40 - 60,000 people. This was to be achieved by dividing the coterminus boundaries of health and social services into six localities, which matched the existing internal localities of the local authority.

Accessible:

- the service was to be organised so that people in each locality would be aware of the service that was being provided. Whilst existing methods of access into the service were to be maintained, a variety of different ways of access were to be developed to meet the different needs of individual clients. The community mental health resource centre (a resource within the community that deals with referred mental health problems and coordinates the delivery of mental health services for the catchment area) was to act as the focus for their development and people could present "from the street". Resource centres were to be staffed by a team of people, including a social worker, community psychiatric nurses and a psychiatrist.

Comprehensive:

- the service was to be planned to meet the whole range of mental health problems.

The core group decided that the detailed strategy would need the involvement of others who were themselves involved in the delivery of mental health services. Five sub-groups of the core team were established to develop a strategy for each client group (adult, child and adolescent, rehabilitation, drug and alcohol abuse and the elderly).

Each of the consultant psychiatrists was invited by the chair of the division to lead one of the five sub-groups. (The consultant on the core team was excluded from this with his agreement.) A member of the core group was assigned to one of the five sub-groups to provide consistency of interpretation and views between the core group statement of principles and the sub-group consideration. As a result, around 100 people were involved in the formation of the strategy from a range of different disciplines and organizations, including consultant psychiatrists, social workers, community psychiatric nurses, hospital nurses, occupational therapists, hospital nurses, psychologists, GPs, paramedical professionals, CHC members and the voluntary sector. Three of the five consultants took up a responsibility to lead the sub-groups. Richard believed the failure of two consultants to assume leadership roles to be the result of "the chair of the division's weakness in management terms " and his failure to explain the importance of the involvement of the consultants in each group". No attempt was made by management to make any further effort to involve the consultants in the sub-groups because Richard felt he could not "command them to participate...so there was no point fighting a battle I was certain to lose".



Each sub-group produced the recommendations for their service developments within the philosophy statement of the core group, but without any financial statement. The chair of the core group, the Senior Physician in Community Medicine (SCM) and the strategy implementation manager (the DNS), put together these ideas to form a compendium which was compatible with the original philosophy statement and met the deadline set by Richard. The DGM was pleased with the compendium, but as it was not yet a costed strategy, it was said not to be suitable for formal external consultation. This was the "official" reason. Unofficially, Richard was concerned about the quality and viability of the sub-group strategies. In practice many of the sub-groups met once, probably twice. The consultant psychiatrist who headed one of the sub-groups, produced a document that was inappropriate because it was hospital-based only and was in fact rewritten by the DNS.

An internal period of consultation was undertaken using the compendium of ideas document. In parallel with this, a manpower and financial analysis was carried out. It was during this phase that Richard noted the first overt signs of a lack of commitment on the part of the psychiatrists. During the writing of the sub-strategies, the chair of the division withdrew from his involvement in the strategy without officially giving any notice. Richard and some of his colleagues attributed this response to peer group pressures. The chair of the division's association with the core group led to accusations of betrayal from his colleagues. His colleagues saw the development of a community based service to be a direct and very real threat to psychiatric beds. The chair of the division attacked the strategy in a letter, thus gaining favour with his psychiatric colleagues. In the letter (on behalf of his colleagues), he highlighted the essential elements of a "successful strategy" which included compatibility with national trends, compatibility with the regional strategy ensuring a specialist orientation, appropriateness to local needs and acceptability to the profession.

This letter was received some 10 days after the closing date for internal consultation, a process which had yielded comments which were mainly favourable. The strategy, as a result of the points put forward in the letter, missed the target DHA meeting. This is in itself an interesting indicator of power. Subsequently, a seminar to present the strategy was arranged for members. The consultant psychiatrist (the original member of the core group but no longer chair of the division), spoke out vehemently against the strategy in his presentation, much to the surprise of the DHA and the DGM, who assumed that the strategy was agreed. Richard argued at this point that his assumption as to the cooperative stance of the psychiatrists was based on the consultant's "participation in the core group." At the heart of the presentation of the consultant's objections was a complaint of lack of involvement. Other complaints included the inadequacy of the local authority provision, the inadequacies of the DGH based facilities, and the claim that community psychiatry was an unproven method of service delivery. Underlying these objections was a concern about the building of a "resource centre", one of six planned, which were seen as a threat to hospital-based provision.

At the time Richard felt the lead consultant psychiatrist had "stabbed him in the back", because of his desire to rebuild his status with his colleagues. The only objection Richard considered to be valid was the inadequacy of the local authority provision. He planned to retrieve the commitment of the psychiatrists. He was under pressure to do so because of a high profile national conference and presentation of the strategy which had been planned for three months' time, backed by some regional funding. The conference day was retitled to accommodate the consultant's concern. It was no longer a launch of an agreed statement, but renamed "Mental Health Services in Transition".

Richard decided against any personal involvement in dealing with the psychiatrists' objections for fear of being accused of self-interest, and because of a genuine feeling

of vulnerability in discussions of issues of clinical need. In order to keep the momentum of change going, he assigned to the SCM and the strategy implementation manager (the DNS) the task of talking to the psychiatrists individually, hoping that this would resolve their objections.

Meanwhile, plans for resettlement and rehabilitation of mental illness patients, in line with the regional strategy and separate from the district strategy, went ahead. To meet HAS criticisms of overcrowding on the hospital wards, a proposal was developed by the DNS to reduce the beds in one hospital and to compensate by using three nearby houses (owned by the DHA) to provide 11 places for people in the process of being rehabilitated. The local community complained strongly, public meetings were held, and the management were forced to reconsider the plan. The DHA had not been informed of the proposed use of the three houses and when it hit the press, the DGM was criticised and regretted his error. "I didn't realise its potential in the public arena." This incident led to claims that the mental health strategy was being implemented before it was agreed. In particular the consultant psychiatrists argued the incident was a clear indication that the strategy was designed to take away some of the beds in their charge. Richard, however, saw the problem as a misunderstanding and a confusion between the existing regional strategy, which was to happen regardless of any initiative pursued independently by the district and the new mental health strategy.

The consultants' irate reaction was seen by Richard as an indication that his attempts to retrieve the commitment of the psychiatrists via the SCM and DNS had failed. He attributed this to the personalities involved. The SCM, he argued, "lacked the assertiveness necessary to engage the consultants in a realistic dialogue", and the DNS failed to pick up any signs of dissention because of his "unbridled enthusiasm". Indeed, Richard admitted:



"Looking back on it, I was not sensitive to this unbridled optimism in him. I wanted to hear that the problems had been overcome so I chose to let it remain in my subconscious."

The conference itself went well. Members, representatives from the region and the professions attending, seemed to respond favourably. The "soft objective" for the conference, to improve the district's public image, was, according to the DGM, achieved. The refined consultation document, refined in the sense that it was now a costed strategy (in terms of finance and personnel), was put to the DHA and a formal consultation process began. In the middle of this process the DNS psychiatry was headhunted for another job. Despite this loss, the DGM was confident things were "going well" and remarked on the success of joint planning. The UGM of hospital X and the community, a former unit administrator from another district, was regarded by Richard and his chair as "the natural successor" to oversee the implementation of the strategy because of his experience in working in the community sector.

At the end of the second consultation period, lasting some two months, the received responses were positive, with the exception of those from the local medical committee (the GP body). This committee, chaired by the GP representative on the management group of the DHA, was largely apathetic. Richard described this GP as "the only shop steward I have met in doctoring terms". He had always opposed the strategy from an "ideological" standpoint, was unwilling to join the core group and, medically, saw it as a threat to the independence of GPs. Richard believed the GP falsely perceived that this was a "management written strategy".

A week after the closing date, a letter from the psychiatrists arrived, reiterating their previous objections, the main one again being loss of beds. The strategy missed the DHA meeting, instead responses were presented at the DHA meeting. At this juncture the DGM saw the DHA as "having to make a decision whether to back the

medical view or that of general management, supported by representatives of consumer groups and other professions who had made favourable responses to the consultation document."

The UGM community and the DGM met with the consultants to try to sort out the issue of bed levels. The SCM was consulted on this issue, although not present in the discussions with the psychiatrists because of her perceived ineffectiveness by the DGM in the previous round of discussions. The DGM and UGM felt that they had gone as far as they could to "explain the strategy to consultants", "to obtain their understanding that the strategy was in the best interest of the service" and "that it was in their interest to support it". The matter, they argued, had to be put to the DHA without the support of the consultants. Richard tried to "rebuild bridges" with the consultants by negotiating with the region's treasurer £35,000 to be channelled into the district's psychiatric services from the region, put by to fund a vacant sixth consultant psychiatrist post.

On the day of the special health authority meeting to discuss the strategy, the consultants asked to see the chair of the DHA. The chair gave total support to the DGM in his objectives for mental health services in the district, but according to Richard, "found a means of allowing the strategy to proceed with the psychiatrists' qualified support". In particular, he offered to look at the hospital bed requirements again and to monitor the community resource centre during its first year of operation. To consolidate the "good will" the chair and the DGM invited the new chair of the psychiatric division to sit on the appointments panel for the new DNS psychiatry. This agreement was written down and read out at the beginning of a special DHA meeting. The strategy was then supported by the DHA, formally approved at the next meeting, and implementation proceeded.

## Synopsis of Implementation of Joint Mental Health Strategy 1986/91

The following synopsis of what happened to mental health services was written by Richard in September 1993 at my request. His response is recorded in full in the next few pages.

### **Resettlement Programme**

The Resettlement Programme was the key to the re-shaping of the service, because it was to provide the additional and surplus resources needed to build up the community component of the service in particular. The original strategy assumed some 70 people were to be resettled. In the event, nowhere near that number have been resettled. This arose from a combination of difficulties of releasing funds from the long-stay hospitals at a level that was acceptable. This was a regional problem - not just a district one. There were difficulties in obtaining both sufficient capital, and suitable accommodation, to house the resettled patients.

The main success was the placement of 14 people at a hostel in the district, which was purpose-built with sufficient capital assistance from the region (£0.5m). A further scheme in the district to house 11 people in two adjacent converted terraced houses, which had three floors of accommodation, was not successful because not enough patients with sufficient mobility could be found to fill the bed spaces available, particularly on the upper floors. Eventually one of the two houses was sold and the accommodation reduced to only 7 people. This is now running well.

Planning is now underway to establish a further set of accommodation for some 24 people. This is being handled now by the DHA, in its purchasing role, so I am not



involved.(18) I do believe this concludes the outstanding resettlement requirement from the long-stay hospitals. It has also been supported by regional capital funds.

### **Community Mental Health Resource Centres**

Arguably, the first centre was successful, and remains so. However, some concerns are being raised that it deals more with the 'worried well' rather than being the first port of call for those with potentially acute mental health problems, or as a base for supporting rehabilitation activity. A second mental health resource centre has been established in the district, on the back of funds specifically for mental health available from local authority. This largely pulled together existing staff to operate from this shared community base for local authority and health professionals. As the short-term funding of the grant runs out next year, the local authority and health authority are having to inject new recurrent money to maintain the facility.

### **Acute Services**

It proved impossible to obtain applicants for the sixth consultant psychiatrist post and hence it was not filled. Indeed, 3 years ago, under extreme financial pressures for cost improvements programmes, the funding associated with the post was given up. One of the psychiatrists has retired and then returned on a part-time basis, so there are now effectively 4½ psychiatrist posts. This contrasts with the 7/7½ psychiatrists that were required in the original strategy. Quite a lot of money has been spent on improving the old facilities in the hospital and an additional £120k was put in to improve nurse staffing levels. Advances were made in drug and alcohol services, utilising government funds. These are largely community-based teams.

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(18) Purchasing refers to the split between the purchasing and providing of health care following the 1989 White Paper (see Chapter 10 for a brief discussion).

The inability to draw any substantial additional funds, either from the resettlement process, or from mainstream DHA funds, proved to be a major inhibiting factor in the implementation of the strategy. Another inhibiting factor was the lack of ownership by the consultant psychiatrists in particular, and the inability to increase their numbers. The local authority also have been under constant financial pressure and have not been able to play their part in extending community-based services and residential places. Whilst the strategy was clearly not implemented, it did provide both the focus for, and the vehicle for, commencing the process of change and achieving specific developments. These developments, however, have added components into the existing services in a somewhat disjointed and opportunistic fashion, rather than providing a genuine comprehensive service.

Having described in some detail the development of the strategy and documented Richard's assessment of its success, the rest of the chapter seeks to analyse why the strategy was only partially achieved, and in a disjointed manner.

#### Why change was difficult - the DGMs' view

Richard saw the main problem in individualistic terms, centering on the difficult personalities of the psychiatrists. He did not consider the psychiatrists to be natural leaders, managers or interested in the future of their services "in any developmental sense", indeed he believed they primarily wanted to keep the status quo and for these reasons Richard believed they perceived the strategy to be a "dilution of beds". In short, Richard argued, "they felt threatened, acted like children and ran away with the ball".

Another possible reason for the difficulties, he suggested, was his desire to establish himself in the new general management role. His "newness" to the health service meant his "vision" of the strategy was poorly defined. He admitted that his own

understanding of his objectives in making the change had grown as he was forced to justify the strategy to others and his enthusiasm for the project had at times overridden his judgement. Richard did not feel that the location of consultants' contracts at the region had hindered the progress of the strategy, or would have influenced the way in which he had chosen to involve the consultants in this particular initiative.

### Why change was difficult - other managers' views

Informants were divided in their praise and criticism of the strategy itself, the DGM's role in its formation and the consultation process. Those who were complimentary about each of these issues also saw the problems lying with the attitude and obstinacy of the psychiatrists. A number of quotations illustrate this personality-based view of why change was slow:

"You will find they say 'yes' to everything you have to offer if it's going to occur ten years hence. When they realised it was going to happen they did a U-turn." (UGM community)

"They are impossible people to deal with, they are not a cohesive group but kick one and they all limp." (district treasurer)

"They were on board when it was conceptual - they put their heads together and worked out the ramifications and it frightened them." (the chair)

Many interviewees, however, were at least partially aware of the importance of some social processes, for example, some thought the psychiatrists felt threatened because the strategy, with its emphasis on the community care, served to erode their



traditional base of hospital beds. An additional threat was seen to be the enhancement of the status of other professions relative to their own.

"We were expecting the psychiatrists to agree a new policy that will make them redundant...we were, in fact, abandoning the medical model." (UGM community)

The DGM was criticised by most of his managerial colleagues for his failure to gain the commitment of his senior managers to the strategy. One informant claimed the district management board members collectively were never overtly asked their opinion, yet many had deeply held concerns about the viability of community care as an option for the NHS. The UGM for the acute unit said:

"It was never actually discussed as a proper item in the management board and certainly not in terms of 'what do you think? what can we do?' It was brought to us as 'what we have done'."

Managers also highlighted poor advice to the DGM as one reason for the problems. Some managers spoke of his failure to know where the real flow of information in the system was because he was a newcomer to the NHS. For example, Richard was criticized for believing the chair of the division represented the views of the psychiatrists" and only listening to the DNS.

Several informants spoke of the "unnerving" pace at which the strategy was pursued as a reason for its limited success.

"Members were overwhelmed by the pace and were always worried about it."  
(the chair)

"Because of the pace, not all the psychiatrists were consulted...Management was almost saying they knew more about what was required than the psychiatrists." (consultant psychiatrist)

Several were critical of the fragmentation of the "core group" which meant the strategy itself became fragmented.

"The strategy was written to satisfy too many people. The ideas were good individual ideas but there were too many people who felt it was their responsibility, so no-one was in charge."

Finally the confidence placed by Richard in the DNS was given by other managers interviewed, as an explanation for the problems experienced. The DNS was thought to have a similar character and managerial approach to Richard, "a lateral thinker, a bit impetuous and adopted an attitude of we must get it through at any cost". Such similarities were thought to blind them to each other's faults.

#### Why change was difficult - the consultant psychiatrists' views

The five consultants who responded to the questionnaire were in the main, critical of the rationale behind the strategy and two felt the word 'strategy' to be a misnomer. This group of consultants felt that the medical viewpoint was drowned out by the paramedical and nursing staff and members from social services.

The psychiatrists were asked to comment on the role of the general manager and the general management process with respect to the strategy. All responses echoed the following quotation:

"It appeared to be democratic, but, on the whole management made decisions and in this respect it (the strategy) appeared dictatorial."

Most comments echoed the statement of one psychiatrist:

"The DGM means well, but he does not know what his junior management colleagues are doing. (They were particularly critical of the UGM Community). We take part in meetings and discuss things, but the final decisions are made by the so-called managers and not by the clinicians who, in many respects, know best."

However, the consensus view from psychiatrists was that they did not want to play a managerial role in the NHS. The following quotations capture this point:

"Doctors would probably prefer to go on "doctoring" if they felt they could trust managers. Trust is the big issue - if that was there, we would be happy merely advising.";

"The clinicians' time is very valuable and shouldn't be used for administrative purposes."

In short, the psychiatrists as a group felt that the strategy had not been successful:

"We don't have a strategy. You cannot call resettlement of a few patients from the mental hospitals, a mental health strategy."



## Discussion of the case

There are a number of interesting points relevant to the research questions that lie at the heart of the thesis that one can draw from the case. Firstly the policy process does not follow the neat, rational models of change set out in some of the management literature (for a review of the theoretical approaches to the management of change see Legge, 1984; Spurgeon, 1989). Attempts to change policy are more complex and messy than this literature suggests and are almost invariably characterised by unintended outcomes, or by what Elias calls 'blind social processes'. In part, this is a consequence of a variety of groups pursuing what they see as their own goals, but of no one group being sufficiently powerful to impose its decisions on other groups. This is not to imply that there are not winners and losers. The more powerful the group, the closer the outcome is likely to be to what that group desired. For example, the consultant psychiatrists managed, to a large degree, to fight off the challenge to hospital-based psychiatry inherent in the strategy. By the same token, the less powerful the group, (i.e. the psychiatric nurses) the outcome is less likely to be what the group desired.

Secondly, those involved in policy processes and in changing them rarely understand fully the constraints under which they work and frequently misunderstand, or at best only very partially understand, the actions/intentions of other actors. For example, Richard is adamant that change was hard to achieve because of the difficult personalities of the psychiatrists, his "newness" in the job, the ineffectiveness of the SCM and the enthusiasm of the DNS. His managerial colleagues identify the major problems as the obstinacy of the psychiatrists, Richard's poor judgement in choosing the project manager, the hurried pace of the change, the inappropriate membership of the core group, as well as the fact that he did not fully involve them and therefore did not get experienced advice. The psychiatrists blamed the inexperience of junior management rather than Richard, seeing him as "meaning well". What is consistent

about these explanations is their personality-centric nature and the fact that such explanations ignore almost entirely the structural constraints within which people work in the NHS. In short, Richard found it difficult to take a detour *via* detachment, to stand back and to analyse other people's difficulties, not from his own, but from a relatively detached position. Had he been more able to do so, he might have encountered fewer problems. However, in the responses of the psychiatrists one can see the glimmer of a non-individualised explanation of why change was so difficult to achieve. This group of psychiatrists quite simply did not wish to get involved in management which, in their view, is a low-status, largely administrative, activity. They want to spend their time doing what they have been trained for and what they enjoy, what they get paid well for - doctoring. It is important to note that this reaction from the doctors contained both cognitive and emotive elements, though it was likely to be seen by others as a non-rational and emotive form of opposition, based on personality differences.

