NHS management structures and culture from c.1960-2000

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This summary gives an overview of the successive hospital management structures from the 1960s to the 2000s, illustrating the ways in which the different structures have promoted particular cultures of interaction between doctors, nurses and administrators/managers. Some of the inherent features across the period such as the tendency for successful relations under one set of structures to determine outcomes under subsequent structures are also highlighted.

c. 1960-1974

- When the NHS was created in 1948 the structures of administration originated from voluntary hospital structures – mainly 18th c. charitable institutions in origin.
    - These comprised tiers of management at hospital, group and regional levels.
    - Hospital Management Committees (HMCs) took day to day administrative responsibility for groups of hospitals within a region.
    - Individual hospitals were managed by a triumvirate: a hospital secretary, a medical administrator and a matron who had day to day responsibility and reported to the Group Secretary of the HMC.
    - Management was organised vertically with focus on upward and downward communications.
    - Teaching hospitals had negotiated special arrangements and reported directly to the Minister of Health.
- The new system created stresses and strains as it grouped together hospitals with very different histories and cultures and there were longstanding differences between the administration of voluntary hospitals and local authority hospitals.
    - The loss of local independence was a significant factor for voluntary hospitals.
    - The structures reinforced existing inequalities between lay, nursing and medical authority.
    - Existing tensions between medical, nursing and administrative staff were exacerbated.
    - Medical authority overrode that of nurses and administrators.

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NHS management

- Debates about NHS management began in the early 1950s. These were partly in response to the conclusions of the Guillebaud Committee (1953) – set up to investigate the cost of the NHS - that financial imbalances were the consequences of a failure to anticipate demographic change and inflation when the NHS was being created and that the NHS required more 'oversight and supervision'.

- Specialist training programmes for NHS administrators were introduced in 1956. By the 1970s it was axiomatic that better management could improve the efficiency, economy and quality of services.

- The 1972 NHS Reorganisation White Paper differed notably from previous drafts in its stress on effective management: 'the importance of good management in making the best use of resources can hardly be overstated'.

- Enacted in 1974, the reorganisation introduced consensus management, prescribing multi-disciplinary teams which brought together doctors, other health professionals and administrators.

1974-82

- The choice of a consensus management model in the 1972 White Paper originated from a Study Group of Department of Health and Social Security and NHS officers working with the consultants McKinsey and Co and the Health Services Organisation Research Unit of Brunel University. In some ways it formalised the pattern of relationships which had worked best in the NHS, given its dependence on a self-regulating and autonomous medical profession.

- Management at all levels – region, area, district, unit – was through multidisciplinary management teams. At hospital level the team consisted of the unit administrator, director of nursing and unit medical representative. At district level, additional members included a finance officer and two elected doctors – a consultant and a GP.

- Consensus management as a model seemed more attuned to some hospitals and specialties than others. In some circumstances it proved a highly effective tool, rebalancing lay and medical powers and proving instrumental in service development.

- There is strong evidence of the difficulties that could be caused when the ability to veto change was exercised by doctors for example in blocking rationalization plans or bed allocations.

- Embedded in consensus management was the philosophy that management was a support system rather than strategic driver.

- In 1979, the Royal Commission on the NHS reported favourably on consensus management.

- Importantly, the establishment of strong and cooperative doctor–administrator relations during this period became a critical local determinant of the successful introduction of General Management in 1983.

1983-91

- The Griffiths' Inquiry of 1982 was a pivotal moment in hospital management as it ushered in the ideologies and practices of managerialism which significantly increased perceptions of the legitimacy of managers' control over clinical services and promoted new management roles for doctors. It has been described as the first serious attempt to shift the 'frontier of control' between doctors and the government.[1]

- There were wide local variations in the implementation of General Management and good relations seemed to rely more on the interpersonal qualities and skills of managers than on their new positional authority.

- Managers were explicitly encouraged to think about the organisation in a much broader sense.

- The new arrangements gave managers increased authority over clinical services and many regional health authorities capitalized on these new powers, appointing managers with the specific task of sorting out the finances at unit level with the consequence that previously good relationships could be severely destabilised.

- New managerial jurisdiction over clinical areas could be hampered by the lack of common language.