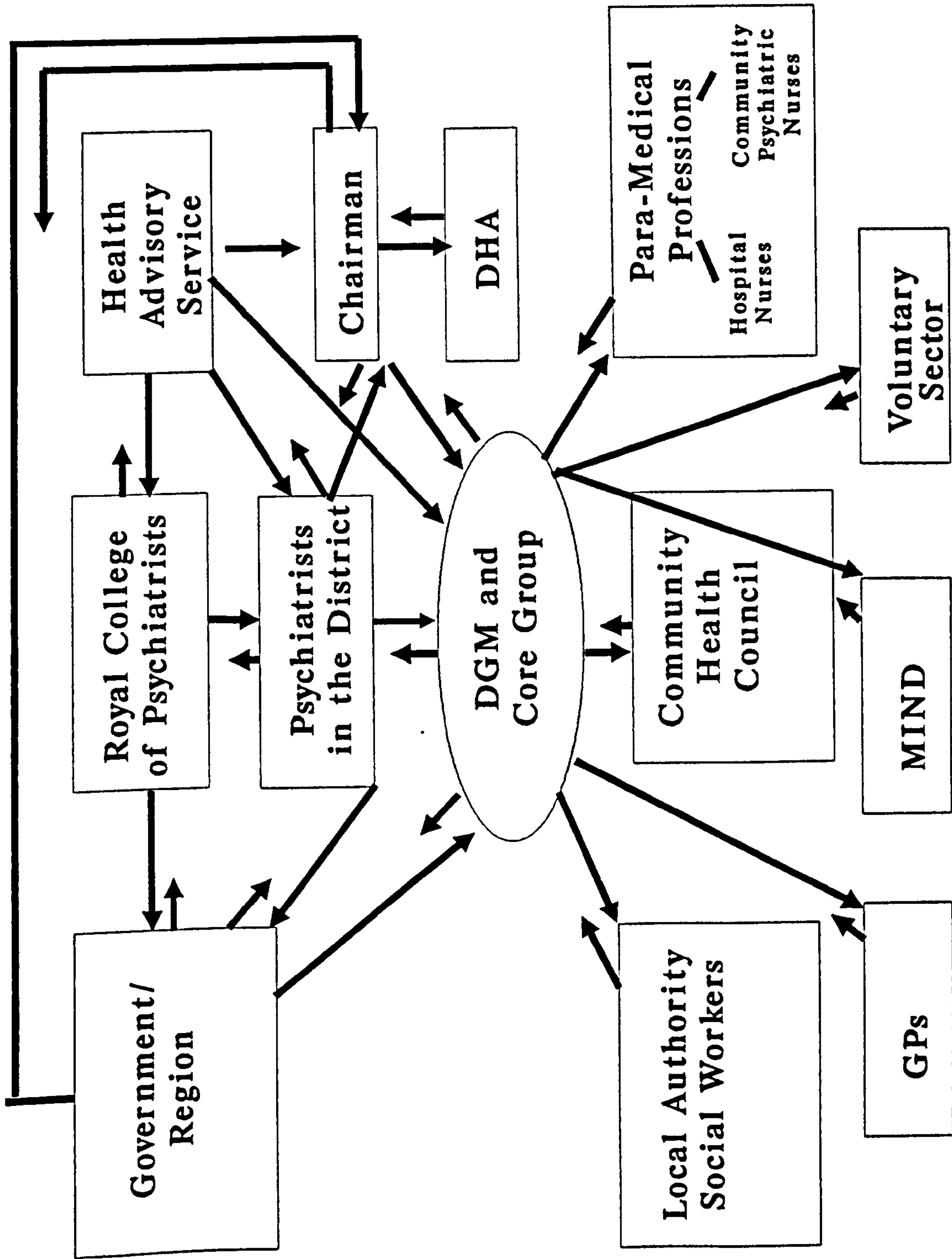
This case illustrates not just a conflict amongst health care workers about the merits or demerits of a mental health strategy, but is an account of a very real conflict of interests on a social structural level. A better mental health service for the psychiatrists is one which maintains and expands their powerful established position within this health care arena - namely more wards, more beds, a better library, etc. A better mental health service for the paramedical and social service professions is one which allows them to play a fuller part in the 'treatment' process guarded so jealously by the psychiatrists, and hence the welcome by the former for community-based care. A better mental health service for management is one which is good "value for money" and is in line with the government policy to move mental health patients back into the community so that they are able to satisfy the demands from region, the department and, in this instance, show how general management can make a difference and make things happen as Griffiths said it should.

Elias's game models provides a contrasting analysis of why Richard found it so difficult to achieve change and why the strategy seems to have been a time-consuming, complicated failure. Figure 25 is a diagramatic representation of the 'game' during the development of the mental health strategy. The figuration of interdependent players and of the game which they play together, is the framework for each individual move. Again, the diagram necessarily oversimplifies a very complex and dynamic process.



*The Figuration Involved in the Change of the Districts Mental Health Service*

Higher Tier



Lower Tier

Length of arrow signifies the power of the people/groups

The object of the game is that the DGM and his core group should significantly improve the mental health services of the district, a move made all the more urgent by constraints from higher-tier players. These constraints included a damning HAS report and the government and region's community care programme. Despite a desire to succeed in this area, the DGM has, by his own admission, failed. Again we must look to the existence of other players in explaining why. The psychiatrists, despite being a weaker branch of the medical profession, are, in this figuration, still relatively powerful. On several occasions, their refusal to co-operate with the new strategy caused delay in its bureaucratic approval. They drew on well-rehearsed arguments - clinical autonomy, trained medical opinion, erosion of beds and so on. As a group, they preferred to liaise with the chair of the DHA in putting their case, seeing him as more powerful than the DGM in influencing the management process. Their intervention in the policy process came quite late, signifying their disinterest in management or policy issues. However the consequences of their intervention, when it came, were an index of their power in this figuration. The lower-tier players all played a role in the consultation process and were key players until the psychiatrists' concerns came to the fore, when the lower-tier status of the former became very clear.

The role of groups representing the community is particularly interesting in this figuration. These groups were consulted in the time-honoured tradition of the NHS about the formation of the strategy, namely the receipt of a weighty strategy document. Yet Richard and his management team did not anticipate nor obtain comments about the community's anger towards the proposal to use three houses owned by the DHA for the rehabilitation of eleven mental illness patients. This suggests not only that the CHC and DHA did not represent the community very well but that local community groups as lower-tier players were largely ignored by Richard. However, the fact that local community opposition forced a rethink is a clear indication that even lower-tier players are not powerless.

The diagram of the game discussed in the case illustrates two points made earlier in this thesis. Firstly, the complexity of the NHS in terms of the number of interest groups involved, means that making any change in such a context inevitably means interests are challenged in some way and in this conflict there are winners and losers. It is also important to emphasise that the capacity of some groups to resist change is obviously greater than others. In this case, as has been argued, the psychiatrists are the most powerful actors and, insofar as anyone emerged as winners, it is probably accurate to say that it was the psychiatrists who did so.

Secondly, studies of health care management which have as their main source of data what individual managers say about issues associated with health care management are seriously flawed. Richard's account of why change was hard to achieve in terms of obstinate personalities of the psychiatrists, should be treated not as an explanation, but as data to be explained. Quite clearly, if actors such as Richard had an adequate understanding of processes of organizational change, there would be no need for - indeed no place for - sociological analysis. Data which take the form of perceptions of those involved need to be complemented, not just by other accounts from other key people, but also by an analysis of the complex figurations in which all these people work. People work in complex sets of relationships of which they are not wholly aware and which they do not wholly understand, but which nevertheless severely constrain their actions. The policy process involves members at different levels in a hierarchical organization, and the extent to which individuals and the sub-groupings are committed to or opposed to the prevailing policy, plays a crucial part in determining its effectiveness. However, the perspectives of the actors should be treated not as detailed analyses, but as more or less involved expressions of their perceived interests. What this chapter suggests is that the extent to which people within the organization perceive themselves as having interests in common, or



opposition to other groups, can only be adequately understood in terms of the emerging structure of differential power relationships.

### Chapter 8 Revisited

This chapter sought to flesh out a number of points made in earlier chapters - the complexity of the NHS, the difficulties of achieving change, the need to move away from considering managers' actions in isolation from the complexity of the social relationships of which they are a part. It also begins to suggest ways in which an Eliasian analysis can assist in understanding issues of managing change in the NHS. The next chapter considers other empirical studies of the introduction of general management in the NHS in order to contrast the findings of this thesis.

## **CHAPTER 9**

### **The Impact of General Management: An Overview**

#### **Purpose of the Chapter**

This chapter considers other empirical studies of general management. Although a number of academics and research teams have studied the implementation of the Griffiths Report, only three other longitudinal studies have been completed, one of which concentrated on the nursing profession. The findings of these studies are discussed and compared to the empirical findings reported in this thesis. In addition, the chapter explores some of the arguments put forward by research teams to tease out why there seemed to be a gap between the promise of general management and what general management delivered.

#### **Other studies of the implementation of general management**

The literature that was generated following the Griffiths Report took various forms. Speculative comments were made about the Report as a signal of fundamental change in the arena of welfare. Day and Klein, for example, highlighted a change in language from the mobilization of consent to the management of conflict and argued that if the health service was to move from a system based on the mobilization of consent to one based on the management of conflict - from one that has conceded to a variety of interest groups the right to veto change to one that gives the managers the right to override objections - then that process would mean radical and painful change. As discussed in an earlier chapter, Celia Davies saw the Griffiths Report as an important step in the strategy of gaining a greater 'central grip' and concluded that the Report signalled that centralization and the creation of a market in health care are not as opposed as they might first seem.

A second strand of writing placed the Griffiths Report within the context of the changing national political economy. Petchey, for example, saw Griffiths as transferring in an uncritical way managerial concepts from the private sector where, he argues, management is less problematic than it is in the NHS:

"Griffiths's prescription is a liberal application of private sector management techniques - what he overlooks entirely is the possibility that such techniques operate successfully in the private sector only because there exists consensus about both the ultimate objective of the organization (to make profits) and the criteria for evaluating alternative means of achieving that objective".  
(Petchey, 1986, p.92)

A third strand of writing consists of empirically based studies examining changes in the management of the NHS following the implementation of Griffiths, very often drawing on a single case study. Figure 26 lists the empirical studies, their aims and general conclusions that I found as a result of my database search.(19)

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(19)In the last month of writing the thesis I got a copy of "Just Managing. Power and Culture in the National Health Service", (Harrison, Hunter, Marnoch and Pollitt, 1993). This provides another overview of empirical work on general management. The table summarising this overview is given as Appendix VIII to the thesis. It includes a number of small-scale studies I did not find and does not include some I did. The findings of these additional studies do not significantly alter the points made in this chapter.



RESEARCH BASED EVALUATIONS OF THE IMPACT OF GENERAL MANAGEMENT

AUTHOR(S)	AIMS OF THE RESEARCH	GENERAL CONCLUSIONS ON THE IMPACT OF GENERAL MANAGEMENT	EMPIRICAL BASE
ALLEN 1986	EXAMINE THE EARLY STAGES OF THE INTRODUCTION OF GENERAL MANAGEMENT	<p>BIGGEST CHANGE - INDIVIDUAL RESPONSIBILITY AND PERSONAL ACCOUNTABILITY</p> <p>A BREAK-AWAY FROM THE STRAIGHT-JACKET OF PROFESSIONAL HIERARCHY</p> <p>A SIMPLIFIED MANAGEMENT STRUCTURE.</p> <p>MAJOR PROBLEM-PRODUCING 'CULTURAL CHANGE', CLINICIAN RESISTANCE, AND MEMBER MORALE AND DHSS 'MEDDLING'.</p> <p>PRIORITIES: IMPLEMENTATION OF GENERAL MANAGEMENT AND MEETING BUDGET</p>	<p>INTERVIEWS WITH 14 DGM's</p> <p>34 QUESTIONNAIRES SENT TO DGM'S (AUG-SEPT 86)</p>
SPURGEON 1987	DESCRIBING HOW GENERAL MANAGERS VIEW ORGANIZATIONS TRANSITIONS	<p>GREATER EMPHASIS IS PLACED ON BUDGETING AND FINANCIAL SYSTEMS</p> <p>PLANNING IS SEEN AS CRUCIAL</p>	<p>RANDOM SAMPLE OF 100 GENERAL MANAGERS ASKED TO COMPLETE A 'KIT OF MEASURES RELATING TO THEIR PERCEPTIONS OF ORGANIZATIONAL CHANGE &amp; CHANGE PRIORITIES'</p> <p>66% RESPONSE RATE</p>

FIGURE 26

RESEARCH BASED EVALUATIONS (continued)

AUTHOR(S)	AIMS OF THE RESEARCH	GENERAL CONCLUSIONS ON THE IMPACT OF GENERAL MANAGEMENT	EMPIRICAL BASE
TRADE UNION RESEARCH UNIT 1987	EVALUATE GENERAL MANAGEMENT	NO REAL IMPACT IN THE AREAS HIGHLIGHTED BY GRIFFITHS AS IMPORTANT  CONFUSION RATHER THAN CLARITY OF MANAGERIAL RESPONSIBILITY	QUESTIONNAIRES DISTRIBUTED THROUGH COSHE IN 10 DHA'S (APRIL 87)  26 INTERVIEWS IN 4 RHA'S
McNULTY 1989		GENERAL MANAGEMENT IS AFFORDING SENIOR MANAGEMENT AT UNIT LEVEL GREATER FREEDOM TO SHAPE ORGANIZATIONAL FORM AND BEHAVIOUR ACCORDING TO LOCAL CIRCUMSTANCES  THE CONFLICT BETWEEN THE CULTURAL ASSUMPTIONS HELD BY CLINICAL PROFESSIONS AND MANAGERS WILL NOT ENABLE MANAGERIAL EFFECTIVENESS  UNITS VARY IN POWER AFFORDED TO THEM	3 UNITS

RESEARCH BASED EVALUATIONS (continued)

AUTHOR(s)	AIMS OF THE RESEARCH	GENERAL CONCLUSIONS ON THE IMPACT OF GENERAL MANAGEMENT	EMPIRICAL BASE
ROBINSON, STRONG & ELKAM 1989	TO GAUGE THE REACTION OF CHIEF NURSING ADVISORS TO THE EFFECTS OF GRIFFITHS ON NURSING	DEVOLUTION OF DECISION-MAKING RESULTED IN THE WHOLESALE ABOLITION OF THE NURSING HIERARCHICAL STRUCTURE  NURSES NOW IN 'A HOTCH POTCH' OF JOBS/OFTEN HYBRIDISED WITH GENERAL MANAGEMENT FUNCTIONS	NATIONAL SURVEY OF ALL CNA'S IN ENGLAND AND WALES (80.8% RESPONSE RATE)
STRONG & ROBINSON 1990	TO CAPTURE THE NEW CULTURE IN THE MAKING  REVIEW THE CHANGING ROLE OF THE NURSING FUNCTION	GRIFFITHS WAS ONLY A PARTIAL BREAK FROM THE PAST  GENERAL MANAGEMENT WAS TRAPPED INSIDE THE OLD NHS HIERARCHY. WITH POLITICAL INTERFERENCE. HUGE ATTENTION WAS PAID TO FINANCE, VERY LITTLE SERIOUS CONSIDERATION WAS GIVEN TO OUTCOME (p183) 'DOCTORS STILL GAVE ORDERS, NANNY STILL NEW BEST' (p164)  NURSING HAD RELATIVE MANAGERIAL UNIMPORTANCE	140 INFORMAL IN 7 INTERVIEWS DISTRICTS 13 MEETINGS OF NURSING AND MIDWIFERY PROFESSIONAL ADVISORY GROUPS  2 MEETINGS OF SENIOR NURSE MANAGERS  12 MANAGEMENT CONFERENCES 17 DHA MEETINGS FIELDWORK JAN-JUNE 1986 JAN-JUNE 1987  KINGS FUND FUNDED



RESEARCH BASED EVALUATIONS (continued)

AUTHOR(S)	AIMS OF THE RESEARCH	GENERAL CONCLUSIONS ON THE IMPACT OF GENERAL MANAGEMENT	EMPIRICAL BASE
KINGSTON AND ROWBOTTOM 1989	PRODUCE A GUIDE FOR GENERAL MANAGERS & HEALTH PROFESSIONALS IDENTIFYING EXISTING PROBLEMS AT VARIOUS NHS LEVELS AND TO PROVIDE TOOLS TO HELP OVERCOME THEM	THERE REMAIN STRUCTURAL DEFICIENCIES - CONFUSED ROLES, UNWORKABLE RESPONSIBILITIES, INSUFFICIENT AUTHORITY DEFICIENT ARRANGEMENTS FOR ACCOUNTABILITY, PROLIFERATING COMMITTEES, CLUMSY PROCEDURES WHICH CANNOT BE PUT RIGHT BY GOODWILL, BETTER INFORMATION, IPRS OR ANYTHING OTHER THAN BETTER STRUCTURES (p9)	4 YEARS APPROX. LONG TERM IN DEPTH CONSULTANCY 5 DHAs

RESEARCH BASED EVALUATIONS (continued)

AUTHOR(S)	AIMS OF THE RESEARCH	GENERAL CONCLUSIONS ON THE IMPACT OF GENERAL MANAGEMENT	EMPIRICAL BASE
PETTIGREW, FERLIE & MCKEE 1991	STUDY OF THE MANAGEMENT OF STRATEGIC SERVICE CHANGE PROCESSES WITHIN THE NHS  TO IDENTIFY MOTIVES AND BARRIERS TO CHANGE	<p>EIGHT FACTORS (A LINKED SET OF CONDITIONS) WHICH PROVIDE HIGH ENERGY AROUND CHANGE</p> <p>Shaping Strategic Change</p> <p>Receptive contexts for change: the eight factors</p>	COMPARATIVE, LONGITUDINAL AND ISSUE BASED CASE STUDIES 8 DISTRICT SITES FIELDWORK 1986-1990  FUNDED BY A CONSORTIUM OF REGIONS

## RESEARCH BASED EVALUATIONS (continued)

AUTHOR(S)	AIMS OF THE RESEARCH	GENERAL CONCLUSIONS ON THE IMPACT OF GENERAL MANAGEMENT	EMPIRICAL BASE
<p>POLLITT, HARRISON, HUNTER &amp; MARNOCCH 1991</p>	<p>DESCRIBE THE WORK OF GENERAL MANAGERS MAP PERCEPTIONS OF THE IMPACT OF GENERAL MANAGEMENT DEVELOP THEORIES OF ORGANIZATION IN THE NHS</p>	<p>IMPACT CONSIDERABLE AT LOCAL LEVEL BUT NOT ENOUGH TO SIGNIFY A CULTURAL SHIFT VARIED EXPERIENCES OF GENERAL MANAGEMENT IN DISTRICTS - NOT RELATED TO THE TIGHTNESS OF RESOURCES GENERAL MANAGEMENT WORKED BETTER WHERE CONSENSUS MANAGEMENT WORKED WELL</p>	<p>339 'LOOSELY STRUCTURED INTERVIEWS' WITH GENERAL MANAGERS, SENIOR OFFICERS, PROFESSIONALS, MEMBERS, CHC, LOCAL AUTHORITY &amp; TRADE UNIONS IN 9 ENGLISH DISTRICTS &amp; 2 SCOTTISH BOARDS. FIELDWORK OBSERV- ATION &amp; DOCUMENT ANALYSIS (1986-88) ESRC FUNDED.</p>
<p>SPURGEON &amp; BARWELL 1991</p>	<p>EXPLORE GENERAL MANAGERS HANDLING OF THE CHANGE PROCESS</p>	<p>EXTENSION OF PERSONAL NETWORKS AS A MECHANISM FOR IMPLEMENTING CHANGE PREFERENCE FOR INFORMAL FACE TO FACE MEETINGS</p>	<p>RANDOM SAMPLE 100 DISTRICT AND UNIT MANAGERS 66% RESPONSE RATE TO QUESTIONNAIRES</p>



Though differing in scope, the existing empirical studies offer a number of common findings about the implementation of general management which are discussed below.

The Centre (government, management board and supervisory board) is often cast as having failed to provide the service with strategic leadership. The management board is consistently described as a remote body, incapable of providing clear direction for the service. Regions fare no better. Often described as paternalistic and distant, they are portrayed as trapping local management within a straight-jacket of central directives, political interference<sup>(20)</sup> and inadequate central funding.

Although studies vary in the extent to which doctors were consulted as to their views about general management, most studies conclude that the general management process left the power of doctors relatively intact and support Harrison's statement that: "The prime determinant of the pattern of health services is still just as before Griffiths, what doctors choose to do" (Harrison, 1988, p.323). Although agreeing with the thrust of Harrison's point, my data do not suggest doctors remained untouched. Some consultants were well aware that if they did not get involved in management, someone else would make decisions without them and others were genuinely interested to see how management could help them improve their service.

Another general conclusion to be drawn from these studies is that there has been no significant increase in the involvement of the consumer in decisions about the shape or priorities of health services. CHCs and other consumer representatives remain peripheral to policy decisions.

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(20) This is a value-laden vocabulary. After all how can the NHS be free of political "interference"?

Nursing it seems has undergone significant change following the Griffiths Report. The studies which examined the impact of general management on nursing point to its radical effects on the profession (Glennerster, Owens and Kimberley, 1986 and Strong and Robinson, 1990). Glennerster et al considered the implementation post-Griffiths of structural changes affecting the nursing profession in one region. They found the break-up of traditional professional lines of accountability, while the post of chief nursing officer had disappeared in most districts, often being transformed into a nursing advisory post, usually combined with an operational role. The nursing advisor in most structures was found to have an anomalous role, not fully understood by the incumbents or by unit staff. A survey of chief nursing officers carried out by Robinson, Strong and Elkin, found no coherence in nursing across the country following Griffiths. Some twenty-nine different job titles are reported for nurses advising at district level, and in terms of bodies and jobs, little had changed. 42% had been CNOs before Griffiths. Men still predominated relative to the population of nurses, despite not being more highly educated than women. Only a quarter of CNOs in the sample perceived their professional role to have been strengthened following Griffiths. It seems that Griffiths has undermined a previously separate career structure for nurses above the level of unit, and, furthermore, has effectively separated the management and control of the workforce from other functions such as professional advice and standard-setting (Strong and Robinson, 1990).

Although my data do not deal specifically with many of the issues raised by Strong and Robinson, they support the view that the power of nurses to change policy has been reduced as a consequence of the introduction of general management and the abolition of consensus management.

Most studies report improvements in the hotel aspects of the service. Many studies reiterate the points made in Chapter 7 that there were improvements in the state of the waiting accommodation and improvements in reception activities.

A point made in many studies is that decision-making following the introduction of general management is quicker. It is important to treat this finding with caution because it is a finding about people's perceptions of decision-making, not about decision-making as such. For example, Hunter et al argue that managers (finance, personnel, planners and nurses), were much more likely to believe that decision-making had speeded up, especially if they had previously worked at regional level. Clinicians, however, saw the DMT as having merely changed its name and reported no significant change in decision-making (Hunter, Harrison, Marnoch and Pollitt, 1991, p.5). Again the trades union research unit reported that 40% of their sample felt there was no change in the speed of decision-making, 32% believed there was more centralization and only 22% felt they had more freedom to take decisions. Empirical studies are also littered with complaints about the slowness of decision-making by those at the region and the Centre without, unfortunately, providing any insight into the decision-making process.

A consistent comment made by research studies is the significant increase in the level of managerial rhetoric and vocabulary. Managers in the NHS, it seems, constantly fell back on the managerial rhetoric so prevalent in the middle 1980s, as if this was a sufficient explanation for the managerial actions taken.

The majority of the studies of general management were relatively small-scale, consisting of a case study or a small-scale survey. The most comprehensive study of the implementation of general management was that carried out by Harrison, Hunter, Marnoch and Pollitt. Their data are published in an article in *Public Administration* (1991) and the book "Just Managing: The Power and Culture of the NHS" (1993). In their assessment of general management, they concentrate on recording the views of a range of NHS staff on which features of general management appear to them to be working in the ways the official line has suggested they should. A more detailed



summary of their findings is given below, because the scale of the research was significantly greater than was the case with the other studies of general management.

In all the authorities they studied, there had been changes in the formal organizational structures attendant upon the introduction of general management and in most of them these changes have been substantial (Harrison, Hunter, Marnoch and Pollitt, 1993, p.55).

Senior managers were roughly equally divided on the question of the speed of decision-making and implementation. UGMs emerged as a group particularly likely to think acceleration had occurred, while district-based planners and administrators tended to be more sceptical. Consultants were the most pessimistic group - very few of them could see any speeding up, while the majority of nurses believed that decisions were being arrived at much more quickly, giving as their main reason the elimination of one or more tiers in the nursing hierarchy (*Ibid* p.55). Clearly different staff were thinking about different kinds of decisions. As the authors note:

"The optimistic nurses are usually referring to getting this or that done on the wards, routine operational adjustments. UGMs tended to cite minor works or changes in the deployment of nurses. Planners and administrators found the numbers of clearances needed to get documents circulated and plans discussed were fewer than hitherto...By contrast, both consultants and senior managers remained dissatisfied with the often slow handling of issues which involved going outside their own organizations. Much irritation was expressed by districts about regions and by regions about the DHSS." (*Ibid.*, p.56)

Most of their interviewees thought the introduction of general management had resulted in more precise allocations of personal responsibilities. However, many of them believed this greater clarity did not extend very far down the hierarchy. Below

UGM level, things became murky. "Consultants were the most pessimistic group, the majority claiming that they could not see the allocation of responsibilities between managers was any clearer at all". (*Ibid.*, p.55)

Greater responsiveness towards consumers was not a feature of the research findings. The majority of both nurses and consultants thought there were no significant changes in this regard. Most changes, they believed, were no more than rhetorical or superficial gestures by management towards consumers.

In terms of management budgeting, there were a few enthusiastic managers, many cautious ones and a handful of enthusiastic consultants, but a large majority of determined sceptic (*Ibid.*, p.57). The sceptics included a number of consultants with extensive experience of management budgeting, few of whom found the information they received to be particularly interesting or useful. (For a review of management budgeting and Griffiths see Pollitt et al, 1988). The use of Performance Indicators (PIs) by DGMs and planning and financial staff appeared to be more frequent than by medical or nursing staff. There were considerable differences between performance data used between districts and between specialties. Clinical quality was still regarded as professional territory.

Despite the differences in scope and funding, empirical studies of general management confirm the general finding of this thesis that there was a significant gap between the aspirations of the Griffiths Report and what the introduction of general management was able to deliver. This will come as no surprise to those working in the health service at the time. The important question for them is why the gap existed and what light can academics and others shed on this question. Unfortunately many of the empirical studies reviewed for this chapter fail to pose this question, let alone answer it. This may be partly a consequence of the funding arrangements for these

studies and the interests of the funding bodies.(21) It may also reflect the absence of helpful concepts or frameworks because of the disinterest shown in health care management by medical sociologists (Cox, 1986) and the feeling amongst academics working in the area of management studies that the health service is not a fruitful research and consultancy area(22). The rest of this chapter considers explanations offered in the available literature for the gap between the aspirations of the Griffiths Report and what general management was able to deliver.

Strong and Robinson, reporting on the implementation of the Griffiths Report in a sample of districts, concluded that the reason for the failure of general management to meet expectations was that although the Griffiths model was 'radical', it represented a compromise with the very different tradition of central planning, so that general management was still trapped inside the NHS hierarchy, with its political sensitivity and control over funding.

"Whereas writers such as Drucker had urged "socialist competition" for this special type of service institution, the NHS remained monolith. Griffiths might have installed a line of command and imposed a micro-management ethos but it had left its macro-structure intact." (Strong and Robinson, 1990, p.183.)

Sir Roy Griffiths hinted at the problems associated with such a compromise in a public lecture in 1991. He believed change had not occurred as fast as he would have liked because of poor leadership from the supervisory board and management board. Both, he argues, "were absolutely correct in concept", but were "half-hearted in their implementation". Major policy issues were left uncovered, there was no attempt to

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(21)Certainly this was true of the Templeton study of DGMs (details of which were reported in Chapter 5).

(22)This situation is, I think, changing particularly after the introduction of the internal market in the NHS following the 1989 White Paper.



establish objectives at the Centre and no concentration on outcomes. (Griffiths, 1991, p.12)

In addition, Strong and Robinson argue that local factors affected the transition between the old and the new style of management. In particular, they point to the way that previous structures had sometimes foreshadowed the new regime, how far the old DMT still existed and moulded events, and the influence of the new DGM's background and preferred style of working. These points are unfortunately not elaborated.

Harrison, Hunter, Marnoch and Pollitt explain the gap in terms of tensions internal to the Griffiths' model. They highlight three key tensions. Firstly, that the managerialism of the Griffiths' model was founded on distrust, which contrasted with the consensus mode of working, which rested on trust.

"To transform such a system into one in which identifiable individuals have to take personal responsibility for qualified targets, is to shine a strong, harsh light into processes of intricate political bargaining which may require degrees of flexibility, creative ambiguity and even downright secrecy in order to function most efficiently. This may be no bad thing, but it does cast doubt on the claim that Griffiths made to be able to preserve the good features (unidentified) of consensus management system alongside the new model." (Harrison, Hunter, Marnoch and Pollitt, 1993, p.68)

A second tension identified by this research team is the failure of Griffiths to offer a convincing analysis of the relationship between the business of running the NHS and the workings of the political system in which the service is set.

"The NHS is a major, and highly popular public institution. It generates the never-ending stream of issues of local or national political interest. Underpaid "angels" (nurses or ambulance staff); new wonder treatment; lengthening waiting lists; doctors with controversial diagnostic approaches to children who are suspected of having been sexually abused, other children who are kept waiting for treatment for life-threatening conditions because of staff shortages; scandalous conditions in long-stay geriatric or mental hospitals - the list is endless. Ministers have seldom been able to resist the pressures to intervene when one of these issues blows up, and there is no obvious reason to expect they will exert greater self-restraint in the future." (Harrison, Hunter, Marnoch and Pollitt, 1993, p.69)

The final tension identified that the proposed cultural revolution was posited on the existence of some tolerably clear objectives, which simply did not emerge. The researchers conclude that:

"The implementation of the Griffiths' model has been handicapped by tensions and limitations which were inherent in the original Report, by flawed understanding of the management problems of the NHS and by wider developments (the failure of government to set clear priorities, plus the deteriorating financial situation) which were beyond its remit." (*Ibid.* p.72)

They offer a theoretical perspective drawn from political science where notions of power, culture and puzzlement or uncertainty are to the fore in explaining the relationship between doctors and managers and the problems general managers faced in implementing general management policies within the NHS. Chapter 1 of their book is devoted to explaining these key concepts, but the book is disappointing in the sense that there is no overt attempt to apply these concepts to their data on general management. Their preferred theory of power is taken from Steven Lukes's seminal

work "Power: A Radical View". In this book Lukes criticises empiricist notions of power which focus on decision-making and/or observable non-decision-making. He notes:

"...the bias of the system is not sustained simply by a series of individually chosen acts, but also, most importantly, by the socially structured and culturally patterned behaviour of groups, and practices of institutions,..."

"...is it not the supreme and most insidious exercise of power to prevent people, to whatever degree, from having grievances by shaping their perceptions, cognitions and preferences in such a way that they accept their role in the existing order of things,..."

"...the most effective and insidious use of power is to prevent such conflict from arising in the first place." (Lukes, 1974, pp.21-22)

Lukes is critical of what he terms the first and second dimensional views of power for resting on the "concept of subjective rather than objective interests". He reproves the pluralists for being opposed to any suggestion that interests might be unarticulated or unobservable, and above all, to the idea that people might actually be mistaken about, or unaware of their own interests. He develops this theme. It is wrong to assume, he argues, "that if men feel no grievance, then they have no interests that are harmed by the use of power...To assume that the absence of grievance equals genuine consensus is simply to rule out the possibility of false or manipulated consensus by definitional fiat". Linking both the above criticisms, he writes:

"What one may have here is a latent conflict, which consists in a contradiction between the interest of those exercising power and the real interests of those they exclude. This conflict is latent in the sense that it is assumed that there



would be a conflict of wants or preferences between those exercising power and those subject to it, were the latter to become aware of their interests."

It is not clear from the book how Lukes's concept of power is used in relation to these researchers' analysis of the NHS.

The second key concept the authors advocate as helpful in understanding the implementation gap is puzzlement and uncertainty which are common features in respect of policy-making and implementation. As Heclo succinctly puts it: "Politics finds its sources not only in power but also in uncertainty - men (sic) collectively wondering what to do...policy-making is a form of collective puzzlement on society's behalf; it entails both deciding and knowing" (Heclo, 1975, p.350). Harrison et al argue that managerialism of the Griffiths type could be interpreted as a response to managing uncertainty as to what to do about the increasingly complex issues which beset all developed health care systems, for example, determining the optimum levels of spending on health services and obtaining robust information on the impact of medical interventions on health statistics.

Organizational culture is the third framework these authors highlight as useful for understanding the implementation gap. They give three reasons for this choice. Firstly, the notion of culture is the single most pervasive element in contemporary prescriptions for improving organizations; it was popularised in Peters and Waterman's "In Search of Excellence" (Peters and Waterman, 1982) and a succession of derivative works (see Meek, 1988 for a review). Secondly, culture surfaces in the stated aspirations of many proponents of recent organizational changes in the NHS and, thirdly, culture denotes the prevailing assumptions and beliefs within a group, that which is taken for granted. It is therefore an indicator of what a group would be likely to perceive as legitimate and illegitimate, of change it would welcome and change it would resist (ibid., p.4) The authors document in some detail Handy's

discussion of four cultural types (Handy, 1989), partly to make the point that the connections between power and culture are subtle, particularly in relation to the third dimension of power. Cultural assumptions, symbols and rituals may focus attention on certain aspects of the work process and draw it away from others. For example, if the culture is one where subordinates are not expected to have new ideas, they may not expend much energy thinking of them - it becomes a pointless activity. Handy's model is summarised below:

Summary of power relations within Handy's four cultural types

Cultural 'Ideal Type'	Location of dominant power
<i>Power</i>	One or a few key individuals at the centre of the organisational web. They need to be dynamic, risk-taking etc. if the organisation is to adapt to a changing environment.
<i>Role</i>	Power and authority largely coterminous. Authority is parcelled out in well-defined units to particular positions in the hierarchy. Those in the top positions hold the largest amounts. Expert power is accepted, but only in its allotted place ('on tap but not on top').
<i>Task</i>	Power lies with those who are positioned at the intersections of networks of specialist, task-oriented groups. These may be experts, or simply good 'fixers'. In general power is more widely dispersed than in any of the other three types. It is a team culture in which the skills of collective organising are highly valued.
<i>Person</i>	Power lies with the 'star' individuals around whom the organisation is formed. The power base is usually expertise of some kind, so neither the 'fixers' of the task culture nor the entrepreneurs or 'dictators' of the power culture will be prominent here. Rules are few and controls are light. Collective action occurs only when there is mutual agreement between the 'stars'.

Source: Harrison et al, 1993, p.13.

Harrison et al's conclusion about the reasons for the implementation gap does not explicitly draw on the three explanatory concepts they advocate, rather they state:

"Implementation failure is not necessarily the fault of general management. Indeed, in some of our districts, general managers struggled against all the odds to make progress. The fact they either failed or were only partially successful has less to do with general management per se than with the prevailing culture, resource context, organisational relationships (both intra- and inter-), uncertainties in the external environment and the power-dependencies among key groups of stakeholders. They conspired to act as a more powerful determinant of policy implementation than general management. Where successful progress was possible in particular local circumstances, the converse prevailed though instances of this were, given the complexities, understandably more rare." (*ibid.* p.112)

Another framework for understanding the difficulties of achieving change in the NHS is put forward by Pettigrew, McKee and Ferlie. They argue much research on organizational change is ahistorical, aprocessual and acontextual in character. For this group, research into health care organizational change needs to be processual (an emphasis on action as well as structure); comparative (a range of studies of local health care agencies); pluralist (describe and analyse the often competing versions of reality seen by actors in the change process); and historical (take into account the historical evolution of ideas and actions for change as well as the constraints within which decision-makers operate (Pettigrew, McKee and Ferlie, 1988, p.301). They argue the 'promise' in their framework (see Figure 27 below) lies in the interdependent exploration of content, process and contexts which, they argue, could provide a novel framework for researching the problem of management of change in the NHS.