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[1] Stephen Harrison, *Managing the National Health Service: Shifting the Frontier?*, (Chapman and Hall, 1988).

- During this period doctors and managers began to build knowledge of each other's enterprises in a new way, with managers becoming more deeply involved in clinical services and doctors taking on new management responsibilities.

- The introduction of clinical directorates in the 1980s was a strong manifestation of medical involvement in management.

- There was very little training or advice for doctors engaging with management although the view that 'medical management was for weaklings' began to shift.

- In 1991 a small group of doctors, led by Jenny Simpson, a paediatrician, formed the British Association of Medical Managers (BAMM). BAMM's self-appointed task was to improve care for patients by 'changing the way clinical professionals work with managers'.

- Throughout the 1980s, the 'value for money' ethos forced lay and medical managers to focus on 'balancing the books'. It is notable that in organisations where good relations prevailed between doctors and managers, conflicts over resources were usually resolved without tremendous escalation: 'paradoxically, therefore, General Management probably tended to work better in those places where the previous system of consensus management had itself been relatively successful'.[2]

1991-2000s Markets and Trusts

- The reforms introduced by *Working for Patients* (1989) marked a watershed in the history of the NHS, with the introduction of the internal market and further strengthening of management.

- The new NHS Trusts brought together hospitals and other units providing patient care in self-governing organisations managed by executive boards with statutory duties. Teaching hospitals particularly welcomed the return to independence.

- Trusts had direct accountability to the Secretary of State for Health and responsibility for organisational performance was shared by doctors and managers.

- No locality during this period was immune from the difficult process of reconfiguring services and meeting targets. Clinical opposition to potentially contentious events like hospital closures

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[2] Christopher Pollitt et al., 'General Management in the NHS: The Initial Impact, 1983–88', *Public Administration*, 69 (1991).

or service reconfigurations was less likely if the decision had clinical as well as financial grounds.

- The creation of Trusts was believed to intensify the onslaught against medical autonomy. But in some localities the conditions of the market created new dynamics that prioritised co-operation and collaboration in the executive team.

Summary

- Improving NHS cost-effectiveness and efficiency has been a main driver for reforming management structures and cultures over the period.
- The administrative structures established in 1948 exacerbated existing tensions between
- hospital administration and medicine and nursing and the grouping of hospitals created
- new difficulties.
- The introduction of consensus management in 1974 was intended to establish team-working. Retrospective assessments of its success have been mixed but in some circumstances it proved to be highly effective, rebalancing lay and medical powers and proving instrumental in service development.
- General Management in 1983 marked a new era in hospital management, establishing management as a strategic driver rather than a support system.
- Over the period doctors and managers have gained knowledge and understanding of each other's enterprises, with managers becoming more deeply involved in clinical services and doctors taking on new management responsibilities.
- Good relations between doctors and managers have been dynamic and sensitive to adverse forces.
- Different hospital management structures have promoted particular cultures of interaction e.g. consensus, positional power. But these have been significantly influenced by the local context especially the history of working relationships.
- There are some inherent features over the period including the tendency for successful relations under one set of structures to determine outcomes under subsequent structures.

Note on terminology

I use the common term for each period: 'administrator' until the introduction of General Management in 1983 and then 'manager' from 1983 onwards. It is, however, important to recognise that these semantic shifts, which are often assumed to be evolutionary and associated with changes in practice, are challenged by oral history evidence in which administrators working in the NHS from the 1950s onwards described themselves as managers from the outset. Stewart[3] has suggested that the terms 'administration', 'management' and 'leadership' operate as a hierarchy, but Grey draws attention to the way in which the choice of such terms is highly context-dependent: 'the ascription of the term "management" to various kinds of activities is not a mere convenience but rather something which has certain effects. The use of words is not innocent, and in the case of management its use carries irrevocable implications and resonances which are associated with industrialism and modern Western forms of rationality and control'.[4]

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[3] R. Stewart, *Leading in the NHS: A Practical Guide* (London: Macmillan, 1999).
[4] C. Grey, "'We are all Managers Now"; "We always were": On the development and demise of management', *Journal of Management Studies*, 36 (1999) 561–85: 577.