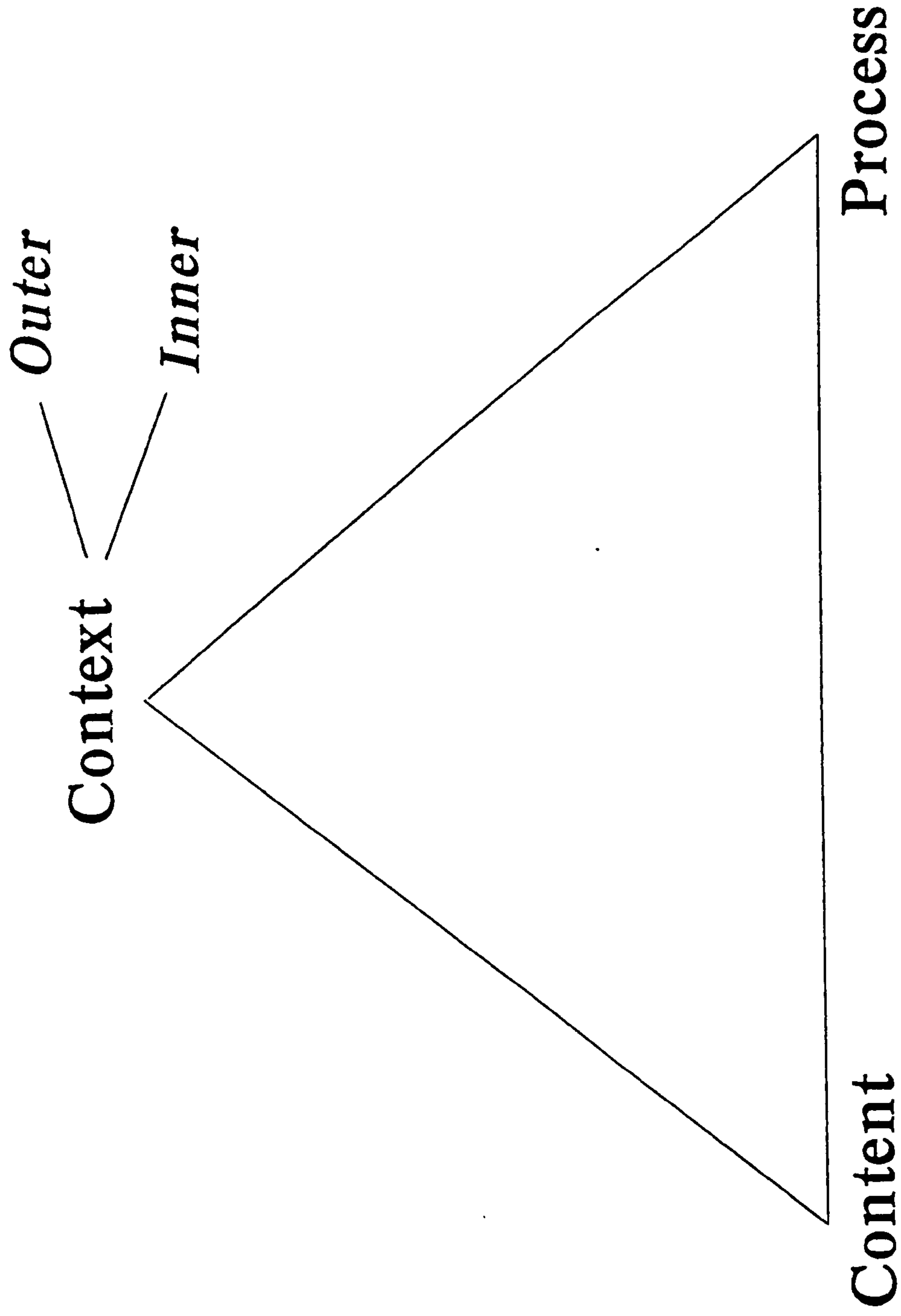


FIGURE 27

Source: Pettigrew, McKee and Ferlie, 1988 p301

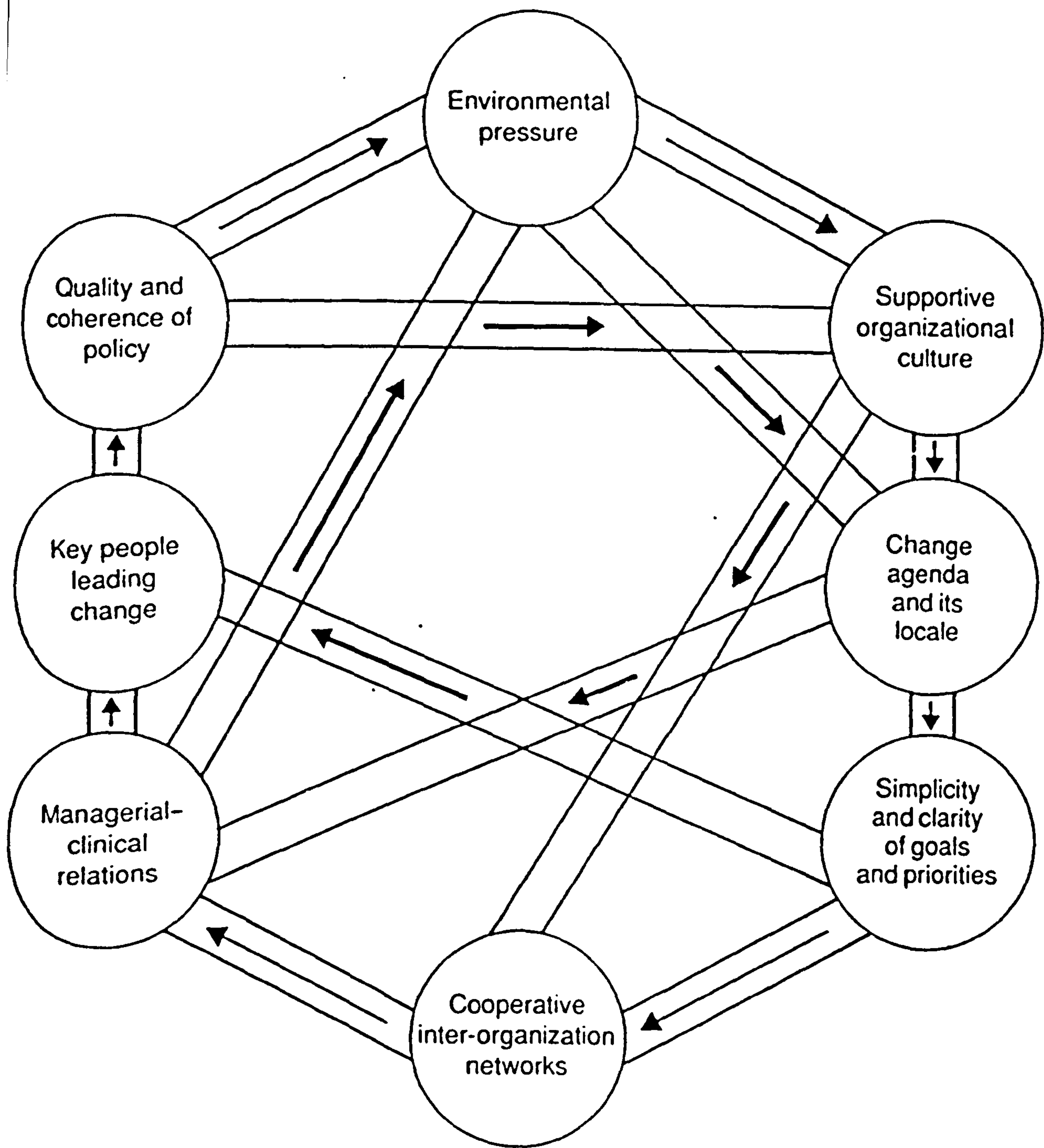
The analytical challenge is to connect up the content, context and processes of change over time to explain the differential achievements of change objectives. This analytical challenge is not one they take up with respect to their data on general management. However, they do give more details on the model. Content refers to the particular area, or areas, of transformation under study. Context is split in two. Outer context refers to the national economic, political and social context for a DHA as well as the perception, action and interpretation of policies and events at national and regional levels in the NHS. Social movements and long-term professionalization or deprofessionalization processes also form important aspects of the outer context. Inner context refers to ongoing strategy, structure, culture, management and political process of the district which help shape the processes through which ideas for change proceed. The process of change refers to the actions, reactions and interactions of the various interested parties as they negotiate around proposals for change. Broadly speaking the 'What' of change is encapsulated under the label 'content', much of the 'Why' of change is derived from an analysis of 'inner and outer context' and the 'How' of change can be understood from an analysis of process (Pettigrew et al, p.7). The authors argue:

"Links between the outer and inner context will permit the analysis of national and local barriers to implementation. Analysing the fine shading of the inner context of districts will differentiate between receptive and inhibitory contexts for change and will highlight the importance of management style, strategies and tactics. In this way it will be possible to explain why districts facing similar environmental and policy pressures behave differently and achieve different outcomes and differing degrees of success". (Pettigrew, McKee and Ferlie, 1988, p.314)

From their studies of strategic service change in eight RHAs they outline eight factors (see Figure 28 below) derived inductively from the research which provide a set of linked conditions which provide a high energy around change.



*Shaping Strategic Change*



*Receptive contexts for change: the eight factors*  
(Pettigrew, Ferlie and McKee, 1992, p.276)

An interesting characteristic of the evaluations of the introduction of general management is their rationalistic bias. That is, the argument seems to be that if only things had been organized differently if mistakes had not been made, then general management might have been more successful. This assumes that it is possible to draw up a rationalistic organizational structure and that people will act in a wholly rational way within that structure. It follows from this that any intention and outcome can be explained in terms of non-rational action, or in terms of mistakes. These mistakes may involve the failure of the government to produce clear policies, a lack of information, the failure of managers, but they all involve failure. Furthermore, the failures or mistakes are contingencies which are not built into theoretical models of change. Figural or process sociologists would not share these assumptions. This is not to say that figural sociologists do not recognise that some action may be more rational than other forms of action, but a central part of Elias's approach to understanding human behaviour is that humans are not merely cognitive animals but also emotional animals and that all of our actions, without exception, involve a mixture of cognition and emotion. Some actions are based on a higher degree of cognition, others on a higher degree of emotion, but even the most cognitively-based forms of action involve emotion as well.

As an example Elias cites the case of scientific innovation and points out that the replacement of one scientific theory by another is not simply the question of the application of cognitive processes, but involves overcoming emotional resistances too. If this is the case even for science where intellectual and cognitive processes are stressed most explicitly and where the organizational structures which are being established have been set up to privilege cognitive and intellectual processes, then it follows that as one moves away from scientific procedures, the emotive content of behaviour is likely to increase. Certainly it is the case that when approaching something as complex as organizational change, especially in an organization as complex, as multi-faceted and with as many interest groups as the NHS, no

figurational sociologist would make the assumption that people will act in a totally rational way and that mistakes will not be made. Indeed, a fundamental assumption of "figuralists" in this respect would be mistakes (things not planned for, not intended or not foreseen) are an almost inevitable consequence. In this sense, mistakes, unintended consequences, are an inevitable outcome of change. They are not to be explained in terms of some deviation from the model. Furthermore a satisfactory model must be one that incorporates human emotion as part of the explanatory framework and conceptualises human beings as they really are, involved, emotional beings rather than as humans who have no emotions - who have no feelings and who are concerned simply with the application of rational procedures to the exclusion of all else.

Most people I spoke to about the change to general management were most concerned about how the change affected them. Questions they asked about the implications of general management were emotional ones, for example: "What does the change mean for me?"; "What are the implications of the change in terms of how my work is being valued?"; "Is my work being demoted?"; "Does this mean people don't value me, don't value my work?"; "What are the implications for my sense of self-worth?". For example doctors were not just defending occupational interests on a rational level, but were, in part, defending their self-image as a person doing a good and worthwhile job that is being threatened by other people who do not understand, for example, the nature of clinical medicine.

A rationalistic bias is also a feature of the models used to explain why change was difficult. For example figuralists would agree with many of the criticisms Lukes makes about pluralists' conceptions of power. However, figuralists would be sceptical of the notion of "real interest" - that it is possible to determine someone else's interest with absolute certainty. Aside from the variety of methodological and operational problems this concept presents, the notion of "real interest" implies a



dichotomy of one group of people, the powerful, the dominant group who are wholly rational, who have perfect access to all the information they need, understand their "real interests" and the "real interests" of the subordinate group, and are able to use their power to prevent the subordinate group from articulating their interests. This is an untenable position, there are no groups of people who do not make mistakes. Subordinate groups are portrayed as people who do not know their "real interests" either because they are too stupid, too emotionally involved, or have less access to information, therefore they do not act in a rational way. This dichotomy is not helpful, not least because it does not correspond to social reality. What we have in reality are different people/groups who perceive their, and other people's interests with varying degrees of accuracy. We have different groups able to act with different balances of emotive and cognitive intellectual processes and are able to, with differing degrees, to distance themselves and stand back with a degree of detachment and we have different groups who have differential access to information.

Within a complex organizational structure like the NHS, there are a multiplicity of groups, some acting in a more rational, some in a less rational way, or a more involved or less involved way, some groups with more access to information which will aid their decision-making, other groups with less access to the information they need in order to take rational decisions. There is also a variety of groups with different career interests and these are emotive as well as cognitive, who will be struggling over those. Within this situation, mistakes are not only probable, they are inevitable. It is important to take these sorts of emotional resistances to change into account when building models of change, thus avoiding the building of rationalistic models which do not work because people are not rational in this sense.

Discussions of power and interest in the thesis have been centrally related to organizations, their management and the policy process. Organizations are power structures, management are particular groupings within these structures of

relationships and policies are the expressions of different groupings, both inside and outside particular organizations, pursuing their interest sometimes with a degree of unity, but often in the face of resistance from other groups. The unequal distribution of power in human history also has a pervasive effect upon outcomes. Because of the complexity of social processes, these outcomes are not inevitable or, at least, they are not knowable with any high degree of certainty. A crucial insight one gains from a consideration of Elias's work is that people cannot control processes of change in complex organizations because one of the consequences of that complexity is that there are always unintended outcomes.

The game models act as a sensitising agent which encourages us to ask questions about the policy process and power issues. They are objective distillations which capture a specific aspect of social reality. Game models allow one to examine how organizations like the NHS are locked into on-going commitments of varying complexity. Policy objectives like all social phenomena exist in a broad context, therefore it is more helpful to stand back and see objectives for what they are, assess their viability with the aid of the available evidence. It is out of these reflective processes that policy comes. The Griffiths team did not stand back in this way, the information-gathering was limited and little time was given to detached and critical reflection. Decision-makers who deny the relevance of this analysis are denying themselves crucial knowledge. This is not to say that such knowledge, if acquired, will lead decision-makers to act in particular ways, but rather that the absence of such knowledge will limit their perception and, therefore, hinder their scope for action.

### Chapter 9 Revisited

This chapter considered the achievements of general management as reported in other empirical studies. A number of common findings were discussed which highlight a gap between the expectations of what general management would deliver and what it

actually delivered. The final section of the chapter suggested that all too often these findings were treated uncritically. In the chapter it was argued that some of the ideas of figurational or process sociology can act as useful sensitising tools which encourage academics, policy-makers and managers to ask important questions about the policy process in the NHS which seem not to be dealt with in existing discussions or research studies.



## **CHAPTER 10**

### **Conclusions**

#### **The Purpose of this Chapter**

This chapter follows custom. It reviews the scope of the thesis, the areas in which it seeks to advance our understanding, reiterates conclusions flagged up in previous chapters and adds some more general conclusions.

#### **The Thesis Revisited**

The meat of this thesis can be found in Chapter 3, where a comprehensive review of the Griffiths Report which prompted the third reorganization of the NHS was given. This Report was an attempt to shift the culture of the NHS from an administrative culture to that of a managerial culture. General managers were to be the key change agents in this respect. It was they who were ultimately responsible for attempting to improve quality, ensure value for money, provide a customer-focused service and encourage professionals to play a part in the management of their service. The Griffiths Report is remarkable in the sense that for such a brief document it caused a sensation in the NHS. It raised many heartfelt concerns for those working in the NHS and was yet another change for them to adjust to, coming as close as it did to the 1982 reorganization.

The Report made a number of important assumptions which were addressed and challenged in Chapter 3. These included: politicians will deliver clear policies which general managers will implement; general management will not challenge existing arrangements for accountability; private industry is more effectively

managed than the public sector; it is possible to transfer approaches employed in business management to the management of the NHS; the democratic nature of the NHS leads to poor management; the general manager can be the final decision-taker and manage the considerable power of professional groups in the NHS; output/outcome measurement is straightforward in the NHS and the NHS consists solely of hospital services. The discussion of these assumptions in Chapter 3 is not meant to convey political carping but merely to illustrate the points of debate that might have been taken up following the publication of the Report, yet rarely were these points debated in the commentary and furore which followed its publication. Furthermore it was argued in that chapter that a team of highly regarded and highly competent business people could not be expected to get to grips with the complexities of the NHS in the time they were given by government. In short, because of the constraints on the members of the Griffiths team in particular, the pressure on the team to come up with a quick diagnosis of the problems of the NHS - it was difficult for the team to take time in reaching their conclusions, to reflect and to consider calmly, in short, to take what Elias called a detour *via* detachment.

Policies such as those arising from the Griffith Report are not born in a vacuum, but emerge out of existing relationships and policies. Chapters 2 and 4 attempted to explore these issues. Specifically Chapter 2 drew on historical data documenting the formation of the NHS, the pressures to reorganize and details of the two reorganizations. This chapter revealed the growing complexity of the organization of the NHS, as well as the increasing interdependence of groups involved in delivering health services. Chapter 4 considered some of the more recent empirical research of these issues at a more local level. These largely ethnographic studies are extremely helpful in highlighting the complexities of delivering health services and they consistently question the rationalistic assumptions of the essentially bureaucratic reorganizations of 1974 and 1982.

The more general conclusions of these studies include the following: those working in local health care systems can, and do, circumvent national policies; decisions affecting local health care delivery evolve in bargaining situations and although policy processes at local level are incremental and plural, the distribution of power is weighted towards the medical profession; there is genuine uncertainty amongst health service managers as to how to prioritize the many demands on finite resources; managerial behaviour is problem-driven rather than objective-driven; there seems to have been great reluctance, amongst those managing health services, to question the value of existing patterns of service or to propose major changes in them, and finally, managers seem to behave as if other groups of employees, rather than the public were clients of the health service.

These are extremely useful points for those undertaking research in the area of health services management. Interestingly the fruits of this body of research have rarely informed policy discussions. Nonetheless it was argued initially in Chapter 4, that a weakness of the existing research on health services management is that studies do not adequately locate managers' action in the social context - that is the complex network of relationships of which managers are a part. Indeed, quite often the complexity of these networks is reduced and managerial relationships are seen as relationships involving only those people with whom the managers or management team has face-to-face contact. In addition this body of research seems not to consider the impact of health services management on patient care and health. The tendency for researchers to concentrate on face-to-face relationships is not surprising as it reflects the tendency, particularly in western societies, to think of relationships in largely individualistic terms and also reflects the fact that in the course of development of most western societies, people have come to experience



themselves increasingly strongly as separate beings, distinct both from other people and from natural objects.

This thesis explores the possibility of applying some of Norbert Elias's ideas to the study of health care organizations and management. It argues this is a fruitful framework which allows researchers to consider the actions of managers within the social context of which they are a part, thus overcoming some of the weaknesses of previous research on health services management. The main principles of figural or process sociology, an approach pioneered by Elias, was outlined in Chapter 4. Specifically four themes of Elias's work were considered to be particularly helpful.

Firstly, Elias highlights the importance of viewing sociology as the study of people in the plural. In short, it is the study of human beings who are interdependent with each other in a variety of ways and whose lives evolve in and are significantly shaped by, the social figurations they form together. Figuration refers simultaneously to acting human individuals and their interdependence. It implies a reference to action and structure, thus avoiding the separation of action and structure that has fuelled so many sociological debates. Secondly, Elias notes figurations are constantly in flux undergoing changes of different kinds. It is therefore critical that researchers pay attention to how relationships have come to be, a figural approach is necessarily a developmental approach. Thirdly many of the long-term developments taking place in human figurations have been and continue to be, largely unplanned or unforeseen and it is in this context that Elias referred to "blind" social processes. It is the unintended outcomes flowing from complex human interaction which makes a sociological perspective imperative. Finally, central to Elias's concept of figuration is the concept of power chances or balance of power. This is, people who are interdependent are not necessarily

equally interdependent. The more dependent individuals are on others, the less power chances they have and vice versa. However, it is important to note that very powerful groups are never all powerful, for they are inevitably dependent to some degree on other less powerful groups.

The empirical element of this thesis attempts to explore the figuration of which newly appointed district general managers are a part and, in particular, how people within this figuration are bonded to each other so as to form a composite unit. In doing this I hope to have gone some way to taking the detour *via* detachment that Elias argued was necessary for the development of a more adequate understanding. In addition, I have attempted to consider issues relating to how general management came to be seen as a solution for the problems of the NHS.

A second contribution the thesis seeks to make is offering fieldwork data focusing on the process of managing change and specifically on how general management was implemented over some four years at district level in the NHS. Chapters 6, 7 and 8 convey the findings in this respect. To summarize the findings, it was found that despite the confident rhetoric of the Griffiths Report, the DGMs in this sample were very uncertain about their role, spending most of their time designing new organizational structures and exploring what general management actually meant in practice. The uncertainty as to the scope of the DGMs' role and their managerial task may be partly explained in terms of DGMs struggling with varying degrees of success, to understand the complexities of the figuration of which they were now a part.

The uncertainty which the DGMs experienced is not surprising, given that the DGM role was a new one and, as such, those who filled the role had to establish the boundaries of the role and their own credibility. This situation was not helped by

the lack of detail in the Griffiths Report. The advice given to general managers consisted of harnessing the best of consensus management and avoiding the worst problems it presented. Comments from the sample suggested that the background of the DGM was an important variable in helping to explain how individual members of the sample sought to cope with uncertainty. The tendency for people to fall back on more comforting, familiar ways of seeing the world when faced with uncertainty has been documented in the medical sociology literature which deals with illness behaviour and the doctor-patient relationship, and was also of relevance in explaining the behaviour of DGMs in this study. This highlights another problem with the Griffiths analysis of managing health services. It assumed NHS managers do not have a past that might influence not only the way they interpret the requirements of the new role, but what priorities they chose to pursue. General managers are not free-floating individuals. Like all people, they have a history, they grow up within complex figurations of social relationships and these have an enduring impact on the way they view the world.

Interestingly, the individual DGM's initial statements about their objectives echoed the key themes of the Griffiths critique. Conspicuous by their absence are statements, in either the documents DGMs produced or in their interviews, about what might be considered the real object of better management - namely to improve health services or health.

A striking feature of the second, third and fourth year of the job was how much time the sample DGMs spent dealing with district management issues (the relationship between district directors and UGMs and the role of these people in relation to strategy or managing operations) and dealing with issues generated by the Centre, often elaborated through region. Less time was spent on issues to do with the DHA, the main vehicle to ensure that local health services were accountable to



the local community. Significantly more time was spent on the relationships with doctors (in terms of dealing with the consequences of doctors' activities) than nurses or with the array of community groups one finds associated with local health services. Chapter 7 presented a great deal of largely descriptive data focusing on these relationships and the efforts the sample DGMs made to improve the quality of the local health services. It also documented what the sample DGMs said about the accomplishments of general management and their disappointments about the change. Briefly, most of the DGM sample and other people interviewed in the district (see Chapter 5 for details) believed that general management had not meant significant changes in the delivery of services or the improvement of patient-care. We know, of course, that health services are but one of many influences on health status, but it is important to emphasise that there is no evidence to suggest, nor any reason to suppose, that managerial changes have affected patterns of service or medical outcomes (see Whitehead, 1992).

In order to tease out why general management seemed not to have achieved significant change, I found it useful to draw upon Elias's game models which are outlined in the first part of Chapter 7. Game models are sensitising models. If one maps the complex social relationships of which the DGM is a part, it is possible to see the complexity of the figuration in which the DGM is involved. An obvious point to make is that individual DGMs are situated in different figurations, with some actors being more powerful in some districts than in others. The figuration of interdependent players is the framework for the game. Simply put, it is the existence of other players which serves to muddy the rules of the game for the general manager. Particularly powerful in this respect are the government, the medical profession and the press. Doctors and their professional bodies have a wide array of powerful arguments that can be marshalled to counter health policy and priorities for health services, for example, those concerned with increasing

community care and preventive health services, and reducing acute services. Doctors may cite individual cases where a patient has not been able to have access to expensive treatment because of inadequate health care budgets, or they may publicise the existence of advanced medical technology that could have prolonged a patient's life if only the funds had been made available. Such arguments have a significant emotional impact and are beloved of the press who, in narrating such cases, stir up local communities and MPs to bring individual cases to the attention of Parliament and, in so doing, may scupper a district's spending plans geared towards meeting the evolving health needs of the district population. Health interest groups also lobby government and use the press to influence policy. This dynamic at the higher-tier has profound effects on district management and on the web of social relationships within the district. It means that planning and issues of strategy are open to compromise at any time. It also means that managing change is vastly more difficult. Another profound higher-tier influence on district management is the time-honoured tradition of changing either funding projections for health care or some aspect of health policy in order to win the support of voters as a general election looms large, and again the press - a game player almost wholly beyond the control of local health service managers - are centrally involved.

The game models discussion in Chapters 7 and 8 add weight to a central point made during the review of the existing empirical studies of local management of health services, namely that it is not possible to explain the actions, plans and aims of people if they are conceptualised as freely-chosen decisions, plans and aims of each person or group considered on their own, independently of other people. An adequate explanation requires, at a minimum, that investigators consider the constraint each group exerts upon others by reason of their interdependence.

The discussion of the data in Chapters 7 and 8, drawing on a figurational or process sociological perspective, highlights the importance of considering the implementation of general management, not as a wholly rational process - as most models of management would suggest - but as a complex social process involving emotional resistances to be overcome and an interweaving of the actions of many different groups in such a way that the outcome may not be one which was intended by any group. In fact the empirical data suggest several unplanned outcomes of the Griffiths changes and in some cases, these outcomes were the very reverse of what was intended.

Firstly, there appears to have been a trend towards greater centralisation of power within the health service, accompanied by increased bureaucracy, a proliferation of policy objectives and a shrinkage of resources, all of which served to curtail the freedom of the district to meet the needs of its local population.

Secondly, there seems to be more, rather than less, confusion in terms of accountability structures in the NHS. At the beginning of their appointments, general managers were extremely clear that they were accountable to their DHA and, through them, to the community. The data in this chapter suggest that in practice, three channels of accountability weighed heavily on the DGMs: (1) The Secretary of State, regional chair and district chair; (2) DHSS, RHA, DHAs and (3) The management board and RGM. These three channels combined to obscure general management's accountability to the public and also led them to play down, in relative terms, the importance of nurses, trade unions and other local groups.

Thirdly, within districts, very different models existed of district/unit relationships. DGMs differed in their views of their leadership role and the place of professional advice in the implementation of the general management change agenda.



Fourthly, the status and power of the nursing profession appears to have declined. Nurses were often given quality assurance roles which were frequently seen as 'non' jobs, and this reduced their credibility in shaping policy decisions.

Fifthly, because general management was introduced at a time when the government, led by Margaret Thatcher, was seeking dramatically to reduce public expenditure, general management and cuts became inextricably linked such that notions of improving the management process were greeted cynically.

Sixthly doctors, as an established and powerful group in the NHS, united against the introduction of general management and saw it as a tool of government to undermine the NHS. They did not flock to take up general management posts as government had hoped and were deeply suspicious of general management as a vehicle to improve health services. They did not see themselves as 'natural managers' as Griffiths believed would be the case.

Seventhly, improvements in quality mainly took the form of improvements in hotel services, rather than improvements in the quality of medical care. In part, this was because improvements in the former did not involve managers in challenging the power of clinicians, and in part, it was because improvements in the former were easier to measure and could be taken as an indication of managerial "success".

Finally, more or less independent groups within the NHS become more interdependent. This situation occurred partly as a result of a general management system replacing the old functional professional hierarchies and partly because static resources, numerous new priorities for health care, an increase in monitoring and

poor information meant there had to be more dialogue between groups if a health service was to be provided at all.

The existence of such unplanned outcomes should not be a surprise since our knowledge of the figurations of which we are a part is virtually always imperfect and, to a greater or lesser degree, inaccurate. Therefore, strategies of action based on this inadequate knowledge, almost inevitably have consequences which we do not foresee. Unplanned outcomes in Elias's terms, or what Merton called unanticipated consequences are not, therefore, a curious effect of unusual situations, but should be seen as a normal aspect of social life.

A final contribution the thesis seeks to make is in the discussion of the research process. Chapter 5, where this is located, is not a conventional review of methodology, but seeks to recall the complexities of working on an action research project. It therefore attempts not to reiterate the advice one can find in numerous methodology text books, but puts forward some of the lessons I drew in carrying out research. It is hoped that this is not merely of autobiographical interest, but that it does address a number of problems commonly associated with action research.

### The future NHS

During the writing of this thesis, the NHS was reviewed for the fourth time. The review, led by Margaret Thatcher, the then prime minister, reported in January 1989. Essentially the proposal separated responsibilities for funding and providing health services, as well as providing sharper definitions of the role of each level of the service - national, regional, district and unit. At national level, the policy board and the management executive were to deal with national, strategic and policy matters and setting the service and management priorities of the NHS. At the

regional level, RHAs were to concentrate on the core strategic functions of planning, resource allocation and performance review, with the key role of managing the changes set out in the White Paper. At district level, the DHAs were to identify the health needs of their resident populations, and buy in the services necessary to meet those needs. Finally, at unit level, hospitals were to provide through contracts on management budgets, high quality, cost effective services to patients from wherever referred.

A number of themes of the White Paper were common to the Griffiths Report. These included the delegation of functions from regions to districts and from districts to units; the involvement in management of hospital consultants and ensuring clinicians use resources more effectively and increased effort to audit the effectiveness and quality of medical care. However, there were some significantly different and new proposals to improve the management of health services, specifically those enabling hospitals to apply for new self-governing status within the NHS. Self-governing status enabled hospitals to have a degree of autonomy which would allow them to earn revenue from the provision of health services (service contracts were to be the main source of revenue), to determine the pay and conditions of their own staff, and to acquire and dispose of assets and to borrow capital within agreed limits. These trusts were to be run by small boards of management operating like a board of directors with up to five executive and five non-executive directors and a chair appointed by the Secretary of State.

A significantly different development was the change in the role of GPs. Large GP practices above 11,000 patients were able to apply for their own NHS budgets, covering the purchase of a defined range of services direct from hospitals, including elective surgical inpatient care, outpatient services, day-case treatment and diagnostic tests. The remuneration system for GPs was changed, such that various



incentives were offered for what was seen as improved performance. The region and DHAs were to be reduced in size and reformed along business lines with five non-executive directors (chosen for their personal involvement and representative contributions) and five executive directors including the general manager as chief executive.

Family practitioner committees were to be accountable to RHAs reformed in the same way as DHAs, with a substantial reduction in professional membership (from 15 to 4) and the new chief executive attracting a salary significantly lower than the family practitioner committee administrators.

At the heart of the reforms was the new funding system. The RAWP formula was replaced by a simpler population-based funding system for regions and districts. The intention was to shift from a system biased to reflect historical patterns of service provision to a system giving authorities a fairer share of national resources relative to their resident population. The direct funding of hospitals and community services was replaced by a system based on management budgets and enforceable contracts, specifying the nature and level of service provided (including quality standards) and the basis on which costs were to be reimbursed.

A striking feature of the White Paper is its studied innocence or forgetfulness as far as NHS history is concerned. It is not appropriate to dwell on the latest reorganization of the health service, except to say that the reforms will further increase the complexity of NHS management. The research agenda is large and interesting. Some of the ideas put forward in this thesis may be of use to those of us attempting to contribute to ongoing debates about health care and, in particular, to ensuring that debates usefully feed into what most medical sociologists would hold to be the ultimate goal of health services - improving health.

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PERSONAL  
CONTACTS

ISSUES

MODE (please tick)

(if none, please leave blank)	(Brief headings)	By Tel.?	Met in Your Office	Met at Your Request?	Planned?	
						8.0
						9.0
						10.0
						11.0
						12.0
						1.0
						2.0
						3.0
						4.0
						5.0
						6.0
						7.0
						8.0

Ask Number :  
(please leave blank)



[NOTE FOR INTERVIEWER – WATCH FOR SPECIFICALLY DA QUESTIONS IN INTERVIEW]

## REVISED QUESTIONS FOR DGMS

Do you have any questions about the research?

### PERSONAL BACKGROUND

When did you officially start in the post?

Did you start doing any work before then? If so, when?

Did you start doing any planning before then? If so, when?

Previous career [if outsider probe for previous contact or familiarity with NHS].

Time in district.

What motivated you to apply for the DGM's job?

### PERSONAL ACTIVITIES

How have you been spending your time since you took up the job?

Has that changed since you started? If so, when, how and why?

What takes most time at present?

[For DAs – what are the main differences from what you were doing before?]

What have you been trying to find out? – have you been doing so? How satisfied are you?

What are you still doing that belongs to your previous job?

### CONTACTS

Now about the main people whom you have to, or could work with.

What role does the chairman play? What do you do together? What does he/she do on their own? In what ways is he/she helpful? a constraint? a concern?

Do you spend time with other DHA members outside meetings? If so who? When and why?

In what ways have the DHA affected what you do? Do you have a strategy/guidelines for handling your relationship with them?

How much contact with RGM? How do you view this relationship? Other contacts with Region?

Which of the chief officers are you spending most time with?  
Why?

[Where relevant] Are you spending more or less time with them  
than before you become DGM?

Do you see any of them as being especially important to achieving  
your objectives?

Which group of staff have you been spending most time with?  
Doctors? Nurses? Admin? Others? Why?

Which external people have you been seeing? Social Services?  
CHC? TU officials? Press? Other DGMs? Others?

### OTHERS EXPECTATIONS OF YOU

Have you been given any objectives? If so, what are they? When  
and how were you given them?

What are the main expectations held of you? By whom?

Do any of these expectations conflict? [Chairman, Region, Senior  
Officials, Clinicians, Other]

### PERSONAL OBJECTIVES, PRIORITIES, GUIDELINES

Do you know what you want to achieve during your contract?

During your first year?

Have you set yourself any definitive objectives? Target dates?

Do you have any personal guidelines or assumptions in thinking  
about what you should do? (i.e. What to do or not to do as a  
general manager [Probe for their rationale])

What are your priorities, and why?

What do you feel sure about?

What are your major uncertainties?

In general, how clear do you feel about what you want to do?

## DISTRICT

Can we start by asking a few questions about the district, although I shall leave you with a short questionnaire that I would like you to get filled in and return.

What are the characteristics of the district that affect your job?

Are there any that have a special influence on the job of the DGM?

What are the district's major problems?

## CHANGES MADE AND PLANNED

Where have you got to on the structure?

What changes are made in it and why?

Do you still have a DMT? If so, are there any changes?

Are there likely to be changes in the number of units?

What are looking for in UGMs? How and from where do you expect them to be appointed?

Will they be on the management board/DMT? Why? or Why not?

What are the main issues about the UGMs? Any concerns?

What will be left at district level?

Are you currently working on any other changes? If so, what?

Why did you choose that/those?

Do you see yourself as selling change? To whom?

Who? What? is/are most likely to constrain what you want to do?

[Where relevant] Do you see the DGM's job as in part a continuation of what you were doing before? In what ways?

What constraints do the higher levels of the Service impose on you? Does your Region impose any particular constraints?

What are the major constraints?

What is the main difference that having the job has made to you?

Do you expect your job to get easier? OR easier in some ways - harder in others? [Probe]



## EXPERIENCES SO FAR AND LEARNING

What has surprised you?

What has gone well? Why do you think that is?

What has not gone well? Why do you think that is?

What have you learnt since you were in the job? What do you think you still need to learn?

Have you felt any need for help? If yes, what kind?

Who/what has helped?

Have there been occasions when you were particularly conscious of being the DGM? Examples?

## CONSTRAINTS

What constraints do the higher levels of the Service impose on you? does your Region impose any particular constraints?

What are the major constraints?

What is the main difference that having the job has made to you?

Do you expect your job to get easier? OR easier in some ways – harder in others? [Probe]

What is the main difference that having the job has made to you?

Do you expect your job to get easier? OR easier in some ways – harder in others? [Probe]

## ASSESSING EFFECTIVENESS

How do you expect others to assess your effectiveness?

Do you know how you will assess it yourself?

When do you think a judgment can begin to be made?

## THE RESEARCH

What do you hope to get out of it?

Discuss details of future contacts

## LEARNING TO BE A DISTRICT GENERAL MANAGER

Rosemary Stewart and Peter Smith

This article is one of the first coming from an action research project, which is tracing the aims, views and activities of twenty District General Managers over two years. It is funded by NHSTA and has as one of its major aims to understand the nature of the DGM's job and the learning needs of present and future DGMs. The research is based at Templeton College, the Oxford Centre for Management Studies, and is directed by Rosemary Stewart. John Gabbay and Sue Wyatt, the two full-time research associates, started in May 1985. Derek Williams is consultant to the project and Peter Smith is a part-time member of the research team.

The sample of DGMs was stratified by region, type of district and occupational background, including at least two General Managers from the different career backgrounds found amongst DGMs. This enables us to compare what the DGMs from these different backgrounds said they had been learning and what they felt they still needed to learn. A comparison of how the DGMs said they were tackling their jobs, and of the problems that they met, also suggested other learning needs.

An account of how the DGMs are learning to handle their new jobs should be helpful for present and future DGMs. It will also offer some guidelines to other managers taking up another job, particularly UGMs, and to those in management development who want to know what they can do to help.

Any manager starting a job has to learn in what ways the job differs from his or her previous one. Such learning takes time as different aspects of the job become clearer, the individual discovers the demands of the job, the nature of the constraints and recognises at least some of the available choices. The new job holder discovers, too, what adaptations he or she needs to make to the behaviour that was effective in the previous job. What has to be learnt, and how long it takes, will vary with the individual's preferred methods of learning and with how radical is the change of job. In a radically different job, managers are likely to see that they must learn. Where the change is less radical, the need to learn will be less, but it may not be recognised.

Our sample of DGMs differed in the following respects that affected their learning:

- (1) the relevance of their previous training and experience to understanding the job of DGM;
- (2) what and how their previous experience had taught them to learn;
- (3) whether they saw a need to learn and what they felt they should learn;
- (4) how great was the stimulus to learn posed by the new job.
- (5) their own preferred method of learning. David Kolb provides one model for identifying learning styles. He distinguishes four kinds: concrete experience, reflective observation, abstract conceptualisation,

and active experimentation. Learners, he says, should use all four, but may in practice, primarily use only one or two.

### What DGMs had to Learn

One can distinguish the following types of learning required for the job. A particular DGM would need to learn one or more of the following:

- (1) to take an organizational view rather than that of a particular profession or function;
- (2) to accept overall responsibility and the isolation that many General Managers feel that brings; particularly for DAs;
- (3) the differences in their ability to influence the various professional groups;
- (4) how to manage; the skills and knowledge required in any senior management job, which includes establishing working relations with all those on whom the DGM must depend;
- (5) for those recruited from within the Service, the 'insiders', to understand the parts of the Service that they knew too little about before;
- (6) for those recruited from outside the Service, the 'outsiders', to understand the working of the NHS including its culture and internal politics, and the kinds of uncertainty to which it is subject;
- (7) for insiders who move districts and for outsiders to understand the characteristics of that district.

The Insiders: Most commented on the responsibility and isolation (the second point above) and on the difficulties they found, and for some also the pain that came from the separation that they felt from their former fellow team members. They had to learn how staff's perception of them had changed with the new role. Only a few referred to the need to learn more about the NHS, the workings of other parts of the Service or about the district. One commented that he found that he was much less of a generalist than he\* had thought; another that he thought that understanding the nature of being a general manager was a gradual process.

Most of the learning described by the insiders, and what they felt that they still needed to learn, came under the fourth point, that is managerial knowledge and skills. It included how to: understand and manage other people whether subordinates or not; handle changed relationships; vary their management style; become more decisive and in new areas for them; and be more outgoing and better at public relations. This suggests that some of the training that could help general managers is common to most management jobs in any organisation. Some of it is learning that in many organizations would occur earlier in a manager's career.

The Outsiders: Their prime need was to learn about the NHS and their district and how it worked. They did not mention managerial learning

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\* 'He is used in all the examples because to use 'she' when female DGMs are a small minority, is to make the example too easily identifiable.



probably because they thought that their previous career had taught them the necessary managerial skills and knowledge.

It took the outsiders about six months to feel that they had a working understanding of the job, though its boundaries were still obscure. Some of the learning was painful: that things move so slowly in the NHS and one is constrained in trying to change this; that the information available is poor; that compartmentalised professionalism is rife, that there is no such thing as confidential information and that the GM role and their individual authority is far more constrained than in industry. The outsiders' perceptions of the Service seemed to have more similarities than that of the insiders whose variety of views of what needed changing seemed only partly related to their professional background.

### How the DGMs Learnt

The DGMs learnt in the following ways:

- on the job in an unplanned way often as a result of being surprised when people reacted in a different way from their expectations. All managers in a new job will learn in this way though some of the learning will probably be unconscious and so cannot be described to the researcher;
- on the job in a planned way;
- by taking time for induction while another officer was the acting GM;
- by visiting other districts and other countries;
- by finding someone who acted as a counsellor;
- by attending learning events with other DGMs;
- by attending external management training programmes;
- by joining the research project.

The main way in which DGMs tried to organize their own learning on the job was by visiting and by arranging discussions with particular groups of staff. Two of those with an armed services background, who had always been expected to visit their units, made much use of visits both as a way of learning about the people, jobs and problems in their district, and as a way of getting themselves known. One of them commented that in any army posting of three years he would have expected to spend one year visiting. One did this in a very organized way to ensure that he covered all the localities and types of staff in his large district. So did a few of the insiders, particularly where they had moved districts.

Learning to understand other people's viewpoints was, and is, a concern for many of our DGMs. A number of them used special ways of trying to do so in addition to the normal meetings and consultations. One had 150 systematic individual discussions with members of staff. When he was new in the DGM job, a former administrator talked individually with about fifty consultants and senior managers around the district to learn their views. Another has, more recently, spent half a day with each of several consultants and GPs observing them at work. His aim was to get a better

understanding of their work and of how it looks through their eyes. Doing this also gave him, he said, another perspective on how the organization works. Readers of the HSSJ may remember an article in the issue of 2 January describing how the DGM from North Devon, (not in our sample), who spent time with many different kinds of staff, participating in their work when he could.

Visiting was used by some DGMs as a purposeful, rather than an incidental, way of finding out what staff are thinking, what morale is like and of tapping skills and ideas. One of the consultants eats in different canteens with nurses and ancillary staff as one way of doing so. Another DGM, who is from industry, has established an under-thirties group with whom he meets periodically to hear what they think. Yet another has run five, large lunch-time seminars to hear staff views and concerns about the reorganisation.

A DGM from industry had a formal meeting with each of his senior staff shortly after his appointment, sending them in advance some searching questions about their job. This method helped him to learn both about their jobs and their approach to them as well as indicating, by the questions, some of his own expectations.

Some DGMs felt the need for someone whom they could turn to for counsel. Three of the DGMs used an external adviser on an ongoing basis. Two of them consulted a member of staff of health education centres. The third used two former colleagues as gurus. Some of the other DGMs used a colleague or the Chairman as a counsellor.

Ten of the sample had attended, and often were still attending, one of the NHSTA sponsored programmes for general managers. This number cannot be taken as necessarily representative of the proportion of DGMs attending such events as our sample was selected to include more of the DGMs from a minority background and started with four members of a Templeton DGM programme. Some of the DGMs had also gone to other NHS learning events on general management. Since their appointment only one had attended a public management programme for those from other organisations, although a few hoped to do so later. Two of the sample had gone on a study tour overseas. A few visited other districts to learn about particular developments there.

Two of the sample, one insider and one outsider, said that they felt no need for outside help in their learning and so had attended no learning events and consulted no external adviser. Two others described learning needs but did not attend any programmes nor use an external adviser. Several have said that they find participation in the research project useful in providing an opportunity to talk about and to reflect on what they are doing.

### Implications for Management Development

For Teachers and Training Officers: Our study of the twenty DGMs, if teachers and training officers are to help others to learn about general management already general managers, they should recognise the need to:

- Understand the nature of general management jobs at the different levels in the Service;



- Understand the particular needs of those with different career backgrounds;
- Help individuals to recognise what they need to learn and how to manage their learning;
- Understand, and seek to use the different opportunities that can be provided to help learning.

Our research project is seeking to contribute to the knowledge of the first two, which is necessarily incomplete at this early stage of general management in the NHS. Unless teachers recognise the need for this knowledge they are likely to provide help that is too generalised and hence unsuited to some DGMs and potential DGMs. A mentor may be particularly useful in helping individuals with an unusual career background.

Most teachers of managers will have recognised that only some want to learn because only some recognise that there is anything they need to learn. This seemed to be true for a small number of our DGMs. The pressures of their new role also gave them little opportunity, if they were not that way inclined, to think about what they might need to learn, or to reflect upon what was happening in their new role. Further, as one DGM said he did not know what questions he ought to be asking, that is he knew that he was unaware of some of his areas of ignorance. It should be the task of teachers of future general managers to identify what those from different backgrounds need to learn. Future DGMs should, and can be better prepared.

The easiest area for educationists to take action now is the fourth point, that is of encouraging the provision of different opportunities for learning. It is tempting for many training officers to think mainly in terms of development off the job, whether by courses, workshops, or action learning groups rather than of what can be done to facilitate learning on the job. Some of the examples given earlier illustrate different ways of learning on the job. Another, that was not available to the first DGMs, but which can be an important source of learning, is having an opportunity to observe someone else in the job. A role model, whether positive or negative, can be helpful.

One way of learning, which some DGMs showed great interest in, is from other DGMs with different backgrounds. Some of the insiders were keen to hear the impressions of the outsiders and some of the latter saw the insiders as a valuable source of information. Opportunities for cross-fertilisation of backgrounds should be exploited, both between insiders and outsiders and between insiders from different professional backgrounds.

The development that some DGMs need, the outsiders and the non-administrative insiders especially, is not just management development in the narrow sense. It is learning to understand the new environment within which they are working, which includes an appreciation for outsiders of the history, culture and internal politics of the NHS, and probably for all DGMs a better understanding of the practices and values of the different professions making up the health service.

### For DGMs and Educators

Learning for some of the DGMs was uncomfortable, for a minority it was painful. One of the insider DGMs who recognised the greatest need to



learn to change his behaviour found that behaviour that had been applauded in previous jobs now produce strong adverse reactions. Some of the DGMs reported no discomfort, yet that is probably necessary for learning. It seemed hardest for some of the insiders in the same district to recognise that the new role required unlearning previous patterns of work and ways of thinking. It was hard for some of them to let go of their previous work.

A potential problem for insiders was their familiarity with the complexity of the district, which made it harder for them than for the outsiders to see clearly some of the major problems that should be tackled, and to believe that they could be tackled. They knew too well the problems and the personalities and could be too sensitive to what had happened in the past. They, and future general managers from the inside, need help to transcend their professional background and get a broader and fresher view on the districts work. The methods used in many large companies of lateral moves and broadening programmes with managers from other organisations would also benefit future general managers in the NHS.

## THE TRACER STUDY – A POSITION PAPER

### May 24th

#### For consideration at the June research meeting

This paper aims to take stock of our research so far, of what is required of us, and of how we might make the best use of our results and resources to produce the best and most useful outcome from the project.

#### Taking Stock

The most obvious point about our research so far is the great richness of raw data that we have been accumulating, but also the fact that this richness has not been converted into the output of research results. We have all put great efforts into establishing good rapport with our DGMs, and spend a good deal of time talking to them and producing lengthy descriptive reports that cover a very broad area, and contain much interesting material. However, the very breadth and interest of the material, and the great differences between the DGMs and their districts mean that comparative analyses inevitably filter out most of the richness. Furthermore, (and this was made very apparent in our discussions with Fred Fiedler) the form of our data is such that valid comparisons are very difficult to substantiate, and in the end are vague, subjective and often fairly vacuous.

It's notable that the most interesting results we have produced have not resulted directly from the bulk of the research process. Or if it has, a lot of effort has gone into separating the wheat from the vast quantities of fascinating but not directly relevant chaff. The work on the DGM/UGM relationship, on the DHA and on the board meetings is beginning to get to grips with concrete issues, and of course could not have been achieved without the enormous effort that has gone into understanding our DGMs and their developing roles. But information about such concrete issues could now, against the background of that hard won harvest, probably be achieved much more efficiently by different methods in the future.

Gathering a broad array of material has become almost an end in itself. Certainly in terms of the time which is allocated to that process, it dominates the research. Presently the researchers produce long reports which are, when it comes down to it, all read only by Rosemary. It's frustrating that we don't have time to read each other's reports; and it's a pity we can't do more therefore to supplement Rosemary's analyses.

It has been essential to do the spade work of producing such reports, which has been a necessary foundation for anything else that we do. But were we to continue in the same way, there would be little time left to build on those foundations. A moment's calculation and reflection will show why this is so. A brief audit of the time that Sue and John spend on producing interview reports has shown that in fact each quarterly interview takes up about 3 and a half days' work in total (including travel, interview, transcription, dictation, checking, indexing and summarizing) – not to mention Val's time too. Each telephone report takes up between a third and a half a day in total. That works out, surprisingly perhaps, to our spending between 2/3 and 3/4 of our time on the production of that raw data alone. In addition to that there have been the chairmen's interviews and the observation sessions which are equivalent to about 2 extra

quarterly interviews over the past quarter or so. If one adds to this the time spent in research meetings, and in preparing briefing papers and other documents, it is little wonder that the researchers feel unable to contribute significantly to the analysis of the data, or the pursuit of research ideas and hypotheses. It is not a job with a lot of scope for choice!!

Even were the data that we are producing to be all highly relevant to the analyses that are required of us, that would be a poor distribution of our time and effort. Given that much of that data is in fact a scanning process, inevitably discarded as we produce research results, then it must clearly be absurd for that situation to continue.

That is not to say that the work which has taken place so far has been anything but absolutely essential as a means of understanding our sample, and the nature of the problems that they face. Our system of quarterly interviews has been important as a means of scanning for differences and developments in the demands, choices and constraints of our DGMs, and for exploring – it must be said, fairly superficially and loosely – their networks, agenda, learning needs, etc. It is notable, for example, that the first two pages of the 6–page interview schedule tend to take up some 3/4 of the time spent at interview, and this tends to be mainly about their activities and their contacts. Therefore, we now understand those aspects of their work well, but it is difficult to see how to translate that into useful or penetrating analyses of specific issues, or of learning needs. But we are surely required to concentrate our efforts on analysing important issues, and assessing learning needs in those issues; we must therefore shift our resources into those areas, and spend less time in the broad and general scanning which is yielding diminishing returns. We cannot afford to let the gathering of data about activities, contacts and the issues with which DGMs become involved become a self–serving process, a treadmill that uses most of our energy, but gets us little further on.

### Why Change?

There are two sets of reasons for proposing major development in the work of our project.

Firstly, there are the pointers that emerge from the above reflections on the work so far.

Secondly, as the pace of change in the districts slows down, there are rapidly diminishing returns from our present data gathering methods.

Thirdly, there is the ever clearer requirement from the NHSTA that we focus our research on to a set of specific topics that will provide useable and useful material for the training and development of DGMs, rather than continue a more general study of DGMs. Since we don't have the resources to do both, we should pursue the former (the specific topics) with greater vigour, and make a good job of them.

### Where next?

Let's start by considering the resources we now have. We have a large data base. Its chief use is the insight which it has given us into the similarities and differences between the DGMs as people doing jobs with different demands and constraints. It does not lend itself to rigorous analysis, nor to the testing of hypotheses, nor to the in depth pursuit of



the issues raised. It is a starting point, literally a base, and to continue in its accumulation would be to lead us away from making productive use of the data we have, and the resources which we have available to us over the next year.

We have willing and industrious researchers (!) bringing many different perspectives and brimming with ideas for potential analysis if only they had the time and space in which to do that.

We have 20 varied and interesting managers who are committed to the project and willing to help develop ideas. And we have a rapport and established system of setting time aside for interviews.

Perhaps the time has now come to make more imaginative use of those resources.

It is probably no accident that the more interesting papers we have produced have come from projects where we have specifically asked DGMs to explore certain themes with us (the flavour of the month topics). Nor is it any accident that those ideas have emerged at some of our most productive research meetings where we gave bounced ideas around together freely from our different perspectives. Surely this demonstrates that there should be more of that kind of interactive approach to the research, and that it should now take priority.

The research should be more interactive. We need a more dynamic interaction between (a) the ideas and the data-gathering, (b) the researchers and the DGMs and finally (c) the researchers themselves. By freeing up the research methodology from the time-consuming and current fairly rigid demands and constraints, we would be able to pursue more questions in more depth. The drawback, of course, would be more risk-taking and a loss of that comfort to be gained from always having familiar questions to fall back on in interviews. Those disadvantages of breaking out from the current mould would probably be largely offset by more frequent exchange of ideas between the researchers, and a more rigorous and searching approach to the ideas that researchers may be developing. Moreover, there are signs that the DGMs are becoming rather bored with our repetitive approach, and that we may lose their commitment, or at best begin to elicit stock answers to stock questions.

The new pattern might look something like this:

At a series of major "planning meetings" (of which the June meeting might be the first) we develop several lines of enquiry to be pursued over the next few months. We also (exactly as in our flavour of the month discussions before) produce sets of questions and criteria for analysis. One member of the team is then given responsibility for carrying out that part of the analysis (beginning with a review of our present data-base), and for ensuring that further appropriate relevant data is made available in a form that he or she needs. The researcher is given responsibility, in other words, for managing that "sub project", for producing work suitable for dissemination by a given target date, and for keeping colleagues fully informed of progress.

Under this new scheme of things, a minimum of time will be spent scanning for new issues, and for the changing pattern of work and contacts amongst the sample. Interviews, research discussions and written

communications between the researchers, would be heavily biased in favour of the ideas developing in each of the "sub projects".

We would need to think through the question of how to keep up with new developments and changes in the jobs, without that process becoming the sludge-gulping exercise it currently is. A new method of feeding back results and communicating and co-ordinating our findings will be needed. Certainly we will need to be more disciplined about rapidly communicating the nub of our findings to each other, which despite all our efforts, is simply not happening at the moment.

It is important that the researchers all think through the implications of this position paper, and decide whether they agree that this new thrust will be the best way to proceed. If we do agree on the new pattern of doing research, then the next section "Possible themes for exploration" is tentatively put forward as a basis for exploring together how we might structure the research ideas.

## POSSIBLE THEMES FOR EXPLORATION

It would probably be most useful for us to look at the outcome of the new management, rather than concentrate so much on the processes. The Griffiths report gives us several clear goals that the new management in the health service is supposed to be achieving. Our research has shown us both the mechanisms whereby the DGMs are trying to achieve those goals, and also the roles that the DGMs are playing in manipulating those mechanisms. We have, then, a triad of aims, mechanisms and roles.

**THE AIMS** may be listed as follows:

**A - Improving staff involvement in managing the service:**

1) fuller, clearer involvement of all staff in the management process,  
e.g.

- involving clinicians
- breaking down professional compartmentalisation
- staff development

**B - Sharpening up the management process:**

2) Clearer responsibility/objectives/appraisal/performance review and accountability

3) Fuller devolution of decision making/responsibility

4) Improving systems for information, finance and for health and health care evaluation

## 5) Facilitating the management of change

- debureaucratisation
- more proactive management
- enacting national policies (e.g. community care)



**C** – Improving public involvement/participation:

- 6) Better awareness of public/consumer needs and demands
- 7) More appropriate accountability to/consultation with the public (CHCs/press/?TUs)
- 8) better involvement of/accountability to the chairman and health authority
- 9) better quality assurance/marketing/pr

**D** – Sharpening up performance:

- 10) Improved performance/quality
- 11) Improved efficiency/cost initiatives

THE MECHANISMS include: the chairman and members, the officer/directors (planning, information, finance, personnel, quality assurance unit managers, community medicine, works, etc.), the clinicians, the nurses and other professionals, the "public" (e.g. the CHC, the press, the unions), other services such as the local authority, the FPC, community health, etc., the whole process of information gathering, (e.g. by "walking about" and by reading reports), and other mechanisms such as objective-setting, the review process, the new district management meetings, and the planning and finance systems.

THE ROLES that the DGMs have been developing in their interaction with and use of those mechanisms have been becoming increasingly clear from our research reports so far.

Putting all these together one can come up with a list of key aims or tasks which all our DGMs should have been working on to some extent. That would include many of the "Griffiths aims" listed above. If we were to pursue each of those, asking how the DGM has set about achieving them, and evaluating their success or failure, and what they may have learned or needed to learn from that process, then we would be a long way towards producing a number of useful research reports about what the new management is achieving, and about the learning needs.

Although there is the slight disadvantage that we would, in basing our "aims" on Griffiths implementation, be focusing on a 'one off event', this is offset by two things. First, we would be examining a set of aims that all DGMs are facing, whatever their local circumstances (here, indeed, is the "circular" we've been looking for!!). Second, it will help in the evaluation of Griffiths implementation – which will be a hot issue soon for the NHS.

It is on the basis that we have suggested a series of questions that we might ask for each of the aims and that might replace the current standard quarterly interview (and possibly a good deal of the time spent on the phone with our DGMs and allow us to make more efficient use of research time, as suggested above.)



(N.B. The person in charge of a 'sub project' would manage the relevant data gathering, but not necessarily carry it out. We would probably still in the main continue with our own districts.)

This new methodology also gets us round long-standing set of misgivings that have beset the project, namely the worry that we are not getting enough validatory angles on what is happening. If, for example, one of us is looking at the ways in which DGMs have been involving clinicians more effectively in the management process, then it will be perfectly clear that questions about that cannot be answered without talking to at least some clinicians. It will also become clearer what information we will need from those people; and the most appropriate way of finding out (be it questionnaire, telephone interview, observation, or group interview during a visit, etc.) will be addressed during the research meetings, and taken forward by the person responsible for that sub project. The fact that these triangulation measures will therefore be goal-directed, and not yet more scanning, will make them short, sharp and to the point; they will therefore be much more likely to be carried out properly in the time we have available.

Naturally, we also feel that the interaction with the DGMs, and indeed the whole research process, will be sharpened up and more to the point. And it will be more in line with our remit from NHSTA. Indeed, looking at the list of key areas required by Griffiths, it seems as though our new proposals will themselves be much more in line with the new management ethos! To parody slightly the "Aims" above: there will be fuller, clearer involvement of the researchers in the research process, clearer accountability and responsibility, with better performance appraisal and review; better devolution of responsibility and decision-making; improved systems for information-gathering; a less bureaucratic and reactive approach to the research; more awareness and reflection of our consumer needs (as emphasised at the steering committee), more interaction with our DGMs (and possibly our target audience, such as NECs); improved quality of research output; and last, but not least, a much more cost-effective and efficient research process.

In short the major difference that we are proposing is that in future the questions that we ask (many of which are already asked generally in the quarterly interviews) should be structured around a number of topics (sub projects) which the team has decided to pursue, and for each of which one researcher has assumed overall responsibility. The research therefore becomes a goal-directed interactive dialogue between researchers and sample members, and communications largely take the form of the development and testing of ideas and hypotheses related to those sub projects. We shift the balance, in other words, from empiricism to hypothetico-deductivism.

SC28.8

TEMPLETON STUDY OF DISTRICT GENERAL MANAGERS

## PUTTING THE RESEARCH INTO ACTION

This paper describes how we plan to fulfill the action research requirements. We are now at the stage where we can define which aspects of the DGM's job to study more intensively and suggest how best to disseminate the results of these studies.

In the research, as it has developed, we are trying to do three things:

1. To understand the nature of the DGM's job so as to draw lessons for the selection, appraisal and training of general managers. The first results of this work were used in the report to NHSTA on Learning Needs.

2. Identify the different approaches to the job and their strengths and weaknesses so as to draw lessons for selection, appraisal and training of future general managers. This has been partially done and a few of these lessons were included in the report to NHSTA. Our current perceptions will need checking against future developments and in selected districts by interviews with the role set.

3. Identify particular subjects that are, and are likely to continue to be, issues of key importance to the effectiveness of DGMs and crucial to the general management of the Health Service.

In the next stage of the research our main work will be these issue studies and their dissemination. We call them issue studies because they will analyse the issues underlying the subjects, as well as illustrating what DGMs have done and suggesting applications.

PLANS FOR ISSUE STUDIES

We have selected the following as worth further investigation and separate dissemination:

The DGM and the DHA

The DGM and the Chairman

Managers and the Community: Awareness and Accountability

Devolution, including the relative roles  
of DGM/UGM.

. Changes in Planning

Coping with Health Service Finances

Managing with Doctors

Multidisciplinary Management

Dealing with Region and Department

In Pursuit of Quality: the DGM and the  
development of quality assurance

Keeping in Touch with the Organization:  
the use of information

We have already completed a research plan for most of these.  
We attach the one on Managing with Doctors as an example.  
This, like the others, has still to be reviewed and revised.  
Each issue study will be the responsibility of one member of  
the research team.



## DISSEMINATION: PAST AND FUTURE

Our results so far have been disseminated as follows:

Workshop for sample members	November 1985
Article, Health Service Journal	March 1986
"Confused DGMS Speak Out"	
Mail-shot to DGMS and RGMs and centres for management development and education - "Starting in a New Job"	April 1986
Workshop for sample members	April 1986
Article in BIM, Employment Bulletin and IR Digest "Management Changes in the Health Service".	

The mailshot had an accompanying letter asking for suggestions for the sections to be amplified for teaching. This produced above fifty letters mainly describing the writer's views on the subject or more generally about the role of the DGM. We also produced a report for NHSTA on The Learning Needs of DGMS which suitably revised we propose to publish in an introduction to the Issue Series.

Further dissemination was postponed until a new dissemination strategy had been developed to take account of the priorities set out by the Steering Committee on 22nd May. After meetings of the Templeton research team, with the Lancaster evaluation team, and Mr John Newcombe of Marketing Training, a new dissemination strategy has evolved linked to the issue studies.

Our plan is to mail-shot a series of issue studies to target audiences. The core group of:

- Education centres
- Regional Training Departments
- NHSTA
- DGMS
- Chairmen
- selected Health Authority Members,

would receive each mail-shot, gradually building up a library. Where appropriate, a mail-shot could also - with little extra effort be sent to other significant groups. The issue study on community views, for example, could be sent to CHCs secretaries, and to the National Council for Voluntary Organizations.

Each folder would contain a letter which explains the whole scheme and introduces the particular study. Additional material based on the feed back from the disseminations can be sent out later and easily added to the folder. An advantage of the folder presentation is that different action sheets can be prepared for different recipients of the mail-shot. A preliminary draft is attached to help to explain the scheme to you.

## ISSUE-BASED DISSEMINATION FOLDERS

Draft letter for the next mailshot

Dear . . . . . ,

### TEMPLETON STUDY OF DISTRICT GENERAL MANAGERS

This is the first of a series of folders in this style from the Templeton Study of District General Managers, funded by the NHSTA, and directed by Rosemary Stewart. Most of you will have received an earlier folder last spring describing the research and including a paper on Starting in a New Job. The study follows for two years the aims, views and activities of a sample of 20 district general managers in England and Wales.

We have identified subjects that raise issues of concern to many general managers, some mainly to DGMs but most to RGMs and UGMs too. The attached is an introductory paper on the Learning Needs of DGMs. (This still has to be rewritten for this purpose.) It will be followed by a series of issue papers. These will have a similar format, falling into 3 sections. You will find those 3 sections enclosed as separate inserts in this folder, labelled with distinctive logos for ease of identification.

The Templeton Study is action research, which means that we want to disseminate our results so that you find them as useful as possible. We shall try to incorporate your reactions and responses into further issue studies, and into supplements for the folders you will have received.

Our aim is a series of resource packages which help to develop general management in the Health Service.

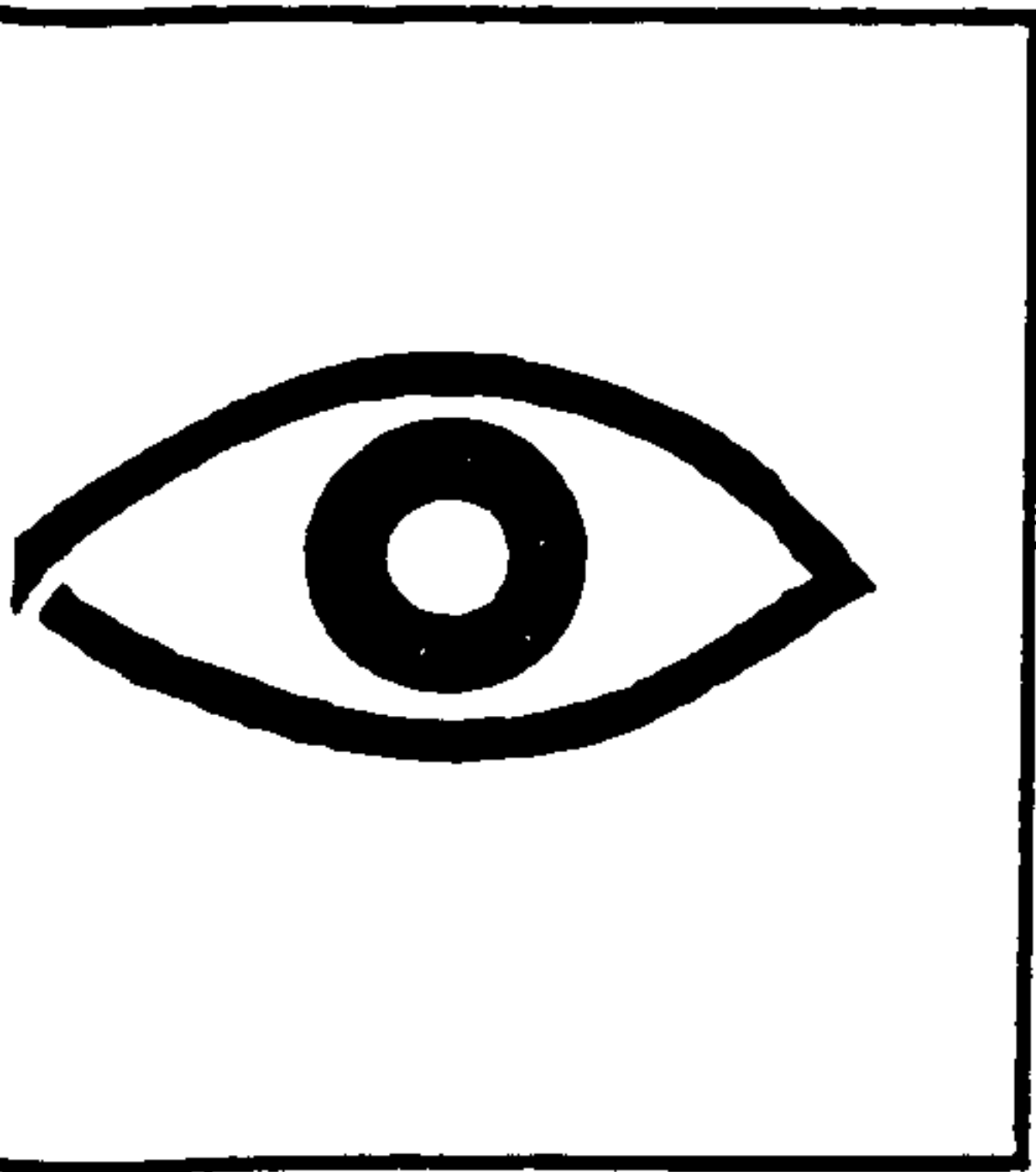


Please read this issue study and let us have your reactions, and pass it on to others in your organization.

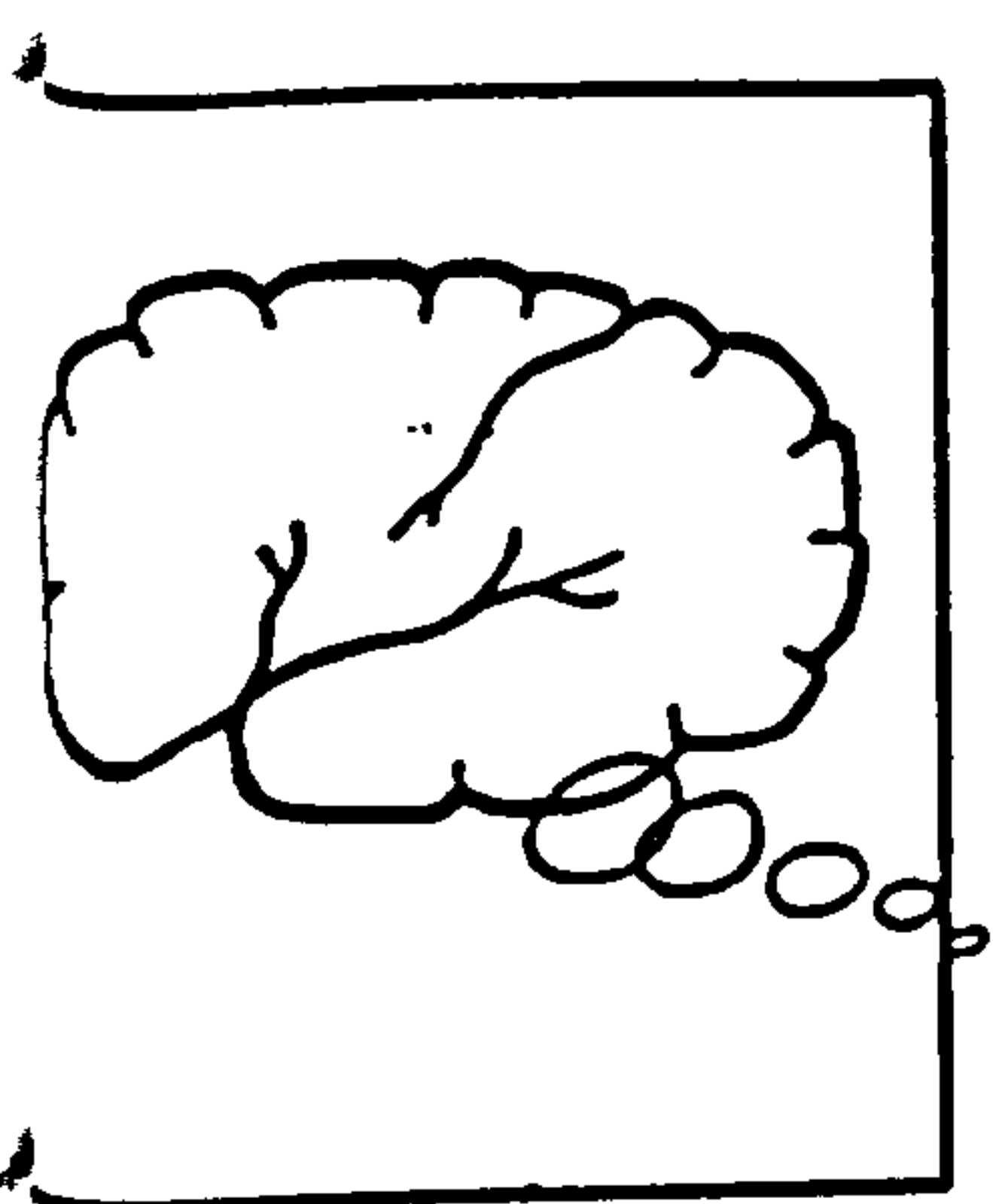
We hope you find it useful.

Rosemary Stewart, Sue Dopson,  
John Gabbay, Peter Smith,  
Derek Williams.

## TEMPLETON STUDY OF DISTRICT GENERAL MANAGERS



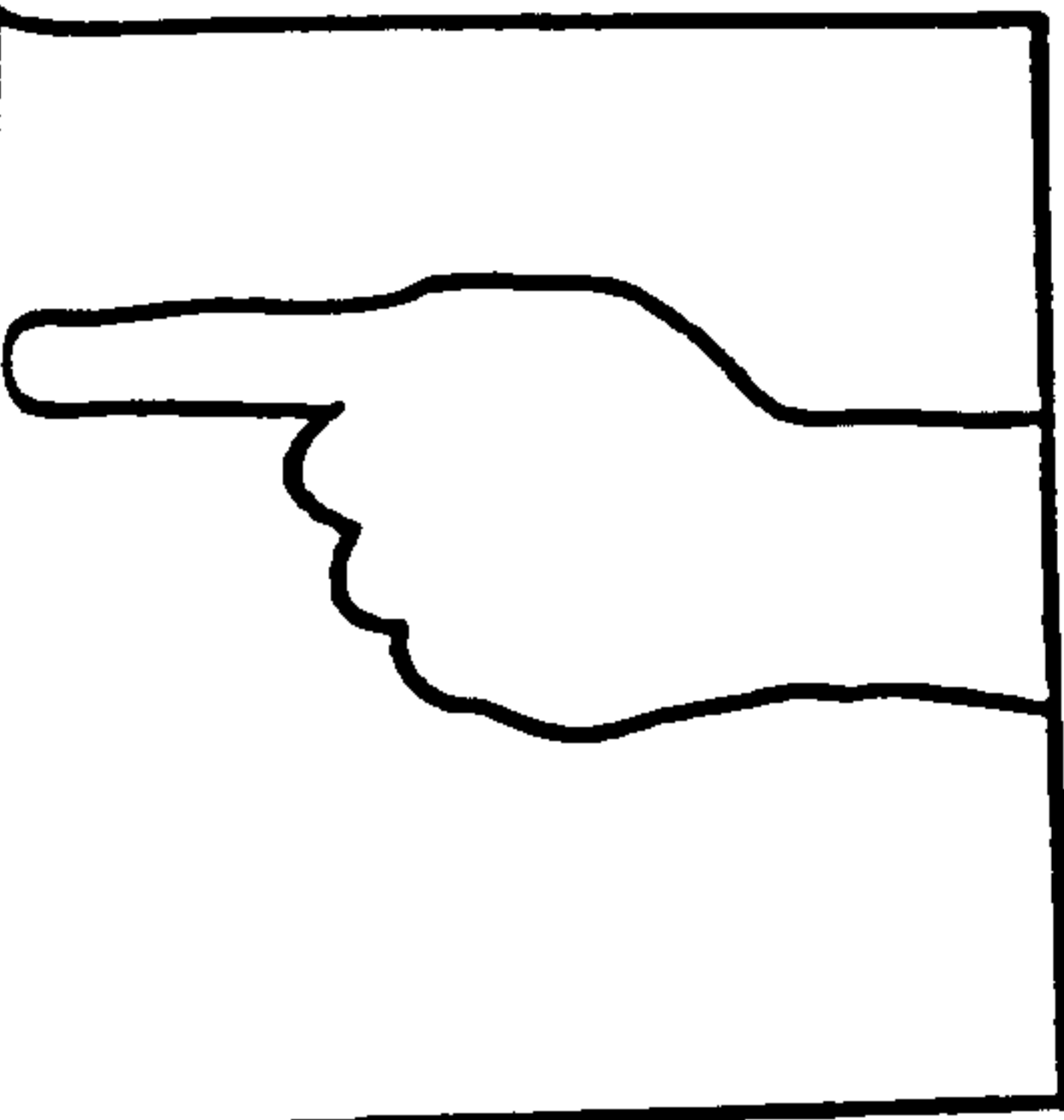
The 'eye' section provides an over view of the current situation in the sample for this particular issue, e.g. how our sample DGMs are dealing with quality assurance, or with clinicians. We set out the range of our findings, illustrate some interesting cases, and/or present contrasting approaches to the issue.



In the "brain" section, we ask the reader to think through the action implications of the issue. We try to provide a framework that helps to make sense of the research findings, and hence of the reader's own situation.

We offer illuminating examples of successful and unsuccessful practice, and use the research findings and our analysis to ask thought provoking questions about the implications. By the end of the "brain" section, the reader should be stimulated to review his or her own local attitudes, knowledge and behaviour about this issue.





In the "hand" section of the folder, we invite the reader in the light of the earlier "eye", "brain" sections to work through some of the implications, and to decide whether local changes are needed. If so, we offer examples of how DGMS have effected, or plan to effect change, and provide suggestions that will help DGMS to address the issue. We avoid being prescriptive, but try instead to show how the research material can be used as a resource for management development, and as a guide to action.

Reactions please!

## FEEDBACK AND EVALUATION

Each folder would have a form, preferably designed for computer analysis, which allows readers to :

(a) Give their views on both the content and presentation of the issue study.

(b) Say whether they feel that they have learnt anything as a result of reading the issue study.

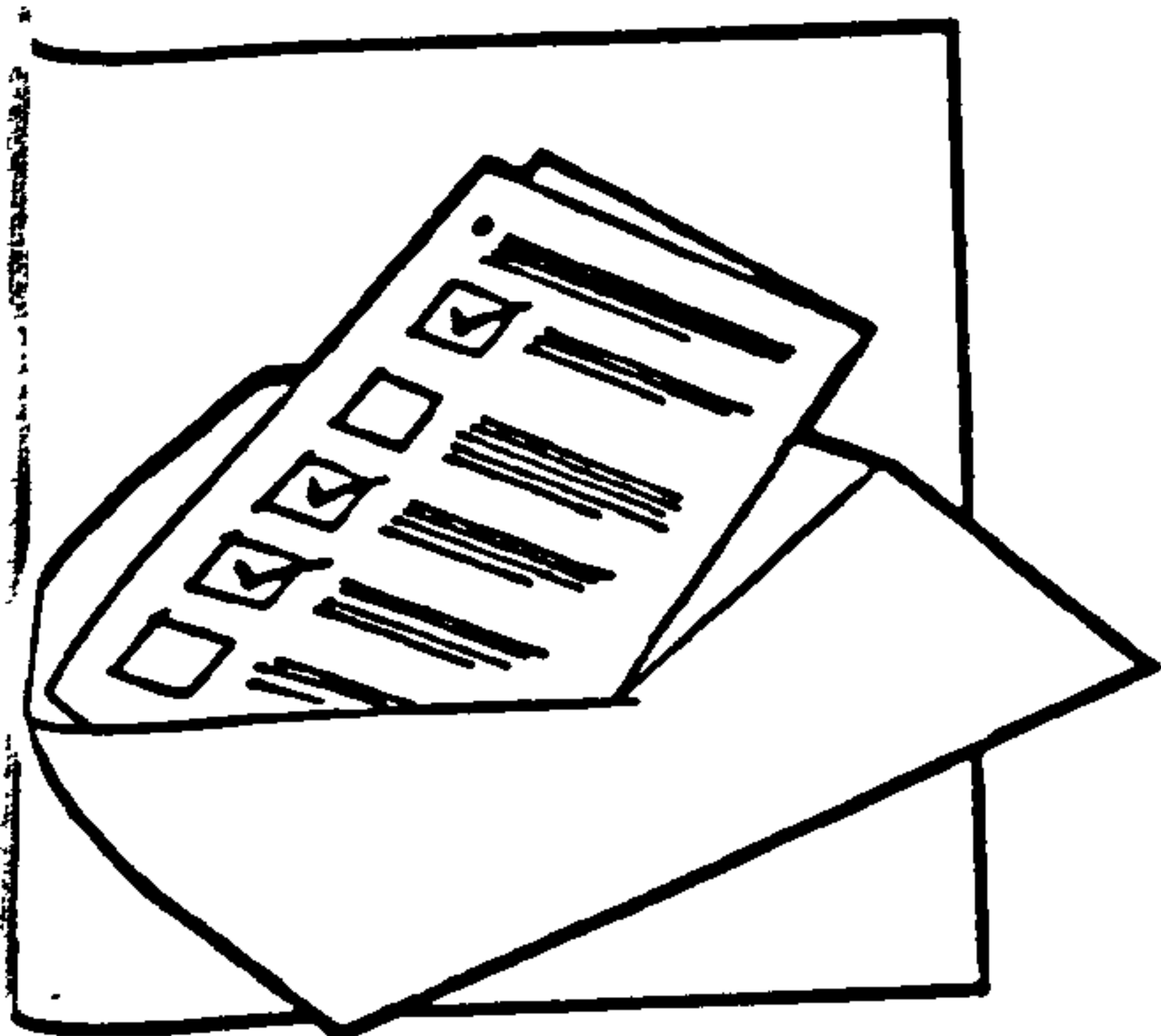
(c) Say whether they are considering making any changes as a result of reading it.

(d) Tell us whether, and if so to whom, they have circulated the folder within their district.

(e) Place orders for this and other issues studies, which will be listed here.

(f) Report their own experience, where relevant, and other views on the issue or issue study.

This evaluation sheet has two advantages. It can stimulate the respondents to think about what actions they should take as a result of reading the issue study. It will also provide feedback to the researchers about reactions to the content and method of dissemination.



## ACTIONS BY THE STEERING COMMITTEE

Now that you have read the overview and explanation of our proposal for issue-study dissemination folders, please let us have any comments, criticisms, or suggestions at the steering committee meeting on 28th August 1986.

If you feel generally happy with the proposal, we should like your advice on the following:

1. Do you have views on the relative importance of the issues listed and the depth to which they should be pursued? Are there any that should be included or omitted? We may not have time to tackle all of them..
2. Any specific criticisms of the draft letter or other features of the folder contents?
3. Would it be useful to obtain a brief letter from, say the Chairman of the NHSTA, or even of the Management Board, to launch the series?
4. If the folders are well-received by the core group, should we charge for extra copies for others such as health authority members, clinicians, CHC secretaries, etc, to whom specific folders may be relevant?



## CLINICIANS

Confidential

## ISSUE STUDY ON MANAGING WITH DOCTORS -- INFORMATION SHEET

(When answering the questions, please record any major differences between consultants, as groups or individuals.)

## THE INITIAL CONTEXT

1. Are any aspects of the district's characteristics especially relevant to this issue study?

Recent deterioration in financial situation has warmed up the clinician/DGM relationship: see, for example, Tel 1. 16/11/86

2. Are any aspects of the district chairman especially relevant to this issue study?

After lingering over the word 'especially', no.

3. Broadly, what were relationships like between clinicians and administration before the DGM was appointed? Any particular major areas of co-operation or conflict that s/he inherited?

I don't know but it's my impression that they were amiable and undemanding. Certainly no major inheritance of goodwill or problems.

4. Any note at the time of the consultants' initial reactions - to general management?

- to the DGM in particular? Why? (e.g. ?because of DGM's background, etc.)

(If relevant, distinguish behaviour as rep, from that as individual, from that in group meetings)

First reactions of clinicians on Jt Advisory Board (JAB) apprehensive - they felt isolated. Jim anxious to bring them round Tel 1. 25/5/85 p4

5. Is there any evidence about DGM's early attitudes towards consultants? Record relevant comments from interviews.

As treasure had been isolated from clinicians.

At beginning, keen to build links + had ideas about how to: see Tel 1 28/4/85 p1.

6. Any conclusions or other comments about the initial context?

Jim wanted to see some consultants appointed as UGTs because he thought they would be decisive

Q1 13/5/85 p13

Jim thinks most consultants work hard

Q1 13/5/85 p15

REMEMBER TO CITE LOCATION OF EVIDENCE FOR ALL ANSWERS

- 7a. Where did initial relations fit on this diagram, (Mark 'X').  
7b. Where did the DGM think they should be? (Mark 'O')

conflict

frequent interaction

X infrequent interaction

see Tel 1  
28/4/85  
PI

O

cooperation

8. Any other ideas for such polarities? (e.g. "level of concern" -RS)

9. Any other analytical concepts that might help us here?

-----  
WHEN THE JOB WAS NEW

10. What steps were taken by either party to establish (new or different) relations?

Jim toured the District, meeting all doctors individually or in small groups  
Q1 7/6/85 p15

11. What was the form, frequency and style of interaction between the DGM and clinicians?

(e.g. -if we have the data - was it mostly DGM or clinician initiated; mostly planned or ad hoc; mostly casual or at formal meetings? How organised? Roughly what proportion of the DGM's time? On what sorts of issues? Any other features about the form or style of interaction?)

Mostly DGM initiated: DGM 'ploughing its own furrow'  
eg on size of acute unit. Q1 7/6/85 p15

Interactions ad hoc, but some early signs of  
DGM influence on consultants eg the case  
of the consultant job description; Q1 7/6/85 p16

DGM asks to see proposals for all new  
consultant posts Tel 1 23/6/85

REMEMBER TO CITE LOCATION OF EVIDENCE FOR ALL ANSWERS

~~CONFIDENTIAL~~

12. What priority did the DGM give consultants? E.g., compared with other groups (e.g. nurses, members), how high a profile did clinicians have in the early stages of the DGM's job? Why?

Not particularly prominent. curiously, very few references to clinicians between June 85 + December 85

13. How clear was the DGM about what s/he wanted to achieve from those interactions?

Initially, quite clear + even imaginative e.g. make clinical leaders interested in management, to learn about clinical depts, to help clinicians construct cases

Tel 1  
28/4/85  
P1

14. What, if any, were the overall objectives? (e.g. Was it to get clinicians closely involved in management as Griffiths required?)

see (13)

Give examples, too, of specific objectives (e.g. to change working patterns, agree advisory machinery, getting co-operation over some issue...)

see (13) + make JAB clinicians happy

Tel I 25/5/85

15. What were the consultants trying to achieve (as seen by the DGM)?

One issue that caused ill will and, I suspect, damaged subsequent communications. Consultants + Jim disagreed over who should be acute UGR. Jim won - a pyrrhic victory?

Tel 13/1/81

16. Did the DGM achieve anything worthwhile from these early interactions with doctors? If so, what, and why did it go well?

Nothing noticeable.

17. Did the interactions run into problems? If so, what and why?

i) See 15

ii) By Dec 85 Jim is saying that he doesn't have much contact

18. Were the problems resolved satisfactorily? How so? with clinicians + the latter regret it

No really

Tel I 6/11

19. How, in retrospect, could it have been better handled? (i.e. What lessons of wider significance for the study?)

By DGM building better communications - keeping up/regularising early contacts; pursuing early aims more determinedly

20. How did the initial phase affect subsequent relations and why?

Initial phase itself characterised by start of decline in level of communications.

21. Any conclusions, lessons or other comments worth noting about the early stages?

Any thoughts about how to analyse this information for the final write up?

'Tis not in mortals to command success: one has to work at it.



Q1 29/5/86  
p20

## WHEN THE UGMs WERE IN PLACE

22. What was the structure of medical advisory machinery? Any changes later?

~~2 clinicians~~ 2 clinicians on TAB; within units professional advisory boards include consultant + GP members.Q1 24/3/86  
p1

23. What steps were taken by the DGM or clinicians to develop their relations?

← My data suggest very few: essence of Tim's approach was to rely on + support UGMs in their dealings with clinicians

Q1 24/3/86  
p3

24. What was the form, frequency and style of interaction between the DGM and clinicians?

(e.g. - if we have the data - was it mostly DGM or clinician initiated; mostly planned or ad hoc; mostly casual or at formal meetings? How organised? Roughly what proportion of the DGM's time? On what sorts of issues? Any other features about the form or style of interaction?)

Ad hoc, problem oriented. Tim aims to meet them individually or in small groups. In Wob, seen to be not structural arrangements require interaction

25. What priority did the DGM give consultants? E.g., compared with other groups (e.g. nurses, members), how high a profile did clinicians have in the early stages of the DGM's job? Why?

Not high: I don't know why.

26. How clear was the DGM about what s/he wanted to achieve from those interactions? (leave in theory)

27. What, if any, were the overall objectives? Give examples, too, of specific objectives.

See Q13: also need to change consultants' conservative attitudes eg to beds

Q1 29/5/86  
p19-

28. What were the consultants trying to achieve (as seen by the DGM)?

In general terms, hard to say. ~~Supra~~

29. Did the DGM achieve anything worthwhile from these interactions? If so, what, and why did it go well?

No.

30. Did the interactions run into problems? If so, what, who and why?

Were the problems resolved satisfactorily? How so? (Give details)

How, in retrospect, could it have been better handled?

(i.e. What lessons? Why do different methods go well or badly?)

Yes. Real problem, perhaps, was that Tim won some battles (eg see Q15) + made some assertions (eg see Q27; also about occupancy levels + empty beds [Q1 6/12/85 p18])

without painstakingly building good communication with clinicians other than through casual/informal channels.  
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31. For any of the questions so far in the above section, (Qs 22 - 30) where there have been changes from the early phase of the job, why do you think that is?

Decline in level of communications attributable, perhaps, to two factors: i) Tim's unease with consultants, some of his alien background ii) Tim being drawn into admin role iii) Tim's concern with delegating

32. Any conclusions, lessons or other comments worth noting?

cross refers to chairman study. It puts into context chairman's last remark, 'I don't know who does the work around here'.

#### THE ROLES OF OTHERS

33. With respect to clinicians; a) what does the DGM see as being the role of -  
b) what has been the role of -

-the chairman doesn't say

-the UGMs The major role: see, for example Tel 1 23/4/86 p 3  
Q 1 29/5/86 pp 3, 4, 5, 6, 18.

-the DMD doesn't say

-MEC chair, consultant Board member

-others of significance?

I'll pursue at an interview

#### ONGOING MEANINGFUL RELATIONSHIP SITUATIONS

34. Has the DGM changed his mind about what s/he wants to, or can, achieve with the clinicians? If so what are the objectives now, and why? How might it have been otherwise (e.g. where did things go, or could they have gone, wrong)?

Not so much changed his mind as failed to pursue valid objectives. He is now beginning to repair the damage, e.g. writing to clinicians re DGH desks, + offering to meet them, either individually

35. Where are the DGM's (explicit or implicit) objectives with respect to clinicians being fulfilled, and how and why is that success being achieved?  
or in discussion

Q 1 22/9/86 p 25

(has belatedly discovered that consultants very uninformed re management intentions)

Tel 1 13/10/86 p 4

• meeting Med Staff Committee

" "

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36. Where are those objectives failing, and why?

See various comments above

37. What has the DGM learnt that others could benefit from? How has s/he learnt?

38. What does this DGM still need to learn in order to manage more successfully with consultants

mainly to introduce systems that encourage DGM/clinician interaction

39. Any ideas/techniques/ploys the DGM is working that we should follow up?

No

40. Anything else of note about the present state of this issue in this district?

---

#### REFLECTIONS

41. What further questions need to be asked, and what aspects of 'the other side of the story' do we need to know in order to get a better perspective on what's been happening in this district?

The objectives of this issue study are to

- review what DGMs are trying to achieve with clinicians
- review progress/impasse/ retreat,
- analyse the reasons why
- suggest lessons for action in districts,
- highlight areas for learning and research,

42. Is there anything about this DGM that hasn't been covered in the above proforma but would contribute to those objectives?

43. Would this DGM be worthy of a case study, and if so why?

I don't think so

43. Which of the role set should be interviewed (in order of priority)

JAB Clinician members  
DMO

REMEMBER TO CITE LOCATION OF EVIDENCE FOR ALL ANSWERS



Clinicians 7/7

44. Anything we should note about this DGM and GPs?

*The fierce and angry response of the GPs to  
proposed economy measures*

TEL I 16/11/86

45. Ditto community physicians?

Do any interesting suggestions for analysis on this issue across the whole sample spring suddenly to mind (or even slither squelchingly into some half-hidden neurone)? If so make a note now, however vague.

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# INDIVIDUAL PERFORMANCE REVIEW (IPR) FLOWCHART

## NOTES

- 1) The process shown below normally takes 12 months and is then repeated.
- 2) The chart shows who does what and indicates which sections of the supporting model documentation need to be completed at each stage.
- 3) This system is obligatory for General Managers. It may also be adopted - perhaps with local changes if necessary - by other managers.

YEAR 1

INDIVIDUAL

MANAGER

GRANDPARENT

PERSONNEL  
DEPARTMENT

Issue IPR documentation to individual in adequate time before first meeting.

### PERSONAL PREPARATION FORM (OPTIONAL)

Individual completes this before a major review if desired.

### IPR MEETING CHECKLIST

Manager plans meeting.

### IPR WORKING DOCUMENTS (PAGES 11-17)

Individual and Manager meet to discuss, clarify and agree:

- nature and content of job - any changes
- key objectives for next 12 months
- how to measure progress

Referred to Grandparent for agreement.

### PERSONAL DEVELOPMENT PLAN (Pages 19-20)

Individual and Manager also agree Personal Development Plan for above and for longer term career development.

Referred to Grandparent for agreement.

Copy to Personnel Department for record and action.

Individual and Manager use Working Document and Personal Development Plan as a basis for regular progress review discussions.

Grandparent advised of any significant changes as appropriate.

### PERSONAL PREPARATION FORM (OPTIONAL)

Individual reviews previous form or completes new form before a major review if desired.

### WORKING DOCUMENTS

Manager prepares for major review by completing Notes on Attainment and Rating (Cols 5 & 6).

Grandparent agrees overall rating if appropriate.

Copy to Personnel Department if individual wishes (optional).

### IPR WORKING DOCUMENTS (Pages 11-17)

Individual and Manager conduct major review. Manager summarises discussion.

Individual comments on Manager's Summary. Both sign-off form.

Grandparent countersigns.

Copy to Personnel department for Personal File (optional). (If Performance Related Pay applies, document to be retained for three years.)

Job  
Clarification  
TargetingMonitoring  
ProgressMajor  
Performance  
Review

YEAR 2

New cycle starts with Performance Plan and Key Objectives agreed in the light of experience in previous year.



NHS



Table 4.1 Empirical research in the NHS: 1985-90

AUTHOR(S) AND PUBLICATION DATE	FIELDWORK	SCALE AND SCOPE	METHODS AND SOURCES
ALLEN (1986)	1985	72 DGMS	Interview pilots, Questionnaire
COE (1985)	1985	11 Regions	Documents (formal organisation structures)
CANDLIN (1989)	1985-6	Child health services in 1 DHA	Interviews
SMITH (1987)	1985-7	56 UGMs	Questionnaire
STEWART (1989) GABBAY & STEWART (1987) GABBAY & WILLIAMS (1987, 1989) DOPSON & GABBAY (1987)	1985-7	20 DGMS & their networks	Interviews, Observation, Documents
STRONG & ROBINSON (1988a, 1988b, 1990) ROBINSON & STRONG (1987) ROBINSON <i>et al.</i> (1989)	1985-8	7 Districts, plus all DHAs in England and Wales	Interviews, Observation, Questionnaire
CHANTLER (1988)	1985-8	Study of 1 teaching hospital	Observation
PINDAR (1986)	1986	5 General Managers	Interviews (attributable)
SCRIVENS (1988a, 1988b, 1988c)	1986-7	155 DGMS	Questionnaire (open-ended)

Source: Harrison, Hunter, Marnock and Pollitt, 1993



Table 4.1 (Continued)

AUTHOR(S) AND PUBLICATION DATE	FIELDWORK	SCALE AND SCOPE	METHODS AND SOURCES
GLENNERSTER & OWENS (1986, 1990)	1986-8	1 Region, detailed study in 4 districts	Participant observation, Interviews
OWENS & GLENNERSTER (1988)			
PETTIGREW <i>et al.</i> (1988, 1989a, 1989b)	1986-9	10 Districts in 8 Regions	Documents, Interviews, Observation
McKEE & PETTIGREW (1988, 1989)			
McKEE (1988)			
FERLIE & PETTIGREW (1988, 1989, 1990)			
SCARFE (1987)	1987	50 staff in 1 District	Interviews
JENKINS <i>et al.</i> (1987, 1988)	1987	16 Districts	Questionnaires, Interview
BARDSLEY (1988)			
HARRISON AND SCHULZ (1988)	1987	Psychiatrists in 1 Region	Questionnaires
ASSOCIATION OF CHCs (1988)	1987	69 CHCs	Open-ended Questionnaire
CONFEDERATION OF HEALTH SERVICE EMPLOYEES (1987)	1987	85 respondents in 4 Regions	Interviews, Questionnaire